# The elderly and collaboration between Primary and Tertiary care

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## *Introduction*

Politeness dictates that I thank the organisers for kindly inviting me to present a paper at this symposium. However, if you want me to be completely honest, I am far from thankful! I remain uncomfortable when asked to discuss ethical issues, even when the elderly are concerned. I still expect ethicists to present ethical issues and I still equate ethicists with religious people, preachers, Moses and the Ten Commandments, and judges. I certainly do not fit in this circle! Imagine a judge with his wig of wisdom and compare his crown to mine! People who know me will note that there are obvious differences!

However, I have accepted the invitation to present this talk, so here goes.

## *What is preached*

I would like to first inform you about what is preached, because even in collaboration between primary and tertiary care, there are 'commandments' or 'codes of practice' that touch on the obligations, rights and dignity of both clients and health care professionals. In the end they all strive to lead to a better quality of care that can be given to our clients.

I will then go on to give examples to try and illustrate whether these guidelines or codes are actually adhered to in Malta. Just like the Ten Commandments I suppose. We all know them by heart, but do we break them, and if yes, how often?

## *Definitions*

Before proceeding further, I have to take a moment to define what I will be talking about.

The *elderly* are those aged 70 years and over, with problems of health and frailty.

*Primary care* is health care provided in the community by family doctors (with apologies to other members of the primary health care team).

*Tertiary care* is health care provided in a specialised hospital for the elderly by a consultant geriatrician (again with apologies to other members of the hospital health care team).

*Collaboration* is to work together. I feel I have to remind the audience what this word still means since, in everyday practice, it is often ignored!

***The Commandments***

So what are the commandments or codes of practice that guide primary and tertiary care collaboration as regards the elderly? A lot of material can actually be found in policy statements issued by esteemed authorities such as the Royal College of Physicians and the British Geriatrics Society. So I have extracted some of them, threw in a few of mine and grouped them into three with the following headings:

(1) What elderly patients want.
(2) What family doctors want.
(3) What consultant geriatricians want.

I would like to emphasise that these 'wants' are as seen through the eyes of a consultant geriatrician.

***What elderly patients want***

- To be referred by their family doctor to the hospital department best able to meet their needs.

- To be assessed and admitted quickly and efficiently.
- To remain an in-patient as long as their clinical condition requires.
- To have a planned discharge with all the necessary instructions and community support.
- To be assessed in their own homes by a consultant if the situation requires it.

*What family doctors want*

- To decide which hospital department to refer their patient to.
- To have a clear system of referral.
- To have access to a hospital consultant when required to discuss a particular case.
- To be involved, when necessary, in the management/decision making of an inpatient (for example advance directives).
- To be informed about a planned discharge of their patient (especially if the case is complicated and in need of support).
- To have a discharge letter sent with the patient on discharge.

*What consultant geriatricians want*

- That their specialist expertise is recognised and requested by family doctors.
- That the admission policies of their units include direct admissions from the community.
- That they have the necessary resources to respond to cries for help from family doctors, at the time of need.
- That all the relevant information on individual patients is provided by the family doctor.
- The clinical freedom to decide a patient's admission/discharge.

*Levels of collaboration*

Based on these wants, collaboration between family doctors and consultants at the community/hospital interface can, therefore, be grouped at three levels:

- The *time of admission*, which is initiated by the family doctor and to which the consultant responds.

- The *inpatient period* which is conducted by the consultant and to which the family doctor can contribute, for example in making certain decisions.

- The *time of discharge* which is initiated by the consultant, with all the necessary information given to the family doctor.

All three levels have guidelines that ensure continuity and quality of care through collaboration between primary and tertiary based professionals. This collaboration requires communication. It has been stated by the British Geriatrics Society that shortfalls in communication at the hospital/community interface are the most frequent causes of complaints by patients, carers and doctors. Although this statement was aimed at services in the United Kingdom, it certainly holds water also for Malta. And when one considers how fascinated we all are with the means of communication that exist today, it is even more surprising how easily we seem to forget to contact one another!

***So, do we practice what is preached?***

I thought I would give some examples which illustrate everyday practice and for which we can all reach our individual conclusions. I thought I should call these experiences:

***'One week in the (working) life of Dr. F, a consultant geriatrician'.***

***Example 1.***

Ms. A - an 82 year old woman, an inpatient at Zammit Clapp Hospital (ZCH).
Her main problems are: pressure ulcers, dementia, with nasogastric tube feeding, very dependent, bed-bound.
Her sister (aged 80 years also) wants her home at all costs: 'a strong believer that God will look after them'.

Detailed discharge planning with required community services is carried out with the family doctor contacted and involved.
Patient was discharged.
2 weeks later 'medical problem' – no place at ZCH – ended up as an inpatient at St. Luke's Hospital.
*Comments:* Good discharge planning; limited resources to respond promptly to a cry for help from a family doctor; collaboration in continuity of care interrupted.

***Example 2***

Mr B – 75 years old.
Family doctor phones and mentions several medical and functional problems.
Obviously a case for admission to Zammit Clapp Hospital.
But no empty bed available – 100% occupancy.
Situation cannot wait – patient admitted to St. Luke's Hospital.
*Comments:*
Again inadequate resources leading to an inappropriate admission to a general medical ward where 'their presence can be resented, their needs inadequately met'.

***Example 3***

Ms C, a 71 year old woman, an inpatient in a general hospital.
Main problems: brain tumour just diagnosed, refuses palliative operation.
Remains with balance problems and weakness in one upper limb.
Discharged home, nobody at home. Family doctor not informed, no support services organised.
*Comment:* Poor discharge planning.

**Example 4**

Mr D, an 80 year old man, an inpatient at ZCH for 2 weeks.
Diagnosis: post fracture neck of femur operation and rehabilitation.

Now walking safely with frame and is independent in activities of daily living.
Home visit carried out by therapists and social worker: will be safe at home.
Discharge date given – no further inpatient management required.
Family doctor phones, VIP phones, 'please postpone discharge for two weeks as carer not ready'.
*Comment*: inpatient management complete; inpatient facilities will not be made available for next patient on waiting list; consultant obligations – request for further inpatient stay not possible.

***Example 5***

Authorities change Zammit Clapp Hospital admission policy:
'No direct admissions from the community'.
*Comment*: an impingement on the rights of patients, general practitioners, consultant geriatricians; collaboration between primary and tertiary care interrupted.

***Example 6***

*The Home Consultation visit*

This is a visit to a patient's home by a consultant, at the request of the family doctor and normally in his company, to obtain advise on the diagnosis and treatment of a patient who is unable to attend hospital because of his/her medical or functional condition. The visit is accepted practice, both abroad and locally, with known advantages. Such a visit may avoid an admission into hospital but may also lead to an admission to hospital. However, it is carried out outside the normal working hour duties of the consultant and therefore a fee is involved. Dr. F carries out such visits at the request of the family doctor.

Imagine Dr. F's amazement and distress to wake up one Sunday morning and find this heading 'Preferences for those who pay for private treatment' in a local nameless, newspaper with his name splattered all

over the front page. The article basically stated that to get admitted into Zammit Clapp Hospital, a certain Dr F had to pay you a visit at home and get paid. And to add insult to injury the article also quoted our Archbishop who had recently stated that 'the sick patient should not be used as an object of business and profit'. All Dr. F. was doing was carrying out home consultation visits at the request of family doctors, getting paid for it (as he should), and admitting some of the seen patients to the geriatrics unit if required.

*Comments*: problem of overlap between private and state-run medical services;.

### *Private and State-run medicine*

So even when consultants and general practitioners are actually collaborating together, intentions can get misinterpreted. However this situation also highlights the dilemmas that can be encountered when there is an overlap between state-run and private medicine. In certain situations they are kept completely apart. However, in other cases there is an overlap, as can happen with home consultation visits. The ethical issues involved, when health professionals work in both state-run and private-run systems, can open a whole can of worms and could possibly be discussed at a future symposium organised by the Bioethics Consultation Committee.

### *In conclusion*

It can be stated that we work in a daily minefield of ethical issues. I often feel as if I'm being made to walk a tightrope and it can prove difficult to keep one's balance, trying to juggle with all the requests and situations that arise during a normal working day. However, if existing codes of practice and obligations are adhered to, then quality care is guaranteed, and the rights and dignity of patients, family doctors and consultants will be safeguarded. We talk a lot about the rights of patients. But it is important to remember that doctors and consultants also have rights, as I have mentioned.

Finally, I would like to emphasise that it is essential for all doctors to keep collaborating, which means communicating. I would also like to ask the authorities to increase the resources to be able to provide more specialised hospital care for the elderly. We reached saturation point a while ago and cannot cope with the demand.