INVITED ARTICLE

METHODOLOGY IN GERIATRIC MEDICINE

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ABSTRACT

Geriatric Medicine encompasses physical, mental and social problems in the elderly individual. To cater for varied changing needs a flexible system is required providing a range of services. A positive approach is advocated : without this, institutions will be overwhelmed by the flood of immobile, bedridden aged. Individualised care needs to be developed to ensure a good old age.

Keywords : Active Care, Holistic Approach, Framework of Services, Independence, Planning

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"Health is a state of complete physical, mental and social well-being and not merely the absence of disease and infirmity" - World Health Organisation.

INTRODUCTION

The practice of Geriatric Medicine combines the basic principles of Geriatric Medicine together with important additions peculiar to Geriatric Medicine. These additions emphasise the physiological changes occurring with ageing affecting the presentation of disease, and the intimate relationship between physical, mental and social well-being in the elderly.

Geriatric Medicine offers the practitioner the opportunity to be involved both with individualised patient care and with the broader aspects of the provision of care for the elderly in society. The Geriatrician may be involved with the patient, the family, the patient's immediate environment and the community. The practice of Geriatric Medicine requires knowledge of both the art and the science of medicine.

The World Health Organisation has defined Geriatric Medicine as that branch of medicine which is concerned with the clinical, rehabilitative, preventive and social aspects of health and illness in the elderly.

BASIC PRINCIPLES

Establishing a diagnosis is still the foundation of sound management. However, difficulties may be encountered. Knowledge of the physiological changes associated with ageing is essential so that pathological change can be appreciated. Ageing itself is not a disease. Altered physiology together with multiple pathologies produce a typical presentation of disease and a challenge to diagnostic skills. The professionals and the older indiviual may both ignore indicators of ill-health mistakenly accepting disability as an inevitable consequence of ageing.

Ill-health in the elderly may be remediable. There is still an immense potential for recovery. This recovery may be hindered by the mistaken belief, held by professionals and the elderly themselves that bed rest is valuable. In fact bed rest, without specific reason for a specified period of time can be extremely dangerous. Forty-eight hours in bed for an elderly person predisposes to hypostatic pneumonia, deep vein thrombosis, pressure area breakdown, osteoporosis and even contracture formation. Bed rest is seen as the panacea for all ills, whereas it is the source of most ills. Early referral for expert advice is vital whenever an elderly individual takes to his or her bed.

An elderly individual with non-specific ill-health requires prompt assessment so that a management plan can be outlined. Rehabilitation should commence immediately. Rehabilitation aims at restoring an individual's maximal potential[1]. In order to be successful a multi-disciplinary approach is required, input from physiotherapist, occupational therapist, nurse, speech therapist and social

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worker being essential for assessment of the whole individual – a truly holistic approach.

In general older people are happier and healthier in their own environment. However, wherever situated they are constantly at risk of disturbances to either their physical, social or mental well being. Unlike in the young individual, the distinction between these three factors is not so clearly defined. Any disturbance in one will affect the other two entities. It is a constantly moving circle, one problem is never uppermost, the other components are always involved. In the younger individual the problems tend to be distinct, they seldom merge, they are independent problems likened to the triangle, a structure which is exceedingly difficult to distort (Fig 1).

Fig 1
The "Young" Triangle and the "Old" Circle

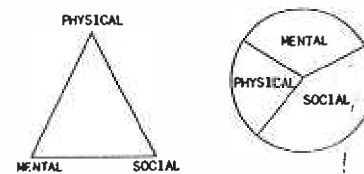

FIG 1. THE "YOUNG" TRIANGLE AND THE "OLD" CIRCLE

Fig 2
The Balance of Care

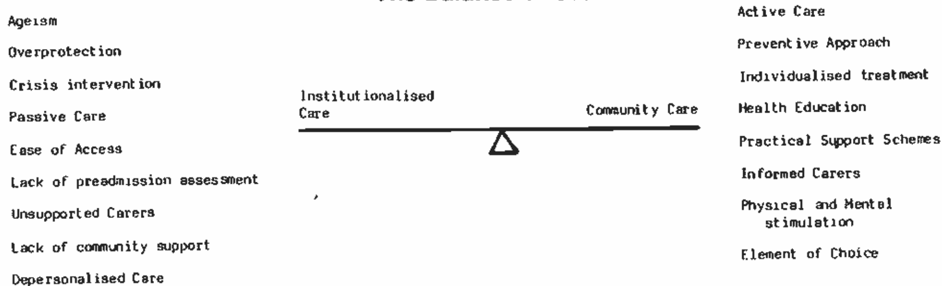

FIG 2 : THE BALANCE OF CARE

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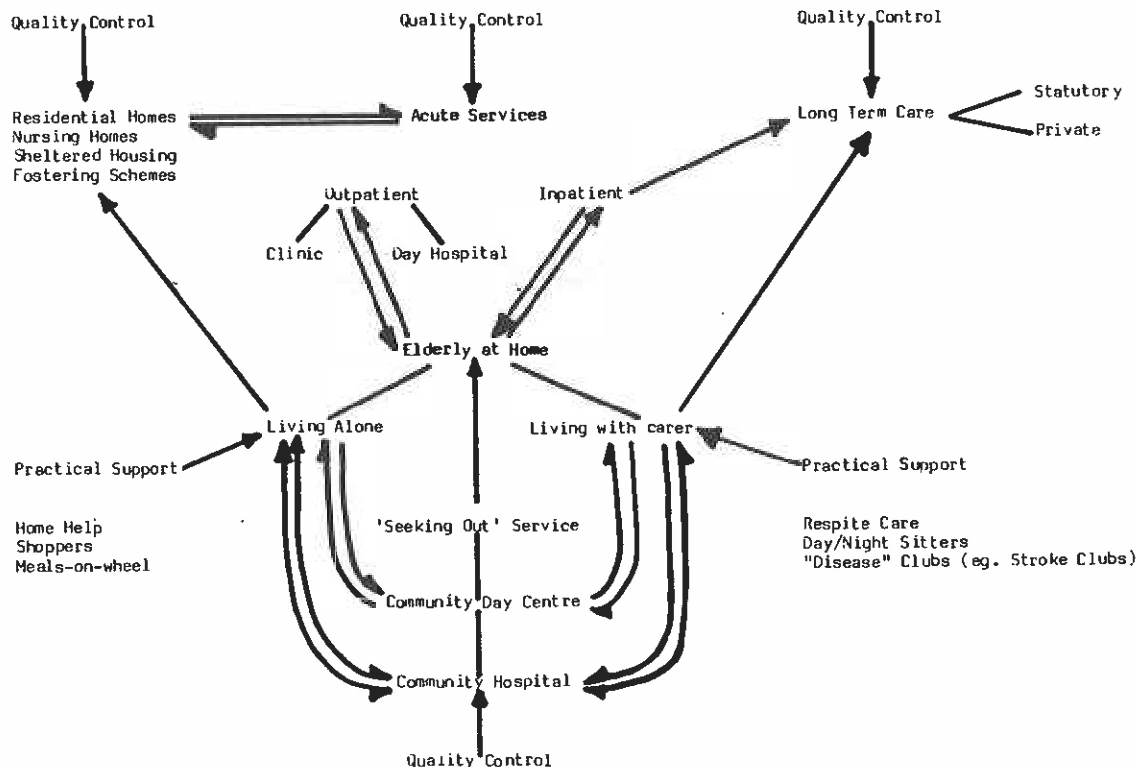
Fig 3
Methodology



THE FRAMEWORK OF CARE

In view of the constantly revolving nature of ill- health in the elderly a framework of services is needed, incorporating flexibility[2]. An inter-disciplinary approach is vital for success. The co-operation of many agents required; family, community, voluntary bodies, government agencies are all inter-related. None can operate in isolation. They are mutually dependent. Services need to be available to all and costly duplication of services prevented. A central co-ordinating body is valuable in ensuring efficient cost-effective use of available resource. A centralised control also facilitates dissemination of information on available services to interested parties.

Assessment, both in sickness and in health, is vital. A range of assessment options is required. The success of assessment units depends on the availability of resource following the assessment. If needs are identified then there should be means available to fulfill those needs, otherwise the whole exercise becomes extremely inefficient. Community and hospital services are mutually independent. Their differing roles require definition and clarification.

If possible, assessment and therapy should be performed whilst maintaining a home base. A variety of outpatient assessment facilities are required. Polyclinics, day hospitals and outpatients are needed, with patients of differing capabilities referred to the most appropriate area. A day hospital (a hospital without beds) can be of great value, providing medical, nursing and paramedical input together with the added bonus of social interaction. Transportation is usually the main problem; the patients who need the facility most being the very ones unable to utilise public transport. Cheap alternatives, available to all, are required.

If admission is unavoidable then specialised units with access to modern diagnostic techniques are required. The multi-disciplinary approach would be practised endeavouring to ensure that a holistic approach is maintained. Not all patients recover their independence. If an acute inpatient facility is to function effectively, it must have access to sufficient outlets. A few patients will remain totally dependent requiring constant trained nursing care. The strain on a limited number of carers at home would be indescribable. Acute units should have access to suitable long term-care facilities staffed by trained personnel who know the importance of quality of care even during protracted chronic illness. Such facilities should be available to all regardless of financial situation. Access should be based on degree of need rather than on financial grounds.

CARE IN THE COMMUNITY

The ideal situation is one where the elderly are encouraged to remain as independent as possible within their own environment despite disability. The alternative is the acceptance of disability, the perpetuation of dependence and the explosion of institutionalised care as the only means of dealing with the problem[3]. This would totally ignore the importance of improving the quality of life for the elderly (Fig 2).

To maintain independent elderly at home, a system is required that not only promotes activity and freedom of choice for the elderly but also seeks out disability at an early stage. Prevention of disability and worsening handicap should be a priority. Seeking out illness may be of immense value.

Assessing the level of stress imposed on carers is also important. Emotional support is not always sufficient. Practical support, available to all would be of great benefit in preventing crisis admissions which often result in premature institutionalisation[4]. It is often the less fortunate families most in need of practical support and they are the least likely to have financial means of obtaining help.

Due to demographic changes, the number of elderly living alone is likely to increase over the next 30 years. In order to accommodate frail elderly wishing to retain their independence there will be a need for varying forms of sheltered housing.

Consideration of alternative means of accommodation frequently occurs at a time of "social breakdown"[5]. The family feels they can no longer manage. A full multi-disciplinary assessment at this time may prevent inappropriate admission to institutional care. If institutional care is unavoidable then that care must be seen to be adequate. The care of patients in a long term facility is a specialised field. Providing a bed and shelter is not sufficient. To ensure certain standards are maintained statutory requirements for basic care needs should be outlined.

CO-ORDINATION OF CARE

To provide good quality care in all quarters requires planning, ensuring flexibility, freedom of choice, supervision and a range of options (Fig 3). The cost implications cannot be ignored and it is essential to ensure that services remain cost effective. A central controlling body would be ideally placed to assess and co-ordinate services ensuring value for money. However this central body would need to be aware of the pattern of ill-health in the elderly – the constant revolution from ill-health to health. A rigid approach would condemn many to institutionalised care who could be maintained in the community given a range of supporting mechanisms. Practical help in the community cannot rely on ad hoc sporadic voluntary contributions. Reliable, regular committed support is required, directed to areas of documented need[6].

The practice of Geriatric Medicine requires a sound knowledge of general medicine. It also requires an understanding of the process of ageing and its effect on disease. The geriatrician must have a wider appreciation of the place of the elderly in society and the conviction that the majority of elderly can enjoy a good old age when society provides the basic flexible framework.

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