Our population is aging. Recent census forecasts have predicted that by 2036, the population of seniors older than 65 years of age will double to 10.4 million. Subsequently, the population of frail elderly, defined as those older than 65 years of age who are dependent on others for their activities of daily living and are often living in institutional settings, will also increase. The 2004 National Physician Survey showed alarmingly that only 1 in 8 family physicians in Canada worked in the long-term care (LTC) setting. The 2010 National Physician Survey showed improvement, with approximately 1 in 6 family physicians actively involved in LTC.

One solution to this problem has been the introduction of a geriatric and LTC component in the family medicine residency curriculum. However, despite this addition, family medicine residents are still reluctant to work in LTC. Some perceived barriers include a lack of a standard approach to managing frail elderly patients, a lack of mentorship during the initial stages of practice, and variable clinical experiences in LTC during residency training. As a result, renewed emphasis is now being placed on addressing these barriers to practice, as well as generating and cultivating resident awareness and interest in care of the elderly.

Why is LTC unique?

Long-term care is unique because the patients within LTC are unique. The combination of relatively short life expectancy; a paucity of evidence; increased medication burden, administrative pressures, and medical complexity; as well as caregivers’ unique experience result in a heterogeneous patient population that makes navigating the fine line between intervening to the detriment of the patient and not investigating appropriately quite difficult. A systematic review reported the median prevalence of dementia in LTC patients was 58%. As the severity of cognitive impairment increases, family members are required to take on an increasingly active role as substitute decision makers for their loved ones in LTC; this can be challenging. Cultural factors, family dynamics, the family’s desire to extend life, the perception that the hospital can provide better care, and infrequent communication with LTC staff can result in disagreements between the LTC physician and the family regarding a patient’s direction of care. Disagreements over issues such as discontinuing a long-term medication, the choice to not investigate a potential cancer diagnosis, the decision to not transfer the patient to the emergency department for an assessment, or the decision to deem a patient’s condition palliative can become heated and result in physician dissatisfaction with working in LTC.

The PAUSE approach to LTC

Modeled after an existing practice framework for polypharmacy in LTC, PAUSE (philosophy of care, assessing the evidence, understanding expectations, simplifying, and medical complexity) was developed to address a specific barrier identified by family medicine residents: the lack of a standard approach to frail elderly patients. Key themes from earlier reviews informed the development of the different components of PAUSE, which was thought to be more useful than providing a checklist of defined roles for LTC physicians. The PAUSE approach (Table 1) pragmatically takes LTC physicians through 5 reflective and interconnected questions that arise when there is a substantial change in medical status (evolution of care).

**Philosophy of care.** This first question asks physicians to reflect on their own practice philosophy within LTC. Physicians need to determine whether their main goal for LTC patients is to maximize quality of life or to actively manage and optimize chronic medical conditions, or whether it is somewhere in between. Recognizing this at the outset will help physicians communicate consistently with patients and their families, as well as offer a basis for making ongoing clinical decisions. It is important to note that a physician’s philosophy of care can vary depending on the patient; this flexibility helps the physician adapt to the heterogeneity seen among LTC patients.
Assessing the evidence. The evidence for most interventions in LTC is sparse; commonly used risk calculators (e.g., CHA₂DS₂-VASc [congestive heart failure; hypertension; age ≥ 75 years; diabetes mellitus; stroke or transient ischemic attack; vascular disease; age 65 to 74 years; sex category], Framingham, FRAX [Fracture Risk Assessment Tool]) do not take into consideration factors relevant to LTC such as comorbidities, treatment burden, and patient prognosis. As a result, it is important to stay up to date on the interventions and screening assessments that have substantial support in the LTC and frail elderly populations including assessments for polypharmacy, depression, and pain. It is important to remember that the evidence that does exist must be judiciously applied with input from the patient and the family. This results in a practice that is evidence informed, rather than rigidly evidence based.

Understanding expectations. Previous research shows that substitute decision making is stressful and substitute decision makers often feel unprepared and unsupported in making medical decisions in the LTC setting. A qualitative study of caregivers and family members of LTC residents revealed that their expectations revolved around addressing basic care needs, assurance that their loved ones were safe, timely communication, and a sense of community for their loved ones in the LTC setting. However, these findings seem to contradict clinical experience, as some physicians report experiences of unrealistic expectations, excessive demands, and criticisms by relatives. Navigating guilt, stress, unspoken relief, and overwhelming often have of being lost, intimidated, and overwhelmed and foster sources of satisfaction for LTC physicians including being able to provide care and improve the health of medically complex older patients as part of a multidisciplinary team.

Simplify. This question challenges the clinician to take an active role in simplifying and communicating expectations of care. Simplifying care is not just about reducing the number of medications or investigations ordered. Although minimizing inappropriate interventions is important, this component recognizes that the quality of care is not associated with the number of tests and investigations ordered. On another level, simplifying care is about creating a management plan and communicating it to the rest of the allied health team; the plan should be consistent with the expectations and determined goals of care of patients and their caregivers. Consistency in how medical decisions are made on behalf of patients helps to minimize confusion between caregivers and the medical team. It also helps to prevent inappropriate or unnecessary investigations and medications when acute medical issues do arise in LTC.

Evolution of care. It is inevitable that things will change over the course of a patient’s stay in LTC. The LTC physician needs to remain willing to communicate with family as a patient’s medical status changes in order to develop the best care plan possible. This includes ongoing discussions regarding active disease.

Table 1. The PAUSE approach to practising in long-term care

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<thead>
<tr>
<th>COMPONENT</th>
<th>QUESTION OR CONSIDERATION</th>
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<tbody>
<tr>
<td>Philosophy of care</td>
<td>Ask:</td>
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<tr>
<td>Assessing the evidence</td>
<td>Consider:</td>
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<td>Understanding expectations</td>
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<td>Simplify</td>
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management, as well as proactive discussions regarding the prognosis and treatment expectations as the patient’s functional status changes or declines.

**Incorporating the PAUSE approach**

Merely having an LTC experience in residency training is insufficient to develop confidence and enthusiasm in family medicine residents for future LTC practice. A more opportune time to first introduce this practice framework might be at the undergraduate clerkship level. By incorporating PAUSE earlier in medical training, medical learners could be exposed to this approach earlier, repeatedly, and with increasing depth throughout their medical education. For example, PAUSE can be introduced didactically at the family medicine clerkship level; subsequently PAUSE can be reinforced at the residency level in the LTC setting by LTC preceptors. Through active modeling, residents can observe how PAUSE can frame and guide week-to-week clinical decision making as well as support effective communication with family members in LTC. However, this does not have to be limited to resident learners; physicians considering practices in LTC would also benefit from mentorship and ongoing communication with tenured LTC physicians on how PAUSE might be used to structure and support their new practices.

Although this approach does not directly address issues such as remuneration or time constraints, PAUSE offers a possible solution to a perceived practice gap. For PAUSE to be most effective, existing LTC physicians need to take an active role in mentoring residents and physicians new to LTC. Therefore, for the existing LTC physician, PAUSE offers more than just a pragmatic approach to practice in LTC, it serves as an encouragement to continue engaging and supporting the development of our future LTC physicians.

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**Competing interests**

None declared.

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**The opinions expressed** in commentaries are those of the authors. Publication does not imply endorsement by the College of Family Physicians of Canada.

**References**


