

How and Why We Should Move Our Geriatric Cheese

Providing care for frail vulnerable elderly patients is quite different from caring for younger patients, who usually present with a clearly defined, single disease. The former routinely have more undifferentiated and challenging syndromes. Taking care of these patients is professionally challenging but rewarding, and given the changing demographics of internists' patients, it is becoming much more prevalent. The Assessing Care of Vulnerable Elders (ACOVE) manuscripts published in this supplement, along with the other manuscripts from the ACOVE project (available at www.acponline.org/sci-policy/), will enhance the abilities of all physicians to improve our management of the syndromes discussed and to evaluate how well we are succeeding.

The papers in this supplement cover all aspects of evidence-based geriatric medicine. Used as recommended, the papers can be wonderful instruments to ensure quality, avoid errors, and highlight areas that should be made a high priority for improvement. Their format and the supporting evidence provided for each topic make them terrific educational tools. The authors point out that the quality indicators listed in each paper are not to be used to audit individual physicians; rather, they are to be used to monitor how we all practice within our various sites, systems, and settings.

The discussion of dementia should be especially helpful because it gives clear, concise recommendations about optimal diagnosis and management of patients who are suspected of having Alzheimer disease or other dementia. Given the current epidemic of cognitive impairment in elderly persons, readers should pay special attention to the recommendations for diagnostic screening, review of medications, caregiver support, depression screening, and treatment.

The review of chronic heart failure is also a seminal offering. This impressive synthesis of emerging data will allow us to further improve the outcomes of older patients with this disorder, which a few years ago had a much worse prognosis than most cancers. The author of this paper addresses the use of angiotensin-converting enzyme inhibitors and β -blockers, evaluation of ejection fractions, the hazards of calcium-channel blockers and type I anti-arrhythmic agents, and management of atrial fibrillation.

The data presented on the care of frail older patients with mobility problems, osteoarthritis, and risk for falls indicate the major disconnect between what is all too often ordinarily done and what should be done. In particular, the review of musculoskeletal aspects of osteoarthritis evaluation, falls, and gait and mobility assessment and the discussion of interventions for improving gait and balance and lower-extremity arthritis offer outstanding options for improving patient care.

In a somewhat similar vein, we need to and can improve delivery of care for elderly patients with chronic pain and those near the end of life. The papers on these topics show us exactly how and why to do this. Their focus on the clinical aspects of how best to use the history and physical examination and their highlighting of communication and compassion emphasize what physicians should do every day.

Iatrogenesis in frail elderly patients is a recurring topic in this supplement. Iatrogenic events are usually related to medications, and they remain a major clinical problem. The theme of how to avoid these events runs through many of the papers; for example, the papers on pain management and osteoarthritis discuss the dangers of nonsteroidal anti-inflammatory drugs. The authors of the paper on appropriate medication use provide an overarching set of strategies to deal with the entire problem, with admonitions and evidence about education, the need for initial assessment of drug indications, and periodic reviews of drug lists. These authors also highlight the all too prevalent but unrecognized underuse of some classes of drugs, such as antidepressants, antihypertensives, lipid-lowering drugs, and angiotensin-converting enzyme inhibitors. They explain the how's and why's of monitoring warfarin and diuretics, and discuss the reasons to avoid using chlorpropamide, anticholinergics, barbiturates, and meperidine. If physicians throughout the United States followed these suggestions, the health status of geriatric patients would improve substantially.

Finally, the quality indicators relating to pneumonia, urinary incontinence, pressure ulcers, and osteoporosis should be considered medical classics. They should become the basis of measuring performance and improving care of vulnerable elders by stimulating system-

wide interventions for correcting deficiencies in the care of these conditions.

I extend my heartiest congratulations to the leaders of the project, Drs. Neil Wenger and Paul Shekelle, and to all the ACOVE investigators. Thanks to Pfizer Inc. and RAND for their support; the American College of Physicians–American Society of Internal Medicine Task Force on Aging; the *Annals* staff for making this happen; and especially Dr. Vinnie Snow, who oversaw hundreds of details. I know that readers will find this supplement

useful, and I hope that they will assure early implementation at their practice sites.

James R. Webster Jr., MD
Buehler Center on Aging
Chicago, IL 60611

Requests for Single Reprints: James R. Webster Jr., MD, Buehler Center on Aging, 750 North Lake Shore Drive, Suite 601, Chicago, IL 60611.

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