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C. Seth Landefeld; Margaret A. Winker; Bruce Chernof

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Clinical Care in the Aging Century— Announcing “Care of the Aging Patient: From Evidence to Action”

C. Seth Landefeld, MD

Margaret A. Winker, MD

Bruce Chernof, MD

THE AGING OF THE GLOBAL POPULATION WILL BE A hallmark of the 21st century, when average lifespan may reach 100 years in some countries, at least for women.¹ Worldwide, the proportion of the population aged 60 years or older is expected to increase from 10% worldwide in 2005 to 22% in 2050, with the steepest rise in the next 25 years.² Individuals aged 85 years or older are the most rapidly increasing segment of many populations. By 2100, more than half of the population of Japan will be aged 60 years or older, as will more than one-third of individuals in every region except sub-Saharan Africa.²

Aging will shape societies, economies, the lives of patients, and the practice of medicine. In the “aging century,” life in the 10th decade will be a new frontier for medicine and society—a part of life about which medicine now knows relatively little. The long-delayed linkage of medical care to social care may promote independence and well-being for those on the aging frontier.³ Physicians will spend more time caring for older individuals; roughly half of visits to physicians in many specialties are already for patients aged 65 years or older, and the proportion of visits increases by 1% annually.⁴ For patients, their families, and society, health care costs double every 15 years of life from age 50 years on, largely because care during the last 2 years of life is so expensive.⁵ Medicare expenditures are expected to continue to outpace economic growth, increasing from 13.5% of US federal spending in 2009 to an estimated 18.9% in 10 years, creating the rising cost curve that economists worry will break the federal bank.⁶

However, summary statistics obscure the heterogeneity of older patients in prognosis, values, and preferences.⁷ For example, although 10% of 80-year-olds die in less than 2 years, nearly half live a decade more or longer.⁸ Common diseases often present atypically in older individuals, and loss of physical abilities, financial resources, and family and friends makes coping with illness more difficult. Although physicians are knowledgeable about the pathophysiology,

diagnosis, and management of organ-specific diseases such as cataract, coronary artery disease, and pneumonia, many geriatric syndromes are not straightforward and do not fit the conventional paradigm of disease.⁷ Are physicians ready for these challenges? How can physicians prepare to meet the needs of patients as they age?

In response to these questions, and to inform physicians in their care of older patients, in this issue, JAMA launches a new series, Care of the Aging Patient: From Evidence to Action. The Institute of Medicine’s 2008 report *Retooling for an Aging America* concluded, “The health care workforce . . . is not prepared to deliver the best care to older patients.”⁹ This new series takes a step to address this problem.

The overall goal of Care of the Aging Patient is to help improve clinical practice and inform policy in care of older individuals, especially those who have started to lose their independence or are at risk of doing so. This series will draw elements from the JAMA series Clinical Crossroads and Perspectives on Care at the Close of Life. Using the real stories of patients and interviews with them, the new series will analyze how to put existing evidence into practice to address pressing questions that arise for older patients, their families, and their physicians. By focusing on older patients’ specific problems, the articles will explore themes that develop with aging. The first 12 articles will explore the trajectory of aging, from the first hints of frailty through events such as difficulty driving a car to the incremental constriction of activities that results from progressive decline, as well as clinical syndromes (eg, falls) with related biopsychosocial issues. The series aims to provide clinicians with pragmatic tools and methods for translating published evidence into daily practice, or if evidence does not exist, recommendations with a rationale and a potential research agenda.

In this issue, Reuben, in “Medical Care for the Final Years of Life,”¹⁰ addresses the clinical issues of Mr Z, a robust 83-year-old man who cares for his wife with Alzheimer disease, is recovering from a fall-related injury, and who observes, “when you’re 83, it’s not going to be 20 years.” What can this man’s physician do, today and

Author Affiliations: Division of Geriatrics, University of California, San Francisco and the San Francisco VA Medical Center (Dr Landefeld), and the SCAN Foundation, Long Beach, California (Dr Chernof). Dr Winker is Deputy Editor, JAMA. **Corresponding Author:** C. Seth Landefeld, MD, Division of Geriatrics, University of California, San Francisco, 3333 California St, Ste 380, San Francisco, CA 94118 (sethl@medicine.ucsf.edu).

See also pp 2686 and 2701.

over the coming months and years, to guide and help him? Reuben recommends that the physician first assess the patient's current situation as a basis for personal decision making¹¹ and then, during the current and subsequent visits, systematically address short-term, midrange, and long-term issues. Assessment of patients in their 80s or 90s includes determination of ability to function in domains that are taken for granted in younger adults (as shown in Table 1 in the article by Reuben¹⁰) and by previous pioneering approaches.¹² Determination of prognosis provides the context for clinical and personal choices that differ in their consequences and timing. Although the wisdom of this approach is understood by patients who have lived through the deaths of friends and family, clinical decisions often fail to incorporate this information. Reuben shows how standard vital statistics provide an initial estimate of prognosis, enabling a tailored approach to a patient's care. Thoughtful, individualized care takes time and, as Reuben points out, can be facilitated by restructuring current practices and building new models of care such as the patient-centered medical home. To permit comment on and discussion of Reuben's suggestions and those of future authors, readers may submit comments for online posting.

Reuben's article¹⁰ raises important questions not only about the structure of current medical practice but also about the policies needed to support good practices. Therefore, with this and subsequent articles, a Commentary illuminates the policy and social issues raised by the article's story. In the inaugural Commentary,¹³ Cassel suggests 6 characteristics of optimal quality of care for an older patient facing the final years of life and policy initiatives that can advance these characteristics. Her suggestions highlight the chasm between current policy and the policy needed to achieve optimal care effectively and efficiently. Cassel's recommendation that Medicare require core content in geriatrics related to every specialty in which training is supported by Medicare is currently far from reality. Her suggestion of payment reform and incentives that will promote geriatric best practices has the potential not only to improve lives during the final years but also to bend the curve of health care costs that outpace economic growth and displace investment in other public goods.¹⁴

Care of older patients often brings joy and satisfaction to their physicians.¹⁵ With enhancement of their knowledge and skills, all physicians have the opportunity to share in this meaningful and important work, which will be the main work for many in the aging century. With this new series of articles focused on geriatric issues and their policy implications, *JAMA* begins to enhance physicians' ability to do so.

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