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Medicine in Old Age

Rehabilitation of the Elderly

H. M. HODKINSON

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Rehabilitation of the elderly patient—that is, helping him back to as normal a life as possible (preferably in his own home environment)—is a vital part of his hospital treatment. Unfortunately, the traditional patterns of hospital care, which were evolved at a time when most patients in hospital were young, are poorly suited to the needs of the elderly and tend to create rehabilitation problems. Traditional care is centred on nursing in bed and the dangers of going to bed, brilliantly expounded by the late Richard Asher,[1] apply with particular force to the old. In addition, there are the dangerous institutionalizing effects of stay in hospital, the "good" patient being the one who most readily allows himself to be regimented and to accept the role of a passive yet grateful recipient of care. The important goals of self care are removed; clothes are replaced by dressing gown and slippers, so emphasizing the invalid role; and the patient is further conditioned to dependency by a plethora of professionals, whose authoritarian status is enhanced by such devices as hierarchies and uniforms. The end result is the patient who, when management decisions are put to him, says "you know best, doctor, I leave it all to you" and unquestioningly accepts being treated rather like a slow-witted child and allows things to be done for him that he can perfectly well do for himself. Here again the elderly are perhaps particularly vulnerable, being undervalued members of the community and survivors from a more authoritarian age.

A further problem is under-expectation. Elderly patients; their relatives, friends, and neighbours; and regrettably sometimes their general practitioners too tend to have an unduly pessimistic view of the likely outcome of the admission to hospital. Their long past experience of the hospital, not rarely a former "workhouse" with perhaps a former unenviable local reputation, is that the old came out of the hospital only one way—feet first. So we constantly hear such remarks as "what can you expect at my age, doctor?" from elderly patients. These prejudices need to be powerfully counteracted, for the benefits of hospital treatment stand up to comparison with those for younger age-groups[2] and most patients can be discharged home again after treatment in an active geriatric department.[3]

The Right Atmosphere

It is therefore vital that an atmosphere of activity and optimism exists in the geriatric wards of the hospital. The right climate, which has such powerful effects on the expectations and progress of the individual patient, depends on many different groups: other patients, relatives, nurses, doctors, voluntary helpers, ward orderlies, porters, ministers of religion, social workers, and paramedical therapists. This very large group of individuals forms a "therapeutic community" and it is this—and not just the "rehabilitation team" of physiotherapists, occupational therapists, speech therapist, and doctors—which determines the quality of rehabilitation in the hospital ward. Good communication is needed if rehabilitation is to thrive. The ward sister, paramedical therapists, and medical staff are important group leaders, who need to create and maintain the right attitudes of enthusiasm and optimism around them; to help and direct others in the application of rehabilitation techniques; and to support and show appreciation of the value of all those forming the therapeutic community.

The establishment of an appropriate rehabilitation environment for the elderly in a ward is greatly helped by its specialized geriatric function, and this is perhaps the major justification for the separation of geriatrics from general medicine. Seeing other patients improve and go home is an undoubted encouragement to the individual patient. More active departments have an advantage here[3] and progressive patient care systems are practised in most departments, long-stay patients being transferred to other accommodation to maintain greater activity in the admission and rehabilitation wards.

Nursing Staff Role

Nursing staff play a very important part. Because of their close contact with patients, relatives, and visitors it is they who can best communicate the therapeutic as opposed to custodial orientation of the department. Nursing attitudes and practice need to be adapted to the elderly. Rather than merely minister to the patient, the geriatric nurse needs to help the patient to help himself and so foster increasing independence. Firm but sympathetic re-education may be needed to modify the patient's expectations. Overprotective attitudes must be abandoned: "don't you walk on your own, you might fall" may negate all that the physiotherapist has done to build up walking skill and confidence. Nurses need to be intimately involved in the rehabilitation of the patient and so must know what stage the physiotherapist or occupational therapist has reached so as to supplement what is being done. Otherwise wily old patients often have the nurse lifting and supporting them when capable of getting up unaided and walking only with supervision by the physiotherapist, or undressing them and helping them into bed when they had dressed themselves and got in and out of bed unaided in the occupational therapy department earlier.

Northwick Park Hospital, Harrow, Middlesex HA1 3UJ
H. M. HODKINSON, B.M., M.R.C.P., Consultant Physician in Geriatrics

The elderly patient in need of rehabilitation may have a specific disability such as hemiplegia, Parkinsonism, or arthritis. More commonly, however, there is no major specific disability but the necessity to get back to normal activities after a period of illness, particularly where this has involved bed rest, which has resulted in impairment of balance, walking and other basic skills.

In assessing the individual patient's potential for improvement full and accurate evaluation of his physical disabilities is clearly important, but it must be coupled with full consideration of mental factors and the social background. Mental factors are of paramount importance, for well-motivated patients with intact intelligence can often overcome the most daunting physical disabilities while patients with poor motivation, depression, or dementia may do badly even with fairly minor physical disabilities. Routine assessment of intellectual function by a simple orientation and memory questionnaire may be valuable in planning the patient's rehabilitation.[4] Social factors determine the specific aims of treatment—for example, whether the patient needs to be able to climb stairs, whether cooking is required, and what degree of self care is essential. Social factors may bear on motivation, with return home the desired goal for most. Others may have to accept more restricted goals, such as admission to a welfare home, and the social worker may need to help patients to adjust to such changes without losing heart. We may have to accept that the patient wants to go back to a far-from-ideal home and we may destroy his motivation if we overpersuade him to accept some seemingly more satisfactory alternative plan.

Basic Requirements

The basic requirements in the individual patient's rehabilitation programme will thus vary. Nevertheless, common to the majority will be the ability to walk with or without mechanical aids, to get up and down from a chair and in and out of bed, to manage the lavatory, and to dress. Stairs, cooking, and other household tasks may be needed also. The occupational therapist is concerned with determining these needs—the so-called activities of daily living (A.D.L.) and in retraining to reach the necessary standards in the hospital A.D.L. Department. When necessary she may arrange home modifications, clothing changes (zips or Velcro to replace difficult buttons, for example) or the provision of gadgets to simplify difficult tasks (for example, a wide variety of gadgets to enable the patient with hemiplegia to do tasks with one hand instead of two). For severely disabled patients extensive thought, re-education, and training may be needed, but more commonly patients need a check-through of A.D.L. and brief practice to regain their confidence.

Remobilization is the principal concern of the physiotherapist. Treatment needs to start as soon as possible; otherwise strength, confidence, morale, and balance may all deteriorate rapidly—for example, rehabilitation of the stroke patient starts as soon as consciousness has returned. The patient practises rising from a chair of suitable seat height, by pushing strongly on its arms while leaning well forwards with feet kept under the front edge of the chair. If needed, help is given with hand-lifting under the axilla. Walking practice commonly uses the walking frame, which gives patients considerable support and confidence. A very simple gait pattern may be taught; the frame is advanced about 18 in (45 cm) and planted securely, the patient takes a short step with each foot, stops, and advances the frame to repeat the cycle. Even this simple regimen may call for repeated instruction of confused patients—indeed, the essentials in geriatric rehabilitation are simplicity, consistency, and repetition. Initially a helper at each side may be needed, but usually progress to walking independently in the frame is rapid. With very disabled patients one may settle for this level of activity. Otherwise progress to a stick and then no aid is typically smooth; patients do not become "addicted" to their frame if their rehabilitation is satisfactorily directed. In hemiplegics one may be obliged to use the less satisfactory tripod rather than a frame if only one hand can grip.

In supporting geriatric rehabilitation the stimulation of the patient's motivation and showing approval of success are important, and the therapist's main tool is her own personality, not complicated apparatus or techniques. Some patients, particularly during the early stages of their rehabilitation, need considerable pressure put on them by the therapist to augment their poor motivation. The successful therapist is the one who can support, encourage, and if necessary push the patient hard without alienating him and can flexibly adapt the approach used to the personality of the patient.

Maintaining Improvement at Home

When the geriatric patient is home again, the doctor is chiefly concerned to maintain the level of activity achieved by rehabilitation. Hence it is important that all concerned should know what this level was, or the patient may slide back to an unnecessarily dependent role. Attendance at a day centre or day hospital may be a helpful stimulus. Modifications of the home may be helpful—for example, fixing handrails or providing more suitable toilet accommodation. Alternatively, more suitable chairs, wheelchairs, or bath aids may be necessary. Many local authorities now employ domiciliary occupational therapists to help in such matters. Moving the bed downstairs may be a great help but should not be done without careful thought, for many old people who walk poorly on the level manage stairs very well because of the help from the stair hand-rails. In such a case bringing down the bed may encourage the invalid role and at the same time cause unnecessary major inconvenience to the other members of the family.

Though this account of rehabilitation of the elderly has emphasized the part played by hospital treatment, the general practitioner has an important part to play. He can be the most powerful influence in the re-education of the elderly and of their relatives, so that they come to have less pessimistic expectations and are aware of the potential benefits of inpatient rehabilitation. He can best do this when supported by an active geriatric service which has no waiting list. He can then help his elderly patients by early referral rather than waiting till a crisis has developed, not accepting advancing disability as an inevitable concomitant of ageing but regarding it as a diagnostic and therapeutic challenge.

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