ORIGINAL RESEARCH

Factors Associated with a Label of Failure to Cope in Older Medical Inpatients: a Case-Control Study*

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ABSTRACT

Background

The term failure to cope (FTC) is often used to dismissively describe hospitalized older adults. The purpose of this study was to identify the factors associated with receiving a label of FTC.

Methods

Age-matched, case-control study with electronic and paper chart review identifying patient characteristics and admission details.

Results

One hundred eighty-five patients 70 years of age or older admitted to a general medicine team over two years: 99 patients with the label of FTC and 86 controls. No patients labelled with FTC came from long-term care. Characteristics associated with a label of FTC included living alone (aOR 3.8, 95% CI 1.9-7.8), falls (aOR 3.8, 95% CI 1.9-7.8), rehospitalization (aOR 3.6, 95% CI 1.7-8.0), and living in an independent dwelling (aOR 2.4, 95% CI 1.0-5.5). A higher number of chronic medications was associated with a lower likelihood of being labelled with FTC (aOR 0.9, 95% CI 0.8-1.0).

Conclusions

The results suggest that FTC is a label based predominantly on social factors and has no role in a medical assessment. The patient's home setting was the key factor in being labelled with FTC, most medical factors did not play a significant role, and a pervasive language of blame was present.

Key words: failure to cope, acopia, social admission, failure to thrive, older adults

INTRODUCTION

We often hear the terms acopia, or failure to cope (FTC), used to dismissively describe hospitalized older adults.[1,3] Accepting that these pejorative labels do not help advance patient care, it is not clear what they mean or why they are used to describe certain patients.[4] Although failure to cope is often used alongside terms such as frail, complex or multimorbid, there have been no studies confirming an association.[5,6] In developing a better understanding of the patient characteristics associated with receiving a label of failure to cope, there is an opportunity to better serve patients by recognizing potential provider biases and improving our communication practices in caring for older adults.

Not just a local phenomenon, terms synonymous with FTC are used across the world. In the UK, Ireland, and Australia, the term is acopia, in Sweden it is described as home care impossible, and in Alberta it is failure to thrive.[4,7,8] These judgmental terms for what is often considered a "social admission" do not provide a clinical diagnosis, and imply the patient is at fault for not managing a condition with which they should be able to cope.[5] Patients with these diagnoses are perceived as burdensome in acute care hospitals and as taking beds away from more deserving patients, and are felt to provide less educational value for trainees.[1]

Failure to cope suggests a condition not requiring acute medical attention. However, a retrospective chart review completed in the UK showed that, in patients triaged with the term FTC, a diagnosis of sepsis was made in 29.6% and a new malignancy was identified in 6.2%.[9] Those labelled

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with FTC also experience delays in care and have longer lengths of stay in hospital compared to controls.[10] FTC has been associated with significant morbidity and mortality, with 15–54% of patients being discharged to a long-term care home at the time of discharge, and a mortality rate of 22.2%.[4,9,11] These data suggest that many patients with FTC do have active medical conditions, legitimizing their need for treatment in an acute care hospital and suggesting that more appropriate language is required.

The purpose of this research study is to examine the likelihood of receiving a label of FTC using patient characteristics. Through this study, a better understanding of the label of FTC will be garnered, with an increased awareness of the term, its usability, and the typical patients it is used to describe.

METHODS

Study Design, Settings, and Population

A case-control study was conducted of patients 70 years of age or older, admitted to a general medicine team at London Health Sciences Centre (LHSC) from January 1, 2016 through December 31, 2017. LHSC is one of Canada's largest acute-care teaching hospitals with two sites in London, Ontario. Research is conducted through LHSC's research institute, Lawson Health Research Institute, and teaching is through a partnership with Western University's Schulich School of Medicine & Dentistry. There are three clinical teaching units at each site, with admissions to the teams completed by resident physicians.

Potential cases of FTC were screened for with the assistance of Health Information Management at LHSC using two ICD-10 codes: Z73.9 ("problems related to life-management difficulty, unspecified") and Z73.89 ("other problems related to life-management difficulty"). Screened charts were then reviewed, with a case of FTC defined in one of three ways: 1) FTC was used as the admission diagnosis on the electronic medical record (EMR), 2) FTC was used in the admission note as a descriptor of the patient's presentation, or 3) FTC was listed as an issue in the assessment. For the control group, 95 patients in the same age range were chosen randomly using SPSS.

This study was reviewed and approved by the Research Ethics Board at Western University (Project ID: 111924) and the Lawson Health Research Institute (R-18-393). The need for informed consent from patients was waived because this study was a retrospective chart review and posed no risk to patients.

Variables and Data Collection

We developed a data collection tool to collect variables from both the electronic and paper charts. Baseline characteristics for all patients were collected, including demographics, living arrangements, the presence of professional (nursing or PSW) supports, functional status, mobility status, and gait aid use. Geriatric syndromes were recorded including a history of falls, dementia, and urinary incontinence. The Clinical Frailty Scale (CFS) was estimated, if the information was available, using the patient's functional and mobility status, with frailty defined as a CFS ≥ 5.[12]

In recording the medical history, chronic comorbidities were defined as longstanding conditions, while previous surgeries or remote diagnoses with no sequelae were not counted (i.e., previous GI bleed, cataract surgery or breast lumpectomy). Comorbidities were also measured using the Charlson Comorbidity Index. Chronic medications were counted using the admission medication reconciliation and included prescription medications and regularly scheduled over-the-counter (OTC) medications such as ASA or Vitamin D. Medications not included were OTC medications recorded as PRN, eye drops, topical ointments, and nasal sprays. Rehospitalization was defined as the admission occurring within seven days after discharge from an inpatient stay or emergency room visit.

Statistical Analysis

To identify how many cases were required for this study, a power analysis with binary predictors was completed. Using a power of 0.8 and an alpha of 0.05, a two-tailed test showed that a sample of 190 was required. Statistical analysis was completed with SPSS Version 25.0. Means and standard deviations ($\pm$ SD) were calculated for all continuous variables, and percentages were provided for all categorical variables. Independent t-test with Bonferroni corrections was used to compare receiving a label of FTC between continuous variables. The association of categorical variables to FTC label was assessed using Pearson's χ^2 tests with continuity corrections to account for sample size. Crude odds ratios (cOR) with 95% CI were calculated for all categorical variables using contingency tables. Multivariable logistic regression was performed to identify key variables significantly associated with the FTC label and calculate adjusted odds ratios (aOR) with 95% CI. The adequacy of the model was assessed using the Hosmer-Lemeshow goodness of fit test.

RESULTS

Using the two ICD-10 codes to screen for potential FTC cases from the two-year study period, there were 149 patients meeting the age criteria. After chart review, 95 of these cases met one of the three criteria for FTC, as defined above. One chart was not available for review in health records. Of the 95 randomly selected non-FTC controls, four were found to meet the criteria for FTC and included in the FTC group. Five charts were not available for review in health records. This resulted in a total of 99 FTC cases and 86 age-matched controls to be included in the study (Figure 1).

Patient Characteristics

Patient and admission characteristics are summarized in Table 1. The mean overall age was 84.1($\pm$ SD 7.9) years, with females making up 57.8% of the study population. The place of residence before admission was an independent dwelling for 73.5%. Patients living alone made up 45.9%. Assistance
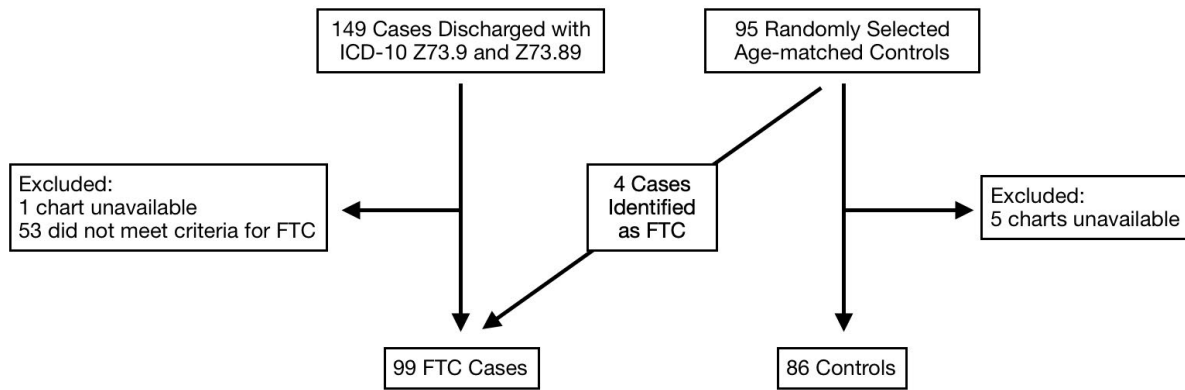
FIGURE 1. Flow diagram of FTC cases and controls

with basic ADLs and IADLs was required in 57.8% and 78.9% of the population, respectively. Before admission, 18.9% of patients mobilized independently, and 58.4% used a walker. There was a documented history of dementia in 23.2%, falls in 41.1%, and urinary incontinence in 35.1%. Applying the CFS, 80.0% met the criteria for frailty. The mean number of chronic comorbidities was 6.7(± SD 2.5) and the mean Charlson Comorbidity Index 6.03(± SD 2.2). The mean number of chronic medications was 8.5(± SD 4.1). History of discharge from the hospital or ED in the seven days prior to admission was present in 29.2%.

Univariate Analysis of Receiving an FTC Label

There were several factors associated with receiving a label of FTC. These statistics are presented in Tables 2 and 3. At the individual patient level, there were no differences found in age or sex between the FTC and non-FTC groups. None of the patients in the FTC group were from long-term care or an outside hospital, and no associations were found with living in an independent home setting ($p = .115$), or in a retirement home ($p = .188$). A lack of informal supports, where patients were living alone, was found to be significantly associated ($\chi^2 = 14.8$, $p = .000$) with cOR = 3.4, with receiving a label of FTC. However, a weak association was found with formal home supports ($p = .08$).

Having a history of falls was significantly associated ($\chi^2 = 19.7$, $p = .000$) with a label of FTC, while patient mobility, use of a gait aid, frailty, and incontinence were not associated. Requiring assistance with basic ADLs or IADLs was not significantly associated with a label of FTC.

The number of medications ($p = .006$) was inversely associated with a label of FTC, yet comorbidity and Charlson Comorbidity Index did not differ by FTC group (Table 2). Other medical factors that were not associated with FTC included dementia and cognitive impairment. Having been discharged within seven days was significantly associated with a label of FTC ($\chi^2 = 11.8$, $p = .001$) with substantial cOR = 3.5. The time of admission was not associated with a label of FTC (night admission $p = .932$).

Multivariable Analysis of Receiving an FTC Label

Multivariable logistic regression was built using the collected variables. A manual stepwise process was used to enter and remove variables resulting in a parsimonious model comprised of five factors (Table 4). Key factors, such as living in an independent dwelling (aOR 2.4; 95%CI 1.0 to 5.5) and living alone (aOR 3.8; 95%CI 1.9 to 7.8), were associated with a label of FTC. A history of falls (aOR 3.8; 95%CI 1.9 to 7.7) and readmission within seven days of discharge from hospital (aOR 3.6; 95%CI, 1.7 to 8.0) were also predictors of receiving a label of FTC. Lastly, the number of medications was an inverse predictor (aOR 0.9, 95%CI, 0.8 to 1.0).

DISCUSSION

Previous literature on FTC has demonstrated that it is an inappropriate term used to dismiss patients who are often found to have multiple active medical issues, experience delays in-hospital care, and have significant morbidity and mortality rates.[8–11] The results of this study add to that body of literature by clarifying which factors make a patient more likely to be labelled with FTC, confirming that FTC is a predominantly social label. Three major conclusions were drawn from this study including: the patient's home setting being the key factor in receiving a label of FTC; most medical factors did not play a significant role; and a pervasive language of blame was present, particularly with failed discharges. These findings highlight a hidden curriculum that fosters negative attitudes towards older adults, impacting the education of trainees in the hospital setting.

Where the patient was coming from was the most important factor in being labelled with FTC. It was those patients living alone, and those not in assisted living (i.e., living in a house or apartment) who were more likely to receive a label of FTC. While in the control group, 18.6% of patients came from the long-term care setting, no patients labelled with FTC came from long-term care. This is a strong statement about the importance of social over medical factors in determining who is labelled with FTC. With a high prevalence of frailty and comorbidity in long-term care homes,[13–15] this result

suggests there is no degree of frailty or functional dependence alone that can result in a label of FTC. Although FTC is often used in place of a medical diagnosis, it is predominantly a statement about a patient's social circumstance.

The lack of correlation between receiving a label of FTC and medical diagnoses, including geriatric syndromes such as frailty, urinary incontinence, and dementia, further suggests that FTC is a social label rather than a medical diagnosis. In the descriptive literature, assumptions have been made that FTC is used to describe medically complex older adults.[4] However, there were no associations found between the number of chronic comorbidities or the Charlson Comorbidity

TABLE 1.
Patient characteristics

	n(%)
Demographics	
Female	107 (57.8)
Home Setting	
Independent dwelling	136 (73.5)
Retirement home	32 (17.3)
Long-term care facility	16 (8.6)
Outside hospital	1 (.5)
Informal Supports	
None, patient living alone	85 (45.9)
Formal Supports	
Home care involved	93 (50.3)
Functional Status	
ADLs	
Independent	71 (38.4)
Assisted	107 (57.8)
Unavailable	7 (3.8)
IADLs	
Independent	29 (15.7)
Assisted	146 (78.9)
Unavailable	10 (5.4)
Mobility Status	
Independent	35 (18.9)
Cane	14 (7.6)
Walker	108 (58.4)
Wheelchair	13 (7.0)
Bedbound/immobile	9 (4.9)
Unavailable	6 (3.2)
Geriatric Syndromes	
History of falls	76 (41.1)
Urinary incontinence	65 (35.1)
Frailty	148 (80.0)
Medical History	
Dementia	43 (23.2)
Cognitive impairment	13 (7.0)
Rehospitalization within 7 days	54 (29.2)
Admission Details	
Overnight admission	135 (73.0)

ADLs = activities of daily living.
IADLs = instrumental activities of daily living.

Index and receiving a label of FTC. Instead, patients on fewer medications were more likely to be labelled with FTC. This lack of medical complexity could, in part, contribute to the dismissive nature of an FTC label. With providers viewing these patients as having a "less legitimate claim to hospital bed space",[3] the FTC label is used to delegate the care of these less-worthy patients to nurses and interdisciplinary staff.[16]

The only medical factor that was found to be associated with receiving a label of FTC was a history of falls. The reason for this is not clear; however, we postulate that trainees applying the label may perceive falls to be a red flag for potential delays in discharge and are making a judgment about the appropriateness of the patient's current home setting. Older patients with falls have high readmission rates and are at increased risk of being admitted to long-term care.[17,18] This can be seen with the high prevalence of falls in patients awaiting long-term care beds in Canadian hospitals.[19] These non-acute hospitalized patients are consistently viewed as uninteresting and non-educational by trainees.[20] This could play a role in their judgmental labelling of FTC in a patient with falls, highlighting perceived safety concerns and barriers to discharge.

Blame is an important part of the use of FTC, with suggestions that the label shifts the blame away from the medical system onto the patient.[1,5] Supporting that assumption is the result that returning after a recent discharge from hospital was associated with a label of FTC. The increasing focus on readmission rates as a quality indicator and even a marker for remuneration has spurred a debate about potential negative consequences.[21] Frustration from care providers manifesting as a language of blame may be one of those unintended consequences. Labels such as "bounce back" or FTC are responses to a health-care system that increasingly celebrates efficiency, and one that is overwhelmed with high demand and limited resources.[3] Although Campbell may be correct in saying "it is the system that is failing to cope",[2] even in a strained system, we must not overlook the impact that the language we use has on the socialization of medical trainees to medicine.[16,22]

The focus on hospital efficiency, along with continued use of pejorative labels like FTC, is an important part of the hidden curriculum, shaping trainees' attitudes toward caring for older adults.[3] During clinical rotations, trainees learn to view older adults as boring, frustrating, and less worthy of receiving care.[16,23] Ageist attitudes can impact how trainees care for older adults in their practice.[3] Negative attitudes can also impact trainees' career choices, making them less likely to choose a career in geriatric medicine.[24,25]

We advocate, as others have before us,[6,10,26] that more descriptive and precise language be used to describe patients with complex social situations presenting to hospital. Continued use of labels such as FTC to air frustrations and lay blame on the patient only perpetuates ageism in the system and in the hidden curriculum of medical students and residents.

Limitations

There were several limitations to our study, which must be considered when interpreting the results. Having to depend

TABLE 2.
Univariate comparisons of categorical variables

	FTC Cases n (%)		Non-FTC Controls n (%)		cOR (95% CI)	
Number of patients	99		86			
Demographics						
Female	56	(56.6)	51	(59.3)	0.9	(0.5 to 1.6)
Home Setting						
Independent dwelling	78	(78.8)	58	(67.4)	1.8	(0.9 to 3.5)
Retirement home	21	(21.2)	11	(12.8)	1.8	(0.8 to 4.1)
Long-term care facility	-		16	(18.6)	-	
Hospital	-		1	(0.0)	-	
Informal Supports						
Living alone	59	(59.6)	26	(30.2)	3.4	(1.8 to 6.3)
Living with spouse	29	(29.2)	29	(33.7)	0.8	(0.4 to 1.5)
Living with family	9	(9.0)	14	(16.2)	0.5	(0.2 to 1.3)
Formal Supports						
Home care involved	60	(61.2)	33	(38.3)	1.8	(1.0 to 3.4)
Functional Status						
ADLs						
Independent	40	(40.4)	31	(36.0)	1.2	(0.7 to 2.2)
Assisted	58	(58.6)	49	(57.0)	1.1	(0.6 to 1.9)
IADLs						
Independent	16	(16.2)	13	(15.1)	1.1	(0.5 to 2.4)
Assisted	82	(82.2)	64	(74.4)	1.7	(0.8 to 3.4)
Mobility Status						
Independent	15	(15.2)	20	(23.3)	0.6	(0.3 to 1.2)
Cane	9	(9.1)	5	(5.8)	1.6	(0.5 to 5.0)
Walker	64	(64.6)	44	(51.2)	1.7	(1.0 to 3.2)
Wheelchair	5	(5.1)	8	(9.3)	0.5	(0.2 to 1.6)
Bedbound/immobile	5	(5.1)	4	(4.7)	1.1	(0.3 to 4.2)
Unavailable	1	(1.0)	5	(5.8)	0.2	(0.0 to 1.4)
Geriatric Syndromes						
History of falls	56	(56.6)	20	(23.3)	4.3	(2.3 to 8.1)
Urinary incontinence	37	(37.4)	28	(32.6)	1.3	(0.7 to 2.4)
Frailty	86	(86.9)	62	(72.1)	1.7	(0.8 to 4.0)
Medical History						
Dementia	25	(25.3)	18	(20.9)	1.3	(0.6 to 2.5)
Cognitive impairment	8	(8.1)	5	(5.8)	1.4	(0.5 to 4.5)
Rehospitalization in 7 days	40	(40.4)	14	(16.3)	3.5	(1.7 to 7.0)
Admission Details						
Overnight admission	73	(73.7)	62	(72.1)	1.1	(0.6 to 2.1)

cOR = crude odds ratio.
ADLs = activities of daily living.
IADLs = instrumental activities of daily living.

on ICD-10 codes to screen for patients may have introduced a selection bias as not all FTC cases were captured. Data collection through chart review was another potential source of bias, as it relied on the accuracy of notes from trainees, nurses, and allied health professionals. This study was also completed using a patient population from a single hospital system that draws primarily from one training institution. Although there is evidence that the term FTC is used similarly in other centres,[1,3] certain practices may be specific to the studied hospitals or the Ontario health-care system, affecting generalizability.

CONCLUSION

FTC is a prevalent and subjective term used to label dismissively an at-risk population of older adults. A label based predominantly on social factors, it provides no medical information and lays blame on the patient. Further research is required to understand better the system-level and provider factors that lead to a label of FTC. There is also a need to identify the consequences of receiving a label of FTC, not only on patient outcomes but also on provider biases that affect care and foster a hidden curriculum of ageism for medical trainees.

TABLE 3.
Univariate comparisons of continuous variables

	FTC Cases Mean (±SD)		Non-FTC Controls Mean (±SD)		p Value (99% CI of difference)	
Number of Patients	99		86			
Demographics						
Age	83.3	(8.0)	85.0	(7.6)	0.132	(-4.6 to 1.3)
Formal Supports						
Visits / week	8.2	(7.2)	8.9	(8.8)	0.719	(-5.1 to 3.9)
Medical History						
Number of chronic comorbidities	6.2	(2.5)	7.1	(2.5)	0.017	(-1.8 to 0.1)
Charlson Comorbidity Index	6.0	(2.2)	6.1	(2.2)	0.704	(-1.0 to 0.7)
Number of chronic medications	7.7	(3.8)	9.3	(4.3)	0.006	(-3.2 to -0.1)

TABLE 4.
Multivariable analysis

	aOR	95% CI
Living alone	3.8	1.9 to 7.8
History of falls	3.8	1.9 to 7.7
Rehospitalization in 7 days	3.6	1.7 to 8.0
Independent dwelling	2.4	1.0 to 5.5
Number of chronic medications	0.9	0.8 to 1.0

aOR = adjusted odds ratio.

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CONFLICT OF INTEREST DISCLOSURES

The authors declare that no conflicts of interest exist.

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