



Treating the Individual — Advice for Physicians Treating Older Adults

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Carefully assessing patients' psychological issues and personal challenges contributes to improvements in their health as well as quality of life.

Geriatricians and primary care physicians providing healthcare for older adults often have the opportunity to address their patients' psychological issues and daily living challenges. By doing so, physicians may be able to help their patients vastly improve the quality of their lives along with their physical health.

In what follows, we provide a case example to illustrate issues typically hidden in patients' lives and use the illustration as the basis for suggestions regarding ways physicians can intervene effectively. Mr S is not a real person, but he represents a patient drawn from the characteristics of many real older adults who struggle with more than physical problems in old age.

Scheduled Exam

Mr S arrives at your office for a scheduled exam. He is 86, has been retired for many years, and lost his wife one year ago. He developed type 2 diabetes five years ago. A good patient, Mr. S lost some weight, and his

blood sugar nearly returned to normal.

He had a slightly abnormal nuclear stress test a couple of years ago, so you watch his numbers carefully. His lipid profile, especially low-density cholesterol, is slightly elevated despite the two medications he takes. His blood pressure, for which he takes three different medications, is good. His heart and lungs sound fine. His feet, which you check as you do for all patients with diabetes, also seem fine.

"How do you feel?" you ask. "Not bad for an old man," he says with a smile. He has always had a good sense of humor. "How about you?" he asks. "Just fine," you respond. "Anything bothering you?" you ask. "Sometimes I get pains in my hands, but I take ibuprofen and it goes away." You look. His hands are slightly, but not unusually gnarled.

"Anything else?" you ask. "I'm not sleeping very well, Doc, but I take a drink before I go to bed and that seems to help." You ask, "How big a drink?" He answers, "Usual size. Just a scotch on the rocks like I've been drinking all my life."

You think to yourself, I hope I'm in as good shape as Mr. S when I'm 86.

Behind the Façade

What did you miss? A lot. In fact, Mr. S is not doing at all well psychologically or developmentally. Had you asked, you might have learned that Mr. S stays at home almost all the time. He sits in an easy chair with a book he doesn't really read. It's not that he's sad, but he doesn't feel like doing any of the things he liked to do before his wife died. He's stopped going to events at his church although he does go to services on Sundays from time to time. He doesn't follow baseball anymore. He still remembers some of the players and some of their stats, but he used to know them all.

He's become cynical about politics. "A pox on both their houses" was what he said to end the conversation when his daughter mentioned something that used to instigate a fun argument. He visits his children and grandchildren when he's invited and takes some pride in their successes, but he thinks they have things to do other than sit and talk with him when he comes over. He is quiet and doesn't really try to engage them.

He has turned his business over to a daughter who has done a very good job of expanding it beyond anything he ever imagined. He believes he has no valuable advice to give her.

When he is alone—which is most of the time—he often sends out for dinner. He usually has a glass of scotch while he’s waiting. He eats dinner while watching TV, often falls asleep, and when he wakes up in time for the 11 o’clock nightly news, he has trouble getting back to sleep. So he takes another scotch, sometimes more. If he doesn’t forget, he takes his nighttime medications with the drink.

If you had asked Mr. S, you might have learned that in addition to being alone much of the time, he feels lonely. His wife is gone, as you know. What you don’t know is that most of his friends are either dead or have cognitive impairments that make them difficult to be with. A few of the couples he and his wife used to socialize with are still living, but he feels like a third wheel—and his wife had been the keeper of their social calendar anyway.

Of course, the men in many of the couples they had known have died. Most of the widows would be happy to spend time with him, but he doesn’t know how to be just friends with them because when they were all couples, the men usually talked with the men and the women spoke with the women. A sexual relationship with any of them holds no appeal even though he does miss sex, which he deals with by masturbating while looking at pornography.

Empty Days

Mr. S is also bored. It’s not that he has nothing to do. He could be more active at church. He could go to ballgames. He could go to a movie. But he has never had a hobby that now could fill his time, and he hasn’t found anything new that interests him. He worked, spent time with his wife, and then retired—but not to anything, just from something.

In addition, were you to ask, Mr. S would say that he is now pretty much nothing—“chopped liver” or “a potted plant.” When he ran a business and earned a good enough living to take care of himself and his family, he had been proud of himself. He also had been a leader in his church and active in local politics. He had been a respected person in his community. He still is by those who remember him, but that includes fewer and fewer people every year.

His grandchildren love him, but they don’t come to him for company or advice. He feels that mostly he is good for the \$100 bill he hands each of them on their birthdays.

Objectively, of course, Mr. S has much to be proud of, but his sense of pride had always been about achievements in the here and now. Past

achievements give him no sense of pride in the present, which they should with respect to developmental appropriateness.

It's likely that Mr. S is suffering from depression, and it may be that he is developing a substance use problem of the kind that's not uncommon in old age. You don't find out because he maintains an affable demeanor when he comes to see you and jokes about his minor aches and pains. You also don't know because you don't ask about what's going on in his life. And you won't find out because you don't routinely screen for mental or substance use disorders.

Intervene—or Not?

Many doctors have reservations about exploring problems in their patients outside of any physical ailments, often rationalizing through one or more of the following:

- I am busy dealing with the physical needs of too many patients. I average eight to 10 minutes per patient visit. Who has time to talk about feelings?
- I can hardly afford to run my practice now. I can't afford to devote time to patients when I will not be paid for it.
- What if my patient started crying in my exam room or said, "I don't want to live"? I wouldn't know what to do.
- It's almost impossible to get an appointment with a psychiatrist or mental health professional. I don't know any who specialize in older people. Even when I do know a good geriatric mental health professional, my patients most often do not follow up on a referral.
- I believe I am not equipped to screen for depression or substance abuse.

Reasons to Intervene

When doctors take the Hippocratic Oath, they do not qualify their promise and say "except for emotional pain and suffering". Mental disorders are not less painful or disabling than physical disorders. Mental disorders are as responsive to treatment as are myriad other common conditions, such as heart disease, arthritis, and diabetes. And treatment for depression or other disorders, as well as targeted efforts to assist your patients in being less isolated and more active, could help them get the most out of the last phase of their lives.

Is this part of your role as a primary care physician? What Mr. S is

experiencing is probably not just run-of-the-mill unhappiness. He probably has a diagnosable mental and/or substance use disorder, as do 20% of older adults. These disorders can be deadly. Consider the following facts:

- Older adults are more likely to complete suicide than those of any other age group. Men and women aged 65 and older of all races are approximately 30% more likely to take their own lives than the general population. And most of them kill themselves within 30 days of seeing a primary care physician who did not ask about their feelings and did not identify their suicidality. White men aged 85 and older, like Mr. S, complete suicide at nearly five times the rate of the general population.
- Older adults with co-occurring serious physical and mental/substance use disorders are more likely to experience medical complications resulting in higher risks of functional disability and premature death. The cost of their medical care is generally more than double that of people with the same physical illnesses but without mental or substance use disorders. They will be back in your office again and again, in and out of emergency departments, and have longer and more frequent hospital stays than your patients without untreated mental and/or substance use disorders.
- People who are deeply unhappy are less likely than others to take care of themselves: keep their weight down, exercise, limit alcohol and other drug use to safe levels, and take medications as prescribed. This means whatever other conditions they have will often go unattended and worsen.

Untreated mental and/or substance use disorders contribute to avoidable placement of older adults in institutions. Although some institutions are lovely places and may be better than remaining home alone for some people, virtually everyone would prefer not to spend their remaining time in a nursing home. Primary care physicians' failure to identify behavioral issues in the lives of their older patients and their caregiving family members can be the beginning of an unhappy slide into a place that most people and families want to avoid.

What Can You Do?

- Take a moment to ask Mr. S about what's going on in his life. Maybe he'd open up a bit; and if he did, he might make an effort to change things, especially if he knew you were going to watch his life, not just his lipids. A growing number of primary care physicians are learning how to do motivational interviewing, a simple and highly effective technique for helping patients change their behavior. You may not get paid for motivational interviewing (though you probably can bill for a more complex visit) and it

does take a little time to read about or get training in it, but you will be a more effective doctor for it. And funding is already emerging to pay for this type of intervention in primary care.

- Talk with family members. Point out, in case they're unaware, that their father is very unhappy, and that he needs more contact with people, including them, and he needs some interesting things to do. They may find ways he can be useful and helpful to them rather than allowing him to perceive himself as a burden. Maybe they can arrange for a friendly visitor or companion. Maybe they can connect him with a local volunteer, a church activity, or a paying job in which he can feel he is making a valuable contribution.
- You can routinely screen for depression and substance abuse among your patients. Elder patients typically prefer that primary care physicians provide treatment. This can include psychiatric medications (in doses specific to older adults with physical diseases); "wellness" activities such as spending time with people they like, exercise, smoking cessation, and eating well; and cognitive-behavioral, problem-solving, or interpersonal therapy.
- The ideal model for responding to mental and/or substance use disorders in primary care settings is to have someone in your office, a social worker, nurse, or a peer care manager follow up with patients who screen positive and whom you diagnose with a mental or substance use disorder. Where will the money come from for an additional staff member? If you work solo, it may not be possible, but sometimes private mental health practitioners can be located in your office and bill independently. With new forms of healthcare such as medical homes, funding will be provided for "collaborative" care for chronic diseases and for the "integration" of physical and behavioral health services.

Screening for Mental and/or Substance Use Disorders

Many doctors believe they can identify people with mental or substance use problems without using a formal screening instrument. If they have time for a long interview, that may be possible, but these disorders are often not evident. People who are depressed tend to be champion hidiers. They don't spend every hour of every day with their heads hanging down on their chests or with tears running down their cheeks. Nor do they necessarily lose their sense of humor or their affability. It can be virtually impossible to identify depression, anxiety, or substance use disorders from ordinary interaction. In fact, in elders, rather than manifesting as sadness, depression often appears as physical complaints, boredom, and difficulty

thinking.

Fortunately, there are screening instruments that patients can complete and score while sitting in your waiting room. For example, PRIME-MD includes the PHQ-9 (Patient Health Questionnaire) for depression and the GAD-7 (Generalized Anxiety Disorder) for anxiety. The AUDIT-C is becoming the standard for alcohol abuse screening. These are not time consuming. You can glance at the score, ask a few follow-up questions, and decide how to proceed if your patient screens positive.

The following are some of the symptoms you should look for:

- persistent sadness or sense of worthlessness;
- loss of interest in people and activities that were previously a source of pleasure;
- thoughts about suicide or a preoccupation with death;
- inability to concentrate;
- ruminations;
- irritability;
- agitation or moving in slow motion;
- too little or too much sleep;
- too little or too much eating;
- fear for no apparent reason;
- fear of social situations;
- repetitive physical complaints;
- paranoia ranging from distrust to paranoid delusions;
- using alcohol to sleep, to quell anxiety, or to dull emotional pain;
- nonrecreational use of alcohol and/or illegal substances; and
- over- or underuse of prescription or over-the-counter medications.

What's the Message?

Being a good doctor means attending to what ails your patients, both body and mind. Talk to your patients. Ask about their lives. Screen for depression and substance abuse. Learn simple techniques to help motivate your patients to retake control of their lives. Stay in touch with families and help them to figure out what they can do.

None of this is easy, and it takes time, but your office can learn to bill for it. You may not feel you are well trained. But in the same way you learned to manage diabetes, Parkinson's disease, and COPD, you can learn to manage mental disorders. When you do, you will see that your patients improve physically and emotionally. That's when you will experience the pleasure that comes from being a good and effective doctor.

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