Advice for foundation doctors on dealing with elderly patients

Introduction

With the continuing growth of the elderly population and the increasing life expectancy, almost all clinicians (with the exception of paediatricians and obstetricians) deal with elderly patients on a daily basis. The elderly population uses a disproportionate amount of most health services, reflecting the increased prevalence of most diseases and physical disabilities in this age group (Cassel et al, 1996).

What defines an elderly patient?

Now that the retirement age will be increasing from 65 years for men and from 60 years for women it may be convenient to think of these ages as arbitrary cut-off values.

What is special about elderly patients?

This article will now discuss some of the issues specific to dealing with elderly patients and look at ways in which they can be addressed.

More frequent presentation to hospital

It is difficult to prevent recurrent admissions, as these patients usually have serious chronic medical problems that are difficult to control and invariably deteriorate. A coordinated approach by hospital doctors and GPs regarding each patient's expected treatment outcomes and management plan may help decrease recurrent admissions somewhat.

Less specific symptoms

Older people's symptoms and signs tend to be more generalized and vague than younger patients, e.g. confusion with urinary tract infection (Bennett and Ebrahim, 1995).

This is one of the most difficult aspects of clinical care in GP and hospital medicine. Taking a good history is vital, paying particular attention to current medical problems and drug history. It is often necessary to liaise with the patient's carer or relatives in person or by phone to try and maximize the amount of information that you can gain (Hall et al, 1993), and enable you to form the right treatment plan for this patient.

It will also prevent you from going down blind alleys with symptoms and signs that are old, e.g. pre-existing hemiparesis in a patient who has had a stroke in the past, confusion in a dementia patient.

Performing simple tests can help identify the source of the pathology, e.g. full blood count, urea and electrolytes, urine dipstick or blood glucose.

Rehabilitation

Long-term rehabilitation is often required post admission. Rehabilitation is of particular importance in elderly orthopaedic patients with a lower limb fracture. To speed their recovery and decrease their time in hospital (and chances of acquiring a nosocomial infection) potential discharge arrangements should be made as soon as possible after admission (such arrangements are revisable) (Victor and Vetter, 1998). When making rehabilitation and discharge plans it should be borne in mind that such patients will usually lose a degree of mobility and hence independence.

Difficulty with family members

Difficult family members are not confined to relatives of the elderly, but they are often the relatives who are not involved in the day-to-day care of the patient. They often live in a distant part of the country or even overseas. They are often shocked to see that their relative's health has deteriorated so much since they last saw him/her (often one or more years ago). Those involved with the patient more regularly tend to have a more realistic and accurate view of his/her condition and prognosis. It can be difficult to face the distant relatives, as they are often angry with their siblings and doctors for not having done enough for their relative. There is also likely to be an element of guilt for feeling that they have not having spent enough time with the patient. With such individuals it is best to chat with them in a quiet room and inform them in a patient and empathic manner of their relative's condition and likely prognosis (Suman, 2005).

Communication difficulties

Difficulty in communicating with elderly patients is probably one of the most common problems encountered when dealing with such patients. It is best to move close to the patient, and ensure they have their hearing aid in place. It helps if they can see your mouth and also lip read, so put their spectacles on. Try and eliminate background noise: turn off the radio or TV, close the door and window. Speak slowly and clearly, do not shout. If confusion is a problem then any organic causes should be identified and treated appropriately. Repeat what you say. Try and have a carer or relative available so that they can reinforce any information that you give to the patient. They can also help with questions that the patient may forget to ask (Hall et al, 1993; Cassel et al, 1996).

Multiple pathology and polypharmacy

Elderly patients may have multiple pathology and often subsequent polypharmacy. This sometimes seems rather daunting, so it is best to deal with issues in a structured manner. Try and deal with the acute medical problems first and foremost in a prioritized manner. This can be difficult as they often inter-related, i.e. ischaemic heart disease, diabetes and hypertension. Put chronic less serious issues, e.g. haemorrhoids, on the back burner as they are unlikely to influence outcome on this admission. If you still have difficulty after dealing with the acute issues, call for help.

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Don't forget

- Elderly patients have the same entitlements and expectations of medical care and information as everyone else.
- Be patient. This is often difficult especially when you are under stress and feel as if there are a hundred things to do at once. Patients will pick up on your impatience and restlessness. This will either serve to hurt their feelings, compromising the patient–doctor relationship, or belittle their problems so that in the future when a problem arises they 'won't want to trouble the doctor'.
- Take your time to obtain a proper history from the patient, paying particular attention to past medical problems and social history. Knowledge of these simple issues will help you present the case on the post-take round and link the current problem in with previous medical or social issues where appropriate. This will help plan the patient's course and ultimate discharge during this admission. The ability to see the bigger picture and think one step ahead from the short-term management will put you ahead of your peers.
- Regarding terminally ill patients, liaise with family members early on. Although they will be upset by the bad news, they will generally be grateful that they know about a relative's poor prognosis, allowing them to spend time with them before their death. If they are not contacted promptly it will lead to resentment and distrust, with relatives claiming (rightly) that 'we weren't told until it was too late… we didn't get to say goodbye'.
- Elderly patients are often lonely, as many live alone after the death of a spouse. They are generally very grateful for the attention and assistance of a kind young doctor. This will help to build your own self esteem and brings the satisfaction of developing good interpersonal relationships.

Conclusions

Dealing with the elderly can be very rewarding, and should not be a daunting task. Remember that ageism is not forgivable; tomorrow the patient lying on the trolley could be your parent or grandparent. **BJHM**

Conflict of interest: none.

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KEY POINTS

- Dealing with elderly patients is rewarding.
- Be patient.
- Symptoms are often non-specific.
- Liaise with carers to gain as much information as possible.