

## STUDENTS' CORNER

# Are we treating our geriatric population ethically? – views of a resident doctor

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### **Abstract**

*With the improvement in health services and continuing advancements in medicine, people are living longer all over the world. Thus the proportion of patients in the elderly age group is also increasing. How ethically are we treating our geriatric patients in India and what does the future hold for them?*

The following is an experience from my early residency days in dermatology in a public hospital. One day at the outpatient department (OPD), an old man (probably in his seventies) hobbled up to me, supporting himself with a wooden stick. He wore broken spectacles that were held together by string and wore unwashed clothes that barely covered his body. With folded hands and in an almost tearful voice, he begged me to relieve him of the persistent itching all over his body. Once I had got over my first impressions of the man, I proceeded with the routine protocol. I asked about the onset of the problem, the mode, duration, exacerbation, aggravating factors, etc. I then concluded that my patient was practically deaf – nothing I said made any sense to him. Much to the amusement of my colleagues, I tried desperately to communicate with him, but to no avail. Exasperated, I decided to treat him for what I could diagnose clinically. It struck me that this man would not be able to buy the medicines and might, on the other hand, be cheated by some unscrupulous chemist. I decided to prescribe an emollient and an antihistaminic, which would at least take care of his symptoms, if not cure him completely.

And then, for the first time in my life, I experienced something which humbled me beyond anything I could have imagined. The old man got up, folded his hands (I promptly asked him not to do so) and placed them on my head to bless me. At one point, he even called me “mother” (in India, female doctors are often addressed as mother in the local language – *amma, ma, aai*, etc). He blessed me with success and prosperity in life. And the reason? Because he had been able to communicate his problem to me and I had listened with patience.

With that, he went off and I felt terribly apprehensive about how he would fare. I wondered whether I would get to see him again. He came back a month later, a bit more cheerful this time, and waited his turn to see me. I was overjoyed, since I had earned my own first patient, someone who specifically came to me for follow-up.

Again he complained of itching all over his body. This time, too, I tried to take a good history, but in vain. I decided to ask him about his family instead. I enquired if there was someone who could accompany him and to whom I could address my queries. That was when I learnt that he had a son and daughter, but no one bothered to accompany him. Basically he was an outcast. At the hospital, too, he had been to various departments which kept referring him elsewhere, and that is how he had ended up at the dermatology OPD. I sent him home with some medication and requested him to report a month later. He came back on time and was the first person in the line at the OPD.

By now, my colleagues knew who he would consult. Over time, I started to feel happy seeing him once a month. I developed an emotional bond with him. He did not live far away. He never missed an appointment and gradually, his symptoms resolved. I cannot say what role the medicines played, but his mood definitely improved over time. I was glad that we had been able to make our OPD a place which gave him a sense of belonging. A place where he would get at least a patient hearing, a kind touch and a few soothing words (and occasionally a cup of tea as well).

For a few days, I pondered over how a man who was apparently well could be one of our most regular patients. Eventually, I asked my professor about what could explain this. He said, “He comes because you spare time for him, patiently lend him an ear and ask about his well-being. Possibly, other people shoo him away before even letting him speak. You make him feel like he still has some value as a person and is not just a burden. Being a good doctor has got less to do with the amount of knowledge you have than with how a patient feels after talking to you. To be a good doctor, become a good human being first.”

These words had a long-lasting impact on me. After my encounter with the old man, I began to notice a trend – most children were accompanied to the hospital by their parents and even close relatives, but most elderly patients came alone. These old men and women would stare in confusion, wondering where to go, in the midst of the utter chaos that is often found in our government hospitals. Other resident doctors, too, have noticed this (1). For the elderly, going to a hospital is traumatising in several ways. First, they have difficulty navigating their way around the hospital corridors

and departments, as their age limits their movements as well as cognitive functions. Second, their terror at having a disease disables them further. Finally, monetary constraints are an important factor in most cases. This is evident if one considers that 68.84% of India's population lives in rural areas and 25.70% is below the poverty level. Less than 10% of the nation's health budget is allocated to the rural areas (2, 3). How many patients from rural India have access to health insurance? Reports show that just about 55% of the rural population has been enrolled under the Rashtriya Swasthya Bima Yojana (RSBY), a national health insurance scheme launched by the government of India. However, in spite of this, more than 72% of the population makes out-of-pocket (OOP) payments during times of illness – one of the highest proportions of OOP expenditure in the world (4). Data from a study by the World Bank reveal that the proportion of public financing of healthcare in India is less than 1% of the world's total health expenditure. This is a bigger problem for rural households, which often take loans that they subsequently cannot repay. Health expenditure has thus become an important cause of poverty in India (5). It has been seen that as a result of the financial repercussions, 6% of patients do not even seek medical treatment (6). According to the Census 2011, less than 20% of elderly women but most elderly men were economically independent. Also, in rural areas, 66% of elderly men and above 23% of elderly women were still involved in some economic activity, while in urban areas, only 39% of elderly men and about 7% of elderly women were economically active. The census also mentions that about 65% of the elderly had to depend on others for their day-to-day maintenance and 64 per thousand elderly persons suffered from one or more disabilities (mainly locomotor) (2).

Given this situation, elderly people from rural areas are even more vulnerable in the face of disease and their treatment-seeking behaviour gets affected. In the public hospitals, everyone is too busy to pay them any attention, while private hospitals do not see them as fruitful investment options.

India is a developing country and a significant proportion of our population is in the age group of 15–45 years. Also, our focus is on reducing our infant mortality, neonatal mortality, under-5 mortality, maternal mortality and other such rates. But what of the other end of the age group spectrum? What about those who spent their youth working for the country? Do they cease to be important once they cross the line of 58–60 years? The national census 2011 shows that 7.4% of India's population is aged more than 60 years. The share and size of the geriatric population has been increasing steadily all around the world. Its share of the total world population was around 5.6% in 1961 and is projected to rise to 12.4% by 2026 (7). Also, since the average life expectancy is increasing worldwide, the number of geriatric patients seeking treatment will also increase simultaneously. In 2012, 11%(809 million) of the total world population was above 60 years of age and this is expected to rise to 22%(2031 million) by 2050. Countries that spend a greater proportion of their gross domestic product on healthcare, eg Sweden, Norway and Germany(7), often have

special provisions for the elderly. For example, they may raise the retirement age to help the elderly maintain economic independence for longer; equalise the level of participation in activities by both genders; shift from traditional hospital-based treatment to home-and community-oriented healthcare; focus on lifelong education and learning, etc (8). Developed nations often make special provisions for the elderly, such as modified signs and symbols, easily decipherable maps, information desks and kiosks, and the attitude towards them is generally respectful.

The stories one hears in our hospitals are sometimes appalling. Once I heard a physician tell an old patient, "You are already so old. How much longer do you want to live?"

I shudder to imagine what old age might be like in such an environment. Forgotten, ignored, ill-treated, abused and cheated are just some of the words that come to mind. Strong social and political commitment and initiatives, including modifications in healthcare policies, are needed in India to bring about definitive changes in the attitude towards the elderly. If adult children took the initiative to take care of their aged parents, the plight of the elderly might improve. Among the measures that may be considered are laws and regulations to ensure that the elderly are not abused or neglected, and pension and health insurance schemes with contributions from the employee/employer/government (9). Given the present doctor–population ratio (69:1 per 1,00,000 population or 1:1800 for the overall population) (2), it is really difficult for doctors to spend more than a few minutes on each patient who visits the OPD. However, surely we could have a few counsellors who can be trained and be the point of first contact with elderly patients who need assistance? Having hospitals with a better layout might also be helpful, for example, a hospital with bigger and well-lit signs, desks that supply general information, ample seating areas, facilities to accommodate those who come alone, inclined walkways, toilets and a supply of medicines at a place meant specifically for the elderly. NGOs and other such organisations which can provide financial support should be involved, as also the Rogi Kalyan Samitis. Most importantly, behavioural training should be imparted to all healthcare service providers. Physicians should be attuned to the needs of the elderly – a kind smile, a soothing voice or a gentle touch is often sufficient to calm an agitated and complaining old soul. All attempts should be made to bring the majority of the population under the umbrella of the RSBY, with special emphasis on the elderly. At the same time, it must be ensured that reimbursements are made on time, without too many hitches, and OOP expenditure is minimised.

Ageing should not be looked upon as the end of all economic and social involvement. The elderly must be motivated and helped so that they may continue to contribute to the economic growth of the nation and maintain their independence and dignity at the same time.

A child's smile is certainly precious – any paediatrician will vouch for that – but a blessing from an elderly man or woman

is equally rewarding. As the old aphorism by Dr Edward Trudeau goes, "To cure sometime, to relieve often, and to comfort always" (10). This is something worth incorporating into our daily lives.

We, in the workforce of 15–45-year-olds need to take a stand now because in the near future, we will cross that magical line of 58–60 years and face the threat of being treated like yesterday's newspapers. If steps are taken in the right direction, they might help us become timeless classics which are the pride of the bookshelves they adorn, and which can give anyone who cares to read an insight into the wisdom acquired over many years. We can thus continue to be an asset to the nation for as long as we live.

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## World Association of Medical Editors (WAME) Conference

The World Association of Medical Editors (WAME, pronounced Whammy) came into existence 25 years ago. One of the key features of this organisation was its virtual nature with communication and interaction mainly by email. However, once in four years, the members attending the Peer Review Congress would participate in a WAME business meeting on the sidelines of the Congress. At the last WAME strategy meeting (the third since its inception), it was felt that the organisation having grown, an international conference for its members should be organised in 2015. This meeting will be held from October 2 to 4, 2015, at New Delhi. For further information please write to: [india.editors@gmail.com](mailto:india.editors@gmail.com) or visit the website: <http://www.wame.org/>