CORE
Metadata, citation and similar papers at core.ac.uk
Provided by OAR@UM

Current Opinion

Rethinking Care for the Sick Elderly

Pierre Mallia, Anthony Fiorini

It is well established that Geriatrics and Gerontology are specialties in their own right meriting separate tertiary and primary care training[1]. Health Care for the elderly also forms a newly added subject to the field of biomedical ethics[2]. Demographic studies are consistently predicting the increasing proportion of "aged" members in our global population[3]. Positive conceptions of 'healthy aging' are rightly displacing negative ageist perceptions that indiscriminately cast the elderly as weak, vulnerable, or incapable of self-determination[4]. When, through the natural course of aging or due to illness or injury, body or mind begin to fail, a legitimate need for intervention – and care – will arise. In this article we discuss what is morally justified for the elderly population and recommend changes necessary in Malta especially in view of the established post-war rise in the elderly population[5] to which Malta has been no exception.

The President of the Malta College of Family Doctors is of the opinion that, "As medical technology continues to develop and new treatments and health care costs escalate, governments all over the world must devise more morally explicit principles whereby health care resources are allocated". He also points out that there exist dilemmas at sectorial levels where different groups of people, with different special needs, may feel disadvantaged. The elderly, for example, he says have less priority than the young in getting 'life-saving cardiac treatment', whilst benefiting from other services helping them to remain active members of society.[6]

No one doubts that the institutions that were available in Malta for the elderly until a few years ago left much to be desired. The phrase "Tax-Xjuh" for the elderly was associated with either "tal-Frankuni" (Mount Carmel Hospital) for the psychiatrically ill or with "L-Imgieret" (St. Vincent De Paul Residence) and many were the elderly who shied away from wanting to spend the last few years of their life in such institutions. Although changes have been recently implemented to improve the quality of care and the quality of the environment in these institutions, much still needs to be done.

Homes

Ideally the elderly should be encouraged and helped to stay in their environment. However, there comes a time when the person cannot take care of himself or herself and needs the full co-operation of the family. An application to enter a residence should be considered if the family are unable to cope with the care required. A dependent individual would need twenty-four-hour care - something a carer may not have the physical strength or the financial resources for, especially if the carer is an old person as well.

A dependent person's needs, for example the administration of medicines, the preparation of food and help with feeding, cleaning and the washing and changing of linen, the help in toileting, and simply carrying the elderly person from the bed to the chair, are chores which can disrupt the entire day for the carer who presumably would have her or his own life to lead. Carers could be sons and daughters who still work and are unable to stay all day with the aged person at home. There have been situations in our practices where an elderly person would wait a whole day to use the toilet i.e. until the carer came home to help them. A patient of one of the authors refused to use a nappy and preferred to wait for her nephew to come and help lift her as the wife of this nephew did not have the strength to do so alone. As soon as she was lifted the change in posture would induce her to incontinence.

All doctors caring for the elderly know how difficult it can be for someone to be admitted into a residence: State run or Church run. The alternative is to pay for a private residence, which is not affordable by all. The increase in the elderly population has not been associated with a substantial increase in the number of places in State residences to cater for the demand. As a result elderly persons who were originally admitted for an acute condition to the main general hospital, block beds as relatives refuse to take them back into their care, demanding a transfer to a residence.

Pierre Mallia MD, MPhil, CBiol, PGDipICGP
Department of Family Medicine, University of Malta
Email: pmallia@synapse.net.mt

Anthony Fiorini MD, FRCP
Consultant Geriatrician, Zammit Clapp Hospital
Email: anthony.fiorini@gov.mt

Hospitalisation

An ill older person is more likely to have a longer hospital stay than a younger patient.[7] In the United States, Comprehensive Geriatric Assessment (CGA) is becoming a common mode of practice for both in-patient and out-patient interdisciplinary care given to older people and their carers.[8] Several centres have established dedicated areas within the hospital setting for this purpose. A similar set up has been in operation in the United Kingdom for many years. An alternative to CGA is geriatric evaluation on a consultative basis as is adopted in Malta. This of course does not provide geriatric evaluation to all elderly patients, as one may argue is their right.

When one compares the paediatric services with the geriatric services at St. Luke's Hospital one finds that children under twelve have separate wards, both medical and surgical. On the other hand, the elderly are admitted with the general population as was procedure for children in the past. Children have, rightly so, a separate out-patient service and there are seven consultant paediatricians including a community paediatrician and one at Gozo Hospital.

The same cannot be said for the geriatric speciality. There are no geriatric wards and no geriatric out-patients on the main hospital site. Moreover Zammit Clapp Hospital (ZCH) does not provide assessment and rehabilitation facilities at the main hospital site.

The numbers of beds catering for paediatrics is sufficient for the number of children needing hospitalisation. On the other hand, the beds at Zammit Clapp Hospital are not sufficient to cater for all the elderly needing hospitalisation. Many elderly enter St. Luke's with medical problems requiring long hospitalisation, for example with a stroke. Of these some may not be able to return home because their carers would refuse to take them. During the winter season many elderly require hospitalization and they can be seen occupying the corridors in the wards.

The function and necessity of Zammit Clapp Hospital moreover needs to be established and should not change at the whim of a government. Indeed the number of beds needs to be increased to cater for *all* geriatric patients in need of its expertise, just as the number of beds in paediatrics is sufficient to cater for all children. Today, no child under the age of twelve is put into an adult ward as occurred in the past. The same procedure, it can be argued, should be adopted with the elderly - not because the nurses and doctors are not good enough, but because, as in paediatrics, geriatric departments will have physicians specialised in the field. Although every physician can cater for an elderly person as much as for a child, once specialists and specialised wards are available everybody has a right to them and we have an obligation to provide such care to all our elderly. It can be argued in the same manner that it would be morally unjustified to have a child needing hospitalzation not being treated by a paediatrician, unless of course another specialist is specifically indicated.

Surgical wards

The same can be argued for surgery. The fact that many Western nations have seen a rise in their elderly population did not mean that there was a subsequent and proportionate rise in the surgical services provided. The experience in Australia has shown that there are long waiting lists for hip-replacement and similar age-related conditions[9]. Similarly an increase in the elderly population in Malta would imply that government needs to increase the percentage of health-care resources allocated to that sector.

Surgery for the elderly can be divided into two groups - those largely used by the elderly population (such as total knee and total hip replacements), and those used by all the population, such as a cholecystectomy. Now a child needing surgery would not have to fall in line with the rest of the adult population. Moreover there are now surgeons specializing in paediatric surgery alone. One can ask whether morally we should be offering the same service to the elderly population who after all have less years to spare. We have seen elderly patients waiting for more than three years for a cholecystectomy who required several hospital admissions for acute attacks before the operation was performed. One year for an elderly patient is a larger proportion of life-remaining years than one year for a forty year old.

It is estimated that one day of post-operative bed rest results in levels of functional decline similar to those of a year of sedentary life style.[10] Dedicated geriatric surgical wards will probably be in a better situation to provide this kind of specialised geriatric care.

A study is currently underway by one of the authors in association with other general practitioners to assess whether in fact the elderly population does indeed wait longer than the rest of the population for general surgery. Although it would be interesting to know the results of such a study, it is not really relevant to the appropriateness of holding a separate operation list for the elderly - at least the arguments are as valid as those for holding a separate paediatric surgical list. One does not need to prove prolonged waiting times in order to justify separate lists. Nevertheless, the study will compare like-with-like, for example cholecystectomies in the 15 – 64 age group with cholecystecomies in the over 64. However there are operations which have a longer waiting list. Thus one would not expect to have the same waiting time for a cataract as for a cholecystectomy. The demand of one may indeed be greater than for the other. But if an operation which is in demand is mixed with a general list because it is done by the same team, then there is an added pragmatic argument for holding a separate list if this decreases waiting time and thus 'adding life to years and years to life'. Thus a patient needing a total hip replacement may have an average wait of one-and-a-half years simply because it is done by teams which have general orthopaedic lists. Why should one suffer an arthritic knee and be unable to walk

in these final years of life because they are put on the general orthopaedic surgical waiting list? Although ideally no one should wait for surgical care and in an aging population it does become imperative to keep actively at work the population that is paying for health services, this should not keep us from improving the general efficiency towards the elderly. If the same team can hold a separate joint-replacement list, as some general surgeons do for their paediatric lists, the overall wait should be improved. This of course does not say anything of the increased resources that would be needed to implement such a change, such as the creation of new consultancy posts and theatre space and staff.

A separate list does not mean that the elderly should be given any advantage over the rest of the population. But the elderly are at a disadvantage when they are mixed with younger people. A just solution would therefore have to be a separate surgical list for the aged, in separate surgical wards.

Again, as Soler points out, clinical discretion may with all good intentions disadvantage one group over another in the absence of a national policy for decision making[11]. It is indeed not known whether surgeons can subconsciously make utilitarian choices when putting a person on an operation list, hence putting a younger person, who quickly needs to return to work and be productive for his family, before an elderly pensioner who may seem not to be leading a productive life. Such judgements, whilst not per se immoral, are nevertheless debatable.

Disability

The fact that Geriatrics is not completely treated as a separate speciality in Malta is logistically reflected in all the services offered including physiotherapy and occupational therapy. When we address problems of people with disability we rarely include the elderly. This was reflected in a recent conference organised by the Bioethics Consultative Committee in which the talks were all related to persons born with a disability and thus fall in a category formerly referred to as 'Handicapped'. However the elderly too are handicapped because of their being elderly. Onset of disease such as ischaemic heart disease, arthritis, diabetic complications such as retinopathy, cataracts and amputations, strokes etc render many people disabled. The elderly, because of their frailty suffer all the more.

A recent conference on Patient Rights organised by the Bioethics Consultative Committee led to the 'Rights of the Elderly' being discussed. Both the opening talk by the minister and the closing remarks by the Director (General) of the Department of Health showed increasing concern and warming towards the issues raised here. Indeed it is hoped that a future conference will be dedicated solely to ethical issues and rights of the elderly patient.[12] We still need to face and discuss, for example, issues of incompetence, dementia and advanced directives, all of which have been given bioethical importance.[13,14]

Conclusion

In conclusion, the country has seen a rise in the elderly population. This has not been met by a concurrent strategic change in medical and surgical management of this category of the population. Whilst we should be dedicating more resources to homes for the elderly we should also be considering the correct approach to medical and surgical management of elderly patients. Whilst specialties like paediatrics and gynaecology (of which no mention has been made here) have seen separate wards and surgical lists for these categories of the population, one may be justified in asking whether it should be considered morally wrong not to have surgical lists and separate medical wards in which to treat our aged.

References

1 Coni, N, Webster, S, *Geriatrics*, 5th edition, Blackwell Scientific, 2000, p. 22-31.
2 Witness three volumes on aging and elderly (Vols 10 – 12) in the new series International Library of Ethics, Law and the New Medicine by Kluwer Academic Publishers.
3 Weisstub, D.N., Thomasma, DC, Gauthier, S, Tomassy, G, *Aging: Culture, Health, and Social Change*, International Library of Ethics, Law and the New Medicine, Vol 10, Kluwer Academic Publishers, Dordrecht, Boston, London, 2001, p. vii.
4 Weisstub, DN, Thomasma, DC, Gauthier, S, Tomassy, G, *Aging: Caring for our Elders.* International Library of Ethics, Law and the New Medicine, Vol 11, Kluwer Academic Publishers, Dordrecht, Boston, London, 2001, p. vii.
5 Featherstone M, Hepworth M, "Aging, the lifecourse and the sociology of embodiment", in *Modernit, Medicine and Health, Medical Sociology towards 2000,* ed. Scambler G, Higgs P, Routledge 1998, p147
6 Soler D., "Equity in Health Care - A Maltese Perspective", *It-Tabib tal-Familja*, No. 16, June 1999, p7
7 Daly MP, Taler G, "Care of the Elderly", in *Textbook of Family Practice,* 5th Edn., ed. Rakel R.E. WB Saunders, 1995, p78
8 Ibid., p 85-86
9 Kuhse H, "Preventing Genetic Impairments, Does it discriminate against people with Disabilites?", in *Genetic Information*, ed Thompson K, Chadwick R, p23
10 Harper CM, Lyles YM, *Physiology and Complications of Bedrest,* in J. of Am. Geriatr. Soc. 36: 1047, 1988
11 Soler, D, "Equity in Health Care", p. 8.
12 See Proceedings of Bioethics Conference 1999, *Bioethics Consultative Committee,* ed., Cauchi M
13 Gray JAM, *"The Health Care of the Elderly"*, in Principles of Health Care Ethics, ed. Gillon R., Wiley & Sons, 1994, p711-720.
14 Norberg A, *"Ethics in the Care of the Elderly with Dementia"*, in Principles of Health Care Ethics, ed. Gillon R, Wiley & Sons, 1994, p. 721-731.