THE CHANGING ROLE OF HEALTH CARE PROFESSIONALS

Physicians

1st OF 3 parts

By Carol Abaya, M.A.

For centuries the role of the physician has been to treat specific illnesses after they have occurred. They see the patient, prescribe medicine or treatment, and then say goodbye until the next illness. In younger people, doctor visits can be years apart.

Medical advances and technology have changed the face of life and death -- and consequently the practice of medicine. For the first time in the history of man, more than half of those who ever lived to be 65 years old are alive today. Chronic illnesses, which years ago killed people early on, are now "controllable," though most often not curable. Chronic rather than acute illnesses have taken over many elders' lives.

Dr. Joanne Schwartzberg, Director, Department of Geriatric Health, American Medical Association, notes that society is faced with the first large-numbered generation which is living to be quite elderly. Therefore, there is no peer model with which to fall back on, to "tell" Sandwich Generationers and the elderly how to handle this new situation and relationship changes.

Physicians, whether family practitioners, internists or specialists, need to rethink their philosophy in relation to patient care. In addition to meeting the specific acute needs of the patient, physicians must now deal with a number of other elements. In the long run, these elements - if not properly addressed - will cause the country's health care costs to skyrocket even faster than they have to date.

The Sandwich Generation©™ interviewed a number of physicians and other health care professionals about their changing roles given the aging population. This first article deals with the new role of physicians, specialists and the family practitioner.

Four doctors and Dr. Schwartzburg were interviewed. Doctor #1 is an Internal Medicine Board Certified private physician who has specialized in geriatrics for 25 years.

Doctor #2 is Board Certified in both Internal Medicine and Geriatrics. He heads the geriatrics department at a large medical center.

Doctor #3 is also Board Certified in Internal Medicine and Geriatrics. He is widely known for his knowledge of Alzheimers.

Doctor #4 is a Board Certified OB/GYN with a sizable senior clientele.

Question: What are the key changes in society that have changed the practice of medicine today compared with say 20 years ago?

Answer: Schwartzberg: The country's demographics are such that we are faced with the care of the first generation of people who have lived so long. We have no peer models for the elderly or Sandwich Generationers who have to deal with the new problems.

Because of the success of medical advances and technology we are faced with an increasing number of elderly and an epidemic of chronic illnesses. We have to get used to the idea that managing chronic conditions over time will be a major part of practicing medicine.

Doctor #3: While many patients live with family or have family close by, we are seeing more elderly who live alone and have no family nearby. The geographic disbursement of families puts new pressures on physicians.

Question: How do these changes affect the basic practice of medicine?

Answer: Doctor #1: The evolving elder care model is no longer bio-medical. It is biomedical, psychological, social, environmental and spiritual. Some factors in acute illness are biomedical. But today age related losses and other non-medical elements impact elder health.

Arthritis may make a person's hands stiff, and this impacts the ability to do daily chores. A spouse dies, and the survivor may be depressed and not eat properly. Children may not call, and the elder feels left alone. So we have to look at and deal with the whole family.

Doctor #3: We have developed a geriatric team because the elderly need more attention and social support. Besides a geriatrician (physician), we include a nurse, a social worker, and at times, a psychiatrist. A multi-disciplinary team approach is important because 50% of elder medical problems are psychologically based.

Doctor #4: Medical advances and technology have helped reduce the length of hospital stays. Older people recover faster at home because their routine rhythm of life is maintained. Also, they don't catch hospital-driven infections. This means the family plays a more important role in recovery and has more of the care burdens and responsibilities.

Question: How do you approach elder medicine on a day-to-day basis? How do you see your role as a doctor?

Answer: Doctor #2: We work closely with the patient and his/her family. We establish common goals, realistic and shared goals. We identify all the health problems and prioritize, with the family, the issues and how to handle them. The doctor should clarify issues for the patient and family and how to handle them. We try to handle one problem at a time so the patient and family do not become overwhelmed. At the same time we need to keep a close eye on the overall problems and treatment. Sometimes medicine for one illness reacts adversely and affects another problem.

We also are less aggressive in using invasive tests, unless the results will help improve quality of life. We look at the treatability factor rather than just the gathering of information. Some invasive procedures can be dangerous to elderly patients.

Doctor #1: We have to shift our way of thinking. We need to look to and at the family for shared responsibility, shared responsiveness and shared decision-making. The doctor has to be open-minded, encourage a team approach, and open windows so that other professionals and the family can come in. We look to empowerment. We need to communicate openly with the patient and family members to recognize the elder's changing needs and try to prevent that next illness.

The doctor's role remains patient and problem centered, with a deep responsibility to improve quality of life.

Doctor #4: As a specialist, I work very closely with the primary care doctor as well as the family. We discuss the case and as a team try to solve problems. Together with the primary doctor, we involve the family to get the whole medical picture. Our objective is to help patients maintain their own routine, and to encourage family members to help them return to normal activities as soon as possible.

Question: What are some of the changes in the public's attitude toward doctors and how does this relate to Sandwich Generation participation in parental care?

Answer: Doctor #2: The mindset of the oldest generations is such that they just do what the doctor says. Sandwich Generationers ask - and they should - questions. Some older doctors may not like to be questioned. But doctors should welcome questions. I want a dialogue with Sandwich Generationers so we can get a broader picture of the situation.

Doctor #1: The office of the physician, like the office of the President, is powerful and respected. But we need to get doctors to adopt a new world view. We might need to have some humility ourselves. We need to stop sitting on our hands. We have the best technology and need to know how best to use it.

At the same time, we become overwhelmed by "the system." So, patients and Sandwich Generationers should ask how they can help the doctor. Emotions need to be acknowledged, and the family needs to be honest about other problems and responsibilities. We all need to define what is and what is real.

Question: What can/should Sandwich Generationers do to prevent parental medical crises?

Answer: Doctor #2: Everyone needs to be aware of "silent" diseases in the elderly, in particularly the frail elderly over 75. 35% of the elderly have hypertension, and many have blood sugar problems. These can easily be identified in an annual checkup.

Doctor #3: Exercise, regardless of age, but especially by women, helps prevent arthritis and osteoporosis and controls diabetes and high blood pressure. So parents should be encouraged to exercise, even if just taking a good walk every day.

As one ages, the body doesn't need as much fat, so diet should be modified.

Falls are prevalent in the elderly, and many can be prevented by increasing the amount of light in the house. Also change carpet and wall colors so that the elder can easily differentiate between the floor and stairs and walls.

Question: What are signposts of trouble? What should Sandwich Generationers monitor?

Answer: Doctor #2: Basically one needs to look out for any change in functioning capabilities, behavior, personality, walking gait, and balance. Signs of a possible heart attack include severe shortness of breath -- and not just chest pain. An infection in the body may cause an elder to fall frequently or be confused. Also sleeping problems or constipation can be indicators of something more serious.

Doctor #3: If a parent is taking medicine, side effects should be watched for and often drugs should be eliminated. The doctor should periodically review medication to identify those which are still really needed.

Question: What should a person look for in a doctor who treats an elderly person?

Answer: Doctor #2: First, if the doctor says to you, "What do you expect at your (or your parent's) age?" seek someone else. The key is that the doctor sincerely likes to deal with the elderly, and the patient feels comfortable talking to the doctor

Second, the doctor should be open with both the patient and Sandwich Generationer and help the elder understand that the Sandwich Generationer is concerned and the doctor is there to help everyone

Third, a doctor should help coordinate care and bring in outside resources as needed.

The kingpin of elder care in the coming decades is "shared responsibility, shared responsiveness, shared communication, and shared decision making."❦

DISCHARGE PLANNERS

Smoothing The Move From Hospital To Home

Continuum of Care focuses on problem-solving with a family based approach. Aging parents care places tremendous pressure on families already faced with an overdose of responsibilities. Often coupled with a long distance factor, Sandwich Generationers have too little time, too many demands, too few supports, and a lack of resources. These strain family life and severely impact the Sandwich Generation's -- and elder's – "I Self".

Yet illness and old age are a family matter.

One geriatric nurse specialist put in this way: "Patients need their families as advocates for two primary reasons. The complexity of the current health care system does not provide the communication pathways for getting direct, coordinated information to the patient in a timely manner. Second, patients are often too ill and need their energy for diagnostic tests and treatment. They lack the strength to seek and process information to make informed decisions."

She also said: "People are products of their social environment. All actions, behaviors, and decisions regarding health care reflect the values of one's culture and subculture."

With this in mind, she said, "The health care worker has a moral and ethical obligation to understand how families work and how and why decisions are made within the family unit."

Role of Discharge Planners

Today, hospital discharge planners (DPs) play a critical role in ensuring continuum of care and helping to reduce family caregiving burdens and stress. DPs are a health care and community resource that families should tap into, regardless of the patient's age.

Three nurses, who are hospital discharge planners and deal with the elderly and their families on a daily basis, were interviewed. Nurse #1 is a past president of the American Association for Continuity of Care. Nurse #2 is a past president of the Discharge Planning Nurse Coordinators of New Jersey. Nurse #3 is discharge planner at a community hospital with an aggressive community outreach program.

Question: What is the philosophy of DP?

Answer: Nurse #1: The discharge planning process is an interdisciplinary approach that is centered on the patient and family or significant other to facilitate the transition of the patient from one level of care to another. It ensures that preventive, therapeutic, rehabilitative and psycho/social , as well as medical needs, are included in the assessment, planning, implementation and evaluation process.

DPs work is based on the belief that continuity of care is an essential component of the health care delivery system and is a holistic health approach that is centered on the patient and family.

Question: What is the basic role of a DP?

Answer: Nurse #3 : A DP bridges the gap from the hospital to the home. He/she is an advocate for the patient, to ensure a safe, timely and appropriate discharge and to help families obtain appropriate help at home.

The DP helps the patient/family to understand the daily care as well as medical issues; provides emotional support for families, and helps families tap into community resources.

The DP melds the different entitlement programs with patient needs.

Nurse #2: The DP team has the responsibility of coordinating discharge planning, with input from the patient's doctors, family, hospital staff nurses and other health care professionals. The DP brings together the patient, family, and health care professionals to ensure appropriateness of referrals and implementation of the discharge plan.

DP nurses can be expected to organize home health care and equipment for patients who need continued care at home, after they have been discharged from the hospital. The role of the DP nurse is to smooth that transition. They meet with family members and the physician and will continually meet with physicians to keep the care appropriate. And while the services they provide are those approved by the attending physician, independently DP nurses can arrange for transportation for a patient, and other services including medical equipment, visiting nurses, home health aides, various therapies, and home delivered meals.

Question: What are the qualifications of the DP staff?

Answer: Nurse #2: A DP team includes at least a registered nurse (RN) and a social worker who have special education or training in hospital discharge planning.

Nurse #1: While the standards for DP nurses varies from state to state, they must be RNs -- as a minimum requirement. They should be a generalist in nursing and have good communication skills. They must be able to help a patient negotiate the health care system.

Question: Does a patient/family need to get the doctor's ok to talk with the DP?

Answer: Nurse #3: No! Every patient/family has the right/ability to seek help from the DP for after-hospital care. Today's medical reimbursement policies and managed care focus on getting a patient out of the hospital as soon as medically possible. With the elderly, families tend to think the patient should stay in the hospital longer than is really necessary. To be able to better handle early discharge, families should aggressively seek help from DPs. They have a right to receive information and help.

Question: What specifically does the DP do for the patient/family?

Answer: Nurse #3: A DP starts out by doing a needs assessment which encompasses the medical situation, the mental status of the patient, the physical level of functioning ability, insurance information, home/family support system, and the home environment.

Once this is completed, the Discharge Planning nurse can arrange for a variety of services. Some of the medical services that can be used include nursing services, intravenous therapy, physical, occupational and speech therapies, home health aides and medical equipment at home. They can also arrange for other community services depending on the patient/family needs.

Nurse #1: The DP must be able to work with the family and know what financial and insurance resources are available to them. Additionally, the nurse must have knowledge of the community resources and reimbursement procedures. Above all, DP nurses should assist in making all of the necessary arrangements for the family or the patient. We don't want to send them to the yellow pages.

Question: How does (should) the Sandwich Generationer fit into the continuum of care philosophy?

Answer: Nurse #3: Sandwich Generationers have the responsibility to learn about the medical condition/prognosis of the patient, both the medical and daily care needs, what resources/help are available, and what insurance/Medicare covers and what families will have to pay for. They must be prepared to spend time to do certain things, to plan and handle paperwork, especially if entitlement programs are appropriate.

Nurse #2: Twenty-five years ago someone was at home all of the time. Now everyone is working. Yet the care that was once provided by the daughter, sister or mother is still the measure for the paid professional, and therein lies the basis for some client-family-care service misunderstandings. Family care once included custodial care and companionship -- two areas that are not covered by insurance. Realistically, families can expect DP nurses to help them determine what services should be provided and which ones will or will not be covered by insurance. They can even help with some relevant paper work.

Question: What are Sandwich Generationers' "rights" when it comes to parental care?

Answer: Nurse #3: Sandwich Generationers and parents should discuss medical care issues and plan today to avoid a crisis tomorrow.

However, as long as a patient has the ability to understand ramifications, family members do not have the right to make decisions. Even with Living Wills, the patient retains the right to make decisions, as long as he/she is able to.

Question: What about the emotional aspects of being older and ill? Are DPs involved in this area?

Answer: Nurse #3: This is a difficult area, but being patient and family centered, we must deal with it. Often we tell people things they don't want to hear. Often they are in denial of the situation and don't really like the options. So we help the patient/family work through their anger and frustrations on a day to day basis.

We also talk to the family about future needs as a patient ages and possibly gets sicker. We help them understand the various care options that exist today.

Nurse #1: It will be the DP nurse who helps the family understand the realistic needs of the patient. That is, the nurse should be able to explain the nature of the illness in relationship to the care that is recommended -- and even explain the nature of a deteriorating condition when a patient is suffering from a terminal illness.

Question: What about the elderly person who is stubborn and won't accept the reality of the situation?

Answer: Nurse #3: A multi-disciplinary recommendation focuses on what is safe and appropriate. Many times what we recommend is declined by the patient, who then makes poor choices and may end up back in the hospital soon after this one incident. Naturally, the family gets upset, but if the patient is mentally alert, it is his/her right to make poor choices.

It's a dilemma for which there is no answer, especially if the patient understands the ramifications of that decision. We try to understand the real issues, the real fears of the elder in relation to independence control and self-image. Often feelings are subconscious.

We need to remember that parents are still our parents and not children. We need to recognize that our parents have their own fears, and Sandwich Generationers may have to compromise. Sandwich Generationers shouldn't dictate.

Question: What should a patient/family do if the hospital DP is not responsive?

Answer: Nurse #3: Keep in mind that Medicare regulations mandate that DPs work with patients/families and provide service. So it's your right to expect help.

Nurse #1: If you do not receive the care you think you should have, do not hesitate to insist on it. Families need to be aggressive about receiving the care they need. Hold the hospital accountable for the service you receive.

If your home care needs are not being met, complain to the hospital's patient representative. And if that doesn't work take your complaint to the hospital's president.❦

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3rd in a Series

Accessing Community Resources

In the hospital, it is clear that a nurse's attention is most often directed on the patient.

In the community, the scenario must be different if the needs of both the patient and the Sandwich Generation(caregiver) are to be met. This dual perspective necessitates nurse/patient/family interaction that is considerably different from the traditional hospital nurse/patient relationship.

According to the World Organization for Care in the Home and Hospice, "the home is increasingly the site for the delivery of care, both in the U. S. and throughout the world. This is a direct consequence of the aging of the world's population, the increasing importance of chronic diseases as opposed to acute illness, the imperative to control health care costs, and the development of new technologies that will enable ill and disabled individuals to remain in their homes."

Home care must be looked upon as a central component of the health care industry, according to WOCHH.

With this in mind, the Journal of Gerontological Nursing says, "The primary strategy must be to provide an individualized approach by looking at situations through the eyes of the client and family ..... the goal....is to assist and encourage family self-care."

The Journal further states that the nurse's role "is to enhance the family unit."

An assessment of today's home care scenario encompasses a number of elements that previously were ignored. The role of the nurse has become critical in this situation.

What's Everyone's Role?

For the benefit of the patient, the healthcare worker and the family must learn to think and work as a team. To envelope the patient and family within the system as an informed, hands-on member of the healthcare team is a relatively new concept. It has been evolving in all aspects of the healthcare system.

A nurse's role today is multi-faceted: as a teacher and counselor, agent and advocate. The nurse-teacher focuses on safe use of medication, treatment techniques, hygiene, nutrition, exercise, rest, stress management and prevention of illness or injury.

As a teacher-counselor, the nurse discusses with the patient and family alternatives in care, nursing care, care-giving at home, the loss of a loved one. Such discussions allow all involved to make educated decisions, adding to the quality of life of the patient and caregiver.

As an agent, the nurse is an "enabler." She/he evaluates barriers to self care and encourages independence. Based on a thorough assessment, the nurse empowers the patient and caregiver by providing them with the knowledge and skills to reach optimum independence. Encouraging respect and active decision making in order to promote quality service and care is also involved.

Nurses today must also be an advocate, taking the initiative to talk with patients and their families about key, and often sensitive, issues. Patients talk more to nurses than they do to the doctors. And doctors usually are "specific condition" oriented. Nurses should take a more holistic approach and look beyond the specific illness(es) to the total environment. The nurse should provide care direction for the patient.

The primary goal of the family-oriented nurse is to help patients and families obtain the knowledge and skills needed to solve their own problems.

Working with Sandwich Generationers

Nursing knowledge is general and based on psychosocial and physiological needs which are scientifically based. Utilization of cultural, religious and ethnic beliefs in collaboration with the individual knowledge from the family is a necessity.

Also open-ended communication is essential to quality care, and nurses today must be willing to share both information and care responsibilities. Knowledge of what is the norm for the patient should be obtained from the family as well as 'tried and true' techniques experienced by the family.

Filling in the blanks and teaching caregiving skills encourage a partnership with the nurse and family. Families who have an understanding of the disease process and why specific techniques are used are more confident, less intimidated, and experience a decreased level of stress. Knowledge empowers the family and leads to autonomy. This is beneficial for the integrity of the patient and family.

Dealing with physicians, social services, the insurance process and discharge planning heighten the stress level of the patient and family. The nurse should help clarify these confusing and often incomprehensible areas. Better understanding of the reality of care and the quality of life can lead to mutually acceptable choices and goals.

There are no firm answers and there are no losers if the patient, family and nurse are partners. Only this partnership can develop the best possible plan of care. Inclusion of as many family members as possible allows expression, feedback and discussion with an exchange of information. Teaching caregiving skills and techniques, and encouraging the family to take on caregiving roles promote feelings of competency, and reduces feelings of helplessness, powerlessness and stress.❦