A call to action - integration of geriatrics into mainstream medicine

Pages with reference to book, From 6 To 7
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A 72-year-old man living in a fourth floor apartment with his bed-ridden wife tries to remember his plan for the day. He retrieves his dairy and manages to read (with some effort) his penciled checklist. Ah yes! Bank for pension, visit for blood pressure check, then see the other doctor for knee pain and most importantly take his wife for her memory…. but how do I get her down those stairs?
These are the golden years where the hard work and struggles of youth are supposed to bear fruit. Whereas quite a few of septuagenarians and octogenarians enjoy good health and a lower burden of responsibilities as their children mature, the vast majority of the elderly struggle with rising co-morbidities in the face of ever-increasing socio-economic financial pressures.
The special and varied needs of the elderly have been recognized to a large degree in the developed world with concrete steps taken to address their medical and monetary concerns. Multiple programmes catering to specific needs of the aged are in place including medical insurance plans, development of appropriate infrastructure and social support systems all of which have had some impact on the quality of life.
The developing world on the other hand is still grappling with this shift in ageing demographics and thus ill prepared to meet the needs of the elderly Pakistan is also expected to join the developing countries where projected numbers of elderly are expected to triple,[1] making one out of eight Pakistanis elderly (the current figures are at six percent of the population).
Till the acceptance of this change in demographics occurs, the well-being of the elderly is primarily their own responsibility rather than that of the state or society.
Whereas a multi-tiered and multi-pronged approach is required with development and funding to formulate a functional policy for the well-being of the elderly, the medical community that stands at the forefront of dealing with their medical issues has to shift its focus to tailoring itself to adapt to this growing concern.
In Pakistan at present, both in the public and private health sector, specialist oriented, disease- specific care dominates medical practice. The concept of multi-disciplinary care is rudimentary and referrals between specialists often result in loss in continuity of care with patients seeking different providers at differing times.
In in-patient settings a somewhat similar situation is seen where multiple care providers see the patient for problems that exist or arise during hospitalization, again resulting in fragmented uncoordinated care and suboptimal patient follow-up.
While this works for a large majority of the non-elderly patients, it poses a great disadvantage to elderly patients suffering from multiple co-morbids going from doctor to doctor for their new and ongoing ailments. Not only does this add to the financial burden of health care to our uninsured masses that already struggle to make ends meet after retirement; but may compromise the quality of care as well.
Care provision may suffer when individual illnesses are treated rather than patient as a whole. In addition the disease oriented care model adds a huge burden of logistics and cost to the elderly needing to visit multiple care providers, often resulting in missed appointments and poor follow up.
Prescribing practices need to be tailored differently for geriatric patients as medication errors abound at multiple levels: differing providers, various dispensers, various caregivers in the face of complex regimens and poor clearing mechanisms.

Geriatric syndromes, a common end result of multiple illnesses e.g. falls often result due to presence of certain co-morbids, straining the ageing physiologic mechanisms at times in the face of an infection like a urinary tract infection. These syndromes therefore demand a thorough understanding of the processes leading to them to allow timely recognition and management by all those involved in geriatric care. An example of the frequency of occurrence of such syndromes was evident from a recent study in Pakistan where delirium was found in one out of every five hospitalized elderly patients.[2]
While the most apparent solution would be recognizing and establishing geriatrics as a specialty in the public and private sector, the real solution lies elsewhere. Establishing geriatrics is only one of the responses to help us better the quality of life of our aged (which we hope is recognized in the near future); however a basic understanding of care of the elderly is the most immediate and practical step that should be undertaken by all care providers medical and allied.
This can be accomplished by: 1) enhancing awareness of illnesses specific to the aged, 2) an appreciation of common geriatric syndromes like falls and delirium and 3) understanding of drug prescribing for all those caring for elderly patients. Not only is that financially feasible but the better understanding of elderly care would translate into better medical practices by all medical and surgical specialties. This also supports a well-established fact that the number of geriatric specialists is at present inadequate[3] more non-geriatricians are looking after elderly patients. To address this issue, the American Geriatrics Society established a separate division for non-geriatricians called Section for Enhancing Geriatric Understanding and Expertise among surgical and medical specialists (SEGUE).[4]
Another effort to address the burgeoning aged population was a report on training of formal and informal caregivers of the elderly proposed by the Institute of Medicine in 2008.[5]
In addition, educating our aged and their caregivers to enhance awareness of common health problems would help them shoulder the responsibility of their health better. Developing and integrating home care services for those unable to access care and improving end of life care for those with limited life expectancy are other areas where the medical community can take action.
A small example of this is currently underway at a private hospital in Karachi where basic geriatric concepts have been incorporated in the curricula of undergraduate medical and nursing students. Core geriatric concepts have also been introduced in curricula of Family Medicine and Internal Medicine trainees. Efforts to educate the public and caregivers of elderly are underway and collaboration with other hospitals is planned. We hope that other, hospitals and medical organizations specialties soon get on board this initiative and recognize the importance of integrating care for the elderly to maximize their quality of life.

References

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