

Care for Elderly Patients in Family Practice

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Abstract

Background: The amount and types of health care services used by older adults is influenced by many factors. Although the need for health services and the frequency and intensity of service utilization are clearly related to health status and level of impairment or disability, many factors unrelated to health needs per se also play important roles.

Aim: In this review, we will look into the care for elderly patients in family practice.

Methodology: The review is comprehensive research of PUBMED since the year 1980 to 2017.

Conclusion: Care of the elderly physicians fills a variety of clinical and academic roles in family medicine and specialized geriatric services. Care of the elderly physicians play important roles in academic settings, both as educators and role models, help increase interest in geriatric care, and alleviate human resource shortages in geriatric medicine and LTC. Although medical knowledge is essential, a proper attitude is equally important when taking care of older adults. The lack of proper education of medical trainees in care of older adults is detrimental to our health care system as a whole.

Keywords: Elderly, Family Practice, Care for Elderly

Introduction

Older people present a variety of challenges in healthcare. People aged 65 and older account for approximately 50% of the visits to office-based physicians [1]. The health care needs of older adults differ substantially from younger patients. The physical, social, and behavioral effects of aging are often occurring simultaneously to both acute and chronic illnesses. The synergistic effects are often debilitating [2].

Many primary care physicians who find caring for elderly patients difficult limit the number of elderly patients in their practice [3]. Family physicians are viewed as the central medical professional in the care and management of chronic disease, in particular; in part, this is due to their longstanding relationship with the patient which allows them to take into account a longer term medical history and greater knowledge of the individual patient context [4].

The amount and types of health care services used by older adults is influenced by many factors. Although the need for health services and the frequency and intensity of service utilization are clearly related to health status and level of impairment or disability, many factors unrelated to health needs per se also play important roles. Among these are public policies that specify the types of services and providers covered by public funds, cost-sharing provisions, the supply of alternative sources and types of care; living arrangements and access to informal care; the availability of adequate numbers of trained personnel; advances or changes in health care technology and delivery systems; and the attitudes and values of potential recipients and providers of care [5,6].

However, while all modern societies are committed to providing health and social services to their citizens, these systems are always in flux, guided by diverse and evolving national and regional policy formulations. Health, social, and economic policies for older persons vary substantially among industrialized nations [7].

Determinants, needs and services for elderly

There are some sociological considerations in the aging of the world. In traditional society there were not so many old people. Each had several offspring and an even larger number of grandchildren. An ageing population tends to have a higher prevalence of chronic diseases, physical disabilities, mental illnesses and other co-morbidities [8].

Elderly care emphasizes the social and personal requirements of senior citizens who need some assistance with daily activities and health care, but who desire to age with dignity. In addition to life prolongation, goals to preserve functional capacity (including cognitive and physical function), maintain independence and quality of life, reduce hospitalization, reduce pain, and moderate personal costs may all be just as or even more important from the patient's perspective [8,9].

Health care service use differs among the elderly, and for this reason, it is useful to divide those 65 years and older into three groups: the young elderly (65 to 74 years), the middle elderly (75 to 84 years), and the old elderly (85 years and older).

It is an important distinction, in that the design of housing, services, activities, employee training and such should be truly customer-centered. It is also noteworthy that a large amount of global elderly care falls under the unpaid market sector [9].

A wide range of determinants such as social concerns (viz. children moving out of their parents' home in search of occupation, leaving them isolated without any physical support in daily activities) maltreatment towards elderly poor knowledge and awareness about the risk factors food and nutritional requirements psycho-emotional concerns (viz. isolation, mental stress, difficulty in keeping themselves occupied) financial constraints (viz. definite reduction in income upon retirement, to the extent that it may interfere with bare needs of life as adequate nutrition, clothing and shelter) health-care system factors (viz. most countries lack effective health insurance system for

elderly coupled with accessibility concerns and inadequacies in the government health-care system) and physical correlates determine the medical problems and thus cast a significant impact on the quality-of-life of the elderly [10-14].

Other measures such as improvement in the health knowledge of the elderly about potential risk factors social measures like developing a culture wherein children voluntarily take the responsibility of looking after their aged parents regulatory mechanisms, which make it obligatory for the members of society to look after their elder parents development of a health insurance scheme to cover their health-care needs development of pension schemes with contribution from employee, employer and government advocating the construction of elderly-friendly houses/roads/staircases promotion of primary prevention to inculcate healthy life-styles in early adulthood information, education and communication strategies toward three broad groups namely elderly persons, the middle aged who would move into elderly age group in the near future and younger people who are the potential care providers for their elderly parents/relatives regarding the issues of hygiene, nutrition, physical exercise, avoidance of tobacco and alcohol, accident prevention measures and awareness about recognition of early signs/symptoms of common geriatric problems training and re-training of medical and paramedical staff to effectively understand the special health needs of the elderly immunization services necessity of periodic health assessment in early detection of conditions provision of prostheses and other medical aids development of gerontology units and ensuring effective communication can be implemented in a strategic manner for achieving the best outcome [10-15].

Continuity of care is one of the defining principles of family medicine, almost a “motherhood principle.” While its value in adult and pediatric populations has been demonstrated, it is unclear whether its value extends to seniors. Continuity of care, the enduring relationship between a patient and a doctor, is one of the defining principles of family medicine [16]. Patients and doctors like continuous relationships. Elderly patients were found to be more likely to value continuity of care than younger and healthier patients were [17].

The following is a brief screen, which identifies potentially preventable or treatable conditions, and can be obtained from the medical record, the patient, or the caregiver [18,19].

- **Appetite:** How is your appetite? Have you lost weight or are your clothes big on you? Do you have any trouble with the taste of food, chewing, or swallowing? Weigh at each visit and compare with prior weights over the course of 12 months.
- **Falls:** Have you fallen in the last year? How often? Did you suffer any injuries? Where did you fall? Do you get dizzy when you stand up? Are you afraid of falling? Do you use a cane or walker?
- **Incontinence:** Do you lose urine involuntarily/accidentally? Do you lose urine when you cough, laugh, or sneeze? Do you often have wetting accidents? Do you get up at night to urinate?
- **Medications:** A complete medication history should be taken including over the counter and herbal therapies used.
- **Memory:** Have you noticed a change in memory or found it difficult to complete tasks you usually do? Are you or a family member concerned about your memory?
- **Mood:** Do you feel depressed? Have you lost interest in things that used to interest you?
- **Pain:** Are you having any pain? Intensity, location, onset, duration, radiation, quality, and associated symptoms.
- **Sleep:** Do you have difficulty falling asleep? Do you have any difficulty staying asleep? Are you excessively sleepy during the day?

Barriers

Some demographic variables are associated with practice limitation, including primary care specialty, urban location, and type of practice (solo, single specialty, or multispecialty). Studies have generally not measured psychosocial or practice level variables that might contribute to physicians' perceived need to limit geriatric practice and no previous qualitative studies have addressed these issues [20,21].

Many primary care physicians who find caring for elderly patients difficult limit the number of elderly patients in their practice [22]. When primary care physicians were interviewed in a previous study, several different reasons for this difficulty were identified. These reasons were grouped into three major domains including medical complexity, administrative burden, and personal/interpersonal challenges (communication barriers). There have been surprisingly few attempts to determine the reasons physicians limit the number of elderly patients in their practices, and results have been inconsistent. Studies have focused on concerns with Medicare fees and documentation requirements, which clearly are sources of frustration for physicians [23]. Frank, *et al.* found that physicians' personalities and communication skills affected whether geriatric patients were satisfied with their care [24].

In a national survey, only 60% of general and/or family practice physicians and 50% of general internists felt that their formal medical training did a good or excellent job of preparing them to manage care needs for frail elders [25]. Another survey of primary care physicians in Virginia found that fewer than half thought their current geriatric knowledge was adequate [26].

However, when the family physicians' elderly patients were interviewed, a perceived greater need for attention to process of care issues (e.g., communication, time management, and attitudes) was indicated [27].

Among the most important policy concerns relevant to health and longevity are the future fiscal viability of pension, health, and social insurance systems, both public and private, and the implications of these systems for savings and investment rates [28].

Due to barriers, such as a lack of exposure to geriatric medicine training, inexperience, and excessive amounts of time required to manage care, primary care physicians have felt overwhelmed. Some have tried to use consultants to cope, but inaccessibility to consultant specialist help was a factor [22].

Health insurance provides access to health care. Not having insurance often inhibits elderly persons from seeking medical attention, putting them at a higher risk for social isolation and lack of access to health care [29].

Another barrier for the elderly is difficulty in accessing and navigating the health care system, especially government health care plans, which are often confusing [30].

Communication barriers, especially those resulting from hearing problems or cognitive impairment, contributed to difficulties with history taking, treatment, and the quality of the relationship. Families often became involved in the care of frail elders. For the physicians we interviewed, this had both positive and negative implications. Involved family members increased the safety of medication use and the home environment [31].

Conclusion

Care of the elderly physicians fill a variety of clinical and academic roles in family medicine and specialized geriatric services. Care of the elderly physicians play important roles in academic settings, both as educators and role models, help increase interest in geriatric care, and alleviate human resource shortages in geriatric medicine and LTC. Although medical knowledge is essential, a proper attitude is equally important when taking care of older adults. The lack of proper education of medical trainees in care of older adults is detrimental to our health care system as a whole.

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