Do no harm

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'Seek ye counsel of the aged for their eyes have looked on the faces of the years and their ears have hardened to the voices of life. Even if their counsel is displeasing to you, pay heed to them.' —Khalil Gibran

Medical advances, public health improvements and in some places greater affluence have led to increased longevity in recent years. This is evident globally both in wealthier health economies as well as developing and lower-income countries and is characterised by growing numbers of older adults. In 2019, the number of people aged 60 years and older was 1 billion. This number will increase to 1.4 billion by 2030 and 2.1 billion by 2050. Furthermore, the number of adults aged over 80 years is expected to quadruple to 395 million during the same period.[1] This increase is occurring at an unprecedented pace and will accelerate in coming decades, particularly in developing countries.[2] People who are fortunate to experience good health in later years are an invaluable resource, their wisdom and ability to fully participate in family and community life enriches society as a whole; however, good health in older age is far from guaranteed and the increase in life expectancy is often accompanied by the development of chronic disease, age-related illness and frailty. Indeed, there is little evidence that longevity has contributed to better health today than in previous years.[1]

Age-related conditions are a significant burden for the person, his or her family, and society. Frailty in particular is an emerging and immediate global public health concern which has significant implications for clinical practice in emergency medicine. The British Geriatrics Society defines frailty as 'a distinctive health state related to the ageing process in which multiple body systems gradually lose their in-built reserves'. A decline in functioning across physiological systems, accompanied by an increased vulnerability to stressors, predisposes a person to increased risk of falls, hospitalisation and mortality.[3] Around 10% of people aged over 65 years have frailty, rising to between a quarter and a half of those aged over 85 years of age.[2]

In this issue, Reagan *et al*[4] explore the experience of attending the ED through the lens of older people, their relatives and carers. A number of the participants found the ED staff to be kind and caring, but this positive perception was overshadowed and outweighed by the negative experiences relating to the most basic human needs: toileting, food and hydration. Long waits on uncomfortable furniture and poor communication also feature. While such findings have been previously described by other authors examining the experiences of older people using the ED,[5] Reagan *et al* provide further robust evidence that such experiences are not isolated. It is hard and sad to hear of such negative experiences from some of our most vulnerable patients, but few of us would be surprised at such feedback and recognise the glaring mismatch that exists between the needs of our older patients and the culture and pace of ED working.

Avoidance of attendance to the ED was clear in the paper even prior to the global health crisis; shielding advice from public health bodies during COVID-19 may have amplified this perception giving older patients a further valid, although misplaced justification, for not wanting to attend. Many of the narratives collected suggest that people reluctantly agreed to go to the ED after urging by family or health professionals. This reluctance was often informed by previous negative experiences in EDs such as being perceived as an added workload to already hard-pressed staff.

Most poignantly, what is clear in this paper is that older people have the same desires and needs as younger people using the ED: to be treated with dignity, to be respected, to be listened to and to have regular communication with staff. To our shame, these interviews have drawn into sharp focus just how disenfranchised and marginalised frail older people feel when using our services. Unlike younger fitter patients, they are less able or inclined to complain or voice dissatisfaction when their needs are not being met. We urgently need to reflect on and rectify this, redesigning our services for all our patients keeping in mind the needs of older people although similar are much more urgent and the ramifications of not getting it right far greater. We know that the cost of corridor care is high. The cost of poor care transitions is also high,[6] expediting the older patient out of the ED is not always well thought through and can be counterproductive.

We are at a turning point in emergency medicine. The last few years of the global health crisis have added to a system that was already under strain. Many of our departments are overwhelmed and our staff burned out. Ironically, some of this burnout can be attributed to the stress of not being able to deliver the quality care that we know our patients deserve. The things that older people in this paper wanted should be available to everyone in the ED—a calm quiet environment, needs for privacy, comfort and food and drink met, reasonable waiting times and communication about the plan of care. To do this we know will require adequate staffing of our EDs and adequate capacity in our hospitals and community health services to transitional care when the ED encounter is complete. Integration of emergency care into older adults' care networks coupled with well-supported pathways back to community-based care are likely to be key.[7] Further development of gerontological competencies for emergency staff in formal training programmes and at the local level should be supported with access to clinicians with emergency geriatric medical expertise to aid complex, time-bound decision-making around discharge disposition. Finally, the built environment of the ED needs to be urgently reconsidered.[8]

We have long predicted a rise in both the number and proportion of older adults using the ED, largely due to the combined and well-rehearsed effects of the post-war baby boom, falling fertility and the realisation of the longevity dividend. There is now an urgent need to adapt our systems of emergency and unscheduled care. Older people are not asking for special treatment or something that is unrealistic or undeliverable, they simply want to matter and that is what all our patients expect and hope for in our EDs. More importantly, we need to remind ourselves that this is what we all signed up to as clinicians. Our systems are floundering, and the

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risk is that we abandon the first principle of medicine and risk harm doing what we have always been doing. Ensuring enabling and supportive environments will only be realised if we engage with older patients and their voices are heard.

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