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PRACTICE OBSERVED

Practising Prevention

In old age

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What are we trying to achieve?

This is best answered by the pithy motto of the World Health Assembly's meeting in Vienna in 1982: "Add life to years," and there is evidence that this is what modern medicine manages to achieve. The fear that large numbers of people are being kept alive to a very advanced age by overenthusiastic medical intervention is not supported by demographic data, which show that life expectancy is being increased but not life span. Furthermore, there is some evidence that people are, on average, staying fitter longer and having a shorter period of terminal dependency as a result of the medical, social, and economic changes that have taken place this century. Sir Richard Doll has said that one of his aims in life is to "die young as late as possible," and this is another excellent way of expressing the aims of a prevention programme; the principal aim is to prevent morbidity, not to postpone mortality.

Attention must be focused on the old person's ability to function: a "normal haemoglobin" is of little comfort to someone who is still too breathless to walk to the local pub. The aim of the measures described in this article is to prevent handicap, and the common handicaps in old age provide a useful list of specific objectives (table I).

TABLE I—*Common handicaps*

Immobility: inability to reach the shops, church, or pub
Inability to dress or undress
Inability to wash all over
Inability to reach the toilet in time
Inability to get enough to eat or drink
Inability to do light housework or gardening
Anything else that the old person regards as a handicap

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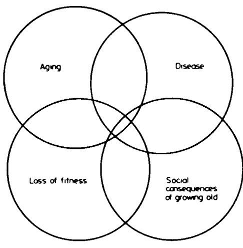
How do we achieve these objectives?

Although the aging process is not preventable much can be done to prevent the problems of old age because most of the problems of older people are not caused by the aging process but by one, or more than one, of three other processes—disease, loss of fitness, and the social changes that accompany growing old.



PREVENTION OF DISEASE

The primary prevention of many of the diseases that cause disability in old age is possible, but for most diseases it is necessary to start the preventive programme in childhood or early adult life. This should not be taken as the basis for a nihilistic attitude to disease prevention, however, because the

diseases listed in table II are preventable by actions initiated after the age of 60.

The commonest single preventable disease in old age is probably iatrogenic disease, and one of the main contributions that the general practitioner can make to health in old age is to prevent iatrogenic disease by careful prescribing and surveillance of people on repeat prescriptions. Much attention has been given to "poor compliance" recently, but remember that "poor compliance" is often the patient's method of preventing iatrogenic disease.

In addition to measures directed at specific diseases there is also evidence that several measures have beneficial effects on health in old age (table III). Furthermore, body maintenance is of even more importance in old age, for minor disorders of feet, skin, or ears can cause as much suffering as the major illnesses that feature on mortality and morbidity statistics. Body maintenance has to be carried out by the individual, but professionals have to teach what should be done and be available when the self-help is not working (table IV).

TABLE II—*Scope for disease prevention in old age*[1]

Iatrogenic disease
Depression
Anxiety
Alcoholism
Hypothermia
Influenza
Tetanus
Constipation
Some types of fall
Some types of incontinence
Malnutrition

TABLE III—*Scope for health promotion in old age*

(1) Stopping cigarette smoking—has no effect on mortality but has an effect on morbidity
(2) Weight control—avoiding obesity, and weight loss for those who are obese
(3) A prudent diet low in calories, high in fibre
(4) Mental activity and involvement with other people
(5) Keeping fit

TABLE IV—*Scope for body maintenance in old age*

Maintenance programme	The professional's contribution
Foot care	Qualified chiropodist, essential for people with circulatory problems or diabetes
Tooth and denture care	Annual visit to the dentist
Skin care	Treatment of eczema or ulcers; skilled nursing is needed if there are pressure sores
Visual care	Biennial visits to the optician, sooner if vision deteriorates
Hearing care	Auroscopic examination if the elderly patient notices hearing loss

PREVENTION OF UNFITNESS

The older the age group chosen the greater the scope for improving performance by improving fitness because the greater is the size of the fitness gap (fig 1). All four physical aspects of fitness can be improved at any age—strength, stamina, suppleness, and skill. In addition, there are considerable psychological benefits. The steps that may be taken to improve fitness are:

(1) Ensure that there are no diseases present in which exercise would be harmful. There are very few contraindications provided that the person increases his exercise slowly and gently.

(2) Reassure the old person and relatives that exercise will not do harm; the motto is "use it or lose it."

(3) Encourage mobile elderly people to continue with sport and exercise or to take up exercise if inactive. Exercises that promote suppleness are particularly important—swimming, yoga, keep fit, music and movement, and aerobics.

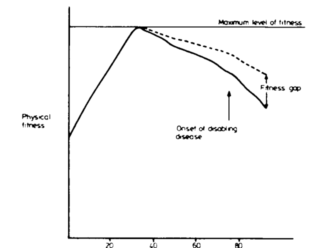


FIG 1—Rate of change of physical fitness with age. Broken line = rate of decline due to aging alone if fitness is not lost. Continuous line = actual rate of decline.

(4) Try to help housebound people reach sports or leisure centres. Give advice on suppleness exercises that can be done at home.

(5) Give advice to relatives and home helps on the health benefits of housework and gardening, especially for the person who finds them a bit of a struggle.

(6) Take an active rehabilitative approach to every immobilising illness. Remember that fitness is lost more easily and regained more slowly the older you are and the effects of a few days' inactivity may take a few weeks of work to overcome.

The fitness gap is usually bigger—and the scope for improvement therefore greater—when a disabling disease is present because of the immobilising effect of most disabling diseases.

PREVENTION OF SOCIAL PROBLEMS

Three types of social problems must be taken into account when thinking of prevention in old age. Firstly, elderly people may have very pessimistic and negative beliefs and attitudes.[2] Many believe that all their problems are due to "old age" and ipso facto cannot be prevented or treated. Some are too depressed

TABLE V—*Common practical problems*

Poverty
Heating problems
Housing problems
Isolation

by their deterioration to try to affect it, and some are too tired by the effort of struggling to summon up the strength to participate in preventive measures. Such people need a very positive approach.

Secondly, the beliefs and attitudes of other people have to be taken into account. Many young people are also very pessimistic and negative about the scope for prevention in old age and many are overprotective—some because they are guilty and thus dislike to see an elderly person struggle or be placed at risk. The problems of relatives are more commonly underestimated by professionals than any other single social problem.

Thirdly, the practical problems faced by some elderly people are immense and must always be borne in mind (table V).

Obviously doctors cannot solve these problems on their own but they can take three steps.

(1) Know about the range of benefits available.

(2) Be prepared to make the initial contact by phone or letter.

(3) Be prepared to discuss her attitudes with the old person who is unwilling to apply or ask for help.

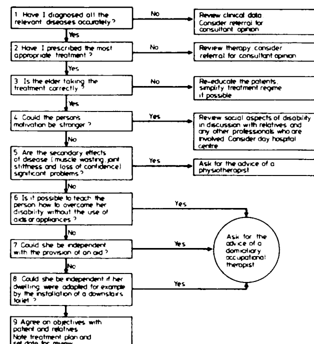


FIG 2—Handicap algorithm: checklist for use when relatives request a service for an old person who has developed a handicap. Always exclude the possibility of a treatable disability before arranging for a service to be given.

How should old people be reached?

Full scale screening is not an efficient approach to reaching old people, and it is more efficient to make full use of the potential offered by any consultation made by the old person or her relatives—the case-finding approach, using the exceptional potential of each primary care consultation[3] because most elderly patients will contact the practice at some time during the year. What is needed to make such an approach effective is:

(1) A record and information system that will indicate which patients over the age of 75 have not contacted the practice during the preceding year.

(2) Sufficient data on each patient to indicate which of those who have not made contact need a home visit. These data may be held by the health visitor or in the patient's notes. Rather than having a separate "at risk" register it is better to consider everyone at some degree of risk and have enough data in the notes to allow the identification of those who are at sufficiently high risk to warrant a home visit.

Where should preventive work take place?

Preventive work should take place where contact is made, either in the surgery or at home. Regular home visiting certainly establishes good relationships, and the importance of good doctor-patient relationships cannot be overemphasised but it is possible to practise prevention without visiting every patient at home regularly. At least one member of the primary care team, however, should have paid a visit to every home so that someone is aware of home conditions, and the home visit should be repeated if circumstances change—when the patient has been discharged after admission for her first stroke, for example.

Who should practise prevention?

Who should practise prevention depends largely on the work load of the health visitor and district nurse, but every member of the primary care team has a part to play—especially the practice manager because of the need for an organised approach to prevention in old age.

References

[1] Wilcock GK, Gray JAM, Pritchard PMM. *Geriatric problems.* Oxford: Oxford University Press, 1982.
[2] Gray JAM, Wilcock GK. *Our elders.* Oxford: Oxford University Press, 1981.
[3] Stott N, Davis RH. The exceptional potential in each primary care consultation. *J R Coll Gen Pract* 1979;**29**:201-5.

FEIGNED DISEASES In one of my daily visits in the prison [a depot for prisoners of war at Stapleton, near Bristol, in 1801] I was requested . . . to visit a man who was stated to be labouring under a high fever . . . his tongue was covered with a brown coating . . . and withal he was vomiting violently. Tobacco was strongly smelt in what he rejected from his stomach; and, on his recovering a little, I requested again to examine the tongue, when I removed a considerable portion of the soft and apparently foul substance, and brought it away with me on a piece of paper, for the purpose of examination: it proved to be common brown soap.

The man was conveyed to hospital, narrowly watched for a few hours, at the end of which time his fever had entirely subsided; when a full acknowledgement was made by him, that it had been a common practice to obtain admission into the hospital by using tobacco and soap, as has just been described. But this discovery nearly cost me my life; for the next time I professionally visited the prison, this man made a thrust at me with a sword-stick, which, but for another prisoner who stood close to me, would certainly have passed through my body.

After this I never entered the prison but with four soldiers as a guard; when this man, on some of these occasions, assisted by a few of his friends, revenged themselves by picking vermin (*pediculi*) from their bodies, and blowing them through quills upon me as I past; so that I have frequently returned to my apartments covered with them. (*London Medical and Physical Journal* 1824;**51**:87-99.)

THE GP, THE SURGEON, AND THE PHYSICIAN It seems to us, that the present state of society demands a division of practice into three distinct branches. In the first place, there ought to be a class of Practitioners whose qualifications should comprise a knowledge of *every* department of the art, and to whom, in the general way, application should be made in the first instance: in the second place, a description of individuals is called for, who, having given from the first an almost exclusive attention to minute anatomy, with medical and operative surgery, should be considered as referee Practitioners in surgical disorders, and operators in all cases requiring much manual dexterity or practical tact: there ought, lastly, to be the Physician—who, inferior, perhaps, to the general Practitioner in the knowledge of minute detail, and certainly below the Surgeon in acquaintance with particular anatomy, should be far above them both in respect of classical information, general science, and the *literature* of his particular art. (*London Medical Repository* 1821;**16**:313.)

Pathology of Partnerships

A resurgent evil

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Nearly 30 years ago I was accepted as a partner in a general practice after serving as an "assistant with view" for 12 months. I was more fortunate than many of my contemporaries but nevertheless resolved that I would never impose on any future junior partner of mine the sort of terms on which partnership was offered to me. It was a difficult era for the many young doctors who were competing for the rare vacancies in general practice, and the indignities suffered by many of my colleagues were a reproach to the principals of those days. The young doctors had no collective strength; the General Practice Reform Association, founded to look after their interests, proved ineffectual and was eventually disbanded when better times rendered its existence unnecessary.

The pendulum swung and young doctors became scarce. Better terms were soon available for entrants to general practice, and my resolve not to deal harshly with prospective junior partners was made superfluous by the turn of events.

These conditions did not last. Once again the young doctors outnumber the posts available for them, and practices in quite unattractive areas are able to recruit new partners of a very high standard from the trainees who have completed their vocational training. It is my good luck to be a course organiser and to meet many of these people, who impress me as being of a higher average standard than that of my own generation of entrants to general practice. Sadly, I am now hearing from them stories (substantiated from other sources) which indicate that exploitation has returned and that some of them are being asked to agree to quite unfair conditions before admission to partnerships. Not all of the old impositions have reappeared because changes in the way in which general practitioners are paid have made some of them unprofitable for the established principal to apply. Nevertheless, it is quite clear that members of some practices are only too ready to profit, both financially and in other ways, at the expense of their younger colleagues.

I have been the unsuccessful advocate of a code of practice for established principals who are about to take a new partner, and the news that I continue to hear reinforces my belief that such a code is urgently needed. I cannot agree with people who talk about "market forces," and I will not listen to those who say, "Well, we had to go through it, didn't we?" I believe that today's trainees are better equipped to enter general practice than any of their forbears, and if they are not to become discontented and disillusioned they must be treated fairly.

I would propose that a prospective partner should be offered terms that observe the following conditions:

(1) The period of probation (or mutual assessment, or whatever name you care to give it) should not exceed six months unless prolonged at the request of the prospective partner.

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(2) The incoming partner should be offered a reasonable starting share, certainly not less than half that of the maximum earner in the practice and preferably far more.

(3) Equitable division of work. No longer should the senior partner opt out of night work without reducing his share of the practice income.

(4) Not more than three years to parity and preferably less.

(5) No unreasonable capital demands to be made on the incoming partner—for example, buying the retiring senior partner's house at his own valuation.

(6) Written contracts must be made compulsory. I would like to see these contracts scrutinised by family practitioner committees, who would have the power to reject them if they were considered unfair.

I hope that any general practitioner who aims to maintain a happy partnership would accept these provisions as sensible. Many, I am sure, do already, but there does seem to be disturbing evidence that a substantial number are prepared to take advantage of the present surplus of vocationally trained doctors. Surely the profession should face the problem and be prepared to take effective action against abuses that can only reflect discredit upon it. Discontented doctors in any field of medicine are likely to provide poorer services to their patients.

FEIGNED DISEASES Zacchias, in his elaborate and learned work, has given five general rules for the detection of feigned diseases, which are so discriminating as to have received the sanction of most succeeding writers. A detail of these will illustrate their universality of application, and the ingenuity of their author. (1) The first is, that the physician must, in all suspected cases, inquire of the relatives and friends of the suspected individual, what are his physical and moral habits. He must ascertain the state of his affairs, and inquire what may possibly be the motive for feigning disease; particularly whether he is not in immediate danger of some punishment from which this sickness may excuse him. . . . (2) Compare the disease under examination with the causes capable of producing it; such as the age, temperament, and mode of life, of the patient. Thus, artifice might be suspected, if a person in high health, and correct in his diet, should suddenly fall into a dropsy or cachexia; and again if insanity should suddenly supervene, without any of its premonitory symptoms. (3) The third rule is derived from the aversion of persons feigning disease to take proper remedies. This, indeed, will occur in real sickness; but it rarely happens when severe pain is present. (4) Particular attention should be paid to the symptoms present, and whether they necessarily belong to the disease. An expert physician may thus cause a patient to fall into a contradiction, and lead him to a statement which is incompatible with the nature of the complaint. (5) The last direction is to follow the course of the complaint, and attend to the circumstances which successively occur. Thus the inflammation of the knee above noticed should have produced fever, and increased in violence, according to the common course, when no remedies are applied. (*London Medical and Physical Journal* 1825;**53**:393-404.)