

FROM THE THIRD GENEVA CONFERENCE ON PERSON-CENTERED MEDICINE: PERSON-CENTERED CLINICAL CARE ACTIVITIES

Person Centred Medicine for the Older Patient, with Specific Reference to the Person with Dementia

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Abstract

The concept of old age differs as the pension age differs between countries and because there is no consensus of the boundaries between middle age and old age, neither socially nor medically. The old patient (i.e. the geriatric patient) constitutes a special challenge for the health care providers because of the often complex presentation of diseases, the frequency of cognitive impairment and specific social circumstances. The old person with dementia requires special attention because of his/her cognitive derangement and the need-driven dementia-compromised behaviours. The person centred approach seems to be relevant to this age group and several programs exist using this ideology, especially in the care of the demented person.

Keywords

Old Age, Elderly, Geriatrics, Dementia, Person Centred Medicine, Dementia Care Mapping

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Introduction

There is no general consensus on what is meant by “the elderly”. Most often the age limit is the one that constitutes the right to old age pension, which differs between countries. The origin of the old age security system was in Prussia in 1889 on initiative of the Prussian Chancellor, Otto von Bismarck. In a letter to the German Parliament it was stated: *“those who are disabled from work by age and invalidity have a well-grounded claim to care from the state.”* One persistent myth about the Prussian program is that it adopted age 65 as the standard retirement age because that was Bismarck's age. In fact the retirement age was set at age 70 and it was not until 1916 that the age was lowered to 65 [1]. It is of interest to note that this age limit was set at a time when the life expectancy in the Western world was much less than today and only a small portion of the society could reach retirement age. The pension age differs between societies generally and at the moment, there is no United Nations standard numerical criterion, but the UN agreed cutoff is 60+ years to refer to the older population [2]. In medical terms the confusion is no less.

The term “younger old” is often applied to the age span of 65 (or 70) to 85 years of age and the term “older old” for those older than 85 years. There are however still many “home made” definitions such as seen by an example of Canadian researchers that defined younger old as 57-74 years and older old as 75 years and older [3]. The confusion arises from the fact that persons approaching or above the average life span of humans tend to be much more medically and socially different from one another than any other age group. From this fact comes the saying “When you have seen one geriatric patient, you have seen one geriatric patient”.

The geriatric patient

Several studies on the value of specific geriatric assessment during the eighties showed the risks of classical medical diagnostic and therapeutic methods for the geriatric patient and on the contrary, the benefits of individual holistic approach [4]. The risks for the geriatric patients can be described by the concept of geriatric

cascade syndrome. When using the organ specified approach the complexity of the medical situation is not taken into consideration and that leads to new medical problems in the diagnostic and therapeutic process. When at the same time, a due consideration is not taken to the need of the patient for mobilisation and rehabilitation, the patient often ends up with seriously compromised abilities for self care and is not able to be discharged to his own home. For successful treatment of the geriatric patient, it is necessary for the carers to know the person behind the disease(s). This is more important than in the treatment of conventional internal medicine, most often of younger patients, as the success of treatment may depend on factors related to the patient's personality, psychological health and social situation rather than to his physical health. Two domains are most important in this regard, the psychological health of the patient including his cognitive abilities, and his social support. Dementia is common in the oldest age groups and when present it can make all attempts to treat the patient futile. Cognitive decline that is not severe enough to merit the term dementia often goes undetected but is nevertheless important. Those treating the patient need therefore to evaluate cognition and more precisely, to what degree cognition has deteriorated and how. To evaluate the psychological health of the patient is also of utmost importance. Older persons often tend to explain their symptoms by their chronological age and that makes their contribution to their own treatment sub-optimal. Depressive symptoms and overt clinical depression are great obstacles to treatment success as well. The time used to evaluate a person's cognition and to communicate with him is therefore time well spent. The social support is also of utmost importance for his possibilities for independent living. For evaluation of social status and support it is necessary to involve others such as family members and the persons responsible for the social service in the community. Before doing that the patients wishes must be respected. He knows best to whom he wants to turn for help and he might trust some and mistrust others. According to human rights charters such as the Declaration of Lisbon on the Rights of Patients [5], he has the right to know everything regarding his illness, treatment and prognosis, to decide to what extent he is treated and supported and whom to consult in his family or community for his benefit. For this holistic approach, the time-honoured method is to use teamwork for evaluation, caring and planning [6]. The personal preferences of the patient must be respected; in other words, the personal centred approach to treatment must guide the work. It can thus be argued that the concept of person-centred medicine applies especially well for the aged patients [7].

The person with dementia

The old person with dementia constitutes a special challenge. Dementia is a frequent condition in old age and

in Europe, the age-standardized prevalence rate of dementia at age 65 and over has been estimated to be 6.4% [8]. As the intellectual and psychological health has deteriorated in the demented individual, the treatment and care is classically based on information from others than the patient himself. The staff turnover in residential care makes it difficult to maintain high standards of professional care and lack of understanding of the patient's wishes and preferences can lead to neglect of psychosocial needs. This neglect as well as practices of physical restraint can exacerbate need-driven dementia-compromised behaviours, leading to loss of self-care, decision making and social engagement as well as increased social alienation [9], comprising what Kitwood called malignant social psychology [10]. More than a decade elapsed from the general consensus on the importance of the holistic, personalized approach to the geriatric patient, to the arising concern of the special needs of demented patient for a personalised approach in care. During the last one and a half decade, more attention has been brought to the needs of the demented patient and new programs have been developed and published. The pioneer work of Tom Kitwood [11] where he put the person behind dementia to the forefront has led to extensive research in this field and promotion of several programs intended to serve the demented patients. He founded the Bradford Dementia Group in 1992 and his own program was called "Dementia Care Mapping" [12,13]. One program based on his idea comes from the CADRES study in Australia [14]. In this study, urban residential sites were randomly assigned to person-centered care, dementia care mapping or usual care. Agitation, a major symptom of distress was significantly lower in the person-centred care than in the usual care. The results confirmed the conclusion made in a comprehensive review of non-pharmacologic interventions for the management of need-driven dementia-compromised behaviours that the most promising treatments seem to be individually tailored behavioural interventions [15]. In another study focusing on the person-centred care as an alternative to pharmacologic treatment, the use of neuroleptics was almost halved in the intervention homes as opposed to the control homes without any increase in agitation or disruptive behaviour [16]. In the intervention homes, the staff received training in the delivery of person-centred care and they were supervised weekly. This effect lasted for 12 months. In spite of this progress in care of demented individuals, an astonishingly small number of studies on the demented persons own preferences and wishes have been published. The reason seems obvious, in dementia; the very ability to communicate with others in words is seriously compromised. However, in times when the diagnosis of the diseases leading to progressive dementia is made at early stages, when the person is still very able to communicate, the focus should be shifted to the person with the disease. Most of these studies have been done with qualitative methods and therefore including few individuals but they have shown many interesting aspects such as the coping skills of individuals with early

Alzheimer's disease [17]. There is a need for bigger studies using quantitative measures as well.

Conclusion

It is in line with this development in person centred approach in the care of the older patient and the demented patient especially that the international initiative of person centred is gaining momentum. This initiative started by a series of congresses, then to establishing a network of interested parties and now by establishing an International Journal for this topic.

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