INVITED ARTICLE

GERIATRIC MEDICINE : THE MULTIDISCIPLINARY APPROACH

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ABSTRACT

Care of the elderly requires a team approach. Effective teamwork requires adequate communication. Each professional has an important role to play. The patient and carer should also be seen as part of the team and involved in management planning.

Keywords: Team approach, communication, rehabilitation, activities of daily living, counselling

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THE MULTIDISCIPLINARY APPROACH

The practice of Geriatric Medicine requires an acceptance of the strong interrelationships between physical, mental and social factors.

To assess a patient completely several specialist viewpoints are required. To instigate therapy several specialists are necessary. Geriatric Medicine, therefore requires a multidisciplinary team approach (1).

To achieve a successful outcome not only does the team have to know each patient but each team member must have an appreciation of his/her co-worker's role, capabilities and limitations. To be successful there must be good communication and mutual respect. There is no place for professional jealousy and the inflexible protection of professional boundaries.

Sound leadership is obviously required. Many question the doctor's assumption that he or she is automatically the leader. It has to be remembered that the team ultimately has to make a decision and someone has to be accountable for that decision. It would seem reasonable to expect that the person with ultimate responsibility makes the ultimate decision.

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The number of people involved with patient care is infinite. However for each individual patient only a finite number of specialists will be required(2). The Nurse and Doctor are usually the people who decide which other professionals are required. A doctor would not prescribe a drug without having some knowledge of its effect both beneficial and adverse - likewise paramedical referral should not be contemplated without thought for indications and expectations.

THE DOCTOR

The doctor is responsible for assessing the overall condition of the patient. He does this by taking a full history, performing a full examination and by interviewing relatives or carers whenever possible.

The doctor is then in a position to enumerate the problems and outline a management plan. The doctor will refer the case to the paramedical staff when appropriate. Therapeutic objectives will be set out and progress assessed at intervals.

THE NURSE

The nurse is probably the foundation on which a good geriatric service is built. Without specialist trained, motivated nurses no department of Geriatric Medicine will survive. The specialist nurse has a role both in hospital and in the community.

The nurse is responsible for assessing the total needs of one patient, making a nursing diagnosis and formulating a management plan for nursing care. Good communication with medical staff is essential to ensure that both are working towards similar goals.

The nurse institutes preventive measures. She is vital for the promotion of continence. Rehabilitation would be impossible without a suitably trained nurse.

Specially trained nurses can assess the elderly at home, promote physical independence and emphasize the importance of secondary and tertiary prevention.

NURSE LIAISON STAFF

Hospital and community services each have their own problems. A liaison nurse working between the two environments facilitates communication and professional understanding. Therapy initiated in either situation can be explained fully. Advice given to relatives and patient in one environment can be reinforced when a patient moves into the other situation.

PHYSIOTHERAPIST

The physiotherapist has two roles, one is directly related to patients, the second is concerned with education, advising relatives and staff about the correct way of dealing with physical problems.

Physiotherapy is vital if patients are to be encouraged to retain their mobility during an acute illness or improve their mobility following an insult to their locomotor system.

The physiotherapist requires information from other members of the team with regards to exercise tolerance, home situation, family and patient expectations and clinical prognosis.

The advice given by a therapist should be communicated to the nursing staff (or to the carers if the patient is in the community) as they have 24 hours contact with the patient, and can continue the therapeutic regime in the absence of the therapist.

Physiotherapists are in short supply. They should be used efficiently - requesting chest physio on a patient with a dry cough is probably a waste of time.

OCCUPATIONAL THERAPIST

Within a Department of Geriatric Medicine the role of the occupational therapist revolves around the assessment and treatment of activities of daily living. These are the activities that are normally taken for granted but which cause concern and consternation when lost, eg. ability to dress and undress, ability to eat unaided, to get on and off a chair, bed or toilet. The occupational therapist is expert at assessing perceptual disorders, a field unfamiliar to many medical practitioners but knowledge of which, is vitally important to all members of the team.

The occupational therapist may assess the patient in the hospital environment but may also undertake a home visit to assess the patients capabilities within their own environment. As a result of this the occupational therapist may recommend that adjustments or additions be made at home ie. rails in toilet or shower, chair or bed to be at correct height.

The occupational therapist also has an advisory role and may wish to discuss domestic arrangements with both family and patient.

In a long term care environment both physiotherapist and occupational therapist may still be of great benefit. Both therapists will endeavour to ensure that each individual patient maintains his maximum level of independence. They may do this by encouraging group therapy with enjoyment, social interaction and a tangible end product.

THE SOCIAL WORKER

Unfortunately, referrals to social workers are often only considered when financial difficulties are encountered. Their counselling skills may be ignored. A family under stress can receive a great deal of support by prompt referral to a trained social worker. Group therapy or family therapy may be considered. The social worker has knowledge of available services and resources.

The preceding team members constitute the core team, required for the majority of patients. Other staff members are important but may not participate in the multidisciplinary team on such a regular basis.

THE SPEECH THERAPIST

Communication is of utmost importance. The speech therapist will assess the speech problem and undertake therapy but he/she will also advise the patient, the relatives and the multidisciplinary team on the most effective form of communicating with individual patients whilst specialist therapy is continuing. He/she may see patients individually or may instigate group therapy.

DIETICIAN

Undernutrition in clinical or subclinical form is being increasingly recognised in elderly patients(3). Income correlates inversely with the degree of nutrient deficit found in elderly people. Socio-economic status is inversely associated with risk of age-associated falls in dietary calcium, vitamin A, vitamin C and protein. Many social factors other than income influence the dietary intake of old people including education, culturally based food habits, eating alone and bereavement.

In general there is a poor prognosis in undernutrition in old people. The dietician is ideally placed to assess nutritional intake and advise regarding necessary supplementation.

PHARMACIST

The elderly are far more at risk of adverse drug reactions than the younger members of the population. They are prescribed more drugs and seem to have an increased susceptibility to adverse reactions. Physiological changes make drug handling more unpredictable. Pharmacokinetics and pharmacodynamics are altered in the aged individual.

The expert advice of a pharmacist can be invaluable in the daily management of an elderly patient. The weekly attendance of a ward pharmacist increases awareness of possible drug interactions and is a positive step towards safer prescribing.

CHIROPODIST

A fully trained registered chiropodist is required on any multidisciplinary team. Foot problems may precipitate hospital admissions and should not be ignored. Foot care assistants may be adequate for routine toe nail cutting, which the elderly find difficult, but the care of the diabetic foot, the ischaemic foot and the deformed foot needs the help and advice of a qualified chiropodist(4).

Trained specialists have knowledge of adaptive footwear and can help in the management of intractable neuropathic ulcerations. Painful foot problems lead to loss of mobility and independence. Adequate chiropody services can prevent this.

THE PSYCHOLOGIST

This specialist studies human behaviour. He is of immense help in assessing situational determinants of individual behaviour. The psychologist may assess an individual patient or may be involved with the whole family.

The psychologist is adept at measuring cognitive decline and has many tests at his disposal to identify differences in levels of cognitive functioning between diagnostic sub-groups of elderly mentally ill patients(6). He is well aware of the importance of continued learning in old age. The psychologist would encourage the team to provide environmental and educational stimulation to each elderly patient undergoing rehabilitation as this would be of vital importance for the psychological well-being of the individual(7).

The key members of an active multidisciplinary team have been outlined. However, two groups have been omitted. The patient and the carer are also important members of the team and unless both are involved in discussion, difficulties will arise. The patients expectations have to be considered, the carer's capabilities have to be assessed.

The professionals cannot work in isolation, they need the co-operation of the patient and his family.

A successful multidisciplinary team will involve patient, carer and professionals all working together towards common aims.

REFERENCES

1. Merriman A. Handbook of International Geriatric Medicine. Singapore: PG Publishing, 1989.
2. Leeming JT. Attitudes, Teamwork, Co-ordination and Communication. In: Coakley D. ed. Establishing a Geriatric Service. London/Canberra: Groom Helm Ltd, 1982: 113-32.
3. Lehmann AB. Review: Undernutrition in Elderly people. Age Ageing 1989; 18: 339-53.
4. White EG, Mulley GP. Footcare for Very Elderly People. Age Ageing 1989; 18: 275-8.
5. Foster A. The Role of the Chiropodist. Care of the Elderly 1989; 5: 230-1.
6. Blessed G. Measurement in psychogeriatrics. In: Arie T. ed. Recent Advances in Psychogeriatrics No. 1. Edin/Lond/Melb/New York: Churchill Livingstone, 1985: 141-59.
7. Diekstra RF, Stafreu G. Psychological and Social Aspects of Mental Health in the Elderly. In: Hafner H, Sartorius N, Moschel G. eds. Mental Health in the Elderly. Berlin/Heidelberg: Springer-Verlag, 1986: 109-14.