Considering the alternatives

Nicholas Pimlott MD CCFP FCFP, SCIENTIFIC EDITOR

Old age is not so bad when you consider the alternatives.
Maurice Chevalier

As an academic family physician at the University of Toronto in Ontario, I am part of a practice-based research network, UTOPIAN,[1] which has access to data about my practice and which sends me quarterly reports about my patient demographic characteristics and some key aspects of the care that I provide. As for many aging male, urban family physicians, my practice is aging with me. Almost 40% of my patients are 65 or older (compared with the Ontario provincial average of about 18%). Of these, nearly 40% have 2 or more chronic health conditions including heart disease, type 2 diabetes, and osteoarthritis. On any given clinic day, more than one-third of the people on my list are 75 or older and most present with 3 or more health concerns.

Eighty-three-year-old Sylvia is a typical patient in my practice. She has a long-standing history of hypertension, mainly well controlled, but requiring occasional adjustment of her medications. Nine years ago she had a hip replacement. Over the past 2 years she has developed considerable low back and leg pain caused by spinal stenosis. Just over a year ago, she needed a pacemaker inserted. This once-active woman has been struggling physically and emotionally to adapt to the changes of aging. She longs for cures for these conditions and has trouble accepting her current reality.

Almost 40 years ago in a highly influential paper, James Fries proposed the concept of the "compression of morbidity," in which increased life expectancy would be accompanied by a lower incidence of chronic disease and a later age of onset of chronic disease.[2] It was an attractive theory that, like the increased leisure time we were all promised in the 1970s, has proven illusory.

There is no compression of morbidity that I can see in my own practice—just the gradual accumulation of health problems and attendant losses. A more recent careful review of the literature by Crimmins and Beltrán-Sánchez[3] reveals that there is no empirical evidence to support the compression of morbidity hypothesis, and that, in fact, over the past 2 decades, length of life with disease and loss of functional mobility has increased. What I see in my own practice is a wider phenomenon. As Crimmins and Beltrán-Sánchez put it, "Health may not be improving with each generation … and compression of morbidity may be as illusory as immortality. We do not appear to be moving to a world where we die without disease, functioning loss, and disability."[3]

Cet article se trouve aussi en français à la **page 409.**

In a recent provocative article in *The New Republic,* influential American physicians Daniel Callahan and Sherwin Nuland have argued that in the wars that medicine has waged against diseases over the past half century, "we have unwittingly created a kind of medicine that is barely affordable now and forbiddingly unaffordable in the long run."[4] When it comes to the elderly, they contend, "Death is not the only bad thing that can happen …. An old age marked by disability, economic insecurity, and social isolation are also great evils. Instead of a medical culture of cure for the elderly we need a culture of care … more heavily weighted toward primary care."[4]

In 2009, almost twice as many seniors visited their family physician 10 times or more per year compared with non-senior adults.[5] What would the proportion look like today?

In this issue of *Canadian Family Physician,* we bring readers a commentary (**page 416**) by Chris Frank and colleagues that speaks to such a culture of care for the elderly grounded in the principles of family medicine.[6] In a collaboration with Patients Canada, a patient-led organization that promotes collaboration among patients, family caregivers, and health care providers, the Health Care of the Elderly community of practice of the College of Family Physicians of Canada surveyed its members (more than 2000 family physicians with a particular interest in care of the elderly) to identify the ways in which they make their practices more senior friendly. The authors present some of the distilled wisdom of some of our family medicine colleagues across the country and invite your further suggestions.

Among the many recommendations, some obvious, others not, are longer appointments, interprofessional team-based care, having a pharmacist as an integral part of such teams, and offering more home-based care for frailer seniors and home-based palliative care for all seniors. While we are arguably making progress in some areas (like the first 3 recommendations), in others we are not (the latter 2 recommendations). These and the many other ideas presented in the paper are compatible with Callahan and Nuland's vision of a health care system founded on strong primary care and concern for the quality of life of aging patients burdened by chronic disease.

References

1. University of Toronto [website]. *About UTOPIAN.* Toronto, ON: University of Toronto; 2017. Available from: **www.dfcm.utoronto.ca/about-utopian**. Accessed 2018 May 8.
2. Fries JF. Aging, natural death, and the compression of morbidity. *N Engl J Med* 1980;303(3):1369-70.
3. Crimmins EM, Beltrán-Sánchez H. Mortality and morbidity trends: is there compression of morbidity? *J Gerontol B Psychol Sci Soc Sci* 2011;66(1):75-86. Epub 2010 Dec 6.
4. Callahan D, Nuland SB. The quagmire. How American medicine is destroying itself. *The New Republic* 2011 May 19. Available from: **https://newrepublic.com/article/88631/american-medicine-health-care-costs**. Accessed 2018 May 8.
5. Statistics Canada. *Canadian Community Health Survey (CCHS)—annual component.* Ottawa, ON: Statistics Canada; 2009. Available from: **www23.statcan.gc.ca/imdb-bmdi/document/3226_D7_T9_V8-eng.htm**. Accessed 2018 May 8.
6. Frank CC, Feldman S, Wyman R. Caring for older patients in primary care. Wisdom and innovation from Canadian family physicians. *Can Fam Physician* 2018;64:416-8 (Eng), e252-4 (Fr).