We faculty are trying to ensure that our patients receive the best care possible and our trainees learn the right lessons from this pandemic; at the same time, my patients are also reminding me of one of the core responsibilities of geriatricians: by our actions we must demonstrate the essential worth and dignity of even the most vulnerable.

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## Canadian Geriatrics in the Time of COVID-19

*To the Editor*: While older persons are at higher risk for severe disease with coronavirus disease 2019 (COVID-19) infections,[1] individuals the same age vary widely in their resilience. A count of years lived is less predictive of outcomes than the person's overall state of health. This entails looking at the balance between health-promoting assets and deficits, such as the type, severity, and number of morbidities, frailty, and disability. As of April 20, 2020, there have been 37,382 COVID-19 cases in Canada, with 1,728 deaths.[2] Persons 60 years of age and older accounted for approximately two-thirds of both hospitalizations and critical care admissions and 94% of deaths.[2]

Geriatrics in Canada differs in significant ways from US practice. This letter summarizes the response of Canadian internists-geriatricians to the COVID-19 pandemic. In normal times, they function as consultants, typically working within academic healthcare centers. They do not provide primary medical care or play a major role in long-term care (LTC) facilities.

During the pandemic, Canadian internists-geriatricians have combatted ageism[3,4] and spoken on the need to clarify and document goals of care before the onset of a potentially life-threatening infection when decisions may have to be made quickly about hospitalization, admission to a critical care unit, intubation, and ventilatory support. A number have contributed to the development of COVID-19 policies, where they emphasized the need for an individualized approach when deciding on allocation of limited healthcare resources. A unique consideration they brought to these deliberations was the assessment of frailty and its severity.

On what seems a daily basis, Canadians hear about large numbers of LTC, assisted living and retirement home residents dying from COVID-19. Some of these reports can only be described as horrific.[5,6] The congregation of highly vulnerable individuals makes these facilities dangerous sites in the best of circumstances, but limitations in the number (and training) of staff, access to personal protective equipment, and the physical environment coupled with lax institutional policies about visiting and staff working at multiple sites (often to earn a living wage) at the onset of the pandemic left them inadequately protected.[7] To support physicians and staff working in these facilities, geriatric groups across the country created advice lines and virtual consultation services, but clearly more must be done.

In early March, the Canadian Geriatrics Society (CGS) provided guidance to older persons on minimizing their risk of contracting COVID-19 that included physical (or social) distancing.[8] While this slows the spread of the disease, many older persons require assistance with daily activities, depend on regular contact with family members, or were isolated before distancing began, and have less familiarity with or ability to use personal communication technologies. How to mitigate the adverse effects of physical distancing has proved challenging.

Canadian internists-geriatricians are involved in the acute management of COVID-19 infections. Specific areas that attracted attention within the field include risk assessment, determining goals of care, atypical presentations, iatrogenic complications, dealing with neurological manifestations, such as delirium, and discharge planning, particularly in complicated cases. Due to attendant deconditioning, stress often aggravated by restrictive visiting policies, sleep deprivation, malnutrition, and cognitive dysfunction with hospital stays, older persons are susceptible to postdischarge complications. A backlog of post-acute needs is building that will have to be eventually addressed.

Non–COVID-19 clinical work is now done primarily as video or voice calls. There has been a good deal of internal discussion about how to effectively assess suspected cognitive impairment with these modalities. Both clinical research and teaching activities have been compromised by COVID-19. What carries on has moved to an online environment. At an organizational level, the CGS established a national COVID-19 group that meets on a weekly video call to share information, resources, and promising strategies.

An unanswered question is what impact the COVID-19 pandemic will have on the future practice of geriatrics in Canada. Some changes are givens. These include being stronger advocates for older persons, being more active in promoting advance care planning, and having greater involvement in the development of health policy. There will also be greater use of communication technologies. After that, things become debatable. Our ability to occupy a larger clinical role is limited by numbers. The most recent national count of internists-geriatricians was 304, less than 0.4% of all Canadian physicians. Strategic thinking and hard choices will be required.[9] Should we seek a greater role in acute care or "at the sharp end," as proponents describe it? What about addressing obvious needs in both facility- and community-based continuing care? If we take on additional activities, what will be dropped?

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