# IT TAKES AN ENTIRE FAMILY TO TAKE CARE OF THEIR ELDERLIES

Adj. Asst. Prof Low Sher Guan Luke

Since young, I've heard of this common saying "It takes a village to raise a child", and I thought it demonstrated the tremendous effort needed to cater to the child's well-being. After years of practising medicine, I realised it often took the entire household to take care of an elderly, but yet no one ever coined that saying. It may have reflected how people placed less emphasis on the elderlies, their care and well-being. Those family members who had elderly patients requiring care-giving would testify to the behemoth efforts needed from all hands on deck to manage such patients.

Unit 1 by Dr Vanessa Mok emphasised the high prevalence of Behavioural and Psychological Symptoms of Dementia (BPSD), with a local study quoting prevalence of 67.9%. Family physicians in practice these days need to be confident in assessing and managing BPSD through a variety of non-pharmacological and pharmacological modalities, given that we deal with an ageing population.

Unit 2 by Adj. Asst Prof Tan Tze Lee gave an update on the Mental Capacity Act (MCA). The Singapore Family Physician first published an article on the MCA in 2009, and its lessons and messages hold for family physicians today. This article further updates on two provisions of the MCA:

1. Lasting Power of Attorney (LPA) Certification
2. Court-appointed Deputy Application for Patients

The processes involved in certifying the LPA as well as the court-appointed deputies will be covered in this unit.

Unit 3 by Dr Matthew Ng and Dr Ng Beng Yeong brought to light an important matter that afflicts many elderly patients – that of sleep disturbance and insomnia. Though often initially dismissed by patients and their families, if left untreated, could have an adverse impact on the patient's physical and psychological well-being. However, treatment with benzodiazepines was not without its own set of problems as it often led to dependence, and if withdrawn too suddenly, it might cause rebound insomnia. This article talked about a combination of behavioural and drug therapy, and how we could achieve that for our long-suffering patients who cannot sleep.

Unit 4 by Dr Joanne Kua described how we had moved from the traditional geriatric giants of immobility, incontinence, instability and impaired memory, to modern geriatric giants including sarcopenia, frailty, anorexia of ageing and cognitive impairment. This more accurately reflected the current challenges we faced in our elderly patients and how to recognise and manage them.

Unit 5 by Dr Shermyn Neo discussed the common condition of Parkinson's disease and many of the diagnostic and management issues that we faced in such patients. Such patients presented with symptoms of falls, cognitive impairment, psychosis and orthostatic hypotension, and non-pharmacological and pharmacological strategies are discussed, all with the aim of allowing our patients to live successfully with the disease.

Unit 6 by Dr Geoffrey Sithamparapillai Samuel touched on the topic of stroke, stroke recovery and stroke rehabilitation, with the three broad principles of the restoration of function, compensation where full restoration was not possible and modification of the environment to aid in activities of daily living. Other than assessing for motor, sensory and cognitive deficits, it was also important to proactively look out for symptoms of depression, spasticity and post stroke shoulder syndrome. Indeed many issues for family physicians to have to work through together with allied health practitioners such as physiotherapists, occupational therapists, speech therapists and social workers.

The ten readings selected by A/Prof Goh Lee Gan included a mix of local and overseas papers and studies that illustrated the multitude of problems plaguing the geriatric population, including memory issues, cognition, behaviour, insomnia, osteoporosis, sarcopenia, nutrition, Parkinson's disease and stroke. No matter which part of the world, the patients primarily face similar geriatric issues. While there might not be an existing good cure for many of these ailments, it is crucial to focus on maintaining the quality of life in such patients. Such issues fuel each other into vicious cycles as well, with some diseases causing complications such as dysphagia that result in reduced nutrition intake, which then compound other problems such as osteoporosis, sarcopenia and frailty.

Care-givers are not spared as well, being part of this long-drawn equation. Maintaining physical, mental and emotional health of care-givers is just as important as it translates to proper care for the patient. There are other non-medical aspects to take note of too, such as willing making, financial planning, surrogate decision making etc., many of whom shun such discussions till it is too late, thus stressing the families during times when the elderly patient is unwell.

It is for this reason that we family physicians have to be competent and confident in managing the many ailments that our geriatric patients present with and to be able to employ pharmacological and non-pharmacological methods to see the patients and their families through all their medical, psychological, social and emotional issues. The family depends on us as subject matter experts to help them through these trying times in caring for their elderlies.