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Case Report

The right to quality care: it begins with our training as internists

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Case report

Despite our increasing knowledge that life expectancy decreases with advancing age, we largely avoid discussing prognosis and expected mortality with our patients. This challenges the ability of patients and caregivers to make informed choices for future care, especially during times of rapid functional decline and extreme illness. Discussions of overall prognosis should be the rule, not the exception. To challenge this culture, we need forms in medical education, beginning at the resident level.

Clinicians may understandably be reluctant to discuss prognosis with patients given the lack of epidemiologic data. This reflects, with some regard, a misalignment of our research interests; however, despite these limitations, there are simple approaches we can take that would improve patient-centered care. One approach is improving how we talk to patients about dying. Research has shown that patients often unclear about the intent of their care. One study in the NEJM in 2012, asked 1200 patients with metastatic lung or colorectal cancer their understanding of the intent of their treatment. The authors found that the majority of the patients receiving palliative treatment thought therapy had the possibility of "curing them".[1] This can likely be extracted to many patients approaching the final stages of life, such as those with end-stage renal disease, advanced heart failure, dementia, or a variety of lung diseases. Combine this data with our collective real world experiences and we are left with a serious problem of miscommunication that needs to be addressed.

It is not easy to tell patients that they are dying and most of us choose not to do it. We all need help breaking bad news.[2] Difficult conversations and end of life training are not a priority focus of most residency training programs. Our shortcomings caring for the dying are best reflected in the cost of care for geriatric patients with rapid declines in functional status.[3] We recommend stating the prognosis whenever appropriate, having early discussions of advanced directives, and focusing on what matters to individual patients at each transition point in care. We question the nature of "informed consent" when patients have limited understanding of the effects of their individual health care decisions. If patients are offered truthful information, they can then "Choose Wisely." What we do know at this time is that targeting patients too late, in the emergency room, the intensive care unit, or the general hospital floors adds to the distress of patients and families and precludes or delays other (perhaps more appropriate) care such as hospice.[4]

Some of our limitations in geriatric care stem from our current training environments. Currently, internal medicine house staff cares for patients in a limited number of venues. Patients are typically seen either in the clinic or the hospital. Most of the care I have provided for patients during training was episodic, and not longitudinal, with the exception of that provided in my ambulatory clinic. I never saw my patients in their homes or when they were admitted to long-term or subacute facilities. I also was often not notified of their deaths or when my clinic patients were admitted to the intensive care unit. And as I entered the final stage of my training, I had realized how little I understood of the disease trajectories my patients followed as they aged.

One way our health care system could improve resident training would be to allow residents to provide longitudinal care of patients in nursing homes or in their own homes. This would be a valuable learning experience to many internal medicine residents who pursue subspecialty training, such as those in gastroenterology, infectious disease, medical oncology, nephrology, cardiology and pulmonary medicine, just to name a few. Such as training program would improve a physician's ability to work within a team, with structured supervision. This allows "real world" exposure to the current interdisciplinary model of care and particularly addresses several geriatric teaching domains that are difficult to encounter elsewhere.

We would be negligent if we did not address a problem that arguably has the greatest influence on the care received by geriatric patients that is the residency training of internists. The difficulty of caring for older patients is highlighted in our approach to end of life care (or lack thereof). Though it is difficult to teach all of what is required of an internist in three short years, the goal of medical education is to teach the basics and prepare providers to be lifelong learners. Aside from teaching new knowledge and skills, these learning objectives should ideally be taught in clinical settings that are reflective of real world experiences. Residents must be able to see how their care can influence the quality of life for older individuals, particularly when they encounter frailty and the final stages of life. If this training does not occur, it is unlikely that our approach to aggressive end of life care would change.

To make care more patient-centered, we need to start helping our elderly patients set goals of care, always taking into account their overall prognosis. The goal for most people is not having a good death, but living a good life all the way to the very end. Medical practice, research, and health policy should empower physicians to address these needs, ensure we have the skills to understand patient wants, and have the support to serve them during times of distress and extreme illness. Failure to do so is more than bad training, it is negligent.

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Conflict of interest

The author declares no conflict of interest.

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