

# Future Geriatric Needs in South Africa

## Hospital and Teaching Aspects

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### SUMMARY

Noteworthy factors in geriatric care, derived from experience in a geriatric clinic, are that symptoms are often wrongly attributed to the ageing process; the aged are often overtreated and subjected to unnecessary diagnostic procedures; and functional abilities of the elderly and social factors are important in planning comprehensive care for the aged. To render total care the services of a visiting sister attached to the clinic are an absolute necessity.

The elderly are often prematurely discharged from hospital. The combination of multiple pathology, functional derangement and social factors necessitates a period of aftercare which entails physiotherapy, occupational therapy and the services of a social worker. Medical students, nurses, students in social work, physiotherapists, and occupational therapists should be enlightened on gerontology and geriatrics during their undergraduate years.

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Throughout the developed world the number of old people are increasing, with women outliving men. It appears that 50 - 60% of people older than 65 years can be judged as normal, 20 - 30% as physically infirm, and 10 - 25% as extremely weak. Of all patients admitted to hospital, 25% are 65 years and older and these patients remain in hospital twice as long as the younger age groups.<sup>1</sup> These figures reveal the extensive needs of older population groups for medical personnel, hospital services, home nursing and social services.

### ROLE OF GERIATRIC CLINICS

#### Disease Profiles and Diagnosis

To cope with increasing geriatric problems, the main causes of death and the disease profiles among the elderly should be recognized. The main causes of death in the aged are ischaemic heart disease, cerebrovascular accidents, respiratory disease and cancer.<sup>2</sup> Causes of death give an incomplete picture of the magnitude of the geriatric problem. The morbidity profile in our geriatric clinic, as an example of that found in the aged population, revealed the following: arthritic conditions — 71%; cardiovascular affection — 54%; hypertension — 35%; urinary tract problems — 31%; respiratory tract abnormalities — 29%;

gastro-intestinal pathology — 26%; neurological problems — 20%; obesity — 35%; malignancy — 12,5%; diabetes mellitus — 11%; and anaemia — 10%.<sup>3</sup> Of greater importance is the multiplicity of pathology found in the same patient.

#### Factors in Diagnosis

Correct diagnosis and appropriate therapy result in improvement of the underlying condition and prevent complications. Symptoms should not be attributed to the ageing process alone. Early detection of new disease or complications of earlier disease is important. Although correct diagnosis and treatment are necessary, one should guard against the opposite extreme. We have found that the aged are often overtreated or subjected to tiring, dangerous and unnecessary investigations.

The many organic defects in the aged are associated with functional derangements directly attributable to disease or to other causes. Assessment of the following functions was found useful in determining the ability of elderly people to care for their own needs: mental ability; urinary and faecal continence; visual ability; hearing; speech; walking; use of hands; and the ability to eat, dress and wash alone. Functional assessment made us aware of the high percentage of elderly people with underlying depression. We were also reminded that visual and hearing aids are important factors in preventing the elderly from becoming isolated, as are the attentions of a chiropodist.

#### Social Factors in Geriatrics

In planning comprehensive care for the elderly it is important to remember that most of them live by themselves or with their children. Those elderly people who live alone and have to care for themselves present the greatest problem. Their personal hygiene is often bad and if they are ill they are unable to care for themselves. Other important problems arise when acute disease in married elderly people necessitates care by the partner. Senility, self medication and lack of income and all it entails also affect planning for geriatric care.

#### Visiting the Elderly

Comprehensive assessment in the geriatric clinic is valuable in deciding whether an elderly person is capable of looking after himself, whether he needs the help of the family or should be admitted to an old age home with or without attached nursing facilities. Assessment in the clinic also provides an opportunity to arrange and co-ordinate community services such as district nursing and social welfare. To render total care, the services of a visit-

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ing sister attached to this clinic are an absolute necessity. This sister keeps records of her observations and reports them back to the geriatric clinic. Positive results are gained by these home visits: they ensure fewer follow-up visits to the clinic, thus making the service available to more elderly patients, and we are enabled to assess home surroundings, hygiene, and interpersonal relations and to render advice. Progression or regression of the disease process and functional abilities can be assessed. If she deems it necessary, the visiting sister can arrange for an earlier appointment at the geriatric clinic. She offers health education and checks and instructs the elderly in the use of medication. The visiting sister can also render valuable service by contacting the district nurse, social service, general practitioner or district surgeon.

### HOSPITAL CARE

It is said that hospitals should do more for feeble old people since the latter occupy such a vast number of general hospital beds. The hospital physician is often more interested in episodic illness than in the sick old person with his feebleness and his quirks. The following quotation by a well-known geriatrician has reference: 'I know one of the world's authorities on strokes. He loves strokes. In the long run he will save more lives than I, but he understands me. He knows that when he has done all he can do, he can lean on me to make the stroke victim feel important and to look after their long range medical needs.'<sup>4</sup>

The lessons learned in hospital are the following: the elderly patient is often discharged from hospital too soon, the functional abilities of the elderly, the social aspects at home, and medical services to be rendered at home, are often overlooked when they are discharged; and the attitude which often prevails is that correction of the underlying pathology solves the problem and that medical responsibility ends there. Some think that the social worker ensures all available facilities in the community necessary for the care of the elderly. Social workers certainly perform an important task in this respect, but that is not enough and does not solve the problem.

Should there be separate geriatric hospitals or geriatric wards for the acutely ill? This is probably not necessary, but a geriatric consultant should be available to sort out problems unique to the aged. For example, the acutely sick elderly person who may become confused owing to dehydration or a sudden change of environment is wrongly thought to be senile. Is the cerebral angiogram really necessary? It might even be hazardous. Is an aortogram for an aortic aneurysm in the decrepit aged or a tiring barium enema, to substantiate the diagnosis of diverticulosis in a frail 80-year-old person, really necessary? The advisability of resuscitation of elderly patients in whom the functional end result is uncertain should always be kept in mind. Is it morally justifiable to resuscitate elderly patients with widely spread carcinoma, repeated myocardial infarction, cardiac rhythm abnormalities, chronic nephritis, etc? Is treatment with antibiotics and blood transfusion really necessary in aged patients with organic irreversible brain syndrome? It must be borne in mind that

for aged people to die is normal and that the aged have the right to die in peace and in a dignified way.

If the sick elderly person recovers within a short period and his functional abilities are normal he can be discharged, but only after the geriatric consultant has evaluated the patient and the social worker has assessed the home situation. In other words, geriatric assessment starts in the acute hospital. This comprises a total evaluation of the clinical, functional and social aspects of the elderly patient to ensure that proper comprehensive medical care outside the hospital can be provided or admission to the aftercare hospital can be arranged.

### The Aftercare Hospital

The combination of multiple pathology, functional derangement and social factors in the elderly might necessitate a long period of hospitalization, even for minor ailments. Elderly patients with chronic degenerative disease such as cerebrovascular accidents, peripheral atherosclerosis, chronic bronchitis and emphysema, or chronic heart disease, or those hospitalized after accidents and major operations, need an even longer period of aftercare, i.e. care after the acute stage of the disease has been attended to. The acute stage of the disease in the elderly necessitates the use of sophisticated instruments, procedures and treatment, all found in the general hospital, but after the acute phase of disease has been properly attended to, there should be a period of aftercare necessitating a different approach before the patient is discharged.

Aftercare should form an integral part of the hospital services for the sick elderly. An aftercare hospital should have well-equipped physiotherapy and occupational therapy departments and have the services of a social worker. One object of aftercare is to assess the following: the extent of physical disabilities and psychological derangements, the extent of functional derangement caused by these disabilities, and the social background. From these observations, a comprehensive plan of action can be instituted. This dynamic rehabilitative comprehensive approach needs a team effort: a doctor with a special interest in the rehabilitation of the elderly; nursing staff with a special knowledge and feeling for the problems of the elderly; paramedical staff, physiotherapists, occupational therapists and social workers, and, when deemed necessary, the services of a speech therapist, psychologist and chiropodist. A minister of religion and the relatives of the patient should also be drawn into comprehensive efforts to care for the frail elderly person.

### Objects of Aftercare

When the elderly person leaves hospital, he or she should have regained the maximal potential of all functional capabilities. We have observed that even with severe paralysis a certain percentage of patients can regain walking ability, but if this is not possible they are taught to cope with life and care for themselves to the maximum extent which their abilities allow. Another objective is to provide active rehabilitation after major surgery to make patients physically and mentally fit to par-

ticipate in the daily activities of life. Many elderly convalescent persons have minor but important functional impairments such as weakened eyesight or hearing loss, which can be corrected. Management of psychiatric abnormalities is another important objective.

Before discharge of a patient the social worker and occupational therapist do home visiting to evaluate home conditions and to give expert advice. After discharge all patients are either referred to the geriatric clinic of the general hospital, the clinic for hemiplegic patients, day hospitals, the patient's general practitioner, or to district nursing services. A point is made to keep contact with the elderly patient after discharge. Patients are brought under notice of welfare associations for further social contact, thereby ensuring the availability of social amenities such as 'Meals on Wheels', or social clubs.

If the abovementioned is not possible, it has to be decided whether an elderly patient should be admitted to a home for the aged, a home for the frail aged or a terminal care hospital, and the appropriate arrangements should be made.

## TEACHING

It is not important whether geriatrics is viewed as a discipline on its own. What is important is that medical students, nurses, students in social work, physiotherapists and occupational therapists should be enlightened on gerontology and geriatrics during their undergraduate years. The approach of teachers in medicine is too often orientated towards disease and not towards the diseased human being.

Students should be taught the multiplicity of pathology found in the aged, the special ways of presentation of disease symptoms and signs, and that accurate diagnosis can cause an improvement of underlying disease even though no permanent cure can be effected. The students should also be made aware that symptoms and signs in the aged should not always be attributed to senility, so that specific beneficial therapy is not withheld from the elderly.

Other factors in geriatric care which should be stressed in teaching are the functional abilities of the elderly, their social background and community facilities. Because these factors were, in earlier years, not viewed as part of

medicine, older teachers are often to blame for not enlightening the students on these aspects. By emphasizing all the relevant factors for the understanding of the sick aged, better feeling, understanding and interest can be engendered in students, thereby ensuring greater competence of the doctor, nurse or other member of the paramedical services.

## Formal Teaching

An example will illustrate the need for the student to understand the physiology of the ageing process. A raised systolic blood pressure and the ejection systolic murmur heard at the base of the heart are often normal features in aged persons.

Time should be spent on the demographic, social and cultural patterns of the different race groups in South Africa. Knowledge of the disease patterns and diseases in the elderly is essential, thereby accentuating problems which commonly occur in the aged, such as foot problems, injuries, respiratory infections, mental disturbances, cerebrovascular accidents, hypertension and blindness.

## Practical Teaching

Practical teaching is done at the geriatric clinic, after-care hospital and/or day hospital, with the following objects: the exposition and discussion of all aspects of the multiple lesions found in the aged; demonstration and discussion of the comprehensive interdisciplinary assessment and then the formulation and planning of a rehabilitation and care programme; an insight into the work and mutual dependency of the different disciplines in the rendering of rehabilitation, and visualization of home conditions after discharge of the elderly patient.

Participants in the programme of practical teaching are medical members of the Department of Comprehensive Medicine, the nursing sister, physiotherapists, occupational therapists and the social worker.

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