REUE | Editorial

# The elderly in the emergency room: the challenge continues

## *El adulto mayor en urgencias: el reto continúa*

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In this issue of *Revista Española de Urgencias y Emergencias*, Fernández Alonso *et al.* address a thorny topic: the care of older adults in the emergency department (ED).[1] Let's be clear: this is a bull that no one really knows how to tackle, even though it is neither new nor surprising. From an epidemiological perspective, in Spain more than 55% of adult emergency visits involve patients older than 65 years,[2] and older adults account for 25% of emergency attendances in Europe.[3] This does not include urgent visits to primary care centers, out-of-hours facilities (at least in Spain), or home calls.[4] And the numbers keep climbing, due to the population aging we are witnessing, along with its corollaries: multimorbidity, polypharmacy, and geriatric syndromes that often bring older adults to the ED.[5]

In addition to being unavoidable, the problem is longstanding. Since I began my residency in geriatrics 23 years ago, older adults have always been a large part of emergency care, and I have the impression that their management has not changed much over the past decades. Generally speaking, the environment is often hostile and inadequate for them: no space for companions, a lack of references to help them orient themselves in time and place, continuous visual and auditory stimuli that prevent rest, and unnecessary bed rest in many cases.[6,7] On top of this, overburdened staff cannot adequately meet care needs and often misinterpret the communication patterns of people who can no longer express themselves normally—leading to antipsychotics and sedatives being prescribed at 3 am.[8,9]

Admittedly, progress has been made trying to improve the clinical aspect of care for older adults in the ED, and different studies support this: from establishing useful frailty criteria to guide therapeutic plans[10-12] to approaches for comprehensive management of older adults presenting to the ED.[13,14] In particular, the use of geriatrics' hallmark tool—the comprehensive geriatric assessment (CGA)—has already proven its usefulness.[15,16] Due to the article by Fernández Alonso *et al.*, representing the Geriatric Emergency Medicine Working Group of the Spanish Society of Emergency Medicine (GEM-SEMES),[1] it is now very clear what needs to be done and how.

However, reading it raises a concern: how will we convince future emergency medicine specialists to use the proposed scales? They seem numerous, complex, and largely unfamiliar outside geriatrics. Once again, we might be accused of being "scale-ologists" (we have all heard this or similar terms used for geriatricians, haven't we?). How do we explain to a future emergency physician, expecting the adrenaline-driven pace of the specialty, that they must take some time to truly get to know the older patient in front of them?[17] Often, this means straining one's voice because the hearing aids were left in the ambulance, or piecing together a history from disengaged families and disoriented or demented patients. Or the opposite—when an elderly woman, who initially seemed sweet, scolds us fiercely because we failed to ask her.

There is only one answer: training.[18,19] The article mentions this,[1] but I want to insist that for me it is the most important point. Theoretical foundations alone prove insufficient; if we do not teach why we do what we do, and demonstrate that it is both feasible and absolutely necessary, progress will not be made. Scales are not used because we enjoy nosing into whether the eldest daughter cooks (families often eye us suspiciously when we ask such things) but because it is the only way to identify patterns in the immense diversity of aging. With those patterns, we can establish action guidelines with a relative guarantee of results. For example: what is the therapeutic ceiling for the fully dependent patient in terminal status? Which robust older adults with severe infection require admission? Which consultations are useful for frail patients who must avoid hospital-associated functional decline at all costs?

When I say, "a 47-year-old man with a past medical history of hypertension and obesity presents with 45 minutes of chest pain and vegetative symptoms," we all have a

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mental picture. But when I say, "an 85-year-old hypertensive, obese woman presents with the same," I have said very little: the picture changes. It is clear that geriatric care in Spanish emergency departments must move forward. Beyond the specific initiatives offered by this article1 and previous ones,[6-16] the groundwork has been laid. Now it must be made reality—at least for those patients who do not arrive with a prior geriatric assessment documented in their clinical record. If such an assessment were performed and recorded in primary care, wouldn't it be infinitely easier? And more logical, of course, since most patients attend primary care rather than the emergency department, where the principles of geriatric care are exactly the same.[18]

Finally, yes, let us train; let us teach what to do, how, and why. But we must not forget to transmit one essential message: erase ageism from our behavior—always, but especially when the patient is most vulnerable and most in need, when they are sick enough to come to the ED. The horrifying "gomer" terminology described in the remarkable book *The House of God*[19] nearly 50 years ago is still embedded in our language, along with other equally or more offensive terms. In the collective medical subconscious, a stretcher carrying a frail patient wrapped in a plaid blanket equals problems: what condition will they have (or not have)? Who will admit them? Will the family want to take them home? This litany often makes us view that stretcher with suspicion before even asking the patient's name. Yet, let us remember that acting in accordance with scientific evidence (and performing the CGA in older adults) is anti-ageist. Let us also remember that tomorrow, we ourselves will be the ones arriving at the emergency department on that stretcher with the plaid blanket.

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