

Restructuring Geriatric Care and Management: Need of the Day

Rajesh Chauhan*, Ajay Kumar Singh and Shruti Chauhan

Family Healthcare Centre, India

*Corresponding author: Rajesh Chauhan, Family Healthcare Centre, 154/6-B, Avas Vikas Colony Sikandra, Agra 282007, India, Tel: +91-9760021192; E-mail: drrajeshchauhan@gmail.com

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Editorial

Restructuring geriatric care and management is an urgent necessity once it is known to all of us by this recent study that expects the life expectancy to be rising considerably, and that of South Korean women to break the barrier of 90 years by 2030 [1]. Life expectancy has been rising steadily, and this recent research results has made headlines in the BBC, CNN, and all other top news channels around the world. As such this is quite commendable for life expectancy to be moving up so swiftly across many parts of the world, but on the other hand to some healthcare administrators and planners it may be a cause for some consternation as well. For sure, this increase in life expectancy will place additional responsibilities and would stretch the available resources, unless we plan to upgrade and increase our present resources. There would be factors which cannot be ignored, like financially viability, easily accessibility, adequate, prompt, round the clock, sustainable, result oriented, caring and satisfactory management of morbidities in the elderly population. Making the situation somewhat more difficult would be that all of those morbidities would come overlapped and intertwined with increasing frailty and senescence as well, where drastic measures cannot be undertaken, thereby leaving little room for maneuvering.

Going by this news, future really holds great responsibilities and even higher expectations from Geriatricians and Gerontologists. Lest we miss out, it's definitely a time to brace up and start preparing to meet the demands, expectations, and the challenges ahead. The year 2030 is not too far from now when we start seeing the 90 mark being crossed and therefore suitable gearing up and restructuring would be necessary while we still have the time to face the challenges and shortfalls. It will be a time for integrated care, with special emphasis on multi-morbidity, avoidance of poly-pharmacy, and of physical and cognitive impairment.

Children of this aged population who are in their eighties and nineties, would most likely be in the geriatric age group themselves, and may also be somewhat incapacitated as care givers and maybe suffering from various morbidities. Therefore, expecting the children to play the role of care givers would perhaps be asking too much. Grand children will have to take on the onus of being the care givers, and to the relatives of two generations, which will be too tedious and perhaps a bit demanding and challenging as well. Separated, divorced, widow, widower, etc. without family support will obviously be finding it more difficult to sustain a normal living. Financial stress and the inability of the state to care for the forlorn elderly would probably push them to constant worry and decreased stamina to cope with increasing incapacities and failing health. We cannot break away from death, but certainly with deliberation and reasonable efforts the imminent downward spiral can be broken.

So where do we start? Perhaps to start from the basics would be most appropriate. Getting the overall diagnosis and the associated comorbidities right would be a good start. In that, a detailed structured history and clinical along with a review of all morbidities and prescriptions, including OTC (over the counter) medicines, would be a good start. Morbidities can be reassessed, as also the nutritional status, fitness levels, and unnecessary prescriptions if any can be taken off. As geriatricians, our minimum basic target should be to make as many elderly self-reliant so as to be able to perform his or her daily chores, be mentally and physically agile, be able to keep a track of prescriptions and the dosages, and be able to seek, grasp, and follow medical advice. The quality of life should be the measurable outcome of all our efforts. Periodical detailed reviews at regular intervals would perhaps be in order. Perhaps it's time to move on to individually tailored and focused treatment in the aged population [2].

Without cutting corners in any way, and by continuing to do and provide only the best, in the best interests of the geriatric patients under our care, there would perhaps be a need to rethink whether all that extra being done as per the latest evidences to increase longevity is actually necessary or beneficial to the patient in the long run. Without sacrificing the benefits, the 'evidences' and guidelines of the recent times have to be reviewed thoroughly for their being really required or worth it, especially when additional financial pressures are already being placed on governments. Even some of the best economies of the world may start finding it difficult to cope up with the regular upheav and increasing demands of fanciful things that really may not add up any qualitative difference in their present health status or in their quality of life. Overcoming elderly self-neglect, loneliness, psychosocial issues, discussing prognosis, reducing unnecessary hospitalizations, discussing and confirming end-of-life advance directives, and where we die directives, would be some other requirements.

Sensory organs, especially hearing and vision will need careful attention. There are many things that can be prevented, for example, falls and injuries, osteoporosis, nutritional deficiencies and excesses, neuromuscular disorders, locomotor disabilities, rheumatism, prevention of end organ damages consequent to conditions like hypertension and diabetes, etc. could be some areas where much can still be done. There may be many elderly patients who would be carrying the burden of occupational diseases which might have failed to manifest in their florid forms in their youth, and now when they have aged, all those consequences may be catching up and confounding the current health status.

Recently there was a study that has revealed that medical errors are the third leading cause of death in the USA [3]. Therefore, errors need to be prevented. Future research needs to be carefully steered, and not left to or overtaken by some vested interests. Costly procedures, investigations, medicines, etc. have raised the costs of management, and therefore one may find it worthwhile to take a second look at all

that is being done or recommended for the elderly patients. Unnecessary tests, unnecessary procedures, unnecessary medicines, etc. will have to be restrained. One of the most serious and yet unrecognized lacunae is the 'evidence based medicine' decides the 'evidence' from only the researches that have been found published in specific journals. What about the other 'evidence' that has as yet not been researched in the proper scientific manner, having come about unintentionally, half-heartedly, or maybe accidentally, and for which there are no takers as yet and no one cares? [4]. Would it be expecting a bit too much for the scientific and medical fraternity to follow the clues from incomplete and unrecognized by conducting full-fledged researches to see their veracity, and incorporate them if there are some actual benefits without adverse effects?

Establishing day care centers, mobile health teams, etc. can be beneficial for the elderly, and a serious thought need to be given for establishing them as per felt requirement in every district, town, etc. Finally, the society, law makers, administrators, pharmaceutical industry, and the scientific and medical fraternity will have to do a rethink in favor of decreasing costs of medicines, appliances, gadgets, and disposables, etc., which could mean a lot for the aged. Thought has

to be given for putting a stop to spurious drugs, and about making vaccines more potent, cheaper and viable at all temperatures without needing special environments and temperatures. Costs of drugs, vaccines, disposables, test strips, and other essentials can be paired to a large extent if their shelf life is somehow increased, without reducing the quality and efficacy. Therefore, all out sincere efforts must be made to increase the shelf life of medicine, vaccines, disposables, etc.

References

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