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Relevant Characteristics for Elderly Patient Biopsicosocial Care in General Medicine

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Abstract

Life expectancy has been increasing progressively. Elderly are the age group that most uses health resources. These patients differ from younger patients in many aspects, and this modifies the process of diagnostic, treatment decision and the expectations of therapy. A series of characteristics of the elderly patient can be described, which are relevant to understand and sustain from them, the GP's health care with this type of patient: 1. Elderly is a frail patient; 2. Integrated vision; 3. Multidimensional evaluation of the opportune intervention approach and knowledge of the psychological dynamics; 4. The disease or diseases of the elderly are usually chronic; 5. Symptoms and their expression in the elderly; 6. Diagnostic category sometimes seems to prevail over other needs and erroneously guides care and doctor-patient relationship; 7. GP must maintain a longitudinal view and take into account the history and personal experience of each elderly patient; 8. Therapeutic intervention must focus not on the complete remission of the symptom, but on the maintenance of a level of autonomy with sufficient quality; 9. Elderly patient presents multimorbidity and frequently polypharmacy; 10. Multidisciplinarity and teamwork are fundamental; 11. Elderly patient-centered care; 12. The family is the fundamental element of the social support and the care of the elderly. General practitioner should prepare for an increasing number of older patients, and consequently they have to develop a better understanding of this population, as well as improve the level of care to them. The role of GPs in the care of the elderly patient should focus on promoting healthy aging, and avoiding physical and functional deterioration.

Keywords: *Elderly, General Practice, Framework, Physician-patient communication, Sanitary Attention, Consultation, biopsychosocial.*

Introduction

In recent decades, life expectancy has been increasing progressively, as has the number of elderly people. The tendency in the industrialized countries is that the population increases in age. By the year 2030, 71 million Americans will be 65 years of age or older, an increase of more than 200 percent from the year 2000, according to the United States Census Bureau. It is estimated that some 6,000 people turn 65 every day and, by 2012, 10,000 people will turn 65 years old every day. The aging of health care consumers will increase the demand for medical services. In the United States, people over 65 visit their doctor an average of eight times per year, compared to the average of five visits per year for the general population. Physicians should prepare for an increasing number of older patients, and consequently they have to develop a better understanding of this population, as well as improve the level of care to them (1).

The elderly are the age group that most uses health resources. Among the different diseases, the circulatory system and tumors stand out (2, 3).

But these patients differ from younger patients in many aspects, and this modifies the process of diagnostic, treatment decision and the expectations of therapy, on the one hand; and on the other, there are also relevant differences with respect to younger patients due to physiological changes related to age and comorbidities typical of age that can increase the toxicity or risks of treatments (4).

Old age has often been viewed from a negative perspective, as a period characterized exclusively by loss, deprivation and demotivation, and by the continuous and irreversible deterioration of abilities, especially in mental abilities. However, many elderly people are independent, active and creative people who enjoy good health. Although, certainly, other elderly people are passive, withdrawn and suffer from bodily and mental problems (5).

Evidence-based medicine (EBM) aims to integrate three elements in patient care: the patient situation, scientific evidence, and the doctors' expertise. But these elements are systematically different in older patients. The ageing process systematically affects all three elements that constitute EBM. First, ageing changes the physiology of the older body, makes the patient more vulnerable with more multimorbidity and polypharmacy and affects somatic, psychological and social function. The heterogeneity of older patients may lead to overtreatment or undertreatment of vulnerable patients, and is evident that the same treatment is not fit for all elderly patients. Second, representative older patients are underrepresented in clinical studies and endpoints studied may not reflect the specific needs of older patients. And third, adequate clinical tools and schooling are lacking to aid physicians in clinical decision-making in these patients. So, in older patients the elements that constitutes EBM need tailoring to them (6).

In this scenario, general practitioners (GPs) may not be sure what kind of medical care should be provided to older patients. In addition, the priorities of health care in elderly patients could be modified, in which the opinions of patients should be taken into account. This article aims to reflect and systematize the differential concepts of GP biopsychosocial care with the elderly patient.

Discussion

In aging, morphological, biochemical, physiological and psychological changes occur due to the dynamic relationship between the person and external factors:

1. Biological changes: decreased response of the cardiovascular system, of thermoregulatory center, renal system (with greater susceptibility to drugs), visual and auditory functions, greater sensitivity of the central nervous system, and degenerative changes of the musculoskeletal system.

2. Psychological changes: they depend more on economic and cultural factors.

3. Social changes: retirement, reduction of income

Table 1 summarizes the main biopsychosocial problems of the elderly.

Table 1. *Summary the main biopsycosocial problems of the elderly*

1.-Biological problems	2.-Psychological problems	3.-Social problems
-Cardiovascular disorders -Muscular and rheumatological processes -Mental disorders - Neurological syndromes -Metabolic, nutritive and digestive disorders -Hematological diseases -Cancer diseases -Hidden processes: sight, hearing, teeth	-Sense of uselessness ("loss of social position") -Load for others -Disappearance of interests	-Economic problems and therefore worse level of consumption and comfort -Urban architectural barriers -Rural isolation -Lack of adequate cultural and recreational offers

A series of characteristics of the elderly patient can be described, which are relevant to understand and sustain from them, the GP's health care with this type of patient (**Table 2)**.

Table 2. *Relevant characteristics for the care of the elderly patient*

	Relevant Characteristics
1	Elderly is a frail patient
2	Integrated vision
3	Multidimensional evaluation of the opportune intervention approach and knowledge of the psychological dynamics

4	The disease or diseases of the elderly are usually chronic
5	Symptoms and their expression in the elderly
6	Diagnostic category sometimes seems to prevail over other needs and erroneously guides care and doctor-patient relationship
7	GP must maintain a longitudinal view and take into account the history and personal experience of each elderly patient
8	Therapeutic intervention must focus not on the complete remission of the symptom, but on the maintenance of a level of autonomy with sufficient quality
9	Elderly patient presents multimorbidity and frequently polypharmacy
10	Multidisciplinarity and teamwork are fundamental
11	Elderly patient-centered care
12	Family is the fundamental element of social support and care of the elderly

1. Elderly is a Frail Patient

Although most elderly people live healthy and active lives without significant functional disability, the geriatric population is a group of frail people with low biopsychosocial reserves and an increased risk of functional loss and long-term institutionalization. Age-related changes in physiology, pharmacology, and disease presentation make health care for frail elderly a challenge for the physician. The presence of multimorbidity complicates diagnosis and treatment and significantly increases the risks associated with having multiple healthcare providers, and the likelihood of medical complications, polypharmacy and iatrogenesis. The elderly are particularly vulnerable to adverse drug reactions, not only because of age-related changes in pharmacokinetics and pharmacodynamics, but also because of the large number of drugs taken, many of them inadequately prescribed or contraindicated. In addition, in these elderly patients there is poor adherence to treatment, which makes the possibility of medical complications and hospitalizations even greater. (7, 8)

2. Integrated Vision

Elderly requires, by his nature, an integrated vision. Its long history and experience of life, the existential and social peculiarity of the elderly person, the possible presence of multimorbidity and polypharmacy, imposes on the doctor the need for a holistic vision.

The long doctor-elderly patient relationship could allow a more comprehensive management of its multiple problems, the substitution of expensive care in the hospital for the lowest cost at the ambulatory level, the early knowledge of changes in their biopsychosocial situation, and an intervention preventive and educational more integral.

The available data suggest that elderly people benefit from a long-term continuing doctor-patient relationship, and are markedly loyal to their doctor, reporting 55% of them who stayed with the same doctor 5 years or more, and 36% ten years or more. The benefits of this long continuity of care and the doctor-patient relationship that it entails, achieves less healthcare costs, improves patient satisfaction, and reduces poor quality healthcare approaches (7, 8).

3. Multidimensional Evaluation of the Opportune Intervention Approach and Knowledge of the Psychological Dynamics

It can include the following elements:

A - the evaluation of social characteristics, social support and their relative experience

B - The structure of the personality, the situational condition, the care problem, the intra and intersubjective dynamics

C - The framing of the problem: the evaluation of symptoms, the etiology, the maintenance factors, and the level of autonomy.

D - the level of stress and coping of this

E - The evaluation of possible psychic factors that contribute to somatic manifestations

F - The complex interaction of the experience lived by the older person vs. the reaction of the environment to the morbid event

G - The mental and psychopathological state

H - The functional status with respect to the activities of daily life

I - The indications or contra-indications of individual or group biopsychosocial treatment (family, community)

Even in cases of cognitive impairment, especially in the mild and moderate phases of gravity, the biopsychosocial and psychotherapeutic dimension

can and must be maintained, allowing for development and orientation with respect to the environment (8).

4. The Disease or Diseases of the Elderly are Usually Chronic

The disease or diseases of the elderly are usually chronic, and unlike what may occur in previous stages of life, in the elderly these tend to interfere significantly in their personal and relational life.

So, the spectrum of morbidity in older age is dominated by chronic diseases that on the other hand, are cost intensive. Higher age is associated with functional difficulties, limitations, and disability. However, inter and intra-individual variability is wide. Sequela of chronic diseases is crucial to the development of dependency and the use of health care (9).

These chronic pathologies in the elderly tend to destroy their self-sufficiency, and in this situation the disease in the elderly is an expression of a complex and polymorphous underground discomfort. There may be loneliness, isolation and economic precariousness, which favor the appearance of discomforts of a different nature, of possible somatic manifestations.

The disease in the elderly patient tends to create important psychological connotations different from those of other stages of life. One of the elder's biggest concerns is the loss of self-sufficiency. The disease can cause the fear of chronicity, of disability, which intensifies the emotional intensity, and the connotation of abandonment, marginalization and poverty (9).

5. Symptoms and their Expression in the Elderly

Many elderly have mild physical disorders. It is difficult to differentiate between the physiological symptoms of ageing and disorders in the elderly patient. Many disorders present as non-specific signs or symptoms in the elderly. The relevance of an abnormality can be judged by comparing the patient's current state with his or her prior level of functioning: what aspect of his or her condition has changed? Attributing an abnormality to a disease instead of aging only makes sense if it has therapeutic consequences for the patient; in this respect, the patient's level of functioning is an important frame of reference (10).

The expression of the symptoms of the elderly is different from that of younger patients (as well as, for example, of men versus women). The age of the patient has an effect on the expression and communication of the symptoms. The symptoms can be defined as "any subjective evidence of a health problem as perceived by the patient". The symptoms are the result of a process of interpretation. The symptoms are integrated into a complex interaction between biological, psychological and cultural factors. The expression of symptoms depends on psychosocial rather than biological aspects. Consequently, there must be a variety of interpretations of the sensations, which are not equivalent to the expressions of the underlying disease. In addition, this interpretation of the sensations, being fundamentally of a psychosocial nature, must be different according to the age of the patient and their psychosocial implications.

Therefore, the symptoms of the same disease may differ between the elderly and younger patients, and the same symptom may have different meanings in the elderly and younger people. If the diagnosis of the disease is based exclusively on the presence of specific symptoms, it is possible that we do not take into account the different meanings due to age, and we generate misinterpretations and erroneous diagnoses. The implications of this perspective are immense. There is a need to develop research that proves alternative conceptions of symptoms as a phenomenon, with differences in age (as well as gender / sex) in health / disease, more rigorously. (11).

The expression of symptoms also depends on the life cycle. For example, when an acute coronary syndrome occurs, the different stages of the family life cycle may show differences in the patient's presentation of symptoms. The recognition of this type of phenomenon (the fact that patients express themselves with a particular clinic type, which shows different nuances in certain aspects, for example in the classic thoracic pain syndrome, according to their life cycle, that can be evidenced through the elaboration of the genogram; That is to say, according to their age and family structure), can be useful for GPs for diagnosis, as it can provide additional information on the assessment of risk factors, clinical history and exploration in elderly patients. (12).

6. Diagnostic Category Sometimes Seems yo Prevail over other Needs and Erroneously Guides Care and Doctor-Patient Relationship

The elderly patient usually represents a certain diagnostic category of standardized classification that make forgets everything that person keeps as a private individual and unique. **Table 3** presents an example, taken from McKee (13).

Table 3. *An unsuitable search example of the diagnostic category in the elderly patient*

Clinical Situation	Medical Response
A 91-year-old patient lost interest in the food and activities he once loved. There was weight loss that could not be avoided through the creative efforts of his family to restore his interest in eating. It was also quite evident that he was depressed and emotionally desperate.	In response, his doctors ordered 2 sets of electromyography, a CT scan with contrast, an esophagogastroduodenoscopy and a colonoscopy. There was also an impressive list of laboratory tests, many of them duplicated and all ordered by a "team" of doctors who neither spoke nor showed any interest in doing so

7. GP Must Maintain a Longitudinal View and Take into Account the History and Personal Experience of Each Elderly Patient

The peculiarity of age in the elderly, which indicates a long life history, suggests to the GP a relationship with the elderly patient who is guided by a longitudinal and current view of the prodromes of the physical symptoms that arise in relation to the previous situation; but above all, in the history and personal experience of each person. The elderly patient, more than any other, requires a unified evaluation of his illness, and when possible, the support and integration of his own family, where that life trajectory has been developed, and where he is inserted as an individual in the current moment (8) Older adults and their care-givers also often express different time and treatment goals (14).

8. Therapeutic Intervention must Focus not on the Complete Remission of the Symptom, but on the Maintenance of a Level of Autonomy with Sufficient Quality

Cure in the classical sense should not be the priority of diagnostic and therapeutic decision making, but more a prioritization of patient-oriented care (14). This situation affects the therapeutic actions and designated endpoints which are different from those in younger persons because preservation of functionality and independence is priority, not survival. GP can not have as a goal the "restitutio ad integrum", and should focus not on the complete remission of the symptom, but on the maintenance of a level of autonomy with sufficient quality. Rehabilitative treatments are important in all settings that care for old and very old persons.

For the elderly patient, the idea of health is generally associated with the recovery of a certain degree of self-sufficiency rather than the resolution of a chronic disease that he has accepted over time and with which he has learned to live. The flow of this problem of resolution vs. palliative care, can lead to anguish and depression, and varied reactions on the last stage of its existence, including somatic responses and physical pain, all of which aggravates its invalidity and manifest pathology. The old man presents a fertile ground for psychosomatic disorders, and the evolution of his organic disease has a multifactorial genesis, including psychological ones (8).

9. The Elderly Patient Presents Multimorbidity and Frequently Polypharmacy

A higher age is usually associated with multimorbidity due to chronic illnesses intermittently aggravated by acute disease and exarcerbation of pre-existing chronic illnesses. Also, physical and psychological diseases often coexist (14).

Communication with elderly patients poses difficulties due to various circumstances that may interfere. It is common for the elderly to coincide with several chronic diseases, which means that carrying out the clinical history takes longer than usual. Also treatments are usually more numerous and sometimes difficult to understand (15). So, medication decision making is complex, particularly for older patients with multiple conditions for whom benefits may be uncertain and health priorities may be variable (16).

Medication-related problems are common for older adults and can lead to harm. The older person's perspective on medication-related problems has been seldom taken into account by the doctor. We know that the reasons for the excessive use of medical treatments and tests are multifactorial. We also know that most of the time, the clinician has good intentions. But, ordering dangerous tests for frail elderly patients who do not want those, shows lack of knowledge and care. The medical community can no longer ignore the excessive use of drugs and diagnostic tests. The lived experience of older people with medication-related problems is multifaceted and complex. Elderly

patients often feel that communication is poor around hospital discharge, and there is an insufficient support with medicines at community level, when problems arise (17).

GPs have to participate in a frank discussion with elderly patients. While patient input would seem important in the face of this uncertainty and variability, little is known about older patients' views of involvement in medication decision making. As GPs, we must increase our awareness and find acceptable solutions for every elderly patient in particulart. GPs must also frame the problem of the excessive use of tests and drugs in the context of a problem of quality and patient safety (13).

The area of "deprescribing" has rapidly expanded in recent years as a positive intervention to reduce inappropriate polypharmacy and improve health outcomes for (older) people with multimorbidity. GPs should take into account the importance of the different clinical, psychological, social, financial and physical deprescribing determinants, in every particular case, and this approach could be adopted by GPs working in clinical practice (18).

Complex medication regimens and uncertainties in decision making are challenges for both GPs and patients. For patients, symptom experiences with medicines, relationship with their prescriber and fragmented care are at the forefront; for GPs, it is the decision-making responsibility in the context of unsuitable guidelines, time constraints, and deficient multidisciplinary co-operation. GP strategies for taking decisions require professional awareness of the problem and establishing a trusting, patient-centered consultation style and supportive work conditions (19).

10. Multidisciplinarity and Teamwork are Fundamental

Many times the treatment of the elderly patient is done by a large "team" of doctors, but often they do not talk to each other, nor show any interest in doing so (13) (**TABLE 3**). Guaranteeing the continuity of care is essential for proper treatment of the elderly. The patient can be seen in the acute care units or in the outpatient clinics of the hospital, but most of the time it is under the supervision of GP. In addition, several specialists in the management of the patient often participate, and elderly patient often this also changes their domicile when they are rotated with different family members, and therefore with different primary care team.

For all this, it is not strange that an elderly patient is treated by many different doctors at the end of the year, even for the same pathology. If there is no good coordination, diagnostic and treatment errors, as well as failure to comply with the treatment is guaranteed. An adequate clinical report can help. But it is essential to establish adequate channels of communication between the different doctors and the patient, which are quick and comfortable. A fluid communication avoids therapeutic breaches, adverse reactions to medications, visits to the emergency room, hospital admissions etc. The telephone seems the most appropriate option and modern communication systems (Internet, etc.) are called to play a key role in the immediate future (15).

11. Elderly Patient-Centered Care

Older adults and their companions (family, caregivers) perceive life-threatening illness and day-to-day decisions about chronic disease to be serious, difficult, and important. The companions' goal of avoiding suffering of older adults may differ from older adults' priorities of self-sufficiency and maximizing survival. GPs should support older adults and their companions (family, caregivers) in identifying important and difficult decisions and learn about the values and information sources they bring to decision-making. With this knowledge, GPs can customize decision support and achieve person-centered care (20, 21).

Using an outcome prioritisation tool leads mainly to the stopping of medication. Medication changes can be easiest for patients who prioritize reducing symptoms as most important (22).

The ideal process of care is patient centered; It is individualized and it supports the knowledge of the unique constellations of problems in an individual elderly patient, adapting the priorities and multidimensional decision-making to that patient. Continuity of care and individual coordination, managed by a GP, may meet some of these needs. Achieving these goals will require developing efficient methods of assessing patient care needs and flexible care management support systems that can respond to patients' needs for different levels of support at different times (23).

Patients with multiple chronic diseases are usually treated according to disease-specific guidelines, with outcome measurements focusing mostly on biomedical indicators (e.g. blood sugar levels or lung function). However, for multimorbidity, a goal-

oriented approach focusing on the goals defined by the individual patient, may be more suitable.

Patients do not naturally present to the GP their goals. Elderly patient goals are difficult to elicit, even when different interviewing techniques are used. They have been communicated four underlying hypotheses which may explain this fact: (1) patients cannot identify with the concept of goal-setting; (2) goal-setting is reduced due to acceptation; (3) actual stressors predominate over personal goal-setting; and (4) patients may consider personal goals as selfish. Therefore, it is advised that the GP maintain specific attention to the skills and strategies that help patients identify their personal goals, and thus be able to develop a clinical method for goal-oriented care. (24).

12. Family is the Fundamental Element of Social Support and Care of the Elderly

Family is the main welfare system and the source of care for people of any age, but this may be even more relevant in the elderly. GP must achieve an active role of relatives and caregivers (in addition to the elderly patient itself), to detect new symptoms or exacerbations of chronic problems, and jointly plan care (7). The presence of the companion is generally an advantage, but can also have disadvantages. In addition, the presence of a companion with the patient in the office could be an indicator of problems in the family context, and should be used as a signal to investigate psychosocial data of the family (25).

Conclusion

There is an intense aging of the population and as a result increased demands of elderly patients. The GP must remember that after what we call "the elderly patient", there are a series of differential biopsychosocial characteristics that can lead to consequences of dependence, illness or fear of getting sick, death or fear of death, and rupture with the environment. As Hermann Hesse wrote: "Times fly by and even the mountains that seem to rise immutable become old" (26). Consequently, the GP should focus on promoting healthy aging, avoiding physical and functional deterioration, and the detection and prevention of chronic diseases.

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