SHARE

NEW PERSPECTIVES: PART I

Demystifying Geriatrics: Stigma and Daily Realities

Yusra Hussain, MD

Dr. Hussain is clinical assistant professor and director of the Stanford Senior Care Center, Aging Adult Services, Stanford Hospital and Clinics, in Palo Alto, CA.

As the Baby Boomers march into the golden age, the demand for geriatric practitioners in the United States has increased significantly, leaving medical institutes and health care administrators struggling to recruit health care professionals for geriatric practices. Geriatric practice is sometimes shrouded with mystery and the stigma of being a seemingly "hopeless proposition," "thankless job," and even a "depressing field." I had the same perception before I did a geriatric fellowship at Stanford. Ultimately, it was my love for the elderly and the support of people around me that helped me overcome my fear of becoming a geriatrician.

If I were to describe in one word how geriatric practice is different from a general primary care practice that word would be "optimization." When health care providers have large panels of patients with significant fractions suffering from one or more chronic diseases, as well as some psychological or social issues, then the providers need to optimize the care they can give their patients within the bounds of time they can afford to spend with them. A practitioner can easily find himself/herself getting involved in the physical, psychological, and even social well-being of patients. As a young person, I spend about 15 minutes engaging in small talk with my doctor when I go for my annual checkup. As a geriatrician, however, I can barely afford to do that and only with a very small fraction of my patients. For the majority of them, I can easily spend another 15 minutes on top of the original 15 minutes talking about health issues. A recurring scenario for me is to have a full clinic and two overbooked patients because of some urgent concerns.

As with primary care providers, patients' health issues are the top concern of geriatric practitioners. However, there are non-medical issues geriatric practitioners might find themselves involved in as well. For example, they can easily be pulled into the middle of a siblings' turf war over who has the right to decide on behalf of the elderly parent. Worse yet is the situation where no sibling is willing to take the responsibility of helping a disabled parent. Sometimes a practitioner receives phone calls from two siblings each requesting the same information, simply because neither of the siblings talks to the other!

At times geriatric practitioners will witness elder abuse and have no choice but to intervene. It is important to realize that some abuse occurs not out of malice but from caregiver burnout. As a keen practitioner, one has to be on the lookout for such circumstances.

No matter how hard we try, the loss of a patient to death is inevitable in a geriatric practice. Even though it is normal to feel sad, this feeling cannot be allowed to distract the practitioner from helping other patients. The reality is that we all need to be reminded that death is the natural conclusion to birth.

Finally, a geriatric practitioner has to be constantly aware that aging is a progressive process that tends to diminish a patient's reserves and, subsequently, increase the susceptibility to ailments. Geriatric practitioners can prevent or alleviate ailments by managing risk factors for patients or addressing them early enough in the process. Avoiding insults to organ systems and maintaining functions are key factors to decelerating age-related decline.

So, what makes a successful geriatric practitioner?

As a general rule, to be successful, the practitioner has to walk in the patient's shoes and allow the patient to express concerns while the practitioner is listening, for half of healing is listening! If the discussion strays too far outside the realm of medical issues, then the practitioner needs to steer the discussion back to where it belongs before valuable time is wasted.

A successful geriatric practitioner needs to thoroughly understand the social aspects of the patient. A good social history can open the door to many aspects of patient care. For example, when my patient's daughter decided to move across country due to job relocation, that news had a significant impact on my patient's wellbeing. She experienced anxiety, depression, and feelings of abandonment, and more importantly the loss of her support system. Being able to get to that history and provide an alternative support structure was *the* key to restoring this patient's health.

Another important element of being a successful practitioner is the ability to create a treatment plan for the patient. To draft a treatment plan, the practitioner needs to sit down with the patient (and at times the family) and agree on treatment goals. Based on these goals, the

continued on page 2

continued from page 1

practitioner can develop a treatment plan and set expectations. I cannot stress strongly enough how important it is to set the right expectations from the very beginning and involve the patient as much as possible in the planning process.

Despite all these efforts, sometimes the greatest concern is not the patient but rather the patient's companions. They may intrude into the method of care, with their intrusion varying from excessive zeal to belligerence. The practitioner needs to be clear that while questions are a valid and normal part of a companion's job, intrusions are not. A second point to emphasize is that as long as the patient has the capacity to make health care decisions, it is the patient's right to do so. A loved one (e.g. partner, daughter, son, or other relative) may have a different feeling or opinion. In that case, it is the patient's wishes that should prevail. When loved ones get involved, the practitioner should make sure that the patient agrees to that involvement and designates only one person to be the spokesperson. If this doesn't happen, the practitioner may end up repeating himself/herself multiple times throughout the day and not being appreciated at the end of it!

Another aspect of a successful geriatric practice is the alliance between the geriatric practitioner and other health care providers, such as physical and occupational therapists, nurses, and geriatric case managers. There is a lot to be learned and gained by working with other health care providers, and sustaining these relationships is an essential part of the job.

Invariably, my students ask the question, "How can I address all patient needs in one visit?" The answer is *triaging*. An important component of a comprehensive geriatric assessment is obtaining good medical, social, psychological, and functional history. Once this assessment is done, the practitioner can then stratify issues based on level of severity, address the critical ones, and schedule the patient for additional follow-up visits.

Let me end by returning to one of the misguided perceptions I mentioned: Geriatrics is not a "thankless job"! On the contrary, over the years, I have received hundreds of "thank you" letters, holiday cards, and phone calls from my patients and their families. What is amazing is that I have even received letters and phone calls from the bereaved families of my deceased patients thanking me for all the effort I put into helping their loved ones.

In summary, geriatric medicine is a wonderful, fulfilling, and fascinating field. Most physician satisfaction surveys have demonstrated that geriatricians are among the most satisfied practitioners.[1] The key aspects of any successful geriatric practice are triaging, effective communication (with the patient, companions, and other health care providers), and excellent interpersonal skills. These skills help create a culture of trust and mutual understanding.

Acknowledgements: I would like to acknowledge Haidar Ahmad, founder, uspapaya.org, and Phil Hubbard, PhD, director, English for Foreign Students, Stanford University, for their wonderful and tremendous efforts in editing my articles.

Reference

1. Leigh JP, Kravitz RL, Schembri M, Samuels SJ, Mobley SI. Physician career satisfaction across specialties. Arch Intern Med 2002; 162:1577-84.