

## Elderly Patients, Physicians and Family Caregivers

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The dual relationship between patient and physician lies at the core of medical practice, as expressed in the Hippocratic oath and in the prayers of the ancient Jewish sage-physicians Maimonides and Assaf Harofeh. Today, this issue is reflected in the ethical principle of the patient's autonomy and in the Patient's Rights bill in Israel [1]. When a third party is brought into the equation, such as the caregiver of an elderly relative, the complexity mounts.

The elderly are afflicted with frailty in different forms and rate of appearance. In order to survive with frailty one needs support. The first line of support is the family, which might include spouse, children, or more distant relatives. As the numbers of the elderly increase worldwide (reaching almost 10% of the population over the age of 65 and almost 5% over the age of 75 in Israel), so does the prevalence of both the frail and the dependent elderly (about 2% of the entire population) [2]. Many of these elderly continue to live in the community, supported by their relatives who sometimes even take on the role of "case managers." Furthermore, the elderly are the major consumers of healthcare services. All these processes lead to a new type of medical management that does not follow the conservative dual physician-patient relationship, but is based on the triad relationship of physician-patient-caregiver. This type of relationship is not unfamiliar to medical practice: pediatric medicine is based on this triad in which the parents are integral players and where the physician also has an educative role, for example instructing mothers in the care of their infants. Although there are certain similarities in the care of infants and the frail elderly in the triad relationship, they differ in many aspects. Parents are naturally and legally the surrogates of the infant, and the child's healthy development is a self-explicit goal of parents and physician. With the elderly this relationship is different. Firstly, the family caregivers are not the legal and natural surrogates; secondly, a dynamic background exists based on the relations of many years between family caregivers and patient. Moreover, several factors obstruct the communication in the patient-physician-family caregiver triad, such as the generation gap, differences in attitudes, opinions and expectations, different educational levels, guilt feelings on the part of the caregiver, and embarrassment of both patient and caregiver to discuss certain aspects of the patient's dependence. And finally, the goals of care are not so clear and self-explicit as they are in pediatric medicine.

In this issue of *IMAJ*, Drs. Yaffe and Klvana from Montreal [3] report a study on the attitude of family physicians towards family caregivers of elderly patients during visits to the doctor's office.

Although the research deals with the primary care setting, it has implications for the acute care setting as well. The phenomenon of caregivers accompanying an elderly relative (for example, with acute pulmonary edema or acute abdomen) to the emergency room, as well as in internal medicine and surgery wards, is not uncommon. Moreover, the diagnostic goals, treatment modalities and sometimes ethical dilemmas are more challenging, more acute and more immediate than in the primary care setting.

The study by Yaffe and Klvana [3] presents several important insights on this problematic relationship [3]. The physicians surveyed in this study on their relationship with family caregivers-elderly patients were clearly interested in the subject, as evidenced by the 71% response rate. While 90% felt they are generally responsive to the caregivers' concerns, 81% found relations with the caregivers stressful. The magnitude of the problem was reported by the physicians to be about 10% of their 10-30 daily contacts in the clinic. It should be noted here that their clinics – part of the nationalized Canadian health service and affiliated with three local medical centers – are well organized and most of the physicians are paid by fee-for-service. Compared to the situation of primary care physicians and hospital staff in Israel, their practicing environment is friendlier. Yet, the Canadian practitioners reported stress, which they attributed to: a) diagnostic problems, namely difficulty in assessing the main problem and the fear of making a wrong diagnosis, b) conflicting responses of patient and family caregiver, and c) reluctance on the part of the patient or caregiver to use available community resources.

The study showed that physicians derive support for dealing with the frustrations of this combined relationship from their nearest environment, which may be family or colleagues. They contend that their problem is primarily the inadequate remuneration. Dr. Yaffe, a leading figure in the Continuing Medical Education system in Montreal, offers this education system as a way to enhance physicians' capacity to deal with the problem; however, the respondents did not find such a program sufficiently attractive. While recognizing the problem of stress caused by this triad relationship, it appears that their priorities lie in other issues of medicine. Continuing education is not limited to formal programs only but occurs during their daily contacts with medical colleagues and other members of the health team. According to the study, this environment helps physicians to deal with their stress and also serves as sources for information regarding community services.

These data reinforce the role of the multidisciplinary team and of

professional counseling in the primary care clinic. We have shown in a previous study on geriatrics in Israel that it is possible to achieve this mission [4]. The role of the consultant is to assist his colleague, not to do his job. Comprehensive Geriatric Assessment is one of the tools for dealing systematically with all aspects of diagnosis and care of elderly patients – the medical, cognitive, functional and supportive components of their condition [5]. Preference of care is one of the aspects of the CGA, as is the work of the multidisciplinary team under medical leadership [6]. CGA – a tool for the use of all medical practitioners, irrespective of their specialty – was recently introduced as an obligatory part of the clinical curriculum in several medical schools in Israel.

Ways to overcome the problem could include: revising some aspects of the medical care and management of the elderly patient, adding reimbursement for the stresses involved in dealing with family caregivers, and providing professional geriatric counseling to practicing physicians both in the primary care and the acute hospital setting. The authors demonstrate in their study that people in crisis seek help from the medical profession, which has the authority and the power to give this help. With the growth in the elderly population, the medical system has to adapt itself to their

special needs, which includes the “case management” and support by family members, albeit problematic. The traditional and well-proven education by colleagues is the mainstay for resolving new problems in medical practice. Clearly, solutions have to be appropriate to the different infrastructures of different places, but they are all based on medical education.

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