Editorials

Improving The Well-Being of Nursing Home Residents

Recently a retired dentist in my practice reluctantly relocated from his apartment to a nursing home. As his family physician for the past decade, I had helped him fight a rearguard battle against time and disease. He lost his wife to cancer, suffered bouts of depression, and required increasingly intense treatment for congestive heart failure. His right foot, which had been affected by polio in his youth, turned progressively inward until he was practically walking on his lateral malleolus, each step awkward and uncomfortable within prosthetic shoes. Until such sessions became too fatiguing, he willingly served as a physical diagnosis subject for medical students and interns, a one-stop OSCE station that included his postpolio syndrome, atrial fibrillation, mitral regurgitation, and an apex impulse in the midaxillary line. A proud and independent man, he drove his ancient Pontiac to every appointment knowing exactly which medications he took and at what times. As his health declined and his medications multiplied, he resorted to keeping a list, upon which we negotiated, and I hand wrote, each change during office visits.

Moving to the nursing home changed all that. Instead of looking for a secluded office within which to raise my voice when answering his telephone messages, I now speak politely to nursing staff about his condition and treatment. When he comes for office visits, it is by van, with a computer-generated list of current medications, which his failing eyes cannot read and about which he knows little.

As is true of most nursing home residents, he receives multiple medications and, therefore, is at high risk for adverse drug events. At the same time, he is no longer able to serve as his own advocate. He must increasingly depend on others to be certain that his health and well-being are preserved to the greatest extent possible and that his own wishes are understood and honored.

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Who, then, should serve as health advocate for nursing home residents, most of whom are like my patient, unable to control and monitor treatments and their effects? Sometimes families assume this role, and this involvement should be encouraged. Though questions and complaints from family members can be trying to physicians and nursing staff, residents with family advocates generally have problems detected more quickly and symptoms addressed more fully than those who have no family visitors. Nursing staff are probably the most important resident advocates in long-term care; yet lack of familiarity with both medications and the residents themselves can often make them inadequate. In the area of medication, pharmacists should serve a central advocacy role; however, their effectiveness is often limited by such issues as working for the same corporation that supplies medication to the nursing facility, not being facility "insiders," and a desire to avoid conflict with physicians and nurses.

The review by Ackerman and von Bremen[1] in this issue of the *JABFP* reminds family physicians that we have a central role in keeping up with the best practices in pharmacotherapy and in seeing that they are implemented in the nursing home. The authors present and discuss 15 categories of drugs that are particularly prone to overuse in the nursing home. The family physician, they argue, can "make a meaningful impact on the quality of life" in nursing homes through reducing unnecessary or marginally helpful medications.[1]

Indeed, there is mounting evidence that polypharmacy can be reduced. One method of reducing polypharmacy is to implement a medication review process as part of the nursing home's quality management system.[2] Such a process should include regular review of telephone orders, since these orders generally involve starting rather than stopping medications.[3,4] The review should begin with those medications most commonly prescribed "inappropriately" to older persons: dipyridamole, propoxyphene, diazepam, chlordiazepoxide, amitriptyline, indomethacin, chlorpropamide, propranolol, methyldopa, and reserpine.[5] It should also focus on those medications

that most often are implicated in drug-related patient events: systemic corticosteroids, digoxin, nonsteroidal anti-inflammatory agents, β-blockers, furosemide, theophylline, thiazide diuretics, sympathomimetic agents, and other benzodiazepines.[6] Ideally, such a process would include face-to-face educational interventions for nurses[7] and would be a cooperative effort among the facility medical director, nursing director, and consultant pharmacist. Iatrogenesis occurs often in this population, and the overall costs of medications being taken (whether inappropriate or not), some of which have an adverse effect on health care financing in this setting, are enormous.

A goal of simply reducing medications is not enough, however. Many nursing home residents, like my patient, would not be alive had it not been for medication. Thus, medication reduction must be judicious and not nihilistic.

It is in these areas that good medical practice must go beyond the recommendations of Ackerman and von Bremen. For example, relief of depression and the application of nursing care are paramount in seeking to manage chronic pain without nonsteroidal anti-inflammatory agents. Admittedly, depressive symptoms are often situational, and frequently medications are not indicated. Nevertheless, management of chronic pain should often include attention to depression through counseling or a trial of a medication with a low risk of adverse drug events in an older population. Furthermore, such physical measures as frequent repositioning, range-of-motion exercises, active exercises, massage, and the use of such devices as recliner chairs are far better than an attitude that the patient should be left alone to "suffer a little." In these areas the physical therapist can be helpful in resident evaluation, in initiating treatment, and in applying special technologies; however, physical therapy alone will rarely be successful in providing pain relief; it must be coupled with attentive nursing care.

Thus, medication reduction is a secondary goal in nursing home practice. The primary goal should be to maximize resident well-being. Here barriers exist that dwarf the issue of polypharmacy: the high occurrence of chronic, disabling conditions; inability of the resident to advocate for himself or herself; low wages and lack of professional status for nursing assistants; poor preparation and minimal supervision for many licensed nurses; inadequate reimbursement for physician services; and difficulty knowing which treatments really provide benefit for a patient. Such obstacles to ideal nursing home care often seem so insurmountable that in times of cynicism the nursing home physician might yearn for the simplicity of, for example, managing cystitis in a young patient or a well-child visit.

Nursing home residents remain an underserved medical population, and their complex needs require some of the best that medical science and humanism can provide. As Ackerman and von Bremen recommend, family physicians should seek to serve as activists in bettering the care of older persons in nursing facilities.

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A Hiker's Guide To General Practice

There is no cogent argument for promoting primary care vocations that do not remain true to the primary care role.

The hiker metaphor comes easily to mind when one resides in the Colorado mountains, but I like

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