Managing Elderly Patients with Multiple Morbidities - Are We Providing Patient-Centred Care?

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Elderly patients often have more than one chronic disease, so that management seldom focuses on a single disease. Furthermore, diseases could also be substituted by the geriatric syndromes of falls, immobility, incontinence, and cognitive impairment. In practice the clinician often manages a combination of diseases and syndromes. This article discusses the geriatric perspective to managing multiple morbidities, the need for 'art' and 'science' in management, and suitable approaches on the part of the patient, health and social care professionals, and health and social care systems.

The Geriatric Perspective

Multiple morbidities may be considered as part of the frailty phenotype, representing a transitional state from robustness, to functional dependence, to death. Symptoms of frailty consist of weight loss, weakness, fatigue, anorexia, and inactivity; signs consist of undernutrition, slow gait speed, balance abnormalities, sarcopenia (or loss of appendicular muscle mass) and osteoporosis. Frailty often results in repeated falls, multiple trauma, functional decline, disability, hospitalisation, infection, institutional care, and ultimately death. It causes considerable suffering on the part of the patients as well as carers. Unlike management of single diseases, there is a need for the biomedical model to be extended to include daily function, surroundings (family, friends, community, health and social care systems), ethical considerations, and quality of life, underpinned by interdisciplinary continuity of care. It should be recognised that this continuity of care in the downward trajectory towards death covers health promotion, focused prevention, an approach to the pathological process that is care rather than cure, rehabilitation that is predominantly maintenance rather than restorative, palliative care, terminal care, and the mourning process of survivors. Key ethical considerations arise in the balance between therapeutic withdrawing and therapeutic harassment that are influenced by culture and beliefs, the professional and legal framework of the country in question, and the level of professional as well as public education.

The 'Art'

Unlike science, which is concerned with the general and deals with repeatable elements in nature, medicine is concerned with the uniqueness of individual patients. People are shaped by differences in culture, ethnicity, socioeconomic strata, and past experiences. Elderly people are particularly variable in their ability to cope with changing personal and the wider social environment. This perspective would be better highlighted if the term "disease" were to be replaced by the term "illness experience". This distinction would be a useful strategy to be incorporated into teaching and practice, to deal with major health care problems such as patient dissatisfaction, inequity of access to care, and spiraling costs, all of which do not seem to be amenable to biomedical solutions.

"Biomedicine has increasingly banished the illness experience as a legitimate object of clinical concern. Carried to its extreme, this orientation, so successful in generating technological interventions, leads to a veterinary practice of medicine".

Illness perception is a key determinant of behaviour directed at managing illness. Negative illness perceptions are associated with poorer recovery and increases health care use independent of objective measures of illness severity. Interventions to change illness perceptions can reduce disability and improve functioning. There is a need to treat patients rather than the disease, understanding their illness perception, and adopting an expanded model of illness to include the impact on patients’ carer and families.

The 'Science', or Evidence-based Medicine

Availability of evidence is a problem in the management of multiple diseases and syndromes, since randomised controlled trials tend to be for single disease in ‘fit’ and ‘young old’ subjects who could travel to the trial centre and adhere to the trial regime. The profile of such subjects does not fit the frail elderly population aged 80 years and over, that many geriatricians look after. In practice results from such trials may be inappropriately extrapolated to the frail elderly population who are often encountered in clinical practice. For example, an article in the British Medical Journal eloquently entitled "The road to hell" pointed out that the application of targets for managing elderly people with diabetes in general practice in the UK, using guidelines from two large clinical trials with few frail elderly subjects, has resulted in many adverse outcomes. The problems with randomised controlled trials for common diseases affecting the elderly include inadequate representation for the very old (treatment of...
Management of chronic diseases in the elderly is primarily a primary care issue, where quality of care, rather than cure, is the outcome of concern, and where system changes in the health and social care sectors are indicated. Concepts to be incorporated include health promotion, self-management, management of high risk patients, case management for high complexity cases, and knowledge management in terms of population needs assessment and service planning. Currently in Hong Kong services are heavily hospital based, resulting in limited accessibility as well as increased costs. There is poor continuity of care and community self-help is poorly developed. There are emerging needs of elderly living in residential care homes. Palliative care in all settings is poorly developed. The interface between multiple service providers (social welfare department, Department of Health, Hospital Authority, Community Rehabilitation Network, and the private sector) is less than ideal. There is increasing financial burden on health care systems and sustainability likely depends on active participation by individuals, for both prevention and management. There is absence of a primary care system that can effectively reduce demands on secondary and tertiary care.

New approaches involve changes on the part of patients, professionals, as well as systems. On the part of patients, the paradigm shift includes taking ownership of their problems with health professionals as partners, a move towards self-management supported by professionals and health and/or social care systems in the community. Programmes can be designed to help patients manage symptoms and contain health care resource utilisation. At present such programmes have only been developed for selected single chronic diseases such as diabetes or asthma. None has been tried for multiple diseases or frailty. Major barriers to be addressed in promoting self-management include patient factors that promote continuing participation, and professional factors that include a cultural change away from a purely medical model of management. Use of a stepped care approach and development of nurses as leaders in chronic care, especially in end of life care, following the principle of patient-centred supportive care and understanding patients’ perspectives, are directions that could be developed. With regard to systems, the development of case management in the primary care setting would be appropriate, in removing barriers to coordinated care. In the US, the Evercare model has been developed, consisting of collaboration with general practitioners, other health and social care professionals in primary care, and expanded nursing role in proactive managed care for patients at high risk for repeated hospital admissions and decline in function. A team based approach is adopted, with risk stratification using predictive tools to identify high risk patients, self-management and motivational interviewing.

This model has resulted in fewer hospitalisations and fewer prescription drugs, higher patient satisfaction with no change in mortality. However this model has not produced the same results when adopted in the UK.

A similar model could be developed for management of multiple morbidities and frailty by adopting these principles to the ageing population. Case management is particularly relevant as functional, social, psychological, and nutritional dimensions need to be incorporated in addition to dysfunction of organs. Furthermore the patient needs to be considered as part of a discrete social network. The main goal is maintenance rather than restorative with respect to function, and maximizing quality of life. Development of such programmes for groups may have the advantage of mutual support, allow incorporation as part of a regular social (and therefore enjoyable) programme rather than rehabilitation sessions; allow constant reinforcement of information and correction of misconceptions, and incur lower cost compared with one-to-one interaction. Community centres could form the nucleus of such programmes, together with other health promotion activities.

**Key Points**

- Multiple morbidities in ageing populations could best be regarded in the context of the frailty syndrome for management
- Management requires a humanistic as well as evidence-based approach, taking into account the patient’s perspective.
- There is little evidence to formulate guidelines for frail elderly populations: available evidence should be extrapolated with caution
- Health and social care system change is needed to cope with multiple morbidities, driven by patients’ needs as well as budgetary considerations

**References**