A6 Care of the Elderly

Objectives

1. To detect and distinguish disease from normal ageing, and where appropriate, treat.

2. To prevent avoidable misadventures (such as hypothermia, side effects of drug treatment).

3. To educate patients and relatives in the changing physiology and needs of the aged.

4. To preserve dignity and self-sufficiency for the patient within a framework of outside help which permits independence of mind if not of body.

5. To manage disease with knowledge of likely natural history and to appreciate that many problems of the elderly are non-curable. Nevertheless, that relief and comfort are always possible.

Problems

1. **Prevention.** Growing old is not preventable, but some medical problems of old age can be forestalled, e.g. painful feet ➔ housebound ➔ lonely man ➔ suicide or broken glasses ➔ fall ➔ fractured hip.

   The elderly are often reluctant to report disabilities as they want to see themselves as healthy and therefore independent. Often they leave problems, obvious to others, to deteriorate to a point where their health is permanently damaged, or where those surrounding them are angered or alienated by their apparent pig-headedness. This is worse in the poorer and less well-educated.

2. **Drugs and surgery** may need extra caution, if they are not to have unacceptably high physical, mental, social or ethical side effects. If things are going wrong, consider stopping a drug rather than starting another.

3. **Isolation** may be physical, social or emotional. Families may have moved away. Inflexible housing may create difficulties for the poorly mobile, and a need will not be detected until a crisis occurs.

4. **Bereavement** and grief are inevitable in married couples.

5. **Suicide, rare, but more common in older men.**

6. **Retirement** may be a crisis for a man or single woman. The abrupt transition may be like a minor death. 'I'm in the way', 'I'm on the scrap heap now'. The retired may have no activities, no role, no status, and worst of all no money. Many are fit to work still, and some find their way back to employment with satisfaction.

7. **Families** may need support to cope with a difficult relative.

8. **Resources** are limited and awareness and knowledge of what is available and useful makes for easier management.

9. **Multiple pathologies** are the rule. A choice has to be made on social and medical priorities.
Vital statistics

○ 15% of our present population are over 65 (i.e. 375 out of a practice of 2500). Of these, about 130 will be men and 245 women. Over 75, women outnumber men 3 to 1. Over 75, all problems of the elderly increase.

○ The elderly population will increase to a peak of nearly 20% at the end of the present century, when the number over 75 will almost equal those between 65 and 75. Consequently, the work load for general practitioners may double, as there is no evidence that there will be fewer health problems in the elderly.

○ Beyond 70 years old, many people cease to be able to lead an independent existence. Those unable to live at home without assistance increase from 12% in 65–69 age group to over 80% at the age of 85 years.

○ Morbidity and disability from chronic diseases in old age are higher in the lower social classes.

○ 94% of the country's pensioners live at home and are therefore cared for by general practitioners. 40% of consultations are with the elderly, who also have the highest consultation rates.

Organization

Combined care from practice team has to be backed up by hospital geriatric unit and social services.

Roles

General Practice

Doctor supervises medical care and follow up, by routine method decided on as below, with preventive work based on knowledge of patients and relatives and backed up by age/sex register where applicable.

District Nurse fully involved with continuing care of some patients, episodically with others.

Health Visitor for preventive work and social visiting.

Receptionists or other workers taking messages, encouraging, making arrangements for transport, etc and acting as the real first contacts with the practice.

District medical services may provide screening clinics for the elderly, chiropody in the home or in clinics, audiology services, dentistry, occupational therapy or physiotherapy.

Geriatric unit

geriatrician for inpatient stay, clinics, domiciliary visits
community geriatric nurse
day unit

Psychiatrist will advise and organize services on psychogeriatric problems.

Social services

Social worker
Bathing attendant
Meals on wheels
Home help
Occupational therapist
Part III accommodation
Day Centre for special needs

Terminal care – (see subsection A7).