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Health care for older people.

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Et al.

length, its use assessed by its impact on medical workload rather than by improved access and convenience for them.[3] For more than a decade enthusiasts have encouraged consulting over the telephone and documented their experience, yet their findings have had little impact on general practice as a whole.[4–6] Despite its support for NHS Direct, the government shows little interest in other aspects of telephone access, and the General Medical Council's guidance on the subject makes telephone consulting feel like a slightly shady activity, best avoided by respectable and prudent practitioners.[7]

These negative attitudes are curious. If, as is often stated, 80% of diagnoses are made from the history, and since not all encounters entail diagnosis, one might expect that an appreciable proportion of consultations could take place by telephone. This could help patients, who save travel time and costs and do not need to arrange childcare or work cover, even if it does not save time for health professionals. We need to measure both the benefits and the limits of telephone medicine compared with face to face consultation, and how best to organise it, so that both doctors and patients can use it as effectively as possible.

The telephone is clearly a communications tool with several restrictions, including an absence of visual clues and non-verbal communication (although this may change in the future).

Despite this there has been little study of telephone consulting skills and little critical thinking about how best to work on its limitations and what background and training (which is scant) users need.[1 2] The relative merits of intuitive clinical expertise versus systematic enquiry guided by computer algorithms; of nursing and medical backgrounds and education, with their different emphases on systematic management and diagnostic judgment; and of telephone and face to face encounter are separate issues, yet they are often confounded. Interprofessional rivalries between nurses and doctors and the financial implications of their different pay scales may influence policy and add to the confusion.

Other questions remain unanswered. What impact does prior acquaintance with a patient, access to personal medical records, and continuity of care have on making telephone consultation more effective, safer, and increasing its potential? How good is telephone contact for patient education and monitoring of chronic diseases? The literature suggests hypotheses, but we need systematic and controlled data. Commercial organisations like banks have put considerable effort into telephone advice systems (with varying success) and telephone helplines such as that run by the Samaritans are an important feature of the voluntary sector. What lessons can we learn from these?

Most of all we need to understand why the telephone, after being part of our lives for so long, has met with so much suspicion and so many irrational assumptions, and why there is so little evidence on how best to use this simple piece of communication technology.

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Health care for older people

Scottish report has international relevance

In response to serious concerns about the health care provided to older people in Scotland the Scottish expert group on healthcare of older people, led by the chief medical officer, Dr E M Armstrong, has released an insightful report entitled *Adding Life to Years*.[1] The charge of the group was to describe the major health problems that older people confront, explain their journey through the healthcare system, investigate potential ageism, and promote good practices. The articulate and comprehensive report identifies a series of themes. Four of these are outlined below. Specifically, the report promotes individual responsibility for health, advocates for primary care, identifies the benefits of multidisciplinary teams in the care of elderly people, and discourages ageism. As indicated by the supporting literature, these themes have international relevance.

Health care is a shared responsibility

An older adult consulted for the report said: "A doctor can do only so much. We oldies must realise we are responsible for our own health." *Adding Life to Years* is to be commended for promoting individual responsibility in health care. Encouraging older adults to be physically and mentally active and to reduce poor health habits is an important theme of the report. For example, when an older adult presents with pain due to arthritis, the "pill for every ill" approach should be avoided and non-pharmacological options explored.[2] Weight loss and exercise may have an important role in minimising symptoms without placing the patient at risk for adverse events.[1] Exercise has been documented to improve muscle strength (thereby reducing frailty, functional decline, and injuries) even in frail residents in nursing homes.[3] Similarly, older adults should be encouraged to stop smoking. As stated in the report, "It is never too late to give up." Stopping smoking reduces the risk of cardiovascular disease, cancer, and respiratory complications. A quarter of older adults (65-74 years of age) in Scotland were identified as smokers.[1] Lower rates of smoking

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have been reported for older adults in other countries, but smoking remains an important public health consideration. [4 5]

Older adults benefit from having a primary care provider

Many older people are healthy, but others, particularly people of advanced age who have chronic disease, are less fortunate. For example, older adults with multiple medical problems often take many drugs to treat their conditions, making them vulnerable to a series of adverse events.[6] Input from primary care can help reduce this risk by coordinating and monitoring complex patterns of treatment. A study conducted in Japan found that older adults with a regular physician (whom they saw when they felt sick) were less likely to be using larger numbers of drugs, which indicates a potential benefit of primary care.[7] In the United Kingdom and other countries such as Canada where primary health care is well established, opportunities exist to expand the scope of primary care to include greater input from nurses, pharmacists, social workers, and other professionals in order to respond to the needs of individual patients.

Teamwork is fundamental to geriatric medicine

A team approach to geriatric medicine has been associated with improved quality of life at no additional cost.[8] Geriatric programmes rely on teams (for example, geriatricians, social workers, nurses, occupational therapists, and physical therapists) that work together not only to help older people cope with immediate health problems but also to optimise their functional status to improve their future wellbeing.[9] Rehabilitation offered in the setting of acute care will help maximise successful discharges to home. In geriatric medicine rehabilitation extends far beyond the context of hip fractures and includes rehabilitation after a range of acute illnesses and surgical procedures.

Ageism is a key issue

To obtain data on the perceptions and experience of older adults with the healthcare system, the report commissioned a survey of over 500 older adults.[1] Most were broadly satisfied with the health care that they received. Seventeen per cent of people surveyed, however, reported feeling that they received poorer service than younger patients. A caregiver interviewed said: "Stop using age as an excuse for not giving proper treatment." Ageism—systematic and negative age discrimination—may take the form of undertreatment. For example, hip and knee arthroplasty is increasingly important to improving the quality of life for older adults with arthritis. Discrepancies have been documented, however, between people who need knee arthroplasty and people undergoing the procedure. This is particularly the case for older women.[10] *Adding Life to Years* reported that among older people in Scotland, health varied with social circumstances. Differential access to health services may contribute to health status and outcomes. For example, socioeconomic status (elderly people often have low incomes) has been shown to be associated with restricted access to invasive cardiac procedures after myocardial infarction and increased mortality.[11]

Many countries worldwide are struggling with the challenges of an ageing population. *Adding Life to Years* recognised a mismatch between what happens in clinical practice and what is studied in research. For example, drugs commonly used by older people have often not been studied in similar older populations.[12] Accordingly, we know little about what seem to be simple issues such as the optimal dose to use when starting a drug in a frail older person.[13] As stated in the report, "Although much of medical care is directed at older people, medical research does not sufficiently reflect this."

Adding Life to Years shows a genuine understanding of the complex issues surrounding the provision of care to older adults. The report not only describes the challenges but also proposes solutions. Written for a country with fewer than a million older adults, this report has the potential to have an impact on the quality of care provided to older people in many larger countries around the globe.

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