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## Care for the Elderly: A Growing Role for Research

✖ Three compelling forces have converged to bring intense focus on the care of the elderly. The first and perhaps most obvious is demographic. The aging of the “baby boom” generation, combined with medical advances, have resulted in the near explosive growth of the elderly population. Octogenarians are the fastest growing segment of our population. It is estimated that the number of US citizens over the age of 75 will quadruple in the next 50 years. At the same time, medical advances in the care of the elderly have been so dramatic, that even a cursory examination of the literature will reveal that the once common definition of

“elderly” as “65 and older,” has now been replaced by studies of octogenarians and even nanogenarians. The third factor which has become increasingly acute, as the nation struggles to come to grips with the price of health care, is that care for the elderly is more costly. In fact, a large proportion of all health care dollars are spent in the last six months of life.

Until recently, the paradigm in American medicine roughly reflected that of the modern “manifest destiny” of the nation—that which can possibly be done should be done. Although perhaps somewhat unrealistic, this approach spawned remarkable advances in all areas of the medical profession. As regards to care of the elderly, the example of cardiac surgery is illustrative. A generation ago, patients with clinical coronary artery disease who were over 70 rarely came to cardiac catheterization. There was no possibility of operating on them, so why do the test? Moreover, those few who did undergo surgery for valve replacement for critical aortic stenosis risked operative mortalities upwards of 15%. Then came the invention of the balloon catheter, and with it the ability to perform angioplasty, opening isolated blocked coronary arteries without the rigors of surgery. Increasingly cardiologists began to perform catheterization on older patients than they formerly would have, looking for isolated coronary lesions to dilate. Unfortunately, what they discovered much more commonly in this elderly population, however, was advanced disease, not suitable for the emerging range of interventional devices, but more suitable for surgery. Increasingly surgeons began to accept the challenge and, with increasing advances in surgical technique and patient management, these operations were performed on older patients with improving results.

Research at the Florida Heart Research Institute has demonstrated that the mortality for coronary bypass surgery in octogenarians has dropped significantly over the past decade to rival that achievable in much younger patients. Moreover, the longevity and patient perception of the quality of life of the survivors rivals that of the same aged population who do

not suffer from coronary heart disease. Despite these many advances, there is no question that the complication rate, length of stay and cost of care for these patients remains higher than that for their younger counterparts. Retrospective studies such as these rely on the judgment of the surgeon and the medical team in selecting patients for operation. Therefore, these studies are extremely helpful in demonstrating what can be achieved. However, what they fail to elucidate is which patients should and which should not undergo surgery, and which patients might do better with an alternative form of therapy. In other words, just because we can do surgery in selected patients, does not mean that we should. And even if we decide as a medical community that we should, this decision does not in anyway reflect on the appropriate management for those patients not deemed to be surgical candidates.

Now enter the sticky issue of cost. How do we decide as a medical community or as a nation whether or not the reported benefits of surgery are worth the cost – especially at the expense of other potentially life-saving therapies, in a situation of limited funds? There is currently a formula for “Quality Adjusted Life Years” which attempts to estimate the cost of therapy for a year of functional life. Estimates less than \$50,000 per QALY are generally accepted as appropriate, those greater than \$100,000 are generally accepted as too expensive, and those up to approximately \$80,000 (the approximate price of renal dialysis) as probably appropriate. Who makes these decisions? How accurate is the model? Does the paradigm need to change in the face of more pressing financial realities? How can physicians mitigate these decisions with their responsibilities to patients?

These are difficult questions which rest as much in the realm of public policy as in that of medical decision-making. However, one fact emerges abundantly clearly – future research is absolutely essential to provide physicians, patients and policy makers with the crucial information necessary to make these decisions on an intelligent and compassionate basis. Only by subjecting the questions to insightful evaluation can we begin to address the pressing issue of our time – the care of the elderly.

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