FROM THE EDITORS' DESK

When Life Span Exceeds Health Span

Malathi Srinivasan, MD FACP

University of California Davis School of Medicine, Sacramento, CA, USA.

J Gen Intern Med 30(3):267–8

DOI: 10.1007/s11606-014-3167-4

© Society of General Internal Medicine 2015

Last week, we enrolled almost 50 % of our medicine team's inpatients into hospice care.

Our team was on call. We sat by the bedside of our 74-year-old patient with advanced schizophrenia and dementia as he lay dying. Through self-neglect from his mental health disorder and poor health care access from his homelessness, he had been deteriorating for over a month. We watched and honored his life, as his breathing labored on a morphine drip. That same day, we met a 62-year-old Japanese woman who had not realized that her childhood hepatitis B was a serious disease, and now presented with progressive abdominal pain and jaundice. As we examined her cachectic form with abdominal masses and new ascites, we knew what the abdominal imaging soon confirmed – that she had advanced hepatocellular carcinoma, not amenable to disease-directed treatment. We admitted a 57-year-old diabetic patient, recovering from septic emboli from endocarditis and a valve replacement, now presenting with a massive GI bleed. A 92-year-old Korean woman with multiple strokes had become non-verbal and bed-bound a year ago. Her son told us that she would not have wanted such an incapacitated life, but he had taken her to the emergency department repeatedly—every time she aspirated—because no one had told him that it was okay to stop.

Three of these four patients died within the week. In each of these cases, the overall health care system failed our patients—due to lack of access, lack of tracking/follow-up, or lack of communication. In failing our patients, we were presented with lost opportunities to achieve medically appropriate, values-concordant medical care. Our team reflected upon the societal issues shaping these health care challenges.

Over the past 50 years, the US life expectancy has progressively increased, with the average child born in 2009 expected to live almost 80 years. Yet patients' health spans often fall short of their life spans, especially with the burden of chronic disease. As was seen with our recent inpatients, this increased life span has been accompanied by ballooning age-related

disorders (such as Alzheimer's) and severe complications of relentlessly advancing diseases (such as diabetes).

This month in *JGIM*, Taber¹ explores these issues on a societal level, considering why some patients avoid medical care—for reasons such as prior negative experiences with healthcare, lack of self-perceived need, and traditional barriers to care (cost, access, etc.). Levy² takes this work a step further for a single issue, examining how health literacy and the expanding digital divide may affect health care—demonstrating, for example, that less than 10 % of older minority low-health-literacy patients search for medical information on the Internet.

The *JGIM* readership, at the interface between clinical care and quality improvement, sees firsthand the problems in our health system, with innovative approaches to improving and coordinating care—especially for medically vulnerable patients. Tannenbaum³ demonstrates that innovative use of decision-support technology while patients are hospitalized, such as partitioning order sets in an EHR around antibiotic-appropriate and -inappropriate clinical conditions, can improve physician decision-making.

Kantor⁴ illustrates how technology support when patients are discharged can help ensure that care transitions are smoother, especially for pending clinical studies. Finally, Aikens and colleagues⁵ take medical care beyond the office, demonstrating that almost half of patients prefer adding personal support (friends and family) into telemonitoring and self-management visits as a means to enhance their engagement and adherence. Collectively, these insights and innovations add to the growing work in clinical innovations that meet the needs of all of our patients.

Conflict of Interest: The author declares that he/she does not have a conflict of interest.

Corresponding Author: Malathi Srinivasan, MD FACP; University of California Davis School of Medicine, 4150 V. Street, Suite 2400, Sacramento, CA 95833, USA (e-mail: malathi@ucdavis.edu).

REFERENCES

1. Taber JM, Leyva B, Persoskie A. Why do people avoid medical care? A qualitative study using national data. *J Gen Intern Med*. doi: 10.1007/s11606-014-3089-1

2. **Levy H, Janke AT, Langa KM.** Health literacy and the digital divide among older Americans. *J Gen Intern Med.* doi: [10.1007/s11606-014-3069-5](https://doi.org/10.1007/s11606-014-3069-5)
3. **Tannenbaum D, Doctor JN, Persell SD, Friedberg MW, Meeker D, Friesema EM, Goldstein NJ, Linder JA, Fox CR.** Nudging physician prescription decisions by partitioning the order set: results of a vignette-based study. *J Gen Intern Med.* doi: [10.1007/s11606-014-3051-2](https://doi.org/10.1007/s11606-014-3051-2)
4. **Kantor MA, Evans KH, Shieh L.** Pending studies at hospital discharge: A pre-post analysis of an electronic medical record tool to improve communication at hospital discharge. *J Gen Intern Med.* doi: [10.1007/s11606-014-3064-x](https://doi.org/10.1007/s11606-014-3064-x)
5. **Aikens JE, Trivedi R, Aron DC, Piette JD.** Integrating support persons into diabetes telemonitoring to improve self-management and medication adherence. *J Gen Intern Med.* doi: [10.1007/s11606-014-3101-9](https://doi.org/10.1007/s11606-014-3101-9)