THE FAMILY DOCTOR'S ROLE IN THE CARE OF THE ELDERLY

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ABSTRACT

With the anticipated increase in the number of aged persons in our local population, there will be an increased workload for the family doctor caring for the elderly in the community. Diseases thought to be attributed to ageing may be non-degenerative and hence treatable. This paper highlights the role of the family physician in the care of the elderly as the doctor's recognition of these diseases and consequent early intervention may result in an improved outcome for the patient. Optimal care can be achieved with the family doctor's systematic planning of the individual's care, networking with hospitals and other health professionals and providing support for carers.

Keywords: *family doctor, elderly, continuing care, multidisciplinary team, carers.*

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INTRODUCTION

Beyond the year 2000, Singapore will see an increasingly ageing population with the proportion of elderly persons above 65 expected to rise from 9.0%[1] to more than 14.5%[2,3]. This increase will have immense socio-economic implications on the rest of the nation. Family physicians can hence expect more consultations with elderly patients who already constitute a sizeable proportion of a doctor's practice. The 1988 one-day morbidity survey conducted by the Ministry of Health revealed that those above 60 years of age constituted 11.1% of attendances in private clinics and 14.5% of attendances in government polyclinics[4]. Furthermore, they also constituted almost 20% of all admissions to public hospitals[5].

The current national policy of "endeavouring to keep the elderly people physically and mentally fit for as long as possible so that they can maintain their normal daily activities and living[6]" is a move to help prevent and manage the health problems which confront an ageing populace. In support of this, the family physician's role in the care of the elderly can therefore be expanded beyond the therapeutics of treating the aged to include other aspects of community-based geriatric care.

SHORTCOMINGS OF CURRENT PRACTICE

In a recent British Journal of General Practice editorial, Tulloch identified the shortcomings particular to the health care of the elderly in the community. These are:

1. underdiagnosis of certain medical disorders, notably depression, dementia, incontinence, disorders of the feet, disorders affecting mobility, alcoholism and physical abuse;
2. poor identification and management of disability and sensory impairment;
3. overprescribing;
4. poor patient health education and health promotion, leading to the poor use of community resources by patients;
5. lack of attention to carer stress;
6. poor standards of record keeping[7].

These shortcomings can be considered relevant to our local situation and family doctors should learn to recognise them, as an oversight might precipitate a crisis in care. They therefore provide challenges to the practitioner caring for elderly people and he needs to organise his management approach to facilitate effective care.

THE FAMILY PHYSICIAN'S ROLE

To overcome these anticipated shortcomings, family doctors caring for the elderly should first re-examine the scope and nature of their work in the following areas:-

1. personal care
2. continuing care
3. care of the family

1. Personal care

a) Individualisation and rapport

One of the main functions of a family doctor is to provide personal care and this is especially true for old people who are more likely to identify with their doctor. They are likely to reveal their problems to someone with whom they are familiar and in whom they can entrust their care[8]. In this respect the family doctor who has become familiar to the elderly patient over the years is well placed to manage the patient's health problems within the community and act as a liaison person for community-based support services should the need arise.

b) Basic geriatric skills

i) Awareness of diagnostic pitfalls

The family doctor's consultation is often the point of first contact between an elderly person with a health problem and the health care system. The doctor can therefore act as a "gatekeeper" by screening and facilitating referrals for secondary care such as the stroke rehabilitation centre or the geriatric ward. In order that these referrals be appropriately made, doctors should be aware of certain pitfalls when making a diagnosis and identifying problems in the elderly patient. In particular, three common pitfalls are:

Firstly, disturbances such as infection or falls which are of minor consequence to a younger person may have serious consequences in an older person and should not be dismissed lightly.

Secondly, there is a tendency for old people to under-report

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Appendix I – The Barthel Index of functional assessment

Ambulatory status : ☐ 1. Ambulant & physically independent without aids
: ☐ 2. Semi-ambulant, using walking aids to move
: ☐ 3. Semi-ambulant with human assistance

Barthel Index

(Circle the appropriate points)

Activities Rated by Examiner	Points for Performance: Independently	Points for Performance: With Help
1. Feeding (if food needs to be cut with help)	10	5
2. Moving from wheelchair to bed (includes sitting up in bed)	15	10 (minor help - 1 person giving support)
3. Personal toilet (wash face, comb hair, shave, clean teeth)	5	0
4. Getting on and off toilet (handling, clothes, wipe, flush)	10	5
5. Bathing self	5	0
6. Walking on level surface	15 (but may use any aid, eg. stick)	10
Propel wheelchair (score only if unable to walk)	5	0
7. Ascend and descend stairs	10	5
8. Dressing (includes tying shoes, fastening fasteners)	10	5
9. Controlling bowels	10	5
10. Controlling bladder	10	5

Total score = ☐☐☐

Interpretation Score:

100 : probably can remain alone at home
80-95 : mild disability– probably needs supervision
55-75 : moderate disability – probably needs 1 person's assistance
< 50 : severe disability – probably needs 2 persons' assistance

symptoms of illness such as declining vision or decreased joint mobility as these are often attributed to old age itself and are therefore thought not amenable to treatment[9].

Thirdly, atypical presentations are commonplace and may be frequently overlooked. Examples include confusion as a presenting complaint in a frail old lady with chest infection and tiredness in an old man with a recent myocardial infarct.

The doctor's recognition of treatable conditions such as chest infection or a silent myocardial infarction is important. Early intervention with the appropriate medical management and referral is crucial to improving the patient's outcome and consequent health status.

ii) The need for functional assessment

Elderly people with chronic disease usually associated with disability for example stroke, need periodic reviews of their health and functional status. This is to ensure that disability does not progress to physical handicap, dependence and hence a decrease in quality of life. The family doctor should thus routinely perform a functional assessment of his elderly patient using a common index of his choice for example, the Katz or Barthel index and the Instrumental Activities of Daily Living (ADL) Index.

The Barthel index, for example, is a simple means of functional assessment by awarding a score to each of the 10 basic activities of daily living (see appendix 1) according to the observed performance of the patient[10]. Uncomplicated functional assessments such as this can be done in five minutes provided the doctor is well versed with the index.

Doctors may also need to conduct assessment of functional status in the home environment to obtain an accurate picture. After the initial assessment is done, the functional state is reassessed whenever an improvement or suspected deterioration in the patient's health status needs confirmation.

For the frail elderly, the prevention of disability and handicap and the maintenance of a reasonable quality of life may be of greater importance than finding a diagnosis or cure. Knowledge of the elderly patient's functional status is important as a sudden deterioration in functional status often indicates the onset of acute illness which if treated promptly can help to maintain the patient's health and prevent dependence.

iii) Prescribing for the elderly

Multiple health problems such as failing memory, poor vision, impaired dexterity, reduced hepatic and renal function can all contribute to problems with medication in the elderly[11]. These problems are often compounded by polypharmacy or multiple medications. In their study of the pattern of medication in the

elderly, Cartwright and Smith also identified several other contributory factors such as the inadequate giving of instructions to patients, inadequate record keeping and inadequate monitoring of long-term medication[12]. These problems are also relevant to our local context and doctors should take steps to review their patients' medication list periodically.

Simplifying drug regimens for independent patients and entrusting disabled patients' carers with the giving of medication are useful methods of reducing iatrogenic morbidity. During each consultation, the family doctor should also enquire about symptoms of toxicity or overdosage. This may occur for example, with hypoglycaemia in the elderly diabetic treated with long-acting sulphonylureas. Usage of over-the-counter drugs or traditional medicines for symptomatic relief is also a common occurrence which should be enquired after.

c) Anticipatory care

This is defined as the provision of all types of prevention by the use of health promotion and education at the same time. This is usually undertaken during normal patient contact time[11] and a systematic approach is required to prevent increased morbidity in the individual. Old people often present with multiple new problems in addition to existing ones and it is often difficult to determine which preventive approach to take. A common approach usually practised by doctors is to alleviate symptoms and prevent handicap by preserving or improving function; the hoped for effect is thus improved quality of life[11].

The proactive approach involves anticipatory care of the elderly with the selective screening of "at risk" groups such as the recently widowed and over 75s or full geriatric assessments for those above 60. Not all doctors presently offer these services to their patients though the Ministry of Health does provide an over 60s health assessment service at its community-based Senior Citizens Health Care Centres.

Much has been debated on the value and validity of screening which can be expensive and time consuming. Many doctors abroad have not been convinced of its usefulness in the preventive care of the elderly. Zazove et al however have advocated limited screening and have developed a checklist of components which "have improved effectiveness in the old old[13]". These items have also fulfilled evaluative criteria developed by Klinkman[14] and are given in Table I.

Table 1 – Checklist of useful items in assessing the geriatric patient.*

History

1. Smoking history
2. Identification of polypharmacy
3. Mental status (especially dementia)

Physical examination

4. Serial blood pressure recordings
5. Visual and hearing acuity
6. Nutritional status (especially the detection of anaemia and undernutrition)
7. Breast examination in women 75 years and under
8. Urinary incontinence
9. State of podiatric care
10. Mobility / Activities of daily living (ADL) assessment

* adapted from evaluative criteria developed by Klinkman and Zazove.

Screening for cancers, diabetes mellitus, hypothyroidism and hypercholesterolaemia which had been thought to have had some value were found not to be so.

Family doctors caring for elderly patients should preferably draw up a simple checklist for selective clinic–based screening of their patients using for example the items given in Table I. This not only provides a systematic review of the patient's health status but also serves as an indicator as to whether further assessment, investigation and follow-up is necessary.

d) Health promotion and health education

Health promotion at the primary level is still pertinent to the elderly and should address healthy lifestyle issues such as giving up smoking, reducing obesity and the modification of diet. The importance of regular exercise and maintaining mental status should also be emphasised. These messages can be given directly to the elderly patient during the consultation or indirectly through pamphlets, videos or even support groups organised by the doctor. The busy doctor can also refer patients to other health professionals such as the dietician or to community-based organisations such as the Diabetic Society of Singapore and the Ministry of Health's proposed Diabetic Education Centre.

Besides actively promoting a healthy lifestyle, the family doctor may also need to explain the disease process, prognosis and management options to his elderly sick patients and their families. This is often a long, tedious but nevertheless important aspect of the patient's care. However with the patient and family's improved understanding of the disease process and the goals of management, patient compliance and family support will be enhanced.

2. Important issues in continuing care

Continuing care refers to the care of the patient with chronic problems which require regular monitoring and/or treatment so that an optimal level of physical, social and psychological functioning may be attained[15]. As the frail elderly are more likely to be suffering from chronic and often disabling diseases with resulting handicap of poor mobility and self care[16], it is important for their family doctors to provide an organised form of continuing care. Recent consensus reached in Great Britain[11] advocates the careful planning of the elderly person's health needs and care by his/her family doctor in the following areas:

a) Health maintenance

In monitoring the person with chronic disease, a systematic approach is needed with regular documentation of standard parameters of control. Doctors caring for the elderly person with chronic disease should provide periodic check-ups for the detection of complications, for example, diabetic nephropathy and retinopathy. This is in keeping with the goals of preventive care of the elderly. Previous emphasis was placed on the early identification of treatable incident disease, however the postponement of possible complications from chronic disease is also now considered important[17].

b) Tertiary prevention

The elderly with chronic disease may already be disabled by complications arising from the disease process. In this instance, it is important that the family doctor initiate the practice of tertiary prevention to minimise this disability. For example, he can advise the family of a bedridden stroke patient to turn the patient at regular intervals daily to prevent the onset of bed sores. The doctor can also enlist the help of the Home Nursing Foundation nurse to teach them the correct turning techniques and thus reinforce his message.

c) Community support services

The family doctor's knowledge of the available range of resources from statutory and voluntary community bodies is important in optimising his patient's care. Organised preventive health services include for example, the polyclinic diabetic retinal screening service or rehabilitative services such as the stroke rehabilitation

programme run by the Senior Citizens Health Care Centres. Day care centres and other community resources which do not provide a paramedical component, exist to enable principal carers to have a break and rest. The family doctor should therefore be able to recommend to the patient and his family the appropriate use of these resources.

d) Networking and the multidisciplinary team approach

Community care of the elderly patient is often multifaceted and is difficult for family doctors to implement single-handedly. Management plans should therefore include the services of other health care professionals such as nurses, dieticians, occupational therapists and physiotherapists. Networking through liaison with these professionals is desirable to provide a multidisciplinary team care approach.

Although this approach to care is currently not practised locally in the community setting, its development is required to integrate and optimise community care for the elderly, and to prevent wasteful duplication of resources. In countries like Britain where the multidisciplinary team care approach is established, the family doctor is often looked upon as the "team leader". He then assumes the managerial role of planning and organising the desired level of care for the individual. This facilitates communication between team members and helps to delegate responsibility to the correct person[18]. The need for similar networking of services between hospitals with geriatric wards, family doctors and the government polyclinic with its Senior Citizens Health Care Services has been mooted at a recent government sponsored workshop in Singapore[19]. This will help ensure a smooth transition of care for the elderly patient from the family to the hospital and back eventually to the family.

3. Care of the family

Family doctors should also address the needs of the elderly patient's family to whom they may provide care. These people often need psychosocial support as they will be subjected to lifestyle modifications while shouldering the burden of caring for their dependent relative. It is especially important for the doctor to recognise the principal carer within the family as he/she may suffer stress from caring.

a) The problems carers face

Principal carers of the elderly sick may develop problems with their own advanced age, problems with their own health, physical difficulties with nursing, concerns about safety, aggressive behaviour of those cared for, incontinence, poor communication, and the lack of knowledge of the disease management and prognosis[20]. The doctor may need to:

1. identify prime carers and alternative plans before crises occur;
2. balance the needs of both patient and carers;
3. communicate to carers the nature of the illness, the medication and the prognosis;
4. recognise signs of strain in carers;
5. respond to carers' needs for help;
6. take the necessary steps for carer support.

b) Management approaches to carers' problems

The management of carers is crucial to the well being and continued support of the elderly individual in the community and they should not be neglected. The relief of carer stress can be facilitated by:

1. giving advice on the care of the bowels, skin and urinary functions of the patient;
2. teaching carers how to look after the disabled elderly; for example, they can be taught transferring techniques by Home Nursing Foundation nurses or by therapists at the Senior Citizens Health Care Centres (SCHCC);
3. helping to educate carers on usage of nearby day and respite care facilities;
4. encouraging carers to participate in locally established support groups such as the stroke club at Kampong Ubi SCHCC;
5. recommending the use of the domicilliary nursing service such as that provided by the Home Nursing Foundation when necessary[11].

CONCLUSION

The family physician's role in the care of the elderly is often viewed as critical due to the close contact developed with elderly patients. It demands that he acquires the clinical acumen to identify the common diseases associated with ageing. He should develop the medical acumen to distinguish between correctable age-related diseases like cataract, from those diseases which are not. It is important that the doctor should also possess the compassion to help carers and sufferers of irreversible degenerative conditions like Alzheimer's disease or dementia.

To overcome these challenges, the family physician needs to equip himself with knowledge of basic geriatric care, acquire the clinical skills to decide on appropriate management plans, develop links with other health professionals and nurture his sensitivity towards the needs of carers. In doing so, the family doctor opens a new and fulfilling dimension in his work within the community.

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