

The GP's role in continuing care for the aged

A commitment to holistic care

- M V Silbert



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Curriculum vitae

Dr M V (Mossie) Silbert was born in 1930, schooled in Paarl and studied at UCT where he obtained the MBChB in 1954. He did his internship at Greys Hospital and has been in general practice in Sea Point since 1959. From early on in his professional life he took an interest in the maintenance and improvement of standards of general practice; this is attested by his active membership of a long list of colleges and similar professional bodies. Dr Silbert's special interests are in geriatrics, emotional problems and the care of the dying patient - and has written extensively on this. He was awarded the Louis Leipoldt Gold Medal and in 1984 he was the recipient of the prestigious Hans Snyckers Award.

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Summary

*Does the GP fulfil the commitment to total, continuing care for the aged? Two months' experience from a Sea Point practice is analysed and compared with other studies in order to answer this question. GPs are not sufficiently aware of the available facilities and support organisations to utilise them fully, and students need to be sensitised to the concept of **cure** and **care** of the chronically and incurably ill.*

In 1974 an important statement was made by the Leeuwenhorst Work Party appointed by the Second European Conference on the teaching of general practice*. It outlined the general practitioner's job definition as a commitment to total (holistic) care. This implies the delivery of physical, psychological, social and personal care to the patient and his or her family.

Does the general practitioner (GP) fulfil this commitment in caring for the aged in the community?

To answer this question we need to examine the nature of the general practitioner's work.

Morbidity surveys over the last 2 decades throughout the world reflect a consistency in the spectrum of illness amongst the aged. In 1967, in a survey conducted by our Academy of General Practitioners/Primary Care, 49 347 diagnoses made by 15 GPs over a 12-month period in the Western Cape area were analysed¹. Of this total 115% were recorded in the 65 years-and-over age group.

In 1975 in another survey, this time from my personal records, 18,2% of the diagnoses made were recorded in the 65 years-and-over age group, reflecting a high density geriatric community. Diagnoses recorded most frequently in the 2 aforementioned surveys were: cerebro-vascular illnesses and hypertension, cardiac disease, arthritis, bronchitis, malignant disease and mental illness. This incidence coincides with similar surveys of this nature; for instance, that of van Biljon done in 1968 in Pretoria², and Polliack and Bialits of the Department of Family Medicine, Tel Aviv University in 1975³.

Such surveys, however, reflect only the morbidity spectrum or patterns of illness, but not the work description, or work load, with which the GP has to cope.

For instance, the category "cerebro-vascular illness" does not reflect the GP's involvement with the patient, from the emergency management at the onset of the illness in the home, to the subsequent continuing care, with appropriate use of paramedical resources in the community, e.g. physiotherapists, occupational therapists, social workers, support groups, patient and family counselling, etc.

Such total or holistic care is not adequately reflected in morbidity surveys. I accordingly extracted figures once more from personal records with the following objectives:

1. To reflect the GP's work description,
2. Whether the GP adequately fulfils his commitment to total care for the geriatric patient and his family,
3. Whether the GP's training adequately equips him for this purpose, and
4. Whether the GP is adequately aware of, and utilises, resources in the community, in the delivery of such total care.

I practise in Sea Point, which comprises a largely white middle- to upper middle-class community, and my figures will accordingly reflect the GP's work description in this type of community.

Method

I extracted figures of patients attended to during the months of July and September 1985, and grouped them into various diagnostic categories. A total number of 1629 attendances to patients were recorded. Of these, 496 were recorded in the 65 years-and-over age group, reflecting a particularly high incidence of 30,4%. A single patient could be attended to on a number of occasions, so this incidence of 30,4% in effect, reflects items of service rendered to the 65 years-and-over age group in my sample during 2 months. It eclipses Sheldon's estimate that the 65 years-and-over account for 18% of the GP's time. JH Sheldon published this figure in "The Social Medicine of Old Age" in 1948, and although the figure of 30,4% may at first glance reflect a vast escalation of the GP's work load in the aged (and indeed, there *has been* a significant increase), Sheldon's figure reflects an incidence in various general practices distributed over the community, whereas my figure is extracted from a single general practice in a community with an acknowledged high population of old people.

Of equal interest is the fact that 47% of these services were recorded on house calls and 53% in the consultation room. This high incidence of house calls increases the GP's work load significantly in the geriatric community. The reasons and significance of this will be referred to in the discussion.

I would like now to draw attention to a few of these illness-categories recorded, with particular emphasis on the GP's commitment to total care.

Table 1: Incidence of illness in patients aged 65 years-and-over, recorded during July and September 1985

Illness Category	%
Musculo-skeletal (degen. and traumatic)	14
Cardiac	9
Multiple system	9
BP checks	9
Cerebro-vascular (Stroke & TIA)	7
Depression	7
Malignant disease	7
Urological	5
Airways disease	5
Dementia & confusional state	5
Gastro-intestinal	4
Leg ulcers (traumatic)	3
Leg ulcers (non-traumatic)	2
Peripheral vascular disease	2
Diabetes	2
Visual	2
Parkinsonism	2
Miscellaneous	6

Musculo-skeletal disorders (including degenerative conditions such as osteoarthritis, spondylogis, osteoporosis) and injuries were the highest incidence recorded viz, 14%. Of these 27% comprised falls and their effects, e.g. fractures or head injuries. Three patients have not been rehabilitated to date and require much time in repeat visits, liaison with physiotherapists, counselling for depression, providing support and encouragement, and attending to the incidental problems, such as impacted stools and urological problems such as infections and blocked catheters. (Over the 2 months there were 12 attendances for disimpaction of stools).

In a leading article in the SA Medical Journal, Peter de Vos Meiring¹ emphasises environmental and other factors causing falls, and alerts the doctor to be aware of these, and correct them where appropriate: these preventive measures are seldom seen as a priority by GPs. Caution in the use of long-acting benzodiazepines and diuretics is advised in the prevention of falls.

Among falls and injuries sustained by the elderly, traumatic leg ulcers were so frequently encountered that they merited an individual category. The increasing incidence is related to injuries sustained by metallic objects and shelving in supermarkets.

Cardiac disorders: There were 6 attendances over the 2 months for acute myocardial infarction or pulmonary oedema. These attendances lasted approximately 1 hour each. Other attendances in this category were largely for monitoring of patients with cardiac failure or ischaemic heart disease.

For the sake of convenience, I would like to discuss the categories *Multiple System* and *Depression* in sequence at a later stage, and will at this stage refer to the category *Cerebrovascular* which includes stroke and transient ischaemic attacks (TIAs or "small strokes").

Strokes (or cerebrovascular accidents) specifically demonstrate the need for total care and the team approach.

The GP is invariably involved in the initial emergency management in the home and hospital. Hospital facilities appear to be adequate, both private and provincial, for such emergency treatment in this community. Facilities for medium-term care and rehabilitation have been provided in the community over the last few years - the Volks' Hospital and Somerset Hospital being examples. Many patients also manage to afford long-term care and rehabilitative care with the employment of nurse aids and private physiotherapists. Where such facilities are not affordable the GP should be aware of the services offered by State Health Geriatric Services. We GPs under-utilise these services as we under-utilise other local services and support groups, e.g. stroke aid clubs. A recent snap survey amongst 57 GPs at a meeting of the Academy of Family Practice/Primary Care, revealed that only 15 knew of the existence of State Health Geriatric Services; of these 15 GPs, only 3 had made use of this facility. With regard to stroke aid clubs, 17 GPs knew of their

Studies must be exposed to the many aspects of caring for chronic incurable disease in the aged

existence but only 8 had used their facilities. By under-utilising these services, we are not meeting our commitment to total care. It would be useful for the Cape Provincial Organisation for the Aged (CPOA) to liaise with the Academy of Family Practice/Primary Care and circularise GPs with their excellent manual of welfare and service organisations. During 1987 the Academy of Family Practice/Primary Care, in liaison with the SA Geriatric Society, will host a conference on geriatrics in general practice, where we will invite, amongst others, a social worker from CPOA to discuss with GPs the services available to the elderly. I recently consulted with a physiotherapist for a patient suffering from Parkinsonism. My patient had become extremely depressed and felt useless because of repeated falls in her home, as well as difficulty in crossing the street with the aid of a companion who would hurry her as the traffic light changed. The physiotherapist will be doing a house-visit to her to educate her in rocking or rotating her body in pre-

paration for initiating her walking. Neither the consultant nor I had instructed her along these lines. We had been adhering to our restricted medical model by manipulating her Laevadopa and other medicines, and had ignored the important role of the paramedic.

I want to refer now to the category of *Multiple system illnesses*. It is indeed significant that this category enjoys so high an incidence. The patient who presents a list of complaints to the doctor often evokes his despair and frustration, and there is a tendency for the doctor to discard the problem. However, often hidden in this list of complaints is the ubiquitous depressive illness. Doctors, as well as students, should be alerted to this entity of "masked depression". The use of antidepressants, or attention to psychosocial problems, or just listening, would be vastly more meaningful than prescribing various drugs for the various, apparently trivial symptoms. Once again appropriate introduction of social workers or support groups and service centres could make a meaningful contribution to the patient's well-being.

It is appropriate here to draw attention to the reverse situation. Elderly people who appear depressed because they become withdrawn, apathetic or difficult may, in fact, have not only a treatable depressive illness, but just as likely an eminently treatable and reversible under-lying organic illness. These organic illnesses may be serious, but also minor, and it is important for GPs to recognise that trivia such as an infected whitlow or ingrown toenail can not only incapacitate a patient appreciably, but also cause significant *anxiety* about mobility. Impacted wax in the ear can interfere with perception and cause depression. It is therefore equally important to attend to these, apparently trivial, problems and obviate prolonged morbidity.

Undetected illness is a common cause for morbidity in the elderly. We must seriously take stock of negative attitudes to home visits. Reluctance to do home visits is not only a sad indictment of diminished care but also deprives the doctor and the patient of the opportunity of screening for undetected illness which, if left untreated, becomes a burden on the family, and ultimately on the state.

In discussing the category *Depression*, although most cases are masked, many aged patients do, however, present with overt depression, easily recognisable, and often associated with bereavement, loss and separation, and loneliness. The GP is uniquely situated to provide support. House calls to the recently bereaved provide opportunities for venting feelings with regard to the deceased or his illness, which, if suppressed, may prolong the depression or morbidity. In addition the GP can utilise occasions when the bereaved patient presents for routine problems, e.g. BP-monitoring, to provide brief counselling and support. Referral to support groups, including Hospice, also plays a significant role in helping the bereaved, and preventing serious depression and prolonged morbidity.

The incidence of 7% in the category of **Malignant disease** reflects 23 visits to patients with malignant or other terminal disease. This figure easily doubles when the GP is caring for a number of patients who are immediately terminal, or dying. During March 1986 alone, for instance, I made 28 calls to 3 patients

Care not only for them as patients, but also about them as people

who were terminal and died. Most visits were for symptom control, but much time was spent counselling patient and family. Such visits last 20 to 30 minutes on average. Many of us in general practice are still not proficient in the appropriate use of drugs such as morphine and others. Post-graduate training programmes and publications in our journals are aimed at correcting this deficiency. Appropriate and intelligent symptom control relieves the patient, as well as the family, of much distress and often obviates admission to hospital.

Counselling and support in cases of carcinoma or terminal disease may often be the only service the GP can offer. Such supporting visits are of vital

importance in the continuing care of the terminally ill, but regrettably are often neglected.

After I had forgotten to visit a female patient suffering from motor neurone disease, her daughter phoned to remind me to call. The patient was upset with me and thought I had abandoned her because there was no more I could do. A few weeks previously I had openly discussed with her the diagnosis and the inevitable outcome of the illness. The daughter's call was a painful reminder to me that I had neglected my commitment to total and continuing care. So much could, in fact, be done. House calls - particularly unsolicited ones - to the incapacitated or terminally-ill, provide much support in an otherwise seemingly hopeless situation. I called on my patient frequently over the ensuing months and identified many of her problems and fears. She had lost the use of her upper limbs, and an occupational therapist gave invaluable advice, including moving the electrical switches from the walls to the floor. A team approach from members of the Hospice, the rabbi, family members and myself, provided meaningful support. We spoke on many issues that troubled her. A major cause for anxiety was fear - not of death (this she had come to terms with), but fear that she might choke to death due to respiratory paralysis. Reassurance that she would be suitably sedated and that there would always be someone at her bedside was of immeasurable comfort to her. She died peacefully in a coma due to hypostatic pneumonia. The 5th-year student doing

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his elective with me was noticeably moved and enriched by this experience, as was I.

The setting of general practice and the privacy of the patient's home or the consulting room, where the doctor-patient relationship can be so effectively demonstrated to undergraduate students, provides a most appropriate and comfortable setting for exposing students to many aspects of caring for chronic, incurable disease and terminal illness in the aged. I cannot allow this opportunity to pass without expressing appreciation for the support and assistance available to the GP, in his management of the terminally-ill, from St Luke's Hospice, the Cancer Association and the Dept of Radiotherapy and Oncology at the provincial hospitals, particularly GHS, with whom I have close liaison because of proximity. They are ever ready to admit patients - often in difficult circumstances - for a medical emergency, or for assessment, or for symptom control.

Caring for incurably ill people is an integral part of the GP's commitment

Finally, I want to refer to the role of the GP in continuing care of *Dementia* and his role in managing *Confusion* in the aged in the community. I have 6 cases of dementia in my practice. Five of these are widows who are being cared for by nurse aids or companions. I am called infrequently to these patients. The sixth patient, a male of 70, periodically becomes aggressive, paranoid and unmanageable in response to electrolyte changes due to medication. Correction of these changes makes him more manageable and his carer, the wife, can cope with the situation. Over the past year I have requested admission on one occasion to the Psychogeriatric Unit at Valkenberg Hospital. I have referred one case to the emergency Psychiatric unit at GSH and also one case for general assessment to the Geriatric Unit at GSH. Two patients have been admitted for assessment to a private psychiatric hospital. I have been able to manage 3 acute confusional states at home using a problem-solving approach according to the DIMTOP (Differential diagnoses: Drugs, Infections, Metabolic, Trauma, Oxygen deprivation, Psychiatric) model. One patient had become dehydrated and was also suffering the effects of benzodiazepines; another had hypoglycaemia and the third patient had generalised carcinomatosis. Admission to hospital or an institution has been obviated in the abovementioned 9 cases, i.e. 6 cases of dementia and 3 of acute confusion.

Caring for old people in the community, some of whom are incurably ill, is an integral part of the GP's commitment. However, there is a tendency for doctors to discard the elderly patient who remains

refractory to treatment, or chronically ill. The patient, his symptoms, his increased demands for attention, are often rejected as the behaviour of a difficult old person. This rejection is seen by psychologists as defensive behaviour by doctors (and nurses) who have a deep-seated need to see their patients get better. We are committed to a curing role which is inculcated in our undergraduate training. Old people who remain chronically or incurably ill, are a threat to this defined role and make us feel frustrated. We unconsciously doubt our own worth and react defensively by rejecting the patient. We in the healing professions need to be aware of these dynamics in the doctor-patient (or nurse-patient) relationship and how it affects caring for sick people. We need to alert our students to our caring role alongside the curing role. It is an attitudinal approach we require to promote.

Conclusion

The general practitioner is a significant figure in the total and continuing care of the ageing patient in the community. Home visits by the GP are a most important aspect of his work amongst the aged in the delivery of both total and continuing care, as well as in the assessment of the geriatric patient. In our commitment to provide total care I, however, feel that we are underutilising community geriatric services and support organisations. I have found that the urban white society as reflected in my practice, seems adequately catered for at present in terms of institutions such as old-age homes, boarding houses and hospitals, as well as facilities for rehabilitation. Practising GPs who are engaged in teaching units of general practice have a responsibility to sensitize students to the concept of "care and cure", and the promotion of appropriate and meaningful support and counselling. This may not only be all the GP can offer at times, but it also helps to introduce a humanistic dimension in caring for the aged - caring not only for them as patients, but also about them, as people.

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