行政院及所屬各機關出國報告

(出國類別：研究)

臨床老人醫學

服務機關：國立台灣大學附設醫院家庭醫學部

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出國地區：加拿大

出國期間：90.9.1～91.8.28

報告日期：91.11.27

系統識別號:C09004287

公 務 出 國 報 告 提 要

頁數: 83　含附件: 是

報告名稱:

臨床老人醫學

主辦機關:

國立臺灣大學醫學院附設醫院

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出國類別: 研究

出國地區: 加拿大

出國期間: 民國 90 年 09 月 01 日 -民國 91 年 08 月 28 日

報告日期: 民國 91 年 11 月 28 日

分類號/目: J2／西醫　J2／西醫

關鍵詞:　老人醫學

內容摘要: 台灣自1994年晉升爲老人國後, 老化速率快速, 到2020年時, 老年人口將達到14%, 約在2036年時, 會達到21%, 在全世界的排名是前幾位的。預計2036年時, 依賴比將達到35.2%, 也就是每3 個人要撫養1 個老人, 社會的負擔, 不可爲之不大。老人的照顧, 涵蓋了醫療社會及經濟層面, 需要多系統間的協調運作。醫療部份, 包括: 護理師、物理治療師、職能治療師、營養師、社工人員、臨床藥師等; 社會福利方面, 包括: 社工人員、房屋計畫、供餐中心、家庭助理人員(從事家庭清掃、洗衣、幫病人洗澡之服務等)之整合、各種機構化設置之分及與管理; 經濟方面, 包括: 保險給付、個人儲金、國家支應等。加拿大的老人照顧, 以長期照護見長, 其體系建構之完善, 對老人的安置, 滿足個人化的需求; 各案管理人制, 整合醫療與社工資源, 並有醫院及社區管理人之接續服務; 長期照護部門, 提供長期照護之規劃; 而個別老人的評估, 又有老人小組的各成員共同參與, 提供全面性的照顧。國內老人照護體系尚在構成中, 擷取加拿大老人人口比率領先三十年之經驗, 評估優缺點及適用性, 作爲未來老人照顧藍圖, 爲國內老人照護制度催生, 期待台灣的老人, 也能早日得到更好的照顧。

本文電子檔已上傳至出國報告資訊網

摘要

台灣自 1994 年晉升為老人國後，老化速率快速，到 2020 年時，老年人口將達到 14%，約在 2036 年時，會達到 21%，在全世界的排名是前幾位的。預計 2036 年時，依賴比將達到 35.2%，也就是每 3 個人要撫養 1 個老人，社會的負擔，不可為之不大。

老人的照顧，涵蓋了醫療社會及經濟層面，需要多系統間的協調運作。醫療部份，包括：護理師、物理治療師、職能治療師、營養師、社工人員、臨床藥師等；社會福利方面，包括：社工人員、房屋計畫、供餐中心、家庭助理人員(從事家庭清掃、洗衣、幫病人洗澡之服務等)之整合、各種機構化設置之分及與管理；經濟方面，包括：保險給付、個人儲金、國家支應等。

加拿大的老人照顧， 以長期照護見長，其體系建構之完善，對老人的安置，滿足個人化的需求；各案管理人制，整合醫療與社工資源，並有醫院及社區管理人之接續服務；長期照護部門，提供長期照護之規劃；而個別老人的評估，又有老人小組的各成員共同參與，提供全面性的照顧。

國內老人照護體系尚在構成中，擷取加拿大老人人口比率領先三十年之經驗，評估優缺點及適用性，作為未來老人照顧藍圖，為國內老人照護制度催生，期待台灣的老人，也能早日得到更好的照顧。

目次

第一章　目的

台灣老化的速度名列世紀前茅。法國在 1865 年進入高齡國,125 年後，其老年人口才達到 14%。瑞典在 1890 年進入高齡國,需要 80 年，其老年人口才加倍。老年人口達到 14%時，德英要 45 年，美國要 65 年，而日本要 25 年,台灣要 26 年,中國大陸要 29 年。

台灣現有老人比率為 8.5% (2000 年)，約有 188 萬老人，65 歲以上需要長期照護者有 9.1%，估計約有 17 萬老人需要長期照護。20 年後台灣的老化人口，根據內政部的統計, 2020 年將達總人口之 14.08%, 2030 年將達 20.07%。但國內老人醫學及長期照護之理念及實務缺乏完整之體系及規劃，為提供未來龐大老人族群的照顧，需要及早規劃，從政策、教育、實務面上擬定前瞻性之藍圖。

和美國百家爭鳴的私人保險制度相較，加拿大的全民健保制度與我國類似；同時，加拿大也是世界排名第三位的長壽國家，現有老年人口比例為我國 20 年後之預估數，他山之石，可以攻錯，提供我們一個很好的未來預後考量，從制度的推行到效益及缺失的評量，凡走過的必留下痕跡，鑑古知今，相信對我國未來老人照顧有所助益。

本院在李源德院長的高瞻遠矚下,有鑒於國內老人人口日漸增加， 需要自歐美先進國家學習第一手老人照顧的資料，乃將老人照顧納入出國進修的優先考慮，本人有幸在陳慶餘部主任的提攜下，成為此計畫中之一員，經過一年來努力的聯繫,及台大公共衛生學院賴美淑教授的協助，終於如願踏上赴加之旅，前往卑詩省的卑詩大學(University of British Columbia) 附設醫院進修臨床老人醫學,而這之中，特別值得感謝的是: 在申請加拿大亞伯坦大學（University of Alberta) 老人臨床訓練時，老人醫學會戴東原理事長、台北縣衛生局李龍騰局長所給我的協助; 家庭醫學部陳恆順、郭斐然醫師在遠距視訊上的專業; 陳慶餘部主任在遠距會談的現場指導，雖然最後不能兩全，只得忍痛放棄亞伯坦大學的機會，但是若沒有這些努力的過程，焉能確保最終目標如願? 而這一年中部裏師長同仁的建議與鼓勵，特別是李世代(現為台北護理學院研究所所長)、王維典、郭斐然、李宇芬醫師在出國經驗上的分享; 計畫負責人內科部嚴崇仁醫師的指導; 回顧此段歷程，心中真是充滿感謝,真的要像陳之藩說的，要感謝的人太多，只好謝天了。

第二章 過程

此次出國進修主要分兩部分，主為為臨床老人實習，了解老人疾病之特質及照顧之方法； 並藉此考察老人照護制度，從巨觀面了解老人照顧之整體需求，以作為國內老人照護之參考。將分述於以下各章節。

老人照護制度考察:

1. 加拿大的全民健保
2. 卑詩大學(University of British Columbia) 醫療體系
3. 老人長期照護制度 (請參見附錄拙作)

臨床老人實習包括:

1. 短期評估及治療中心 (Short Term Assessment and Treatment Center, STAT Center)
2. 急性老人病房(Acute Care Unit of Elderly, ACE unit)
3. 亞急性老人病房(Subacute Medical Care of Elderly, SAM)
4. 出院準備病房(Discharge Planning Unit, DPU)
5. 院內老人照會(Geriatric Consultation Service)
6. 快速老人評估門診(Rapid assess unit)

7. 老人精神科社區訪視團隊(Geriatric Psychiatric Outreach Team, GPOT)
8. 基層社區健康中心 Community Health Center
9. 社區心理健康中心 Community Mental Health Service

第三章 加拿大的全民健保

加拿大是全民健保的國家，醫療費用由政府稅收(GST)及省稅收(PST)比例共同支出，原則上食物以外的消費課取政府稅 7%，卑詩省省稅為 7.5%，各省可依其省份特性發展醫療，但所有醫療費用支出,包括公立醫院的人事費,均在定額的總額預算之內。卑詩省醫療體系下為公立醫院制度，罕有私人醫院或診所，目前在溫哥華有一家以膝人工關節置換術為主的私人醫院，因為在加拿大等候膝人工關節置換術的人很多,平均要等 8 個月，若付 5000 加幣(約台幣 11 萬)，可以很快在私人醫院排到刀。

加拿大的全民健保保費原為每人每月 36 元加幣(約台幣 800 元)，自今年 5 月調高 50%,變成每人每月 54 元加幣(約台幣 1200 元)，給付項目也減少些，眼科、牙科、 復健科不包括，其他診察費均包括，病人無須自付額，但藥費則由病人到社區藥局買藥自付，藥局可以為老人配藥在泡泡包裝(Bubble package)裏，方便病人取用每次的藥量及種類無誤，不良於行的老人，醫師也可以打電話請藥局送藥到病人家中，處方也可以由口語更改，若在醫院則會記錄下你的口語處方。所有卑詩省的藥局都有電腦連線，病人一旦入了急診，從電腦中便可以列印病人最近的處方，十分的方便。

加拿大的全民健保是保障基本求醫權利，但不給付藥費常構成貧困老人的問題，家庭醫師也曾為此請命，但沒有獲得回響。所以大多數的加拿大人都另買一個私人保險，以涵蓋全民健保不包括的項目。不過一般而論，加拿大的全民健保對那些比較難做、需要團對合作、花錢較多、利潤較少的照顧會花費較多人力、物力去執行,例如老人的長期照護、精神病的照顧(包刮社區的照顧)等，是由政府在負責在規劃，但如一般之精神官能症、心理諮商等，則由醫師個人去執行。加拿大的健保的精神，是保重病，不保小病。

但加拿大的老人長期照護系統可說十分周全，所有的長期照護機構均為公立，入住費用依個人所的高低收取不同的費用,但領取政府福利金生活的老人也足以支付，保障所有老人基本長期照護的權利，當然也有些私人的長期照護機構，最高可達月付十萬台幣的高級五星級飯店式機構，則提供額外的選擇。而社區的居家服務，也有基本提供的服務次數，也和個人收入有關，有不同的費用。有關長期照護的部分，請參閱附錄拙作。

第四章　卑詩大學(University of British Columbia) 醫療體系

卑詩大學(University of British Columbia) 旗下的醫療體系主要包括卑詩大學醫院(UBC Hospital)及溫哥華總醫院(Vancouver General Hospital, VGH) 。

在卑詩大學醫院內有家庭醫學部及門診，負責家庭醫學部住院醫師訓練；溫哥華總醫院內也有家庭醫學部及門診，但分為門診部及住院部，住院部的醫師稱為 Hospitalist，負責住院病人的照顧，包括:

1）急性照顧 (Acute Care):

a）急性老人病房(Acute Care of Elderly, ACE);

b）亞急性內科病房(Subacute Medical Unit, SAM),

c）急性內科病房(Acute Medical Unit, AMU)

2）連續性照顧(Continuing Care)

a）出院計畫病房(Discharge Planning Unit, DPU)

b）Purdy 護理之家(Purdy Nursing Home)：在卑詩大學醫院院區

c）Banfield 護理之家(Banfield Nursing Home)：在溫哥華總醫院院區

3）緩和醫療病房(Palliative Care):

整體而言，溫哥華地區的醫療體系包括以卑詩大學為主的醫療體系及以省立醫院為主的醫療體系，整個體系的設計均包括急性、慢性、長期性之照顧，並有護理之家、復健醫院為合作醫院，提供完整性之醫療，其中人員也可互通，檢查也可集中，使得較小型之院所也有好及穩定的醫療資源。

老人的第一線照顧由家庭醫師負責，在卑詩省，內科部下有老人醫學科，內科住院醫師訓練完成後再接收兩年的老人醫學訓練，經過考試成為老年醫學專科醫師，主要負責研究教學，服務主要是接受轉介或照會等。在家庭醫學部，接受兩年住院醫師訓練後，可再申請半年的老人醫學訓練，加強老人照顧的能力，可應用於一般門診照顧，或服務於老人短期評估治療中心 (下述)，其訓練內容包括：老人短期評估治療中心、老人精神醫療、老人照會醫學訓練等。值得一提的是，此訓練也可以用部分時間，拉長受訓日數完成，有利於開業醫師的進修。

長期照護機構採分級制，單一窗口由各案管理員評估後入住。

緩和醫療病房和台灣類似，主要由家庭醫師照顧，也有負責照會的醫師，通常是家庭醫師特別興趣於緩和醫療而自我訓練而來。

第五章 老人短期評估治療中心

(Short Term Assessment and Treatment Center, STAT center)

指導教授 Martha Donnelly 是家庭醫學部社區老人支部之教授，她於 20 多年前創辦了老人短期評估治療中心(STAT center ,Short Term Assessment and Treatment Center)，有日間病房及住院部，為老人評估及短期治療之用。

日間病房每天早上均有兩位兼任家庭醫師，共有 5 位醫師，平均每位醫師每週有 2 次時段，每節薪水加幣 300 元(約台幣 6500 元)，日間病房的病人便依照醫師的時段，每週來病房兩次，個案轉介可由病人自訴，家屬聯絡，家庭醫師或其他醫療人員轉介,所有轉介均須家庭醫師同意，值得一提的是如果醫師覺得這位病人非常需要到門診就診，而病人沒有病識感，只要有一位醫師簽名證明這位病人必須接受治療，警察就會強制送這位病人就醫；若有兩位醫師簽名證明，就可強制這位病人住院，特別是在老人精神疾病的轉介上,十分重要，這也讓我想起國內的精神醫療，有時會遇見苦惱的家屬，因為病人沒有病識感而苦無對策，看到加拿大的制度真是由衷的羨慕，可以減少多少未接受治療的個案及挽救多少不幸的家庭!

轉介的標準包括，年齡 65 歲以上，有複雜的醫療,精神上或社會性的問題,需要老人評估小組評估診治者，可由老人、老人之家屬、

其他醫療成員、或家庭醫師轉介，但所有轉介均須透過家庭醫師。接案後，會有一位個案管理護士先家訪進行評估(Pre-assessment)，決定是否直接到日間病房或先需醫師做家庭訪視以進一步評估。進入病房後，也如一般病房有住院病歷，有固定的醫師及護士接案，病房並配備有護理師、物理治療師、職能治療師、營養師、社工人員、臨床藥師、精神評估師 (neuro- psychologist)，可接受醫師轉介，一起評估病人 。老人在這裡，除了傳統的醫師診治之外，護理師和社工會更進一步評估病人的照護需求及心理社會狀態，營養師會依照會需求，提供營養評估及建議，職能治療師會評估病人的活動力(mobility) 、平衡力等，處方需要的生活輔具及需要加強的老人運動為何，以增進老人的獨立性及減少跌倒之危險，精神心理師也會依照會需求，進一步評估懷疑初期失智症的個案。每位醫師每週均有一次團隊小組會議(Inter- discipline meeting)，所有成員一同討論個案，以作為評估及治療之計畫,或出院準備之用，每個人把自己專業內對病人之了解提出，病人有特殊問題需要討論，可以參酌其他成員的了解及意見，有助於周全性處理。老人在日間病房期間，會有交通車接送，上午九時到院，吃完午餐，下午一時再離開，每次到院有不同的醫療人員評估，需要時也可安排照會或進一步檢查，除了評估檢查，其他時間也有活動師安排各種活動。日間病房和住院部就在隔壁，有些醫療人員如: 物理

治療師、營養師等是共用的。加拿大有很多人即使在醫院工作也是部分時間的 (part-time), 例如營養師每週上班三天, 提供日間病房及住院部的營養諮詢, 兩位職能治療師可合起來提供 1.5 個人力, 當然他們的退休金也是部份的, 這對職業婦女來說, 是一個很好的選擇,沒有經濟壓力的婦女,可以選擇部分時間上班, 不但可以貢獻所學, 也可以兼顧家庭, 也許可以減少一些問題青少年,也使原本擔任家庭主婦的婦女,有機會可以到工作場所, 尋找自己的天空, 這真是一項貼心的另類服務。

日間病房病人以失智症老人為多, 但也包括其他非急性病症, 如: 憂鬱症,心臟衰竭, 功能減退等, 一般評估及治療的時間不超過三個月,所有費用包括餐費,均由健保支出。

住院部有兩位兼任家庭醫師, 平均每週兩次到院服務, 住院部的值班由日間病房及住院部的醫師共同輪值, 老人精神科的醫師也參與照顧及團隊會議, 住院病人也以嚴重失智症、嚴重憂鬱症, 等。

此評估中心提供了適合的場地及人、物力為虛弱 (frail) 老人之多發性問題及高失能狀態尋出可矯治(reversible)因子, 以增進老人獨立之可能; 或尋找合適的資源, 協助老人之獨立性; 而無法獨立的老人, 則評估並安置合適的場所。

老人的物理治療, 以增進或維繫活動力為主, 增進老人的行動

力及獨立性，因此，單一疾病的復健一般並不涵蓋。主要評估方法包括: Time up and go test, Berg test 等，用以評估病人的活動力、平衡力、自我照顧的能力等，以作為復健處方之參考，包括: 輔具的選擇（枴杖、助行器等）、肌力的訓練 、平衡感訓練、耐力訓練等。

老人的職能治療，以老人的居家環境安全評估為主，為常跌倒的老人去除環境中的障礙或危險，創造安全的空間及環境的設計，以減少老人的跌倒。因為老人的跌倒，可能造成髖骨骨折，髖骨骨折可能是病人諸多病因中的「最後一根稻草」，造成病人臥床、失去獨立性等，所以，找出可能引致跌倒的環境因素，加以矯正，不是只有在門診看病而已，更要家訪評估，才能完整的了解與解決問題。

老人的營養評估，主要是了解老人是否有營養不良的現象，老人由於牙齒的問題、眾多疾病及眾多藥物的交互作用、以及是否有能力自己準備三餐等，可能造成攝取量或種類之不足、食慾不振、 口感變差等，而造成營養不良，營養不良，可以造成貧血、虛弱、無力及其他各器官系統的疾病，也減低了老人之活動性，可說和老人的生命力及活動性息息相關，老人的營養評估，從每日飲食量病人皮下脂肪厚度，血中 Pre-albumin 值，可以了解，以作進一步建議之參考。

臨床藥師，主要在了解病人用藥之劑量調整是否得宜，有無須要調整之處方。

第六章　急性老人病房(Acute Care Unit of Elderly, ACE),

亞急性老人病房(Subacute Medical Care of Elderly, SAM)

75 歲以上老人住院時, 依照病情嚴重度及特性, 安排至急性老人病房或臨床教學小組 (Clinical Teaching Unit, CTU), 臨床教學小組是由主治醫師指導醫學生照顧住院病人, 急性老人病房則是由內科部醫師或家庭醫師照顧, 當病人病情較穩定時, 就轉到亞急性內科病房, 所需的護理人力配置較少。急性老人病房的病人和我們的內科或家庭醫學科病房類似, 只是病人年齡層較老, 但在急性老人病房, 有老人照會小組的物理治療師、職能治療師、社工人員可以同時評估及治療病人, 事實上, 不只是在急性老人病房, 其他病房, 甚至出院計畫病房, 也有病房物理治療師、職能治療師、社工人員協助團隊治療的進行, 臨床藥師也在病房工作, 協助藥量的調整等,營養師也接受照會, 可說是真正團隊合作。若有需要進一步評估或團隊照顧者, 可照會老人照會小組。

老人病房的護士, 書記負責檢查醫囑, 製作藥物單, 註冊護士 (Registered nurse)可以給藥、注射藥物及一般的護理工作等,助理護士則作一般的護理工作, 護士的記錄也很有系統, 在每一段記錄前均列有該段記錄的主題, 如: 意識狀態、排泄、皮膚狀況等, 在查閱病例時, 可以一目了然。老人病房的護士, 接受有關老人常見相關症狀之

評估， 如:譫妄(Delirium) 等，由於此狀態常在夜間有激躁 (agitation) 的表現， 需要護理人員確切詳實的記載，以提供臨床醫師之診斷依據; 也接受常見老人疾病處理之了解，如: 失智症、尿失禁等。

老人病房的病人來源，主要由急診室進入，所以入住之後的處理，以內科或家庭醫學科醫師為主的第一線照顧，常照會的科別包括老人科及老人精神科。

第七章　出院計畫病房(Discharge Planning Unit, DPU)

出院計畫病房一共有 42 床，內科或外科病人，度過了急性及亞急性期，而準備住進護理之家的，可轉介到出院計畫病房，一方面等待床位，一方面接受延續性治療，此病房聘有兼任醫師，每位醫師一週工作兩次，非主治醫師當班日，護士會將病人的問題記錄下來，當主治醫師下次當班時交給他。病房也有病房物理治療師、職能治療師、社工人員協助團隊治療的進行，也有大的活動室、物理或職能治療室、廚房等，和護理之家的設施類似。

出院準備病房的醫護人力配置更少，紓解病人壅塞在急性病房，減少醫療支出之成本，並不影響治療之計畫。但老人精神科的病人部列入此病房中,因為他們大多有認知或精神情緒上的問題，不宜再有額外的壓力。

第八章　老人照會小組(Geriatric Consultation Service)

老人照會小組組內有三位老人科醫師，負責全院 950 床的老人照會.

每日照會量平均約 2~3 床，較常照會的單位包括急性老人病房、急診、一般內科病房、外科病房.也曾接受血液透稀室整形外科加護病房等照會。照會疾病種類常見者包括瞻妄(Delirium)，跌倒(Falls)，功能退化，意見諮詢(second opinions) 等,並有老人照會小組的物理治療師、職能治療師、社工人員可以同時評估及治療病人。小組每週開會一次,討論照會病人的狀況並決定是否結案。凡接受照會的個案，小組均會繼續定期追蹤(每週 1~2 次)，直到照會問題穩定或已消失為止。

老人照會小組的醫師，提供了全院老人照顧的支援，保障老人在各科時的老人專家照顧。

老人照會的評估內容，包括：病人簡史(現病史及過去病史) 、過去用藥、現在用藥、住院前之功能狀態(包括: ADL 及 IADL) 、社會狀態(家庭關係，菸酒狀態等) 、智能評估(Mental status examination) 、理學檢查、實驗室檢查、評估與建議。

第九章　快速老人評估門診(Rapid assess unit)

從急診出院的老人，通常只解決了急性問題，無法整體評估，若病情非嚴重至住院，也沒有穩定到轉到日間病房或預約門診，可在急診出院前轉介安排至快速老人評估門診，作整體評估並決定治療的方向。因為加拿大要預約給專科醫師看的等候時間長，有了快速門診，特別是對急診出院的老人，急性的問題處理雖告一段落，但病人還不是很穩定，可以有效的協助病人。

病人的種類和住院老人照會類型差不多，主要是瞻妄(Delirium)改善病人的追蹤、在急診懷疑有明顯的失智症、經常跌倒在等候門診期間恐怕不安全者、多藥物使用可能可以調整者等。在台灣，因為急診後很快就可以預約門診追蹤了，在效率上可能是不錯，但周全性是有待加強。

第十章　社區健康中心(Community Health Center, CHC)

如我們的衛生所一樣，呈地區性的分布，但這個組織提供除了精神疾病以外的社區照顧，涵蓋嬰幼兒、青少年、父母親、及老人等。所以青少年門診，初為人父母之教室等，相當方便及實用。但特別不同的是，除了傳統的醫護人力外，其他醫療人員也一應俱全，如復健師、營養師、社工人員、個案管理師(case manager) 等，真正提供周全性之評估與治療，使得出院回家之病患，或居住社區之病患，得以減少入院治療之機會，不只是老人，需要特殊語言復健之小孩，中心也可以提供。而需進一步評估的個案，如果沒有他自己的家庭醫師，可以轉介給溫哥華的特約社區家訪醫師進行家訪，若需要更進一步評估，可以轉介老人短期評估治療中心。同時，中心也結合社區資源，提供老人就診陪伴或採買日常用品等，可說是多功能的服務。

第十一章 社區精神疾病小組(Community Mental Health Team)

這個地區性的組織只掌管精神疾病，包括成人精神疾病及老人精神疾病的基層治療中心，內有藥局、門診、治療室、活動室等，中心主任是社工人員，其他成員包括醫師、護理師、個案管理師等，也提供精神疾病患者之出院追蹤及居家訪視等。 負責老人精神疾病是中心裏獨立的一組人，以組內受聘兼職家庭醫師為主，老人精神科醫師為輔的團隊照顧，提供診治、處方、追蹤、轉介之服務，轉介可以是老人精神科病房、短期評估及治療中心、急診室、老人日間活動中心、緊急庇護中心(可暫時或隔夜留置，待穩定時再決定處理或安置)，可說是一應俱全。

第十二章　其他

傷口照顧護士(Wound care nurses)

傷口照顧護士是由兩名兼職護士負責全院的傷口照顧，一位負責內科系，一位負責外科系，主要接受腸造口及褥瘡之照顧，不同階段的褥瘡,使用不同的藥材,以促進傷口的癒合，這是一項很專業的照顧，只是不幸的是病房護理人力很少，病人又鮮有家屬或看護員照顧，成效難免會打點折。但是這種專業護士照顧的觀念，在臨床教學及服務上相當有用，不但有可以諮詢指導的人，也可以提供教育一般護理人員的人才，值得引用。

急診部

此間的急診部，效率不如台灣，病人進了急診室等了 1~2 小時才看到醫師是司空見慣的事，除非是大出血等生命攸關的急症，等是一件常見的現象，如果說到人性化,台灣的醫療可說是人性化得多，加拿大的醫療重視的是最終目標，如：等待若沒有提高死亡率，就讓病人等待,而不增高醫療人事成本以使動線快速，也不特別在意病人在等待中的不適(suffering) 。 但是一般加拿大人很少跑急診，除非很及很嚴重才去，他們自己都有家庭醫師，家庭醫師的護士，也可以先協助病人第一線的電話諮詢，在預約門診前協助病患，同時大家有共識，去急診也急不起來，所以真是急症才會出現了。

第十三章　心得

1. 有關長期照護台灣與加拿大之比較請參閱拙作(附件一)
2. 老人照顧分為急性與慢性照顧，急性照顧以醫院內或第一線基層醫師照顧為主，國內老人照顧因國內醫療體制的關係，分散在各科中，國外以家庭醫師為骨幹的照顧，方便達成周全性照顧之目標，同時各級醫療單位均有，互動良好，有利於各級老人之照顧；所需之各項專業人力都共同配合，形成團隊；非專業人力資源，垂手可得。要發展老人照顧體系，必須全盤規劃，從政策上去推動，釐訂責成單位，作跨部會間的討論及整體的配套措施，
3. 老人的急性照顧，醫師更應重視周全性評估，即看病的品質。其實，一般的病人照顧也應如此，只是老人常有很多的疾病，或少報症狀(如尿失禁、行動力差、憂鬱等)或歸因於老化，或較少利用醫療資源等，使得周全性的評估更形重要。而過去次專科化以器官為導向的看病法，及健保制度原本的論件計酬，現在雖改為總額預算制，但因大家仍積極爭取配額量大，醫院也要求績效，一樣是在人次上的要求，品質好的耗時多的變成績效所不容，健保依舊耗費金錢，民眾更得不到好的醫療照顧，更遑論耗錢耗力的老人照顧了。國家政策、健保支付、醫師素養、民眾教育，是該整合改革的時候了。

4. 雖然中國人固有的家庭觀念傾向於由子女照顧老人，但隨著與子女同住比例降低、 兒女數較少、 兒女大多上班、而城鄉差異大也讓鄉村老人很難融入都市兒女的環境中，使得正式家庭照顧逐漸萎縮，即便政府開放外勞照顧政策沒有改變，也要顧及沒有經濟能力或獨居老人是否有能力負擔及是否能得到合宜的照顧，故而公營或有補助(subsidy)之社區形態或機構照顧應該要發展。

十四章　建議

1. 老人照護不只是醫療問題，更是社會問題，同時需考慮財政支應，老人畢竟是較弱勢的一群，缺乏生產力與經濟能力，也缺乏獨立性，規劃未來二、三十年的老人問題，須從現在就起步。否則政府沒有政策，將來只有犧牲老人權利福利，有錢的老人較沒問題，沒錢的老人或是家庭(兒女等)經濟不好的恐怕不是被棄養就是提早死亡 老吾老以及人之老，必須要有所準備。
2. 設立老人政策負責單位，隸屬於行政院，參與單位包括：財政部、經濟部、衛生署、健保局、社會局、建設局、醫師公會、老年醫學會、精神醫學會、長期照護協會、護理師公會、治療師公會、營養師公會、藥師公會、心理師公會等、各層級(安養、養護及護理之家)長期照護單位代表。並確立社區形態之公營長期照護單位在省市立醫院或衛生所，及明定權責。
3. 老年專科醫師今年開始將有認定考試，未來應在內科及家庭醫學科之下辦理老年醫學專科訓練，而各層級的老人照顧機構也應建立起來，做為訓練之場所。
4. 為提升現有各層級老人照顧機構之品質，最好能由衛生署鼓勵機構與醫院合作，有醫師之定期迴診及其他醫療專業人員

之參與。而各醫院也應設立長期照護部門，管理這些業務。

5. 衛生署應試辦醫院內老人團隊模式，以作為推行之參考。社工人員應常規納入老人照顧之中。

6. 對於長期照顧的老人或機構應加以分級，以便於管理。多層級的機構照顧，也是一種可行的模式。

7. 對於醫師的老人社區家訪應給予健保支付與鼓勵。

8. 以護理師為背景之個案管理師較適合我國國情，單一窗口 (single point of entry) 之個案管理師制度在國外行之有年，如何落實及品質管理應設立標準，也包括課程訓練及實習。

9. 社區老人之居家復健、居家安全評估等要統一由省市立醫院或衛生所負責應明定，並舉辦課程訓練及實習。

10. 其他專業團隊成員，均應擬定訓練計畫。

11. 非專業成員應有所組織， 接受訓練，如一般病人照顧，居家服務等，或鼓勵類似團體之發展，資源統一由個案管理師運用。

12. 健保局應釐定政策，遏止各醫院講求績效，不重視周全性照顧的現象。 醫療院所的腳步是跟著健保走的，應提升每診次之支付數，在限量之門診量上，同時要配套家庭醫師或護理師之線上諮詢，給予家庭醫師周全性照顧之給付增加；次專科醫師

只接受轉介，但轉介的支付大大提高，各醫療院所或個人如有偽造，則吊銷執照五年，再犯則永久取消。全民健保開源不易，若不能自一般照顧中節流，移用到老人身上，恐怕老人的照顧，只是一個紙上談兵的故事了。公醫制度，可能是未來之趨勢。

13.民眾的教育，有關老化時之居所選擇及方式，應及早規劃。

附件一

本文轉載自台灣老年醫學會會訊 2002;47:6-14.

以社區為基礎的老人長期照顧：

加拿大與台灣之現在與未來

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老人長期照顧最重要的是維持他們能獨立自我照顧，而不是為他們做所有的事
---Takako Sodei

長期照顧必須考量在最不限制的環境中，有效及安全的提供需要而適切的照顧
--Ethel L. Mitty

引言

長期照顧是指一個系統能夠: 1) 提供生理心理社會 、靈性及維持性的照顧，2)提供連續性或間斷性的長時間服務，3)為功能上有慢性障礙或瀕臨慢性障礙的人所設計。而功能上的障礙可以是日常生活功能(ADL, activities of daily living)或/及工具性日常生活功能(IADL, instrumental activities of daily living)的部份或全部障礙。

符合上述所指之長期照顧，包括在宅服務及居住照顧。居住照顧(residential care)，依照 Hawes[1] 的定義，是指在社區當中的一個限定空間中，群居兩個或以上的無親屬關係的老人，並提供工具性日常生活功能的協助，如洗衣服、備餐、打掃居住環境、監督按時服藥、提供團體活動及運輸等。居住照顧的範圍相差很大，從最簡單的提供居住空間及一般社交機會到機構照顧都隸屬於其中，而護理之家更是最極致的一端。護理之家提供 24 小時的日常生活功能、行動上、精神上及監督按時服藥的個人及護理照顧，並有物理治療、職能治療、營養諮商等，也提供臨時性非重症的醫療服務[2]。

根據多國的統計資料顯示，大約有 5% 到 8% 的老人需要長期機

構照護，其中 3%到 5% 只需要一般性的居住照顧，2%到 5%需要護理之家的照顧 [2]，老人大多能享有獨立性的健康狀態，只在生命的最後幾年有功能上的障礙而成為醫療資源的顯著利用者。

長期照護的供需之間關係複雜，必須考量脆弱老人(frail elderly)多方面的處境及多元化的問題，而尋求特別設計的長期照護系統。以病人的觀點，生活品質、健康層面、病人自主性是重要的考量，然而，各個病人不同的功能狀態、不同的資源，增加了長期照顧的複雜性。而以照顧提供者的立場，強調由醫療及社工等各種不同專業整合，提供以個人為基礎的團隊周全性評估；專業訓練及個案管理是照顧提供者的兩大重要課題。由健康照顧系統而言，長期照護系統必須能夠涵蓋照顧的連續性、了解急性及慢性照顧的分野、連結個案評估和個案管理；由政府的立場， 降低醫療支出、提供基本照護、根據健康需求重新分配醫療資源、並同時兼顧健康成果(outcome) 及生活品質。要整合長期照顧中的幾個要角: 脆弱老人、家屬、專業工作者、家庭協理員、志工等以符合上述的各種觀點，的確是一件龐大的重任[3]。

加拿大長期照護系統的背景資料

加拿大老年人口占全人口之 12.8% (1998)，老年人口數，估計到 2011 年，將從 1998 年的 360 萬，增加到 500 萬，老年女性人口一向超過老年男性，而超過 80 歲的老老人，將增加 19.3%，其中三分之二是女性[4]。到 2041 年，將有 160 萬 85 歲以上的老人，是 1995 年的四倍[5]。

大部分的老人居住於社區，只有 7% 居住於機構中，而這個比率隨著年紀而增高，占 85 歲以上老人之 40%[4]。老人大多能安享健康生活，只在生命結束前的一段時間，成為有障礙或依賴性的醫療資源顯著利用者。

加拿大將健康照護系統之組織及執行權限劃歸省負責，政府提供部分資金援助。在省衛生政策之下，省立醫院仍持續減少急性及慢性住院病床數，急性照顧及慢性照顧的替代服務需求日益增加，前者源於住院日數的縮短及恢復其照顧之需要，而後者則因為老年人口增加及慢性病床數之減少，因此希望以社區為基礎的醫療照顧能填補這個落差。雖然經濟效率的評估仍有些爭議，但絕大部分的人相信居家

照顧是避免居住於機構中之最好方式[4]。而且能在自己家中安度老年，是絕大部分老人的願望，以社區為基礎的老人家庭服務，提供個人照顧、家庭事務協助、備餐服務等可以避免、延遲或取代昂貴的機構照顧[4]。社區照顧的花費約為長期機構照顧花費 10%，而長期照顧的病床可以留給最需要的、最依賴的老人。卑詩省的長期照顧依照認知力、需求表達力及日常功能狀態分為五級，即個人照顧(PC, Personal care)、中度照顧一級(IC-1, Intermediate care 1)、中度照顧二級、中度照顧三級及延展照顧(EC, Extended care) 。目前約有 15%住在機構中老人，其實可以給予較低級數的照顧服務[6]。

以社區為基礎的照顧應能滿足老人家居的支持需求，可使老人生活的有尊嚴、獨立性、有參與性、並兼顧安全、公平、及減少機構照顧費用支出之考量。理想的老人長期照護系統，應能促進個人的成長，並盡量維持外在資源如居住環境，支持性及醫療系統的穩定性。

加拿大卑詩省的長期醫療照護政策

目前加拿大卑詩省的長期醫療照護政策是以社區為基礎、消費者為中心的照護模式(client-centered model) [4,7]。這個模式之特色為：

1. 長期照顧是社會整體的責任 (Care is the responsibility of the whole society): 老人照顧並不是女性的責任而已，而是社會整體的責任。社區的資源依照老人的需求而取用，包括: 運輸(transportation)、志工陪同購物、送餐到府計畫(meal programs)及家庭協理員服務(homemaker services)等以維持老人盡可能獨立在家中生活。
2. 去機構化(Deinstitutionalization): 工作人員協助老人盡量利用資源, 維持在地老化(aging in place)的構想，政府也希望藉由支持老人的獨立來減少健康支出。
3. 去中央化(Decentralization): 強調社工或護理人員背景擔任之個案管理人(case manager)的判斷，單一窗口的政策，不論在醫院或社區，均能得到良好的服務。這個服務也具有醫院社工與社區個案經理人相互轉介的特色。
4. 健康、社會、及房屋政策整合以周全性的方式提供服務(Health,

social, and housing policies are integrated so that care can be provided in a comprehensive way): 個案管理人負責安排在宅服務(in home support services)、居住服務、特殊支持服務及機構照顧服務。以消費者為中心的照護模式(client-centered model)，病人本身也參與決定接受服務項目的選擇，而不是被動的被安排。

5. 訪視醫師、訪視護士、物理治療師及職能治療師的到府服務使得老人得以在家中接受長期照顧(System of home doctors, visiting nurses, physiotherapists, occupational therapists has made it possible to be assured of receiving long-term care at home.) 社區健康中心內由洽詢護士接案，初步根據問題，安排需要的人員訪視，如:單純傷口護理， 安排居家護理師；若需要進一步評估的，由個案管理人訪視後，視需要安排各種醫療或非醫療人員，提供照顧，若需要進一步老人周全性評估(Geriatric Comprehensive Assessment, GCS)者，可由中心安排家庭醫師作家庭訪視，嚴重需要住院評估或日間病房照顧者，可轉介醫院老人短期評估及治療中心(Short Term Assessment and Treatment Center, STAT center)，老人科醫師或老人精神科醫師則是屬於被諮商的醫師。

加拿大卑詩省的長期醫療照護現況

目前加拿大卑詩省的長期醫療照護系統是由卑詩省健康部(Minister of Health)的長期照護支部(Continuing Care Division)所負責，提供的服務包括[5,6,8,9]:

1. 社區居家護理服務: 提供急性、慢性及緩和醫療照顧。
2. 社區復健服務: 提供評估及治療。物理治療師提供以維持活動性、平衡性為主的治療; 職能治療師提供維持獨立性及照顧性的器材協助等，也包括居家環境安全評估，特別是有跌倒(falls)經驗的老人。
3. 家務服務(homemaker): 提供個人照顧必須的服務(如: 洗澡等)，家庭維持服務 (如: 打掃、協助購物等)，送餐服務等。基本的照顧依據個人收入等級收費，接收政府經濟補助的老人不須負擔費用。
4. 居住服務:依據依賴度等級的不同，提供不同層級的居住照顧服務。
5. 日間活動中心: 提供健康、社交及休閒的場所。
6. 評估及治療中心(STAT Center): 接受轉介，提供日間病房或短期住院之評估與治療，做周全性診斷及治療的場所，配備有家庭醫師、

物理治療師、職能治療師、營養師、活動帶領員等，常規性的經由家庭訪視，了解問題全盤的考量。

7. 喘息服務: 提供照顧者短期休息的機會，可以是居家、日間活動中心或短期機構住院照顧。
8. 機構照顧: 提供依賴大部分專業照顧，或需 24 小時一般照顧的居所。

加拿大長期照護系統的未來

加拿大的長期照護系統相當有組織性，也符合加拿大健康照顧系統的五大原則: 均一性(universality)、可近性(accessibility)、周全性(comprehensiveness)、可攜帶性(portability)、公共管理性(public administration)[10]。但是等待入住護理之家的長期等候期，甚至要半年一年的，不是塞車在急性病房佔床，就是在家中等到更嚴重了送急診，實在有違當初組織完善的美意。據他們專門負責研究這種已經完成本次住院的急性照顧，卻因為社會或經濟因素等，還在急性病房佔床者，稱為‘不適任等級照顧’(ALC, alternative care level) 的人指出，不是護理之家病床不夠，是不適合的老人佔了護理之家的床; 或是功能障礙、醫療問題較嚴重的病人，有些護理之家會以配備人力不足為由拒絕病人，使得有需要的老人進不去。但是問題是我們也的確看到了一方面急慢性病床數一再被削減，另一方面又打算砍居家服務的預算，而居家服務又沒有國家標準，各省因為經費或設計問題, 服務內容不近相同。這些，對於以社區為基礎的老人照顧無異是雪上加霜。

因此，未來的發展，應考慮:

1. 全盤評估護理之家床位之供需平衡問題。

2. 了解護理之家中'不適任等級照顧'的老人數、長期照顧等級及原因等，以使真正需要住院的較嚴重老人得以縮短等床時間，並空出其所占的急性病床。

3. 明確在長期照護等級中，區分出不需要專業護理協助的等級等級，並劃分某些機構擔任照顧，可配置極少的護理人力。

4. 擴大出院前準備單位(Discharge plan unit, DPU)的功能: 卑詩大學附設醫院內的DPU單位負責接受各科病情已穩定但須完整治療的病人，或準備住到機構中但在等床的病人，在此，每個醫師負責的病人較多，人力及場地配置如護理之家一樣，備有活動室、每日活動帶動、物理治療師、職能治療師、營養師等。

5. 應設置國家標準的居家照護準則，以保證社區為基礎的照顧品質。

6. 為維持就地老化，不宜過度刪減居家服務預算。從今年起以三年為目標要刪減公營機構人事的預算40% ；也包括居家照顧，將使居家照護大受威脅

台灣長期醫療照護系統之背景

台灣現有老人比率為8.5% (2000年)[11]，約有188萬老人，65歲以上需要長期照護者有9.1%[11]，估計約有17萬老人需要長期照護。

在台灣，傳統中，大多數子女視照顧父母為己任，大多數的子女認為把父母送到機構照顧是不孝順的表現，同時，老人也不希望被送到機構中照顧。

從古老的時代開始，長期照護就由長子規劃，而由長媳執行，也就是說，男人動腦，女人動手。然而，由於現代老人的教育程度較高及經濟較富裕，相對的自主性及決定性提高， 也比較偏向自己安排自己的生活。依據主計處 2000 年的統計， 58% 的老人與自女同住，只與配偶同住者有 17.4%，獨居者有 16%，後兩者相較 10 年前，分別增加了 2.7%及 2.5%[11]。居住狀況若按教育程度區分，可以發現教育程度較高者與子女同住的比例低於教育程度較低者[11] 。因此，可以想見的未來，與子女同住的老人會減少，三代同堂的情形已不多見，健康老人傾向不與子女同住， 只當配偶死亡或身體變得很虛弱時，才由子女接手。但是現代人因為職業婦女較多，有越來越多的婦女無法待在家中照顧老人，而傳統中媳婦照顧婆婆，媳婦熬成婆後，再由她的媳婦照顧的生命週期循環也逐漸式微，因此，現代的環

境中，一位有工作的媳婦不太可能擔任傳統照顧老人的角色，在家庭的單位裏，下一個順位通常是配偶，如果配偶已逝或雖仍在世， 但健康狀態無法擔任照顧的責任， 便由家中子女，通常是媳婦及女兒們輪流照顧，可是因為子女數減少，要輪流照顧以不太可能，傳統家庭的非正式照顧(informal home care)資源萎縮,使得我們必須正視若要貫徹就地老化的觀念，以社區為基礎的正式居家照顧 (formal home care)必須要開始建立。

不過，有些家庭是雇請陪病員在家中照顧，仍達到家庭照顧的模式。但本地陪病員的工資通常不是一般家庭負擔的起的。在開放外籍勞工照顧依賴性老人的政策後，使得僱請陪病員的工資，降到本地陪病員費用的 1/2 到 1/3，這對大多數家庭來說，是較負擔得起的，其價錢和送到護理之家費用相當或一半，而外籍陪病員既可維持老人就地老化(aging in place)的想法，又可提供其他家務服務，也算是非常實用的資源。

我國正式(formal)長期照護體系尚處於發展階段，長期照護的相關資源與人力處於嚴重不足的困境，長期照護病人較難取得適當之長期照護服務，大部份需要接受長期照護的病人只好留置家中，接受非正式、非專業的家庭照護；或至急性醫療機構接受過度的醫療照護，必要時再另聘照護工，提供生活照護，進而形成醫療資源與家庭照護資

源的雙重浪費；或將長期照護病人送至未立案之療養機構，接受不合品質與人性的照護。深究其原因包括[12]：

1. 綜合性與連續性之長期照護體系尚未建立：長期照護問題是一連續且綜合性的問題，包括社會支持、保健、醫療、復健與財務等服務。目前我國長期照護服務分散於不同之行政與服務體系，綜合性及連續性之長期照護體系尚未建立，且福利的獲得有不同的法源依據。體系的紛歧，往往使得需要醫療照護或生活照顧的老人及其家庭不知所措；且體系間各自發展，不但造成資源重複投資，亦容易形成發展不均與服務斷層等現象。
2. 我國目前針對長期照護特定人力的培訓尚未建立制度：長期照護為一綜合性的服務，其所需的照護人力包括社會服務專業人力、醫事專業人力與生活照護人力，甚至社區內之義工團體與人力資源均需有計畫的培訓與組織。
3. 長期照護費用缺乏制度化之財務來源：目前我國長期照護的主要財源，仍以非正式照顧的家庭為主，全民健康保險僅針對部份慢性病人及需居家照護之病人提供部份給付。社會福利對長期照護之病人，則多以低收入戶為主要的服務及補助對象。我國長期照護的財務制度，尚未健全，有待社政與衛生單位共同研擬，並作整體性之規劃。

台灣長期照護的政策

雖然現有的老人長期照護大多數是非正式的以家庭為單位的照護方式(informal family-based care)，但政府也致力於提供正式的居家照顧， 依照醫政處長期照護的三年計畫，台灣長期照護體系統以「消費者導向」及「就地老化」為規劃理念，以「居家社區是照護為主，機構式照顧為輔」為規劃原則 [12,13]:

1. 建立整合性服務網路:試辦長期照護「單一窗口」制度，成立「長期照護管理示範中心」，建立個案管理制
2. 普及機構式照護設施;
   1) 輔導公立醫院部份病床轉型為護理之家，其所需整修及設備經費，由衛生署每床補助十萬元
   2) 輔導民間設置護理之家:由衛生署補助設備費每床十萬元; 獎勵私立或財團法人醫院附設護理之家或日間照護機構，補助其房舍貸款利息
   3) 推動多層級照護服務模式

   護理之家，可依其意願及服務能力附設日間照護、居家照護、日間照顧或安養機構之服務。安養機構亦得依其意願及服務能力附設護理之家或醫療機構。輔導多層級照護機構建立「個案

管理」制度，以確保病患得到連續性之服務。

3. 充實社區化照護設施

1) 輔導衛生所提供長期照護服務。

2) 輔導各省（縣、市）立醫院辦理居家護理服務。

3) 加強推展居家服務:補助中、低收入戶老人住宅設施、設備之改善，放寬中、低收入戶之標準。

4. 加強長期照護人力培訓: 委託長期照護相關團體或機構,辦理長期照護團隊專業人才培訓計畫，包括醫師、護理、復健、社工人員及營養師等，並建立病患服務員培訓及管理制度。

5. 加強長期照護服務品質及評估，喘息照顧病床設置及補助。

6. 加強民眾長期照護教育與宣導。

7. 健全長期照護財務制度，研擬可能方案， 如年金等。

台灣長期醫療照護現況

1. 非正式的以家庭為單位的照護方式：以配偶照、子女、媳婦照顧為主。
2. 僱請本地或外籍陪病員照顧:符合中國人居家照顧的想法, 尤其僱外籍陪病員照顧, 價錢並不比送到護理之家高。
3. 試辦長期照護「單一窗口」制度，成立「長期照護管理示範中心」，建立個案管理制。
4. 衛生所提供長期照護服務：衛生所人員活動在社區，容易做到主動發掘個案的作用。
5. 社區居家護理服務；依據健保局 1995 年 7 月至 1997 年 12 月，居家照護申報案件的年成長率為 28%，1997 年底之服務人數為 4818 人，推估到 2000 年的成長率 60%，目標服務人數將達 18480 人[12] 。就地老化的理念，必須搭配社區各項服務，才能貫徹以社區為基礎的長期照顧。
6. 社區居家服務; 由社會局提供之居家服務，以家務、日常生活照顧服務、身體照顧服務為主，但一般以低收入戶為主[14] 。
7. 老人文康活動中心: 提供健康、社交及休閒的場所。
8. 老人安養養護機構; 非護理專業照顧為主之機構

9. 護理之家: 護理專業照顧為主之機構， 至 1999 年為止，共有 101 家， 4500 床

10.喘息服務: 每年十天，每天補助 1000 元

台灣長期照護的未來

台灣的長期照護，仍屬於制度建立期，多年來，百家齊放，有實的無名，有名的無實，台灣已步入老化國度，老化速率僅次於日本[12]，應該要吸收各國經驗，好好研擬一套適合的制度，以迎接老化的社會。

因此，未來的發展，應考慮:

1. 結合醫療與社會福利體系，落實單一窗口制度，培訓個案管理人
2. 個案管理人直接配置於醫院及衛生所，醫院個案管理人執行住院病人評估，衛生所個案管理人接受社區醫師、家屬、病人等轉介，執行評估，以安排長期照護服務內容或居住安排等
3. 建立周全性評估團隊: 包括醫師、個案管理人(可由社工人員或護士經訓練而擔任)、社工人員、護士、物理治療師、職能治療師及營養師等於衛生所中、 醫院老人評估及治療中心、護理之家
4. 短期住院或短期日間病房評估及治療中心(Short Term Assessment and Treatment Center, STAT center): 作為接受社區個案轉介，以為進一步評估處理
5. 現有長期照護服務統計，均未列及外籍勞工陪病員之比例、品質、

健康結果或指標、病人或家屬滿意度等，若仍開放外勞陪病員政策，應詳細了解其現況優缺點並正式納入統計，才不會在推估長期照護需求時，高估了機構式或居家照護之比例

6. 培訓老年專科醫師及其他團隊成員在老人照顧領域上的能力。
7. 組織家庭服務員(homemaker)供應系統，備餐計畫等。
8. 研擬健全的老人長期照護財務制度。

結語

由兩國的比較，我們慶幸於傳統的中國人對老人的照顧，分擔了很多國家及社會成本，也使大多數的老人達到就地老化的理想，但事實上過去這些年來，也的確有許多的老人在不合宜的場所，度過他們唏噓的晚年，而隨著老化人口的增多， 社會家庭結構的改變，正式的長期照護組織結構更應該要加緊腳步建立起來。他山之石，可以攻錯，眼見加拿大老人在有組織的長期照護系統下生活，我們故鄉的老人，希望能快快有這樣一天。

誌謝

本文得以完成，特別感謝台大醫院李源德院長、內科部嚴崇仁醫師、家庭醫學部陳慶餘主任的提攜；台大公衛學院賴美淑教授、老年醫學會戴東原理事長、台北縣衛生局李龍騰局長、台北護理學院李世代所長、台大家庭醫學部王維典醫師的協助, 得以如願赴加進修；外子郭中誠醫師，小女若眉，公婆及父母的體諒與鼓勵，郭雅琪小姐、黃志浩先生之支援，及加拿大、台灣所有參與受訪討論人員的熱心，並感謝台大家庭學部林月女小姐在文稿之協助，及慈濟醫學院李燕鳴醫師的邀稿，謹此誌謝。

表一. 台灣及加拿大人口學及健康指標之比較 [11,12, 15,16]

項目	台灣	加拿大
總人口數	22,167,000 (2000)	30,286,000 (1998)
65 歲以上人口比例	1975 3.1 %	8.6% (1976)
	2000 8.5%	12.8% (1998)
男性平均餘命	71.91 (1997)	76 (1996)
女性平均餘命	77.79 (1997)	81 (1996)
每人健康支出	US$ 939 (1997)	US$ 2175 (1997)
健康支出/GDP (%)	5.35% (1997)	9.2% (1997)
未納入全民健保比例	3.96%(1999)	0
65 歲以上居住機構內比例	0.9% *(1996)	7%
65 歲以上接受正式在宅服務比	0.275% * *(1997)	17%
每 1000 人口醫師數	1.19 *** (1997)	2.1
每位醫師服務病人數	837 (1997)	463
每十萬人口老年醫學專科		0.44

* 若以 1997 年所有已立案、未立案長期照護服務機構均計算在內，居住機構內比例為 1.95%。

**由 1997 年居家照護服務人數/ 當年 65 歲以上老人人口計算而得。

若依推估居家服務量，2000 年的居家照護服務人數/當年 65 歲以上老人人口，計算而得比例為 0.98%。

*** 僅指西醫師，由每位西醫師服務病人數計算而得

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Geriatrics Rotation

The geriatrics rotation in family practice is geared to helping the family physician resident learn to effectively manage the frail elderly. This frail population suffers from multiple interacting illnesses with associated social problems. They often require an interdisciplinary team approach, both in assessment and treatment. It is imperative that family physicians learn to access resources in the community to assist them in taking care of these patients. Specific site objectives will be handed out at the beginning of geriatric rotations. However, all family physicians need to demonstrate skills or understanding in the following areas in geriatrics:

1. the doctor/patient relationship
   a) interviewing skills with seniors and their families
   b) caregiver stress
   c) working in an interdisciplinary care team
   d) consent and capacity
   e) ethical issues involved in levels of intervention planing and advanced directives as well as the right to be at risk and the use of restraints

2. the family physician is an effective clinician
   a) the aging process
   b) comprehensive geriatric assessment
   c) geriatric giants (mobility, incontinence, cognitive impairment, medication use, failure to thrive, depression)
   d) health promotion with seniors

3. family medicine is community based
   a) community resources
   b) appropriate use of nursing home facilities and the role of the medical director
   c) guidelines for when to and when to avoid hospital admission

4. the family physician is a resource to a defined practice population
   a) patient, family and formal caregiver education
   b) understanding geriatric health planning for a region

General References:

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Community Geriatric Selective for Medical Students/Residents/Fellows*

Outline of Skill-set attained in this selective:

The medical student will become familiar with, and learn to administer and interpret a number of assessment tools. All of these tools will be useful in the community practice of a Family Physician caring for elderly patients:

1. As a screen for dementia:
   - 3MS (modified Mini-Mental Status Exam)
   - Reisberg Global Determination Scale (to stage dementia)
   - the student will begin to learn to distinguish the different types of dementia and learn how this distinction will have impact on treatment
   - the student will become familiar with the guidelines for assessing dementia set out in the Canadian Consensus Conference on dementia.

2. As a screen for depression:
   - CES-Depression Scale
   - GDS (Geriatric Depression Scale)

3. As a screen for functional assessment:
   - the student will learn the meaning of the terms ADL's and IADL's (Activities of Daily Living and Instrumental Activities of Daily Living), and will learn how to assess these with direct experience under the guidance of an OT and indirectly through interviewing caregivers.
   - the student will be introduced to two or three standard assessment scales utilized to assess and monitor ADL's and IADL's.

4. Gait and balance assessment:
   - the team family physician and the physiotherapist will instruct the student in techniques to assess gait and to correlate findings to etiology.
   - the Berg Balance Scale and Timed Get-Up-And Go Test will be provided as screening tools for assessing the risk of falling.
   - Students will learn about assistive devices available to patients and indications for use.

5. Incontinence:
   - the student will learn how to assess a patient for incontinence, diagnose contributing etiologies, and know indications for specialist referral.
   - the student will become familiar with environmental, chemical and barrier techniques of managing incontinence.

6. Financial and Personal Competency:
   - the student will be introduced to the parameters that comprise assessment for financial and personal competency; and learn about the role of the Office of the Public Trustee.

7. Management of Agitated and/or Aggressive Behaviour in the Demented Elderly (with or without psychosis):
   - the student will be introduced to tools for assessing behaviour problems in the demented elderly; such as utilizing Behaviour Flow Sheets.
   - the student will learn techniques of approaching potentially aggressive patients that will facilitate assessment
   - students will have an opportunity to develop skills to guide environmental management as well as chemical management of aggression.

*complexity of knowledge base and understanding will vary according to level of trainee.

skillsetoutline

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Division of Community Geriatrics

Department of Family Practice
University of British Columbia

Fellowship in Geriatrics (Health Care of the Elderly)

Educational Objectives

The Fellow will demonstrate skills or understand:

I.		The Doctor/Patient Relationship is Central to Care of the Elderly in Family Medicine.
a,c	1.	Communication Skills
a	2.	Interviewing Skills
b,c	3.	Principles of Client Centred Care
b,c	4.	Patient Advocacy
a,c	5.	Caregiver Issues
a		1.5.1 Understanding Family Dynamics
a		1.5.2 Family Caregiver Support
a		1.5.3. Elder Abuse
a		1.5.4. Supporting care staff
b,c	6.	Multidisciplinary Care Team
		1. Roles
		2. Collaboration
		3. Team Communication
	7.	Legal Issues
a		1.7.1 Competency Assessment
a		1.7.2 Guardianship Legislation
a		1.7.3 Testamentary Capacity
a		1.7.4 Informed Consent
c	8.	Specific Ethics Issues
		1.8.1 An Ethical Framework for Decision Making
		1.8.2 Confidentiality
		1.8.3 Advanced Directives

1.8.4 Levels of Intervention
a 1.8.5 Living at Risk
1.8.6 Euthanasia
1.8.7. Restraints

II. The Family Physician is an Effective Clinician
c 2.1. The Aging Process - Biopsychosocial Functional
b,c 2.2. Comprehensive Geriatric Assessment
2.2.1 The History
2.2.2 The Physical Examination
a 2.2.3 Mental Status Examination
2.2.4 Mobility Evaluation
2.2.5 Functional Assessment
2.2.6 Collateral History
2.2.7 Standardized Assessment Tools: Choice & Use
2.2.8 Problem List and Evaluation of Remediability
2.2.9 Negotiation of Treatment Plan with Patient and Family
2.2.10 Intervention and Problem Management
2.2.11 Careful Choice of Investigations

c 3.0 Geriatric Giants
b 3.1. Mobility Failure and Falling
b 3.2. Incontinence
a 3.3. Cognitive Impairment
a 3.3.1 Delirium
a 3.3.2 Dementia and Associated Neuro Behavioral Syndromes
b 3.4. Medication and the Elderly
3.4.1. Compliance
3.4.2. Effective Prescribing
3.4.3. Stopping Medication
3.4.4. Polypharmacy
3.4.5. Iatrogenesis
b 3.5. Failure to Thrive
3.5.1 Differential Diagnosis
3.5.2 ADLs and Evaluation
a 4.0 Specific Psychiatric Disorders
4.1 Affective Disorders
4.2 Anxiety Disorders
4.3 Substance Abuse Disorders
4.4 Psychotic Disorders
4.5 Common Symptoms
4.5.1 Paranoia
4.5.2 Agitation

b 5.0 Specific Medical Problems
- 5.1 Parkinson's Disease
- 5.2 Pulmonary Conditions
- 5.3 Congestive Heart Failure
- 5.4 Musculoskeletal Conditions
  - 5.4.1. Foot Problems
  - 5.4.2. Myofascial Pain Syndromes
  - 5.4.3 Polymyalgia rheumatica
  - 5.4.4. Osteoarthritis
  - 5.4.5. Osteoporosis
- 5.5. Stroke
- 5.6 Decubitus Ulcers
- 5.7 Diabetes
- 5.8 Sensory Problems

c 6.0 Principles of Rehabilitation

b 7.0 Palliative Care

c 8.0 Prevention and Health Promotion
- 8.1 Exercise
- 8.2 Diet
- 8.3 Relaxation

a 8.4 Coping Skills
- 8.5 Health Surveillance
- 8.6 Prevention of Pressure Sores

a 8.7 Assessing Risk

a,c 9.0 Documentation of Findings

III. Family Medicine is Community Based

c 1. Community Resources

a 1.1 Home Care Resources

a 1.2 Mental Health Services in the Community

1.3 Adult Day Centres

1.4 Other Resources

2. Nursing Home Facilities

2.1 Admission Criteria

2.2 Basic Principles of Practice

2.3 The Role of the Medical Director

2.4 Administrative Functioning Within Facilities

3. Acute Care Hospital

b 3.1 Use of the Emergency Room for Seniors
b 3.2 Guidelines for When To and When To Avoid Hospital Admission
b 3.3 Step-down Care Units and Their Application and Functions
b 3.4 The Elderly Surgical Patient

IV. The Family Physician is a Resource to a Defined Practice Population
1. Education
a 1.1 Patient, Family and Public Education
1.2 Bedside Teaching of Students
1.3 Audience Presentation Skills
2. A Research Project
3. Critical Appraisal of Geriatric Literature
4. Literature Review Capabilities
5. The Principles of CQI
b 6. Understanding Geriatric Health Planning in the Region

Note: During the "a" rotation, fellow is expected to have experience, read or do seminars in those areas.
This is to be discussed with primary supervisor at beginning and end of rotation

Legend: 1=emphasized in psychiatry rotation
2=emphasized in geriatric internal medicine rotation
3=emphasized in geriatric assessment and treatment unit (STAT Ctr.)

UBC Department of Family Practice
Division of Community Geriatrics

Family Practice Resident Objectives for Nursing Home Learning

EDUCATIONAL OBJECTIVES:

Family Practice Residents ("students") are expected to master the primary care of all the elderly. Some of the frailest and most medically complex are in long term care facilities. Students can learn a lot from exposure to patients in facilities ("residents"), and from an understanding of the special issues in their care. Existing objectives for community geriatrics in general apply in the facility. These include geriatric assessment, creating a problem list, and the management of common geriatric problems. There are some specific extra components of curriculum to achieve an objective of learning appropriate management of patients in long term care facilities. The present document expands this objective, recognizing that the other objectives for geriatrics apply in facility care as well.

Facility teaching may occur in intermediate care, extended care, special care units, or in facilities encompassing two or all types of units. Ideally, all levels of care would be experienced by the student.

OVERALL EDUCATIONAL GOAL:

A student will approach the care of long term care facility residents as a challenging and interesting professional experience, through having acquired appropriate attitudes, knowledge and skills required for their care following the four principles of family practice.

EDUCATIONAL OBJECTIVES:

A. The Doctor-Patient Relationship is Central to Family Medicine

1. Attitude

   a. A student recognizes long term care facility residents as worthy recipients of excellent care, no less than any other group of people.
   b. A student understands that facilities are home to their residents, and that he respect for privacy customary in a patient's home is necessary.
   c. A student is ready to guarantee residents' rights to informed consent, discussion of care options, least restraint, and other elements of autonomy.

2. Knowledge

   a. A student understands advance directives as normally organized and documented in the facility, including:
      i) degrees of interventions

ii) evaluation of capability to decide
iii) the substitute decision maker
iv) cardiac arrest resuscitation

b. A student appreciates the role of family in resident care, and the relationship of the physician to the family

3. Skills

A student conducts an advance directives interview involving:

a. determining the resident's capability to answer questions
b. informing the resident where appropriate
c. documenting the advance directives
d. discussion with and informing of appropriate substituted decision makers.

B. The Family Physician is a skilled Clinician

1. Attitude

A student understands that the technical aspects of medical care of long term care facility residents may be complex and require significant amounts of time and effort.

2. Knowledge

A student understands and is prepared for issues commonly arising in the RN.MD team setting, including:

a. telephone communication
b. nursing reporting of resident change of status
c. which care provider makes various care decisions, and how this is negotiated.

3. Skills

a. A student demonstrates conduct of a facility visit, to include:

i) determining the problem
ii) accessing the medication list
iii) obtaining collateral history from nursing
iv) determining and conducting appropriate physical evaluation including mental status examination
v) planning, discussing, negotiating and conducting intervention
vi) deciding upon and assuring appropriate follow-up.

b. A student communicates well with nursing staff, including:

i) obtaining a collateral history and nursing's view of the clinical situation

ii) negotiating with other professionals a multidisciplinary care plan and arranging for observation of outcome of interventions
iii) discussing a interdisciplinary care plan in a conference setting.

C. Family Medicine is Community-based

1. Attitude

a. A student appreciates the value of the facility as a resource, and utilizes it only when appropriate.
b. A student recognizes nurses as the primary care providers in facilities, and works collaboratively with them.
c. A student understands that facilities are not acute care hospitals, and respects their technical and personal limitations.

2. Knowledge

a. A student is familiar with and respects any explicit medical standards in a facility, including:

i) documentation
ii) visits and follow-up
iii) physician availability

b. A student demonstrates knowledge of:

i) The organization of the Continuing Care system in the province, including mechanism of referrals to it, and criteria for admission to it.
ii) The levels of care and types of facilities which exist in the province
iii) Appropriate costs of care of facility residents, the sources of funding, and the major players in a facility administration.

c. A student knows the role of the facility medical coordinator, including duties and authority.

D. The Family Physician is a Resource to a Defined Practice Population Skills

A student assures regular self-evaluation of effectiveness of care.

Dr. J. Sloan
Dr M. Donnelly 1997

PROJECT: DEFINING THE CURRICULUM IN GERIATRICS FOR FAMILY PRACTICE RESIDENTS AND FELLOWS.

The main aim of medical education probably should be to ensure that the compleat physician acquires a happy combination of the science and the art of medicine in the service of mankind-Gilchrist AR, "The Compleat Physician, 1963, Lancet, ii, 1-4.

The close-up, reassuring, warm touch of the physician, the comfort and concern are disappearing from the practice of medicine, and this may turn out to be too great a loss for the doctor as well as for the patient This uniquely subtle, personal relationship has roots that go back into the beginnings of medicine's history, and needs preserving To do it right has never been easy, it takes the best of doctors, the best of friends Once lost, even for as short a time as one generation, it may be too difficult a task to bring it back again. If I were a medical student or an intern, just getting ready to begin, I would be more worried about this aspect of my future than anything else. I would be apprehensive that my real job, caring for sick people, might soon be taken away, leaving me with the quite different occupation of looking after machines I would be trying to figure out ways to keep this from happening Thomas, L· The Youngest Science: Notes of a Medicine-Watcher, New York, Viking Press, 1983

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INTRODUCTION

Nowhere in the practice of family medicine is the Doctor-Patient relationship and the art of healing more important than in the care of frail, failing older people and their families. It is a cohort-phenomenon For while the young physician may not recall or appreciate the power inherent in it, seniors well-remember and understand the power of the relationship, and how it is designed to work as a healing force. ***Healing*** comes from the old English word ***haelen***, which means to make or become whole. ***Healing*** has also become associated with restoring health. In addition, the word has to do with integrity, that is, making a person spiritually entire. It is closely related to the word ***holy***, which is derived from the same root. Healing is a process, one to which physicians aspire, both for themselves as vessels through which mercy compassion and healing are dispensed. but also directly for a patient Healing is not an end, but a means.

The words ***patient*** and ***passion*** derive from the same Latin root, meaning to suffer. Therefore, compassion is associated with the doctor-patient relationship The concept of relationship involves a link or bridge between two people. ***Relationship*** is defined as "the state or character of being related or interrelated: a connection by way of relation, kinship, ... [or] affinity." William Osler wrote that the M.D. degree entitles one to a lifelong education in two spheres: 1) medical knowledge and 2) knowledge of oneself.

A "patient" is not, and never was, "a passive recipient of health-care", except in the minds of left-wing ideologues, who now prefer the quaint terms, "client", "consumer" or, worst of all, "customer". Medicare has eroded the Doctor-Patient relationship by interfering with the physician's power to heal. Canards such as "Doctors jealously guard their privileged position" or "They act only to line their pockets" only weaken the physician's capacity to work toward healing. Information is no substitute for knowledge, or the internet would have surely led to the demise of Medicine. One cannot know oneself when one is ailing. When one is heart-sick at the terrible prospect of a potentially life-threatening illness one NEEDS a doctor A doctor for diagnosis and treatment, but mostly a doctor for healing. This is especially true if one is old.

The healing act is one that instills hope. There is the opportunity to apply the principles of Balint, Freeling, and others, principles that are best exemplified in the manner that family physicians practise the art of medicine. If the physician demonstrates that she has mastered the principles of Geriatrics, and the art of healing, she will be far more likely to succeed in this task Healing is based on trust, and trust is based on love. If the physician does not love her patient (and their family) she cannot heal them. In the elderly cohort's belief-system, the permission to heal is a dispensation from the Creator. The physician must proceed humbly, respectfully, and with forgiveness.

Geriatrics focuses on the acute, chronic, and preventive care of older people. Its content includes normal aging physiology, common diseases in the elderly, altered clinical presentations and multiple coexisting problems (mental, physical, and social), altered drug pharmacokinetics and pharmacodynamics, and functional status assessment. An important theme is to counter the common and destructive myths about aging and to promote the positive aspects of aging

The elderly are a unique group They are the survivors. Their self-healing powers are exaggerated as a result. This explains why Geriatric Rehabilitation works better the older the recipient (4). Geriatric Rehabilitation is defined as "the restoration of hope and cope" (5). The student and the teacher of Geriatrics can use it to diagnose depression when that innate hope is absent in a senior

The purpose of this review is to define/refine the Geriatrics curriculum for community residents and fellows in Family Medicine. I propose to examine the Educational Objectives, Goals and Skill-set Attainments that are currently in use in British Columbia, and to make recommendations for the adoption of objectives and goals that will unite our efforts while respecting regional and site-based differences. Another purpose of the project is to identify measurable outcomes in the content and the office-based practice-management of caring for the elderly Will the trainee appreciate the special needs of the care of the well-elderly vs. the primary-care needs of adults? Can the trainee identify who amongst her elderly population is frail, (and who is not), and, amongst those who are frail, who is failing? It is a key to effective medical case-management in the practice of community Geriatrics. How will the trainee design her office-practice so that the special needs of this unique group will remain a rewarding

experience for the patient and his family, and for the physician, and her staff? I hope that we will be able to renew our efforts by re-developing the curriculum. This process should be iterative, based on the principles of quality-improvement (including outcomes-measurement). Then this project will have succeeded. – David Brook.

THE CARE OF THE ELDERLY

The Older Person in the Family Physician's Practice

Most of the older people in a family physician's practice-population are not frail In fact, the role of the family physician is to prevent frailty (q.v.) This is achieved through cultivating an enhanced appreciation for the anatomical and physiological changes that accompany aging, and for a resultant increased index-of-suspicion for potential treatable, preventable and restorable conditions whose prevalence and incidence are increased in this population In addition to ascertaining life-style issues (smoking, hypertension, diabetes, hypercholesterolemia, and family history of heart and stroke disease) the mindful family physician will seize on the opportunity to review the bio-psycho-social elements that accompany aging (see CFPC's "To Care Always..."). She will issue a "Prescription for Health" that lends itself well to the primary care of the well elderly – primary and secondary-prevention programmes (such as osteoporosis-prevention).

The Frail Elderly Patient

A smaller number of patients in the family physician's practice-population who require a consultative-model of care are the frail-elderly They are defined as those seniors whose status quo is at risk of failing, unless a programme of intervention is developed. Who are the frail-elderly? They are those people whose horizons are beginning to narrow, who are beginning to experience the vagaries of dementia, falls, incontinence, behavioural and psychological symptoms of brain-diseases, functional incapacity, loneliness and depression/anxiety. The role of the family physician is to assess frailty, to treat frailty, and to prevent the frail patient from failing (q.v.).

How does a physician identify them in her practice? The key to early-recognition lies in timely ascertainment of the "domains" of frailty – the patient's medical, functional, social and psychological/psychiatric status These domains, in turn are evaluated through the administration of valid reproducible tools that must be easy to administer and brief in the time needed to administer them (see figs. 1 and 2, below).

Figure 1: The domains of frailty

(Draw a Venn diagram of four circles, label one "Medical", one "Functional", one "Social", and one "Psychological")

Figure 2: Tools used in the ascertainment of frailty

• Domain	♦ Tools(s)
• Medical	♦ The Targeted Geriatric Assessment (defined below)
• Functional	♦ The Hierarchy of ADLs (basic, instrumental, advanced) ♦ Gait and Balance ♦ Folstein Mini-Mental Status Exam
• Social	♦ Burden to Caregiver Scale
• Psychological/Psychiatric	♦ Geriatric Depression Scale

Once the physician has established that her patient is frail, the nature of the doctor-patient relationship changes The patient is seen regularly, usually monthly, so that each domain of frailty can be monitored. When one is on the "frailty curve" (see figure 3), one rarely gets off it. Moreover, one is always either getting less frail, or frailer. There is no "in status quo" when one is frail. The diagnose of frailty carries with it a set of expectations, interventions and measurable outcomes that involves the patient, his family, the family physician and her team of consultants.

Figure 3: The Frailty-Curve

(Plot a graph. On the "Y"-axis is the label, "Dependency/Burden to Caregiver" Label it "Log" (log rhythmic) at the top of the axis. On the "X"-axis is the label "Ill-ness", representing the sum of the degrees of difficulties experienced in the 4 frailty domains The curve that one plots is almost horizontal to the "X" access (slightly angled upward) for 90% of the length of the "X" axis Then, at that point, it turns sharply upward, almost perpendicular to the "X" axis

The frailty-curve is designed to show that frail older people fail imperceptibly if one measures the failing only against burden to caregiver or to dependency on others. The only way to identify that a frail old person is failing is to be vigilant, to seek out elements contained in the "frailty-spiral" of failing (see Figure 4)

The Frail, Failing Older Patient

Frail people fail differently than the non-frail. Non-frail old people fail much as middle-aged adults do – through accidents, intercurrent diseases and sudden illnesses and death. Frail people are either failing or recovering – there is no status-quo. Their problems do not present in a "p.r.n." or episodic fashion. It is why they must be monitored or case-managed in a vigilant way, by a physician or visiting primary-care Geriatrics team member, who case-manages them, preferably on a monthly basis. (See figure 5). Figure 4 (below), the "Frailty-Spiral", describes the way in which frail old people fail (and contains the clues inherent in the remedy for failing – Geriatric Rehabilitation, q.v.). By understanding the conceptual basis of Care of the Elderly, Frailty, and Failing, the physician can arm herself with an armamentarium that will assure that no older person becomes frail, or fails, before his time.

Figure 4: How Frail Old People Fail

(Draw a large circle At the top, label the circle with the word "Loss". At "9-o'clock" on the circle, label it "Grief" At "6-o'clock", "Depression"; at "5-o'clock", Disinclination", at "4-o'clock", "Inactivation", at "3-o'clock", "Deconditioning", at "2-o'clock", "House-boundedness", and at "1-o'clock", "Fear/Invalidism".

The clock operates counterclockwise, from 12-o'clock when a frail person is failing It works clock-wise when Geriatric Rehabilitation is restoring "hope and cope", promoting self-healing, and reversing the "death-spiral" It is reflected in the point on the frailty-curve in Figure 3 moving to the right (as a person moves counter-clockwise on the circle) or to the left (as he moves clockwise on the circle)

Through vigilance, and through a process of pattern-recognition, the experienced family physician will diagnose the frailty/failing syndrome in its early stages and will develop a treatment-plan that may involve employing a team of health-care professionals to assist her. These professionals consult to the family physician, who must be the case-manager of the frail-elderly (see fig. 5). Treatment is at-once multi-disciplinary (or multi-dimensional) employing specialized assessment and treatment in the various domains of frailty, but it is also inter-disciplinary (the basis of Geriatric Rehabilitation, q.v.)

Figure 5: The Interdisciplinary Geriatrics Team

Team-member (At-home/ Outpatient)	Assessment/Follow-up	Treatment/Intervention
Occupational Therapist	• Evaluation of Living Skills • Cognitive Competence • Needs-assessment of Aids and Adaptations Home-safety assessment	◆ Recommends preventive measures ◆ Provision of Aids/Adaptations
Physiotherapy	• Gait/Balance assessment • Physical function/ strength/range of motion	◆ Strength/aerobics/flexibility training and education ◆ Treatment modalities (short-wave diathermy, ultrasound, trans-cutaneous nerve stimulation).
Social Work	• Social context for identified-frailties (vulnerability to predation, abuse)	◆ Education, counseling, coaching, connecting
Nursing	• Primary-care nursing assessment (hearing, vision, height, weight, skin, nails, hair, teeth. • Continence, sexual function, medication-compliance) • Delegated tasks (various)	◆ Education (e.g. continence) ◆ Dressings ◆ Skin-care ◆ Nail-care ◆ Medications ◆ Other delegated functions
Nutrition	• Calcium/osteoporosis • Protein-calorie malnutrition • Special dietary needs (caused by medical problem, medications)	◆ Diet-plans ◆ Education
Long Term Care Assessor	• Levels of service	◆ Provision of services ◆ Wait-listing/Respite

Figure 6: the Hierarchy of Preventive Care in the Care of the Elderly/Geriatrics

Definition:	Goal of Intervention: In all events, treat the treatable, prevent the preventable and restore the restorable
Well-elderly	Prevent frailty (case-finding)
Frail-elderly	Prevent from failing, reduce frailty (non-p.r.n. care)
Failing frail elderly	• Prevent premature morbidity • Reduce failing (intensive care)

THE CLINICAL PILLARS OF GERIATRICS

The Comprehensive Medical Geriatric Assessment

Comprehensive Geriatric Assessment is comprised of a thorough medical History and Physical, beefed-up with formal ascertainment of the domains of frailty It is incomplete without a numbered Problem list, and an ongoing Plan of Care Family Physicians are uniquely situated to perform comprehensive assessments on their frail patients through a series of appointments and the adoption of the continuing-consultation model of care No one knows her patient better than the family physician.

The Comprehensive Geriatric Assessment is a protocol that can be broken down into 3 parts:

1) The Targeted History (which emphasizes a search for the common disease-states that cause or contribute to morbidity and mortality),

2.) The Targeted Physical Examination (designed to comfirm or validate clinical suspicions garnered through taking the history); and

3.) The use of specialized assessment tools that are quick, easy and reliable in their application.

The Comprehensive Geriatric Assessment is portable, requiring no special equipment other than what is contained in a physician's medical-bag.

The Targeted History – An Affair of the Heart and the Head

A comprehensive review of The Targeted Geriatrics History brings the aforementioned high index of suspicion for preventability, treatability and restorability to bear on an enhanced accounting of the **Presenting Complaint**(s) (PC or CC). It is, frequently, an affair of the heart and of the head. The experienced physician will have "pre-packaged" sets of data that will aid her in recognizing the common patterns of disease-presentation in the (frail) elderly. These algorhythms are available in the Geriatrics literature. The trainee-physician will arrange the **History of Present Illness** (HPI) in a fashion that permits the natural history of disease-states, their impact on frailty and on failing to come through. An example of this is a review of risk factors for atherosclerosis in a patient who has fallen.

Past Illnesses (PI or PH) records events similar to the standard protocol that every medical student learns Of interest to the seasoned physician will be a history of vascular disease (stroke, heart disease, peripheral vascular disease), risk-factors for vascular disease.

Medications need to be listed (vertically – in order to aid in the search for drug/drug, drug/OTC (over-the-counter), and drug/food interactions.

Allergies, including drug-intolerances.

Immunization status, including influenza, pneumonia and tetanus should be itemized

Functional Inquiry is an inquiry after the functional status of the patient, not a review of systems (q.v) The information can be organized in a hierarchy, starting with basic activities of daily living (bADL) such as dressing, grooming, toileting, dressing, feeding and bathing; instrumental activities of daily living (iADL) such as cooking, laundry, shopping, banking, transportation, wills and estates; and advanced activities (aADL) such as pastimes hobbies and interests such as worship, exercise-groups, and clubs The mindful physician will recognize that functional attainments will be lost in reverse-order, i.e., the advanced activities of daily living will be lost first Any loss may tip the physician to the fact that a well older individual is becoming frail, or that frailty is being complicated by failing

Family History is a key to understanding how a patient has come to the point in his life that he has. A good family history unlocks many doors to understanding the unique way in which a particular person suffers. The seasoned physician will sometimes begin the targeted History with the Family History in order to build the therapeutic alliance. If "the apple does not fall far from the tree" then it is worth learning much about the "tree"! Where a person was born, what their father (and mother) did for a living, how much education the person obtained are really the bare-minimum of information required in order to see that the history is comprehensive. Family history of diabetes, tuberculosis, thyroid disease, cancer, or psychiatric disease-states is also important.

Review of Systems is not a functional inquiry In the elderly, it is a review of common co-morbid disease-states that are associated with aging.

These conditions contribute to frailty, and should be taken into account in order to treat the treatable, prevent the preventable and to restore the restorable aspects of the following· hearing, vision, dentition, diet, sleep, memory, energy, mood, evacuation/continence, gait, balance, falls, faints and fits, chest pain, cough and shortness of breath, nausea, vomiting or diarrhea, sexual activity, lifestyle issues (ethanol, drug-use, smoking, exercise)

In this way, in a mindful way, the complicated multi-system problem, attended by a constellation of complaints will become a puzzle to the physician, one to be put together methodically rather than become a quagmire, a mill-stone around her neck, or a medical albatross/Medusa's head If the physician projects a sense of being overwhelmed, all hope is lost. The therapeutic alliance and the ability of the physician to instill hope will have been for naught.

The Targeted Physical Examination

The seasoned physician will adopt a protocol designed to validate or to confirm findings/suspicions developed in the targeted Geriatrics history

A **physical examination** is a physical examination is a physical examination, but the intent of a targeted Geriatrics physical examination is altered in order to identify co-morbid disease-states, their preventability, treatability, and restorability

Physical Appearance can reveal much – a comment about a patient's hair, skin, nails and teeth, as well as a comment about the presence of any disorder of thought-content, congruence of mood, word-finding difficulties, or the like, can "tip" the examiner to the need for more specialized tests that she may wish to perform at another time

Vital signs provide useful baseline data against which to compare the effects of either the natural history of a disease state and its treatment, or to establish a pattern that demands further evaluation. It should include height, weight, pulse rate, and lying and standing (after at least 1 to 2 minutes) blood-pressure. The importance of postural hypotension accompanying drug-therapy is a good example of why obtaining and recording this data is important.

Head and neck examination targets the ear (including looking for treatable coincident conditions such as Otitis externa) the eye (cataracts, macular disease, blepharitis) the nose (atrophic oro-rhino-pharyngitis) and the throat (oral health, palato-pharyngeal/speech and swallowing/gag-reflex). Another area particular to the elderly is the search for carotid and vertebral bruits, and the examination of the thyroid. Finally a comment about the presence of lymph nodes or a sentinel-node is appropriate, above and beyond the non-targeted physical examination of the head and neck.

Chest examination might add a comment about the presence of dorsal kyphoscoliosis/presence of the markers of osteoporosis

Cardio-vascular examination targets atherosclerosis. Peripheral pulses and capillary filling-time of the extremities in particular might give some insights into the corresponding micro-circulation of the brain The presence of varicose veins/venous insufficiency is important for increasing opportunities for secondary preventive measures. Jugular venous pressure is easier to perform on seniors, owing to the loss of subcutaneous fat. Especially

important in the targeted examination is the search for (auscultation, careful palpation) of an abdominal aortic aneurysm, and the presence of bruits in the renal arteries or the inguinal arteries. The presence of the murmur of aortic sclerosis is common in the very old.

Abdominal examination targets aneurysm, and presence of supra-pubic abnormalities (atonic bladder) otherwise is no different than the ordinary physical examination of the abdomen.

Genito-Rectal examination reflects the high incidence of disease-states in the elderly In female patients, there should be a comment about whether there is any evidence of atrophic mucosal linings, skin diseases of the vulva, and architecture of the bladder and soft tissues. A comment about pelvic-floor integrity and demonstrable presence of stress incontinence is worthwhile. The rectal examination is no different from the untargeted examination, except that it should be done regularly on the elderly-patient. In males the digital-rectal examination of the prostate is the same as for younger patients. Examination of the penis and testes should include a search for carcinomata of the skin, the presence of balanitis/phimosis/epididymitis, etc

Neurological examination is perhaps the most important part of the whole examination of the elderly frail patient. (please see separate article, attached).

Musculo-Skeletal examination targets osteoarthritis, gait-disorders due to mechanical problems of the feet, legs, hips or spine, presence of soft-tissue diseases (tendonitis, bursitis) in joints and various bursae, and deformity (including Paget's disease).

The ***Numbered Problem-list*** is designed to function as a working-document for the family physician. It need not necessarily be rank-ordered It assists in tying together the medical functional social and psychological contributors to frailty. The list is not a list of diagnoses, though it may contain diagnoses. It also alerts the physician to the presence of any and all factors that contribute to frailty, and which need to be factored in to any planned interventions (such as medications that might have an impact on something else on the problem-list.)

The ***Plan*** hearkens to the problem-list. It serves as a work-sheet for the busy family physician, a point of reference in the management of the multifarious and diverse needs of the frail older patient. Figure 6 provides an example of a working-document for managing frailty in a primary-care setting.

Figure 6: An Example of a Working Problem-list and Plan

Problem	Plan	Prevention
Osteoporosis (BMD – and hx of #)	Fosamax 80 mg 1x/wk	Calcium 1 g. OD Vitamin D 1000 i.u OD
Osteoarthritis	Tylenol ES 11 po QID	Exercise group 3x/wk
Dementia ?vacular	Baby ASA, trial of Aricept 5 mg. po OD	Avoid NSAIDS/GI bleed
UI/urge incontinence	Kegel's/education/detrol	Avoid Ditropan/cholinergics hard on #3
Hypertension	CaChBlocker/ACE inhibitor diuretic	Watch serum Na+ (diuretic plus SSRI)
Depression (stroke-associated?)	SSRI – Celexa (gradual increasing – 10 mg. po OD	Serum Na+ GI s/eff with Aricept?

Specialized Measurement Instruments in Ascertaining Frailty

The scales in Figure 7 can be used by family physicians to objectify frailty, to monitor the effects of interventions/therapies, and to assist in the case-management of frail older patients They can also be used to characterize the degree to which an older person is failing. When used in concert, the mindful physician will be able to add a degree of specificity to her level of sensitivity-to-change in her patient, a key issue in the timely management and treatment of new diseases complicating the old (or known) ones.

Figure 7: Specialized Frailty-Assessment Tools

Name of Tool	Domain of Frailty
Folstein Mini-Mental Status Exam	Cognition/Function
Geriatric Depression Scale	Psychological/Psychiatric
Zarit Burden-to-Caregiver scale	Social/Psychological
Tinetti Gait and Balance scale Timed Up-and-Go test (TUG)	Function

These tools do more than afford the chance to establish a baseline level of frailty and failing, and the opportunity to monitor change in a measurable way A glaring discrepancy, for example, between the Folstein and the Zarit may point to a patient who is suffering from an atypical dementia. like Lewy-body disease or one of the Fronto-temporal lobe dementias In this way these tools can serve as diagnostic tools

Geriatric Rehabilitation

Geriatric Rehabilitation is a specialized programme of rehabilitation, out-patient or in-patient, that is designed to reverse the Frailty-spiral (figure 4). Invalidism and disinclination, inactivation and deconditioning, houseboundedness and social and psychological inertia are combated by the patient's participation in a programme of purposeful activity that instills hope It is fun. It is carried out with his peers. It is a deliberate act to restore the powers of self-healing contained in the patient. It works best in those who have normal cognition, or, at worst. mild dementing diseases.

Geriatric Rehabilitation is best done in a dedicated location with a dedicated staff well-versed in the particularistic aspects of their discipline (Physiotherapy, Occupational Therapy, Nutrition, Social Work or Nursing), as well as in the generic tenets of Geriatric Rehabilitation (the instillation of "hope and cope", q.v)

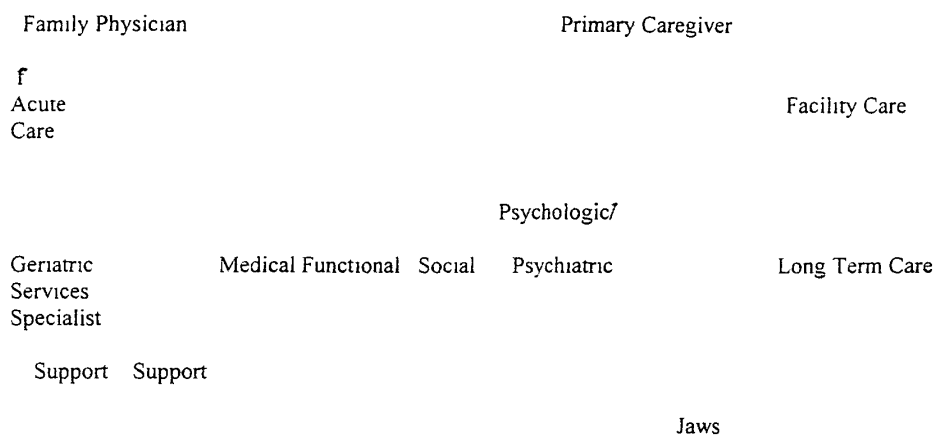
Hope. More than half of patients say their health-care providers stripped them of hope Research into the significance of hope is growing, and it has been shown to prolong lives, increase quality of life and to enhance adherence to treatment plans (7). Geriatric Rehabilitation has to add meaning to life in order to work It overcomes loneliness, meaninglessness, lassitude and inertia. The momentum it generates has to be carried over into programmes for the frail elderly that are designed to maintain functional social and psychological momentum. These maintenance programmes must, in turn, be regular purposeful and fun to attend

Cope. A targeted programme of strength-training, of increasing aerobic capacity, and of improving flexibility overcomes the physical limitations associated with Failing. It overcomes the fear of falling, it restores confidence, general strength, and physical conditioning in generating the physical social and psychological momentum necessary for reducing or reversing Failing in the presence of Frailty

Case-management of the frail failing older patient and his family.

The family physician plays the pivotal role in case-managing her frail failing older patient and his family Unless an agreed-to set of standards of practice is adopted, the complex system of services that has developed to serve this population will not cohere Figure 8 (below) attempts to schematize the idealized system of care needed to meet the special needs of this population-cohort. At present, deficiencies can be identified, in that unless the designated primary care giver and the physician are in close communication, precious resources may be superfluous or redundant. The family physician must assume the leadership role if resource utilization is to be rational It is incumbent upon the funding agencies to ensure that family physicians be appropriately remunerated if the system is to function optimally.

Figure 8 – Constructing the "Bridge Over Troubled Waters"



The "Bridge Over Troubled Waters" attempts to portray how informal and formal supports can be employed in order of increasing need (in the direction of the arrows), and how the Frail Failing older person needs a Family Physician and a primary care giver, each of whom is in close-touch with the older person and to each other, in order to maintain the integrity of the status-quo. Geriatric Services exist to support the Family Physician through the provision of specialized Geriatric Evaluation and Management. Long Term Care services exist to support the patient and his primary care giver and are available without a physician's referral. If each stakeholder does his part, the Frail, Failing older person can avoid premature placement, untimely hospitalization and the vagaries and indignities of preventable morbidities

The family physician must learn to apply the fee-for-service model of care to a special population of seniors, a population with special needs that requires special skills, talents and much time. There are no short cuts in exemplary care of frail failing older people and their families The frustration that young physicians feel in caring for the multifarious needs of the elderly is entirely understandable.

Figure 9 (below) lays out how a family physician might typically bill for the completion of a Comprehensive Geriatric Assessment of a frail older person over 70.

Figure 9: Sample Billing Schedule for Comprehensive Care of Frail Older Patients

Visit #	Time (min)	Code	Amount billed (approx.)	Description of work done
1	15	13100	$30 52	Chief Complaints, History of Present Illness, Folstein MMSE (if any question of dementia). Family History.
2	30	13101	$67 86	Targeted Physical Exam
3	15	13107	$30 52	Past Illnesses, Functional Inquiry, Review of Systems
4	15	13107	$30 52	Allergies, Immunization Status, Folstein, GDS, Zarit (to family, waiting)
5	20	13120	$53.11	Family Conference, Problem List, Plan, Laboratory Investigation
6	15 (monthly)	13100	$30 52	Regular Frailty Management – Weight, lying and standing BP, medication review, functional capacity review. Work through working-problem-list. Phone-calls.

TOTAL				
6 visits	2 hours		$243 05	**Comprehensive Geriatric Assessment and Management**

The Geriatric-care physician/family physician will have learned to order the recording of the information garnered in the above fashion in a protocol-fashion. She will have formulated a numbered problem-list, and a working-plan that aims to treat the treatable, prevent the preventable (primary and secondary prevention) and restore the restorable elements in the domains of a patient's frailty. She will have enlisted the support of an informal "team" of caregivers (who, ideally, will be appended to the practice, rather than constituted otherwise. In other words a district-nurse will cover several family physicians' practices, as will the other services provided by the Long Term Care programme)

Monthly review can assure that medication use and compliance is reviewed, that the plan of care is monitored, that iatrogenesis is minimized or avoided, and that the physician is remunerated fairly for his work and for his special skills in case-managing the frail, failing older people in her practice. The total-cost of 1 year's worth of monthly visits ($366 00) pales in comparison to the cost of one visit to the Emergency Room. Non-p r n. care of frail failing older people empirically and anecdotally saves the system money, and spares the patient the indignity and upset of a lengthy visit to the Emergency Room or other expensive-care facilities.

APPENDIX I: CORE EDUCATIONAL OBJECTIVES FELLOWSHIP IN GERIATRICS/CARE OF THE ELDERLY

Division of Community Geriatrics
Department of Family Practice
University of British Columbia

Note: The objectives listed below can be met in either Horizontal Elective format, or in a Vertical (Block of time) format Extended objectives follow, and are perhaps better suited to the longitudinal format.

1. The Doctor/Patient Relationship is Central to Care of the Elderly in Family Medicine

1.1 ***Communication Skills***

- 1.1.1 Building the Therapeutic Alliance
- 1.1.2 Compassion, Caring, Competence, Courteousness
- 1.1.3 Touching the patient
- 1.1.4 Projecting an attitude of sure-footedness, interest in the special needs of seniors and their families
- 1.1.5 Instilling hope as part of the healing act

1.2 ***Interviewing Skills***

- 1.2.1 Attention to hearing, vision
- 1.2.2 Flexibility vs. Attention to protocol in gathering information
- 1.2.3 Open-ended questions, paraphrasing, reflecting
- 1.2.4 Intergrating bio-psycho-social elements
- 1.2.5 Corroboration in the event of unreliable testimony

1.3 ***Principles of Patient-Centred Care***

- 1.3.1 Appreciation of and for "the Continuing Consultation"
- 1.3.2 dynamics of the Doctor-Patient relationship
- 1.3.3 open-ended questioning
- 1.3.4 autonomy/right to fail
- 1.3.5 information/knowledge/wisdom
- 1.3.6 directive/supportive/coaching/promoting styles

1.4 ***Patient Advocacy***

- 1.4.1 defending the rights of those unable/incapable
- 1.4.2 defending individuals in the population
- 1.4.3 defending independence of ideas/freedom of thought
- 1.4.4 defending the idiosyncratic or unpopular question(er)
- 1.4.5 examine critically the ethics of new models of practice
- 1.4.6 defend our personal covenant with patients to consider the costs for individuals and society of the decisions we make.

1.5. ***Caregiver Issues***

- 1.5.1 Understanding Family Dynamics
- 1.5.2 Family/Caregiver Supports
- 1.5.3 Elder Abuse/Assessment and Management
  - a) resources in the community
- 1.5.4 Supporting Care Staff at home or in a facility
  - a) roles/responsibilities
  - b.) physician as clinical expert
  - c.) physician-as-educator

1.6. ***Multidisciplinary/Interdisciplinary Care***

- 1.6.1 Roles
  - a.) as a consultant in a specialized domain.
  - b) as a team-member in individualizing a programme of Geriatric Rehabilitation for a patient and his family.
  - c.) as a participant in development of educational/research programming and development.

1.6.2 Collaboration
- a.) information management in case-managing
- b.) population-based approach to managing data in identifying trends in a community/locale

1.6.3 Team Communication
- a.) developing a common language/database
- b) legal aspects
- c) remuneration strategies for fee-for-service physicians

1.7. Legal Issues
- 1.7.1 Competency Issues
- 1.7.2 Guardianship Legislation
- 1.7 3 Testamentary Capacity
- 1.7 4 Informed Consent

1.8. Specific Ethics Issues
- 1 8.1 An Ethical Framework for Decision-Making
- 1 8.2 Confidentiality
- 1 8 3 Advanced Directives
- 1 8.4 Levels of Intervention
- 1 8.5 Living at Risk
  - a.) The "Right-to-Fail"
  - b.) The "Uninformed "No" – refusal to accept needed services to minimize threat to independent living or to the status-quo (usually but not always in dementing patients).
- 1 8.6 Euthanasia
- 1 8.7 Restraints (Physical, Chemical)

2. The Family Physician is an Effective Clinician (in Care of the Elderly and in Geriatrics)

2.1 The Aging Process – The BioPsychoSocial and Functional Model

2.2 The Comprehensive Geriatric Assessment
- 2.2.1 The Targetted Geriatrics History (see page 6, above)
- 2.2.2 The Targetted Geriatrics Physicial Examination (see page 7, above)
- 2.2.3 The Mental Status Examination (includes the Standardized Mini-Mental Status Examination)
- 2.2.4 Standardized Tools in Assessing the Domains of Frailty
- 2.2.5 The (vertically-numbered) Problem List
- 2.2.6 Development of a Working Plan for the Continuing Consultation model-of-care (non-"episodic"/non-"PRN" model)
- 2.2.7 Negotiating Treatment/Care goals with patient/family
- 2.2.8 Intervention and Problem management (non-prn care, information-management with other agencies)
- 2.2.9 Evidence-based Investigation/Treatment/Management

2.3. Geriatric Giants
- 2.3.1 Mobility Failure, and Falling
- 2.3.2 Incontinence
- 2.3.3 Cognitive Impairment
  - a.) Dementing Illnesses
- 2.3.4 Behavioural and Psychological Symptoms of Dementia
- 2 3.5 Evaluating Living-skills, and testing cognitive competency
- 2.3.6 Medications and the Elderly
- 2 3.7 Compliance/Adherence
- 2.3.8 Effective Prescribing (Pharmacokinetics/Dynamics)
  - a.) Stopping/Withdrawing Medications
  - b) Polypharmacy
- 2.3 9 Iatrogenesis (Chronic Pain, Insomnia, Somatization)

2.4. Failure to Thrive

2.5 Differential Diagnosis

2.6 ADLs and Evaluation

2.7 Dematological conditions

2.8 ***Specific Psychiatric Disorders***
- 2.8.1 Affective Disorders
- 2.8.2 Anxiety Disorders
- 2 8.3 Substance Abuse Disorders
- 2.8.4 Psychotic Disorders
- 2.8.5 Common Symptoms
- a.) Paranoia
- b.) Agitation Problems

2.9 ***Parkinsonism and Parkinson's Disease***

2.10 ***Respiratory Conditions***

2.11 ***Cardiac Conditions***

2.12 ***Musculoskeletal Conditions***
- 2.12 1 Foot Problems
- 2.12.2 Pain Syndromes
- 2.12.3 Polymyalgia Rheumatica/Giant-Cell Arteritis
- 2.12.4 Osteoarthritides
- 2.12.5 Osteoporosis

2.13 ***Stroke***

2.14 ***Decubiti***

2.15 ***Diabetes***

2.16 ***Hearing/Vision/Olfaction/Deglutition/Evacuation***

2.17 ***Principles of Geriatric Rehabilitation (p. 10)***

2.18 ***Principles of Palliative Care/ End-of-life issues***

2.19 ***Primary/Secondary/Tertiary Prevention in Family Medicine***
- 2 19 1 Exercise
- 2.19.2 Diet
- 2.19 3 Smoking
- 2.19 4 Cancer
- 2 19 5 Screening/Case-finding
- 2.19.6 Lifestyle Modification
- 2 19 7 Assessment of the Well-elderly, the Frail, the Failing older person

2.20 ***Documentation and Information-Management***
- 2.20.1 The Health-record as protocol (problem-list, plan)
- 2.20.2 Identifying practice's population-at-risk
  - a) Immunization
  - b.) Mammogram
  - c) DRE/PSA testing
  - d) Weights/lying and standing BPs
  - e.) Individualized Baseline and follow-up indicators

3. The Family Physician is Community-based

3.1. ***Education***
- 3 1 1 Home Care Resources
- 3.1.2 Mental Health Services in the Community
- 3.1 3 Adult Day Centres
- 3 1 4 Facility-care
  - a.) Assisted-Living
  - b.) Skilled Nursing Facilities
    - Admission Criteria
    - Basic Principles of Practice, Including establishing baseline status, global deterioration scales, case-management
    - Managing acuity
    - DNR/levels of intervention
    - Role of Medical Coordinator
    - Administrative Issues

3 1.5 Other resources
- a.) Drug and Alcohol treatment

3.1.6 Specialized Geriatric Services
- a.) Outpatient Assessment and Rehabilitation
- b.) Inpatient Assessment and Rehabilitation
- c.) Acute-Care consultation/liason
- d.) Domiciliary Visiting
- e) Other

3 1.7 Acute Care Hospital
- a) Tertiary Prevention
  - "Hazards of Hospitalization"
- b.) Emergency Room and Seniors' Health
- c.) Avoiding Hospitalization/Alternatives to Admission to Acute-Care
- d) Subacute/Stepdown/Geriatric Units – role and function, how to access/manage care
- e.) The Elderly Surgical Patient
- f.) Delirium-Care (prevention and management)

4. The Family Physician is a Resource to a Defined Practice Population

4.1 Education
- 4.1.1 Patient, Family and Public Education
- 4.1 2 Bedside Teaching of Students
- 4.1.3 Audience-presentation skills

4.2 Research Project

4.3 Critical Appraisal of the Geriatric Literature

4.4 Literature Review Capabilities

4.5 The Principles of Continuous Quality Improvement

4.6 Understanding Population Health/Epidemiology/Planning in the Region

THE GERIATRICS ROTATION FOR FAMILY MEDICINE TRAINEES

The Geriatrics rotation in family practice training programmes is geared to help the family medicine resident learn to manage the needs of frail failing older people and their families effectively This frail population suffers from multiple interacting illnesses with associated social and psychological problems/implications These often require and interdisciplinary team approach to assess and to treat (including preventing the preventable elements, treating the treatable elements, and restoring the restorable elements inherent in the disease-state. It is imperative that family physicians learn to access resources in the community, in order to employ them in helping the family physician in taking care of the special needs of this special group of patients Specific site objectives will be handed out at the beginning of the Geriatrics rotation; however, all family physician-trainees need to demonstrate skills or understanding in the following areas.

1.) ***The Doctor/Patient Relationship:***

- 1 1 appreciation and understanding of the Therapeutic Alliance. the power to instill hope, and the power of hope in the healing process.
- 1.2 interviewing skills with seniors and their families (awareness of aids to improve communication (e.g. giving seniors the benefit of the light in the room, speaking slowly and clearly, shaking hands, body-language)
- 1.3 working in an interdisciplinary care team
- 1.4 appreciating consent-issues and capacity
- 1.5 ethical issues, degree-of-intervention planning/advance-directives, right-to-fail, avoiding restraints, end-of-life issues, late-failure dementia-care.

2.) ***The Family Physician is an effective clinician:***

- 2.1 mastery of assessment of the aged, of frailty, and of failing.
- 2.2 comprehensive Geriatric Assessment
- 2.3 assessment of the Geriatric Giants (mobility, incontinence, cognitive impairment, medication use, failure-to-thrive, depression, BPSD
- 2.4 Geriatric Rehabilitation (preventing the preventable, treating the treatable, and restoring the restorable elements of frailty/failing including "hope and cope"

3.) ***The Family Physician is community-based:***

- 3 1 learning how to harness appropriate and available community-resources, in a timely manner
- 3 2 mastering the appropriate employment of facility-services (assisted living, skilled nursing facilities); understanding the role of the medical coordinator/director
- 3.3 applying guidelines for when to (and when to avoid!) admitting to hospital

4.) ***The Family Physician is a resource to a defined practice population***

- 4.1 Educating the patient, the family, and the formal caregivers (dementia-care, Behavioural and Psychological Symptoms of Dementia (BPSD).
- 4 2 Regional Health planning for populations (e g., immunization policy)

General References:

1 Sloan, J "Protocols in Primary Care Geriatrics", Springer-Verlag, publishers

2 Woerden, W "Grief Counselling and Grief Therapy: A Handbook for the Mental Health Practitioner", Springer Publishing

3 "The American Psychiatric Press Textbook of Geriatric Neuropsychiatry", Ed. By Coffey and Cummings. Publ by the American Psychiatric Press, Inc

4 Cummings et al "The Merck Manual of Geriatrics", 3d Ed., 1999

FAMILY PRACTICE RESIDENT OBJECTIVES FOR GERIATRICS ROTATION

UBC DEPARTMENT OF FAMILY PRACTICE,
DIVISION OF COMMUNITY GERIATRICS

("Objectives, Attitudes, Knowledge, and Skills" or "OAKS" format)

Educational Objectives:

The Geriatrics rotation in family practice training programmes is geared to help the family medicine resident learn to manage the needs of frail failing older people and their families effectively. This frail population suffers from multiple interacting illnesses with associated social and psychological problems/implications These often require and interdisciplinary team approach to assess and to treat including preventing the preventable elements, treating the treatable elements, and restoring the restorable elements inherent in the disease-state. In taking care of the special needs of this special group of patients, it is imperative that family physicians learn to access resources in the community. Specific site objectives will be handed out at the beginning of the Geriatrics rotation; however, all family physician-trainees need to demonstrate skills or understanding in the following areas:

Overall Education Goal:

A trainee will approach the care of the frail failing older person and his/her family as a challenging and interesting professional experience The trainee will have acquired the appropriate attitudes, knowledge and skills required to meet the special needs of this unique population in his/her practice, through the implementation of the four clinical pillars of Family Medicine.

Educational Objectives:

1. The Doctor-Patient Relationship is Central to Family Medicine

1.1 ***Attitude***

- 1.1.1 A trainee recognizes frail failing older people as being worthy recipients of exemplary care, as having needs requiring a special body of knowledge/expertise
- 1.1.2 A trainee understands the phenomenology of aging, of loss, of the need for autonomy, for self-determination, and for privacy.
- 1 1.3 A trainee is ready to guarantee patients' rights to informed consent, discussion of care-options, the right to fail, and other elements of autonomy.

1.2 ***Knowledge***

- 1 2.1 A trainee understands advance directives of care in her practice, including:
  - a.) degrees of intervention
  - b) evaluation of capability to decide
  - c) the substitute decision-maker
  - d.) cardiac-arrest resuscitation
- 1 2 2 A trainee appreciates the role of family in the care of the frail/failing older person, and the relationship of the physician to the family

1.3 ***Skills***

A trainee conducts an advance-directives interview involving

- 1 3.1 determining the patient's capability to answer questions
- 1.3.2 informing the patient, where appropriate
- 1 3.3 documenting the advance directive
- 1.3.4. discussion with and informing of appropriate substituted decision-makers

2. The Family Physician is a skilled Clinician:

2.1 *Attitude*

A trainee understands that the technical aspects of care of frail/failing older people may be complex, and may require significant amounts of time and effort.

2.2 ***Knowledge***

A trainee understands, and is prepared for issues commonly arising in the multi-disciplinary model of care of the complex and multifarious needs of frail failing older people and their families, including:

2.2.1 telephone communication

2.2.2 nursing/Long Term Care/Community Resource therapist-based reporting/consulting

2.2.3 2.2.3 which care-provider mades which care decision, and how this is negotiated.

3. Skills

3.1 ***A trainee demonstrates conduct of an office-visit, a home-visit and a facility-visit, to include:***

3 1 1 employing the protocol of the targeted Geriatric History

3 1.2 employing the protocol of the targeted Geriatric Physical Exam (including the Mini-Neurological Examination)

3 1.3 developing a numbered Problem List, and a Working-Plan

3.1 4 planning, discussing, negotiating and conducting appropriate interventions

3 1 5 deciding upon and assuring appropriate follow-up.

3.2 ***A trainee leads, and communicates well with, the inter-disciplinary team, including:***

3 2.1 obtaining collateral history and monitoring change in the status of the frail patient

3.2.2 negotiating with other professionals in the development of the interdisciplinary care-plan and in arranging for monitoring of outcomes of the interventions

3.3 ***Discussing the interdisciplinary care-plan in a conference-setting***

4. **Family Medicine is Community-based**

4.1 *Attitude*

4.1.1 A trainee appreciates the value of the care-system in supporting the frail/failing older person in his familiar/preferred living arrangement, and in using it judiciously and appropriately

4 1.2 A trainee recognizes nurses/Long Term Care assessors and Community Resource therapists and nutritionists as co-managers of the continuing care needs of patients, and will show willingness in collaborating in achieving the goals of the patient and his family.

4 1.3 A trainee understands the differences between the technical and personal limitations available at home, in a facility, or in a hospital, and will recognize the need for creative problem-solving and negotiating in advocating for the patient.

4.2. ***Knowledge***

4.2 1 The trainee is familiar with and respects any explicit medical standards that apply to the office-vist, the home-visit or the facility-visit, including:

a.) documentation

b) visits and follow-up

c) physician availability

4 2.2 A trainee demonstates knowledge of

a.) The organization of the Continuing Care system in the province, including the mechanism of referral to it, and the criteria for admission to it.

b.) The levels of care, and types of facilities which exist in the province

c) Appropriate costs of care in the community and in the facilities, the sources of funding, and the major players in community and facility administration.

5. **A trainee knows the roles of acute-care, facility-care, and home-care, the duties of the care-workers and their authority**

5.1 Skills

5.1.1 A trainee demonstrates adroitness in harnessing the system of care, to include:

a.) determining the formal and informal support-system unique to each patient/family

b.) employing the appropriate parts of the system in an efficient timely and responsible fashion.

c.) monitoring the effects of the individual plan, and adjusting/negotiating accordingly

6. **The Family Physician is a Resource to a Defined Practice Population**

6.1. Attitudes

6.1.1. A trainee appreciates the role of the Family Physician in advancing population-based medicine and preventive medicine.

a.) immunization\

b) Prostate/Breast-cancer screening programmes

c.) monitoring blood pressures/blood glucose readings/medication compliance

6.2 Knowledge

6.2.1 A trainee is familiar with evidence-based medical care of the elderly

a.) reputable health promotion websites

b) information materials on management of "geriatric-giants"

c.) knowledge of support groups. specialized Geriatrics programmes and how to refer

6.3 Skills

6.3.1 A trainee assures regular self-evaluation of effectiveness of care

a.) employing measurement outcome

b.) data-base

6.3.2 A trainee demonstrates ability to operate effectively in leading/managing the care needs of frail failing older people and their families

a.) setting up the individualized care-plan

b.) monitoring the effectiveness of the health-care system

c.) participating in activities leading to quality-improvement (CME, committees)

Appendix 1

OBJECTIVES FOR TRAINING OF GENERAL PRACTITIONERS IN GERIATRIC MEDICINE

Amended from the report of the British Geriatrics Society and The Royal College of General Practitioners ("Training General Practitioners in Geriatric Medicine" [1])

The care of elderly people has been re-ordered under the five areas identified in "The Future General Practitioner - Learning and Teaching" [9]:

- Human development.
- Human behaviour
- Medicine and society
- Health and diseases
- The practice

At the conclusion of his/her vocational training the doctor should be able to carry out the following.

• HUMAN DEVELOPMENT

1 Describe, discuss and compare theories of ageing.

2 Describe and relate the physical, psychological and social changes which may occur in old age.

3. Describe and relate the physical, psychological and social adaptations which the old person makes, and to the breakdown of these adaptations.

• Human Behaviour

1. Describe the ways in which physical, psychological and social changes in the environment of the old person manifest themselves early as changes in behaviour.

2. Describe the tendency to disengage in old age, and the interplay between the previous personality and experience of the patient and the present tendency to disengagement.

3 Describe in terms of the patient's behaviour the consequences of an awareness of deterioration unsociability, motivation, mood, or sexual function.

4. Describe the effects of these behavioural changes in old age on family relationships.

5. Describe those changes in behaviour which may be the first manifestation of disease processes likely to occur in old age.

6 Exhibit appropriate attitudes to the care of old people, and manifest these attitudes in the doctor-patient relationship.

7 Demonstrate an awareness of recent progress in gerontology

• Medicine and Society

1 Describe the influence of culture and social class on the status of old people in the family and in society at large.

2. Describe how current medical education determines the personal care of the elderly by the profession.

3. Describe and illustrate the relationship between the attitudes of society towards old people, and the allocation of medical and social resources.

4. Describe the development of social and medical care for the elderly in our society.

5 Describe the major medical and social agencies, statutory and voluntary, and specify their particular activities and areas of concern in the care of the elderly.

6 Demonstrate the uses of epidemiology in the care of the elderly.

7 Describe the effects of government policy and the contractual obligations of general practitioners in the National Health Service for the care of the elderly

8. Construct appropriate programmes of preparation for retirement.

9 Demonstrate an understanding of the needs of the informal carers of older people and how these can be met if the continuing well being of older people is to be maintained.

10. Describe the ethical aspects of care of older people and how they are taken into account in providing care through general practice.

- **Health and Diseases**

1 Describe the physical factors, particularly diet, exercise, temperature, and sleep, which affect the health of the old person
2. Describe the social factors, including previous occupation, financial status, housing, social involvement, and marital status, which influence life in old age, and the interrelation between health status and social status.
3 Describe those threats to the integrity of the old person, such as retirement, bereavement, isolation, institutionalisation, and impending death.
4 Describe the importance of health education and health promotion in maintaining the health of older people and the practical implications for general practice.
5. Describe the features, peculiar to the elderly, which modify the presentation of diseases, their course and management.
6. Describe the management of the conditions and problems commonly associated with old age such as stroke, falls, Parkinson's disease, confusion, etc.
7. Illustrate the way in which a number of different disease processes commonly occur in the same older person.
8. List the peculiar difficulties of taking a clinical history from an old person, with due regard to its slower tempo and possible unreliability, and the evidence of third parties, and demonstrate the appropriate skills required
9 Outline the special features of the clinical examination of elderly men and women
10. Demonstrate understanding of the changes in the normal range of laboratory values that are found in older people.
11 Describe the special features of prognosis of diseases in old age and relate these to an appropriate plan for further investigation and management.
12. Describe the way in which the management of disease processes in old age is influenced by the psychological state and the social situation of the old person.
13. List the special factors associated with the absorption, metabolism and excretion of drugs given to the elderly
14. Describe the hazards of drug treatment in old age, including the problems posed by multiplicity of drugs, non-compliance, and iatrogenic disease.
15 Demonstrate an appreciation of the uses and the limitations of surgery and rehabilitation in the treatment of diseases of old age.
16. Describe the special features of psychiatric diseases in old age, including an appreciation of the features of brain failure, and the effects of disorders of physical function on the mental state.
17 Demonstrate the skills of taking a psychiatric history from an old person, including how to assess intellectual function (e g. using short mental status questionnaires), and how to evaluate the testimony of third parties.
18. Demonstrate the skills required in management of older people with a psychiatric disorder such as·

a) Deciding on the appropriate milieu of treatment;
b) Listing the indications for specialist psychiatric or geriatric care;
c) Describing the indications and procedures for compulsory admission,
d) Assessing the quality and motivation of those persons available to care for the patient;
e) Advising on testamentary capacity, and advising on the management of affairs, e g. by the Court of Protection.

THE PRACTICE

1. Organise his/her practice for the benefit of his/her elderly patients so as to ensure ease of contact, appropriate timing of appointments, and satisfactory cover for emergencies, as well as provide information about these services of the practice, and opportunities for older people and their carers to comment on these.
2. Develop policies for the primary care team, so as to ensure control of repeat prescriptions, the appropriate use of screening or case-finding programmes, and the care of old people in all forms of residential accommodation.
3. Develop systems and policies for the care of older people in all forms of residential accommodation.
4 Advise individual patients about the available types of appropriate residential accommodation.
5 Effectively use the various statutory and voluntary services for support of the elderly in the community
6. Effect liaison and co-operate with the many different disciplines and persons involved in the care of the elderly.
7. Demonstrate an effective use of local hospital resources, including general hospital and general practitioner beds.
8 Demonstrate an understanding of the management of the transfer from one system of care to another, the complications that can arise and how they can be prevented and managed
9. Ensure that the provision of care promotes the patient's sense of identity and personal dignity.
10. Demonstrate understanding of the obligations of the general practitioner under the 1990 contract to older people on the practice list, and the practicalities of how these can be fulfilled.

Appendix II

ATTRIBUTES OF THE INDEPENDENT PRACTITIONER (GENERAL MEDICAL COUNCIL EDUCATION COMMITTEE, 1987)

The General Medical Council's Education Committee published its recommendations on the training of specialists in October 1987. These identified the attributes of the independent practitioner which are presented here to provide the background against which the specific recommendations for general practitioner vocational training in geriatric medicine should be considered.

"All doctors share a common role in the prevention or alleviation of disease or distress through appropriate intervention" Education and training for specialties should not only include acquisition of the technical knowledge and skills of a particular specialty or its branches, but also development of the attributes set out below, together they contribute to a doctor's professional development

1. **The ability to solve clinical and other problems in medical practice, which involves or requires:**

a) an intellectual and temperamental ability to change, to face the unfamiliar and to adapt to change;

b) a capacity for individual, self-directed learning; and

c) reasoning and judgement in the application of knowledge to the analysis and interpretation of data, in defining the nature of a problem, and in planning and implementing a strategy to resolve it

2. **Possession of adequate knowledge and understanding of the general structure and function of the human body and workings of the mind, in health and disease, of their interaction and of the interaction between man and his physical and social environment. This requires:**

a) knowledge of the physical, behavioural, epidemiological and clinical sciences upon which medicine depends;

b) understanding of the aetiology and natural history of diseases;

c) understanding of the impact of both psychological factors upon illness and of illness upon the patient and the patient's family;

d) understanding of the effects of childhood growth and of later ageing upon the individual, the family and the community; and

e) understanding of the social, cultural and environmental factors which contribute to health or illness, and the capacity of medicine to influence them

3 **Possession of consultation skills, which include:**

a) skills in sensitive and effective communication with patients and their families, professional colleagues and local agencies, and the keeping of good medical records,

b) the clinical skills necessary to examine the patient's physical and mental state;

c) the ability to exercise sound clinical judgement to analyse symptoms and physical signs in pathophysiological terms, to establish diagnoses, and to offer advice to the patient taking account of physical, psychological, social and cultural factors; and

d) understanding of the special needs of terminal care.

4 **Acquisition of a high standard of knowledge and skills in the doctor's specialty, which include:**

a) understanding of acute illness and of disabling and chronic diseases within that speciality, including their physical, mental and social implications, rehabilitation, pain relief, and the need for support and encouragement; and

b) relevant manual, biochemical, pharmacological, psychological, social and other interventions in acute and chronic illness.

5. **Willingness and ability to deal with common medical emergencies and with other illness in an emergency.**

6 **The ability to contribute appropriately to the prevention of illness and the promotion of health, which involves:**

a) understanding of the principles, methods and limitation of preventive medicine and health promotion,

b) understanding of the doctor's role in educating patients, families and communities, and in generally promoting good health; and

c) the ability to identify individuals at risk and to take appropriate action

7. **The ability to recognise and analyse ethical problems so as to enable patients, their families, society and the doctor to have proper regard to such problems in reaching decisions; this comprehends:**

a) knowledge of the ethical standards and legal responsibilities of the medical profession,

b) understanding of the impact of medico-social legislation on medical practice; and

c) recognition of the influence upon his or her approach to ethical problems of the doctor's own personality and values.

8 **The maintenance of attitudes and conduct appropriate to a high level of professional practice, which includes:**

a) recognition that a blend of scientific and humanitarian approaches is required, involving a critical approach to learning, open-mindedness, compassion, and concern for the dignity of the patient and, where relevant, of the patient's family;

b) recognition that good medical practice depends on partnership between doctor and patient, based upon mutual understanding and trust; the doctor may give advice, but the patient must decide whether or not to accept it;

c) commitment to providing high quality care, awareness of the limitations of the doctor's own knowledge and of existing medical knowledge, and recognition of the duty to keep up-to-date in the doctor's own specialist field and to be aware of developments in others; and

d) willingness to accept review, including self-audit, of the doctor's performance.

9 **Mastery of the skills required to work within a team and, where appropriate, assume the responsibilities of team leader, which requires:**

a) recognition of the need for the doctor to collaborate in prevention, diagnosis, treatment and management with other health care professionals and with patients themselves;

b) understanding and appreciation of the roles, responsibilities and skills of nurses and other health care workers; and

c) the ability to lead, guide and co-ordinate the work of others

10. **Acquisition of experience in administration and planning, including:**

a) efficient management of the doctor's own time and professional activities,

b) appropriate use of diagnostic and therapeutic resources, and appreciation of the economic and practical constraints affecting the provision of health care, and

c) willingness to participate, as required, in the work of bodies which advise, plan and assist the development and administration of medical services, such as NHS authorities, Royal Colleges and Faculties, and professional associations.

11. **Recognition of the opportunities and acceptance of the duty to contribute, when possible, to the advancement of medical knowledge and skill, which entails:**
a) understanding of the contribution of research methods, and interpretation and application of others' research in the doctor's own specialty; and
b) willingness, when appropriate, to contribute to research in the doctor's specialist field, both personally and through encouraging participation by junior colleagues.
12. **Recognition of the obligation to teach others, particularly doctors in training, which requires:**
a) acceptance of responsibility for training junior colleagues in the specialty, and for teaching other doctors, medical students, and other health care professionals, when required;
b) recognition that teaching skills are not necessarily innate but can be learned, and willingness to acquire them; and
c) recognition that "the example of the teacher is the most powerful influence upon the standards of conduct and practice of every trainee."

Acknowledgement
The above extract from the General Medical Council's Recommendations on the Training of Specialists (1987) is reproduced with the permission of the GMC.

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BGS TRAINING COMMITTEE RECOMMENDED READING LIST

1 JOURNALS

- *Age & Ageing*
- *Gerontology*
- *International Journal of Geriatric Psychiatry*
- *Journal of the American Geriatrics Society*
- *Journal of Geriatric Psychiatry and Neurology*
- *Journal of Gerontology*
- *Reviews in Clinical Gerontology*
- *C.M.E. Journal – Geriatric Medicine*

2 TEXTBOOKS (General)

- *Brocklehurst Textbook of Geriatric Medicine and Gerontology.* Tallis. 5th edition 1998. ISBN 0-443-053707.
- *Oxford Textbook of Geriatric Medicine.* Grimley Evans 2000 ISBN 0192628305
- *Principles and Practice of Geriatric Medicine.* Pathy 3rd edition 1998. ISBN 0-471963488
- *Principles of Geriatric Medicine and Gerontology.* Hazzard. W et al 4th edition 1999 ISBN 007 0275025
- *Merck Manual of Geriatrics.* Abrams 3rd edition 2000. ISBN 0911910883
- *Acute Emergencies and Critical Care of the Geriatric Patient.* Yoshikawa. Norman. Marcel Dekker. ISBN 0824703456

3 GENERAL INTRODUCTION FOR UNDERGRADUATES AND OTHERS

- *Lecture Notes in Geriatrics* Coni. Webster 5th edition 1998. ISBN 086542750X
- *Essentials of Clinical Geriatrics.* Kane et al 4th edition 1999. ISBN 0070344582.
- *Essentials of Health Care of the Elderly.* Bennett & Ibrahim 2nd edition 1995 ISBN 0340545593
- *Ageing - The Facts.* Coni Davison Webster 2nd edition 1992. ISBN 019262149-1 ISBN 019262150-5

- • *Geriatric Medicine - Problems in Practice* Pathy. Finucane 2nd edition 1991 ISBN 04792403-2
- • *Physiological basis of Ageing and Geriatrics.* Timiras 2nd edition 1995. ISBN 084938979-8
- • *Medicine in Old Age* Allen 1998 ISBN 0443057788
- • *Acute Medical Illness in Old Age* Sinclair. Woodhouse 1995. ISBN 0412569205

4 4 BOOKS - REPORTS IN SPECIALIST AREAS

- • *Neurology of the Elderly.* Godwin-Austen. Bendall. Springer 1990. ISBN 3540195939.
- • *Neurodegenerative Diseases.* Calne ISBN 07216 4349 3.
- • *Principles and Practice of Geriatric Psychiatry.* Copeland 2nd edition 2001. ISBN 0471981974.
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- • *Diagnosis and Management of Dementia.* Wilcock, Bucks, Rockwood 1998 OUP
- • ISBN 0192628224
- • *Parkinson's Disease in the Older Patient.* Playfer Hindle 2001 ISBN 0340759143
- • *Parkinson's Disease - Parkinsonism in Elderly.* Meara, Koller CUP 2000. ISBN 0521628849.
- • *Skin Disease in Old Age.* Marks 1998. ISBN 1853172278
- • *Colour Atlas and Text of Dental Care for the Elderly.* Yemm et al. Mosby, 1993. ISBN 0723417105
- • *Textbook on Diagnostic Imaging in the Elderly.* Impallomeni, et al. 1999. ISBN 1899066888.
- • *Clinical Cardiology in the Elderly.* Chester 1999 ISBN 0879934212.
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- • *Geriatric Nutrition the Health Professional's Handbook.* Ronni Chernoff. Aspen, 2000. ISBN 0834210827
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