AMSA Geriatrics

January Newsletter

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I. Addressing Health Disparities: Interview with Dr. Catherine Eng

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This month we feature an interview with Dr. Catherine Eng, Medical Director of On Lok and Clinical Professor of Medicine, University of California at San Francisco. The On Lok program is a world class model approaching health disparities in geriatric patients.

I spoke with Dr. Eng about the field of geriatrics and how we can meet the needs of frail, low income elders.

How did you become involved in the field of geriatrics?

I became involved with geriatrics by accident, or serendipity, depending on how one looks at transforming events. I was trained as an internist and gastroenterologist with a specialization in liver disease. I had conducted research on bile acid physiology as a GI Fellow at New York Hospital/Cornell Medical College. I relocated to San Francisco in June 1981 with my husband, who had taken a position as cardiology fellow at Mt. Zion / UCSF Medical Center. While waiting for my NIH grant to be funded, I took what I thought to be a temporary position as a staff physician at a small community organization called On Lok Senior Health Services in San Francisco. They were looking for a physician to take care of 248 frail elders who were nursing home eligible but who lived in community housing. Prior to working at On Lok I had no formal training in geriatrics. I had never even visited a nursing home or senior center. My medical school and residency training was at some of the most prominent tertiary university affiliated hospitals in New York City. Geriatrics was just not taught in our clerkships or in our residency curriculum. So On Lok was really taking a big chance on hiring me in 1981.

When did your interest in the elderly begin?
It began when I started my work at On Lok. I took the best care of each of my patients, by meeting their medical, social and rehabilitation needs. I honestly did not think of it as practicing geriatrics, nor did I consider myself as being a geriatrician. I was just trying to be the best doctor to people who clearly had not received much medical care, or had fragmented medical services prior to enrolling with On Lok. When I was in New York, I was very used to taking care of medically complicated patients, many of them old. But once they were discharged from our tertiary referral hospital, I never saw them again. My patients at On Lok were equally complicated. The difference was that when I discharged them from hospital after a serious illness, they came back to see me in the clinic, sometimes the very next day. I was always aware of whether my medical treatments were successful or not. I also became aware of the importance of non-medical interventions such as meals, personal care services, overnight home care, and transportation to the overall success of my medical treatment plans and medication regimens. I also became knowledgeable about my patients' families and neighbors, in essence the social fabric that kept them going and complemented whatever magic I could perform as their physician. Thus getting my patients over their acute illness was but a small, though important, step. Helping them to regain their function and their spirit to thrive in their community environment was much more difficult. After several months, I realized the importance of putting medicine together with all these non-medical services. I also learned to work within an interdisciplinary team, and realized that without the team, I would never be able to achieve success in treating my patients' medical conditions. Sure, I could treat them and cure them, but without that social fabric they just did not thrive, or in some cases, could not survive despite the most sophisticated medical interventions.

Did you receive on the job training at On Lok?

No, when I arrived, the last physician who was working for On Lok had left for a private practice in Sacramento six months prior. And the patients were being cared for by rotating on call physicians. Dr. Harry Lee, who was the medical director at the time, recruited me. He had his own private practice in San Francisco's Chinatown community, and he sort of kept an eye on me. But I had to learn a lot on my own.

How did you go about learning things on your own? That can be a very difficult thing to do.

Well geriatrics is actually primary care with an emphasis on elders. As we age, we have more chronic illnesses. It is not a specialty in the sense of gastroenterology or cardiology is a specialty. What I have is excellent training as an internist, which is a primary care specialty. I was very familiar with taking care of complex patients in hospital and in the clinic. I felt very comfortable with my clinical training and experience. The other part of primary care includes addressing patients' psychosocial environment and their functional abilities. That's geriatrics. Even though the specialty is called geriatric medicine, geriatrics is not just medicine. That is what I discovered. I had a lot to learn besides medicine.

You trained in gastroenterology so you had that training. The other skills you are talking about, you had to learn those without formal training. How did you develop those other skills?

I think those skills came through practice, and using common sense. When I face a difficult clinical problem, I have to ask, "What would I do for my parents or someone I knew? What would I do if I were in my patient's shoes?" I'd also ask other team members. One of those team members I called on frequently early in my career still works for On Lok. She also came from New York. She was a first grade teacher before she became a home care nurse. I would ask her questions such as, "Would this person be safe at home? What would it take for me to discharge this person early from the hospital to home?" That combination is important: using common sense, asking the question "What would I want if I were the patients", and calling on people who have different areas of expertise other than medicine.

Students are very interested in skill development and mentorship. Have you had mentors throughout your life or your training as a doctor?

When I think about mentors, I think about people who taught me to work through difficult situations and gave me sincere advice unconditionally. I think my mentors were really my parents. They taught me to be an excellent student, to strive for the highest standards, and to be a physician who contributes back to society. They taught me that people can live very simple lives and still be quite influential. Whenever I looked at my patients, I remembered my parents' teaching. In that sense, they were mentors to me. Of course, I also had formal mentors in medical school, post-graduate training, and in practice. For me a mentor is someone who you can actually admit mistakes to and receive advice you may not want to hear. There are very few times in a medical career that a physician can admit mistakes without fear. It is really difficult to admit mistakes. In fact, you were not supposed to admit mistakes.

Do you feel that has changed at all? About being able to admit mistakes as you go along?

Change has occurred, but not a lot. I think that medical students go in to medicine with very high ideals and for some reason, medical school and post-graduate training transforms students with high degrees of humanism to technicians of medical care. That is what I was really alluding to in my own experience. The technical training rarely includes instructions on admitting mistakes.

Are there certain things you like to do for yourself to develop that humanity? To get away from the technical aspects?

I do a lot of reading. I don't read as often as I should. I am very interested in stories about the human condition and literature about how people develop resilience. Resilience is really the recurring theme in geriatrics. Our older patients come to us,

having survived a lot of personal experiences including living with chronic illness, resolving family conflicts, and difficult work experiences prior to retirement. Most older patients maintain hope while surviving illness and conflict. That resilience is what impresses me in terms of treating older patients.

Have you noticed a strong resiliency in the elder patients you work with?

Oh, absolutely! When I first came to work at On Lok, I was struck by the resolve of my patients, most of whom had very little. They literally lived in 8 feet by 10 feet rooms with no cooking facilities, and their bathrooms were down the hall. Yet they were grateful for what they did have. They had survived the immigration nightmare. They had survived years of separation from their families. They were grateful to be alive but they needed help. People have asked me why I have stayed so long at On Lok. Those human stories that I experienced early in my career were so compelling to me and made me want to stay and contribute as a physician. I appreciate the humanism of people who survive to old age.

Why did you decide to stay with geriatrics?

Over time it has been shown that when people become frail it is about a four and a half year prognosis. I see it as an opportunity to not only provide quality of care in that four and a half years, but also to undo some of the wrong that has happened to them, if I could. For me, what was so interesting was that I could practice medicine and be able to improve peoples' lives knowing that there would be a shorter period of time to make the improvement.

You mentioned that you are able to work on different issues in that 4.5 year window can you give me an example. What are some of the things that you and On Lok are able to provide?

First of all, they come to us and we give them an integrated and coordinated care system. They don't have to go one place for the doctor, one place for the physical therapist, one place for home care. It's all here. The families do not have to do case management one by one, service by service. That is a tremendous burden that is taken off the patients and the families. That means the patients get the care they need.

We also get advanced directives from them. Physicians sit down with the patient and inform them of their medical conditions. We let them know what we can do to help. For some conditions, we can palliate, but can't cure. These conversations are part of our care approach. A lot of times patients already know that something is wrong, but nobody has sat down with them, to talk about how they feel about it. They are able to tell us how they would like to be treated towards the end of life. That is a gift.

Another thing is really having family understand what their loved one is going through. Sometimes with dementia patients, the families are just at wit's end saying, 'Why is this person behaving like this? Why is this person so mean to me? I am their daughter or

son!" We have to explain to families that dementia is an illness that robs a person of memory and judgment. We provide an explanation to the family and hope that reconciliation is an important part of letting go of their parents when the time comes. It is the sense of closure that families have that they participated in providing as much care as they can.

We provide respite. It is hard to live with the emotional strain of caring for a frail elder all the time. The goal is for families to stay in the picture with their loved one. Even though the loved one may not behave or recognize them, it is the familiar human touch of family that is so comforting to the patients. Sometimes we have elders enter our housing for a two week temporary stay so the family can go on vacation. Or we provide homecare so that the spouse doesn't get burned out.

Do you have a personal philosophy of life in general?

My life principles are integrity, honesty, and loyalty.

And how did you come to hold those values?

My parents were very influential role models for me.

What is your personal philosophy towards caring for patients?

I want my patients to know they are coming to somebody who is very open and frank with them, someone who they can trust and who will be there to care for them. I will give them the very best care.

In your writing, you mentioned that in some situations, patients are not able to comply. What do you do in those situations? Do you have a favorite technique you like to use?

Patients can be noncompliant. But patients are independent. Physicians can give treatment recommendations and care direction. But if the patient doesn't follow the directions, there must be a safety net. On Lok is a safety net. We negotiate with patients. The patient might say, "Oh, I really don't want to take this medicine. And I won't." Well, you know, the doctor can't force a person to take the medication, but our staff will monitor to see if they are taking the medications. We are ready to take care of them in spite of their noncompliance. Negotiation is a process.

I'm sure that is something all doctors have to face even if they are not working in geriatrics. How do you work through that? Is there a technique that you use?

It's really the ability to negotiate, sometimes to step back, but never to abandon.

What are the characteristics that a geriatrician should have?

- Be an astute diagnostician – think of the usual diagnoses but be prepared to consider unusual presentations of common conditions. Older persons sometimes do not manifest the same symptoms of a condition as younger patients. For instance, pneumonia in a younger patient may present with high fever, cough and purulent sputum. In an older patient, fever may only be low grade, and there may not be much coughing. Instead the older patient may manifest poor appetite or refuse to eat at all. For persons with dementia, increased agitation or sleeplessness may herald the infection.

- Be patient – treatment of conditions in older persons take longer to manifest success. Treatment of infections requires a longer time on antibiotics. The antibiotics and the bugs are the same, but how the older person metabolizes the drug in their body and how the drug is excreted via the liver or kidneys is different than in younger patients. Once the acute condition is treated, it takes twice as long for older persons to recover their function, appetite and strength. You have to be prepared to support them through the recovery phase.

- Be a good listener and develop excellent communications skills. Every geriatrician learns to be a good psychologist, even without formal training. It's a requirement in order to understand complex family dynamics that definitely affect how the older patient functions or recovers from illness.

- Have empathy and understanding when older patients exhibit rudeness, non-compliance or other kinds of irritating behavior. They are just exerting their independence. It's that independence that has helped them survive. But the geriatrician must intervene and communicate firmly when independence veers into reckless non-compliance.

The patients at On Lok speak different languages and dialects. How do you communicate effectively with them?

I speak one of the Chinese dialects, Toisonese. Many of the older immigrants, such as my own parents, came from the rural part of southern China where this dialect is spoken. I grew up speaking the dialect, so I was able to communicate with many of my patients back in the 1980's. However, the more recent immigrants from China are Mandarin speaking, so I have to rely on translators, usually nursing staff who worked with me in the clinic. I have found that while verbal communication is important, non-verbal gestures, facial expression, and body language are also important clues to communication. Many of the older generation are not literate in either their primary language or in English, so written communication, such as letters or handwritten notes cannot be relied on to convey information. Over the years, we have recruited a physician and nursing staff that speak many languages other than English including: Mandarin, Cantonese, Spanish, Tagolog, Korean, Vietnamese, and Farsi.

You work with frail, low income elderly. What is the biggest challenge facing health care delivery for elders?

- One of the biggest challenges is finding physicians who will take Medicare or Medicaid as reimbursement. These government payers are ratcheting down the payments for services, so many physicians are threatening to opt out of even taking Medicare patients. We already know that Medicaid patients have a difficult time finding primary care providers, and many have resorted to forgoing care or going to the county clinics or hospitals when they get very sick. Now the lack of providers is also affecting Medicare patients. Older person get sick more frequently, and many have a difficult time making their way to clinics. Older patients are very loyal to their physicians, so it is very hard to have the physician tell them they can't afford to take care of them anymore.

- Another challenge is the diminishing supply of personal care workers in the community. These are low paying jobs, and there are fewer people who can live in an expensive area such as San Francisco. Yet the elderly themselves are on fixed, low incomes so they can't afford to pay for the help.

- The number of nursing home beds in our community and nationally is insufficient to meet the needs of the growing numbers of frail elders. This is due to low reimbursements to the nursing homes, and the difficulty in finding staff for the nursing homes. Thus, elders who need nursing home level of care can't get access to nursing homes. San Francisco is fortunate to have the On Lok program, because we take total care of our participant's needs, even finding nursing home access when it is needed.

- The rising cost of healthcare in general and Medicare in particular is very worrisome. People are living longer, but longer life is not necessarily accompanied by good health. Many elders are worried that they will not be able to afford the healthcare they need as their chronic conditions progress.

What are some of the key issues all physicians must learn about in order to serve the geriatric population?

We will be old some day, if we are lucky. How we take care of our elders today will serve as an example to future generations who will take care of us. We are professionals, entrusted with valuable training and stature as healers. It is not enough to be medical technicians, plying our craft. We must strive to be healers of the older person's spirit as we treat their medical conditions. In geriatrics, "Cure sometimes, Care Always" should be our mantra.

II. Geriatrics Summer Opportunities

2008 Medical Student Training in Aging Research (MSTAR) Program

AFAR is pleased to announce the 2008 Medical Student Training in Aging Research (MSTAR) Program. The program provides students with an enriching experience in aging-related research and geriatrics under the mentorship of top experts in the field. Students participate in an 8- to 12-week structured research, clinical, and didactic program in geriatrics. Students may train at NIA-supported National Training Centers, or, for a limited number of medical schools, at their own institution.
Up to 120 scholarships will be awarded. The stipend is $1,731 per month. The application deadline is February 7, 2008.
Please go to http://www.afar.org/medstu.html for the complete guidelines and on-line application or contact AFAR at 212-703-9977 or grants@afar.org.

AMSA's 2008 End of Life Care Fellowship

The End of Life Education Fellowship Program is a six-week summer experience designed to introduce fourteen to sixteen medical students to end of life care issues. Offered in Chicago, IL and Fort Lauderdale, FL, the End of Life Education Fellowship Program combines an orientation to end of life care with weekly seminars and field placements at local hospices, nursing homes, and inpatient units. This year's program will take place from June 23-August 1, 2008.

At both program sites, fellows will spend one to two days per week in seminar sessions and three to four days a week rotating through placement sites where they will work with various preceptors to gain the broadest exposure to a variety of EOL care settings. While at their program sites, Fellows will also be expected to develop end of life curricula to be implemented at their medical schools and to be shared on the web with medical schools across the nation. Although students will have to secure their own housing for the program (with assistance from their program site in identifying potential neighborhoods), a stipend will be provided to assist in covering most living expenses.

As an EOL Fellow, students will:

- Develop and practice basic interviewing and communication skills essential to EOL care
- Understand the psychological, sociological, cultural and spiritual aspects of death and dying
- Understand the pathophysiology and management of common symptoms at the end of life
- Recognize and respond to cultural, linguistic, and spiritual diversity
- Design and develop a plan for integrating EOL education into the curricula of the students' medical schools and residency programs.

In order to be eligible, applicants must have completed their first year of medical school by June 2008. Women and minorities are encouraged to apply. For more information and the application, please visit www.amsa.org/eol or e-mail Angelia Bowman at abowman@amsa.org. Applications are due **Monday, March 24, 2008.**

III. Free Student Membership in American Geriatrics Society

The American Geriatrics Society (AGS) would like to invite all AMSA members to take advantage of AGS's free student membership. Benefits of AGS's free student membership include full web access to the *Journal of the American Geriatrics Society*, an AGS e-newsletter, list serv announcements, access to the Members Only website MyAGS, and discounts on AGS products and publications. Student members also recieve a free download of the PDA-version of *Geriatrics at Your Fingertips*, a geriatrics resource that other members pay for. To sign up, please visit http://www.americangeriatrics.org/education/geristudents/.

IV. Upcoming Conferences

- Association for Gerontology in Higher Education (AGHE): "Disciplinary Convergence: The Nexus of Gerontology and Geriatrics Education." February 21-24, 2008. Baltimore, MD.
- National Council on Aging—American Society on Aging (NCOA-ASA) Conference: "Aging in America." March 26-30, 2008. Washington, DC.

Our very own AMSA Foundation will be conducting two sessions at each of the conferences listed above: ***Building a Better Future for End of Life Care: Expanding Palliative Care Opportunities for Medical Students*** will highlight AMSA's End of Life Education Fellowship Program; while, ***Culturally Competent Care for an Aging Population: Educating Our Nation's Future Primary Care Providers in Ethnogeriatrics*** will highlight the work that AMSA did in implementing a ethnogeriatric curriculum in six U.S. medical and dental schools through its *Achieving Diversity in Dentistry and Medicine (ADDM)* project. For more information about either conference and/or the sessions that AMSA will be presenting, please contact Angelia Bowman at abowman@amsa.org.

- **Mark Your Calendars! AMSA'S 58TH ANNUAL CONVENTION**

Come join us at this year's AMSA National Convention!
health care (r)evolution
March 12-16, 2008 * Houston, TX
http://www.amsa.org/conv/

Check out our Geriatrics programming!

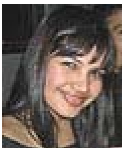
New Frontiers in Geriatrics (3:00 pm)
George E. Taffet, MD, Associate Professor and Chief, Geriatrics, Medicine and Cardiovascular Sciences, Baylor College of Medicine

To raise both an awareness and interest in the physiology of aging and the unique treatments needed to care for the increased vulnerability of the elderly. We will also discuss the changes and challenges that this generation will bring to healthcare as a result of their increased diversity from previous older generations (including race and sexuality). Finally, through the discussion of successful models of aging we will to highlight the rewards of caring for older adults as well as future opportunities in the field of geriatrics.

For more information on the AMSA Geriatrics Interest Group, please visit AMSA's Geriatrics Specialty Forum!

http://www.amsa.org/ger/

2007-2008 AMSA GERIATRICS LEADERSHIP



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