

Guidelines “Treatment and care of disabled elderly people”

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The guidelines “Treatment and care of disabled elderly people” of the Swiss Academy of Medicine address consequences of social and demographic developments that cannot be overlooked any longer. Life expectancy is an important indicator in international comparisons of health care systems and gains in life expectancy are rightly praised as signs of progress. Indeed recent increases in life expectancy have led to a surge in the number of the old and very old in the population. This reflects the better health of the general population. On the other hand, an analysis of days spent in acute and chronic care in later life has shown a semi-exponential increase in days spent in institutions with a doubling for an age increase of ten years. The use of institutions remained constant over the period from 1975–1990 despite the market increase in longevity. This indicates that increasing longevity will affect the number of elderly in institutions disproportionately.

Even reaching old age in good physical health brings with it the experience of physiological decline of mental and physical functions, which eventually leads to frailty and dependency in at least some areas of former autonomy. In reality in the last part of our life, we are all likely to experience a period of illness and loss of autonomy finally leading to death. This is reflected in the semi-exponential increase in mortality with age already observed in the 19th century as described by Gompertz. It is the result of the summation of age-associated physiological decline, cardiovascular disease, tumours, neurodegeneration and a failing immune system. This prospect is a challenge to the aging person, the family and society. Thus it is estimated that the number of persons in need of care will increase in Germany, for example, over the next years from 2 to 3.5 million. Furthermore, the significance and consequences for our informal and social network – eg, the fact that in larger cities 50% of the inhabitants are living alone – are largely unknown and unexplored. On the positive side we may note that today’s “young-old” (<75 yrs) have a level of autonomy and physical activity seen 20 years ago in 60–65 year-olds. However, this difference is no longer present above the age of 80 suggesting a “rectangularisation” of the morbidity and mortality curve.

In a sense the old precept of “senectus ipsa est

morbus” gets a new actuality. It would, however, be a complete misunderstanding of the progress made, if we were to assume that frailty and dependency are the fate of old age and require no medical but merely social action. By identifying distinct clinical conditions as illnesses and developing specific therapies progress has been made and has led to longer autonomy and quality of life. An obvious example is the surgical treatment and rehabilitation of hip fractures. The progress in longevity noted in recent years is strongly due to a decline in cardiovascular mortality as a result of better treatments. But it is not only the experience of age associated illnesses that influence our awareness of old age, it is the historically new experience that death and dying are “banned” in younger age-groups and death is now concentrated late in the course of human life, most often at the end of a period of chronic and debilitating illness. Not very long ago death and dying was associated with the full life cycle and only 50% of children reached adolescence and finally 10% reached 60 years or older.

In a society where self-determination and autonomy are valued highest, the prospect of experiencing loss of autonomy and becoming dependent with old age is threatening. This should not lead to a sociopolitical neglect of aging and the older population but to an active strategy characterised by special efforts to protect this frail and vulnerable segment of the population. The old dependent person has the same right as younger persons to receive the necessary health care. The responsibilities of society towards these persons have to be defined. The guidelines fill an important gap.

The care of the frail, dependent elderly is an interdisciplinary task. This requires that the role and responsibilities of each member of the team has to be clearly defined and respected. The responsibilities of the providers of health care, the different health professionals, the insurance companies, the community responsible for long term care (in Switzerland), the state providing acute care services, all have to be defined. Chronic medical conditions especially associated with frailty may lead to the need for many types of services. It is obvious that the interest of the different providers, given their tasks and obligations, may not necessarily be identical and even in conflict with the in-

terests of the patient. Therefore the guidelines explicitly address the conditions required to guarantee adequate care, namely qualified health care professionals (including physicians with competence in the care of chronically ill geriatric patient), surroundings that keep the risk of falls low, avoid pressure sores, but also prevent solitude and thus depression, provide adequate nutrition and protect against abuse. At the same time the will of the old person has to be respected. Decisions regarding the old person require his or her consent. To make a choice the person has to know the full range of possibilities, be informed about and grasp the consequences of the choice, and the information should be delivered without the (implicit) notion as to what the old person should do. We should keep in mind, that younger people cannot wholly imagine the circumstances of an elderly person and often judge a situation as being worse than the old

person perceives it him- or herself. Very often the old frail person will no longer be able to make his or her decision in his or her true interest. In this case it is crucial to know the intentions and wishes of the patient by advanced directives. An alternative may be the designation of a proxy. In order to truly respect the intentions of the patients' advanced directives and the designation of proxies will be increasingly important in the future. We all should address these issues with our patients and the general public.

In this context the guidelines based on the legal framework concerning human rights set the goals for the interdisciplinary care of the frail and dependent person. They will contribute greatly to a coherent and co-ordinated care and at the same time help to protect the interests of this vulnerable group of our population against the diverging interests of society.

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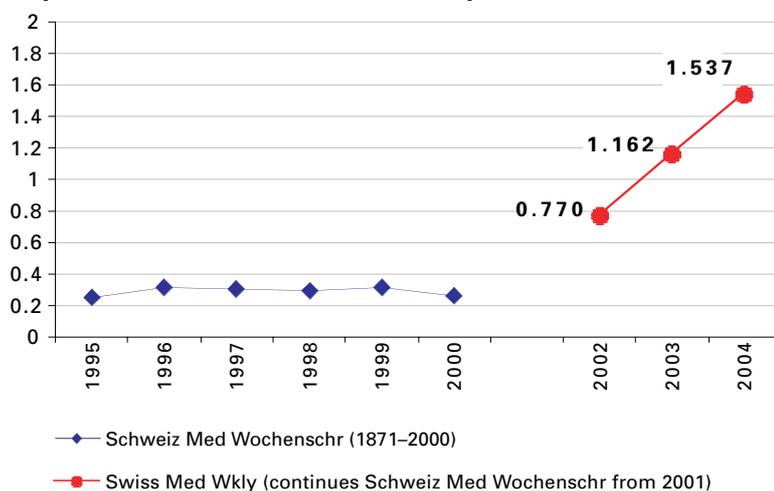
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