Care of older people

Maintaining the dignity and autonomy of older people in the healthcare setting

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This is the first in a series of four articles

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This series will explore key issues in the quality of health care for older people. The basis of these articles is the extensive literature reviews undertaken to inform the development of a national service framework for NHS care of older people in England. As a result of an investigation by the *Observer* newspaper in 1997, the UK Health Advisory Service published a report with 17 recommendations,[1] including the establishment of the national service framework, made up of key indicators of quality care and service provision. Background work for the framework covered evidence about quality in the organisation and delivery of health care for older people. It included health promotion; disease prevention; primary health care; general hospital care; specialist care by geriatric, psychogeriatric, and palliative care services; intermediate care and long term care in the community; and residential and nursing homes. Detailed attention was also given to the care of older people with stroke, falls and their consequences, depression, and dementia. Advice was based not only on evidence based practice but also on the value of fair access to care, a person centred approach, and whole systems working. This series will focus on four areas relating to health care for older people. This first article examines issues relating to the dignity and autonomy of older people.

Summary points

Anecdotal evidence suggests that older people's dignity and autonomy is being undermined in the health care setting

Many healthcare professionals hold stereotypical, negative attitudes towards older people

Tackling negative attitudes through exposure and education can help to preserve older patients' dignity and autonomy

Giving older people and their carers adequate information for them to make informed choices about care further increases autonomy

Insensitivity and disrespect

Health services should aim to preserve dignity and autonomy and minimise distress among patients.[2 3] Yet the literature suggests that, in many cases, these objectives are not being reached. Although the empirical evidence on dignity is limited, many valuable qualitative data are available. Surveys conducted primarily by older people's advocacy groups have directly obtained the views and experiences of older service users and their carers.[4–7] They show an alarming picture of older people being treated unacceptably—insensitively and disrespectfully—by healthcare staff (see box for examples).

Owing to the anecdotal nature of the data, it is difficult to assess how widespread such bad practice is. The international authorship, however, of articles on older people's dignity and autonomy in health care suggests that difficulties in maintaining high standards may be a global problem.[9–12]

Although interrelated, dignity and autonomy are slightly different concepts. Dignity refers to an individual maintaining self respect and being valued by others. Autonomy refers to individual control of decision making and other activities. The literature suggests that both the dignity and the autonomy of older people are often undermined in healthcare settings. Dignity is challenged primarily through negative interactions between staff and patients, a lack of regard for patients' privacy, and a general insensitivity to the needs and desires of an older population.[4–6] Autonomy is threatened when patients (and their carers) are not given adequate information or the opportunity to understand fully their diagnosis and to make informed choices about their care.[7 13–15] Older people in particular easily become disempowered in healthcare settings.[16]

Raising standards

How can standards in geriatric health care be raised? One way is to examine the examples of good practice that exist and identify elements that can be generalised to health services globally. Much of the qualitative information already mentioned, along with several documents focusing specifically on good practice, reports positive comments made by older people and their carers about care received (see box). Such comments shed light on elements of service provision

Negative comments of older service users and their carers

"She was left to lie in her excrement and urine"[4]

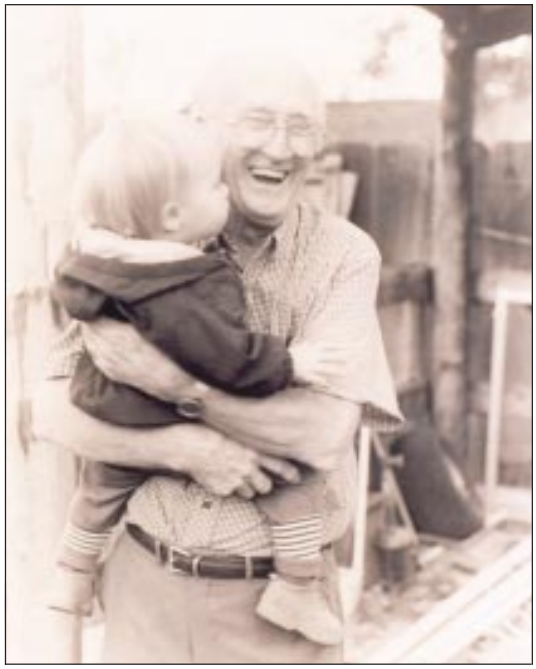
"An old boy about 90 . . . had wet himself. On changing him, they left him lying on the bed (naked), curtains all open"[5]

"I was both shocked and appalled at the callous attitude of the nursing staff on the ward"[5]

"I found my mum's dignity was non-existent in their eyes"[7]

"There were problems with preserving dignity and individuality when meeting patients' essential needs"[8]

"The GP just says 'confused.' She's never explained it"[8]



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that allow older people to feel that they are retaining their dignity and autonomy. The feedback shows that information provision and the quality of interactions between staff and patients are key issues. They are key, too, in the findings of research into good practice in acute hospitals in England.[18]

Tackling negative attitudes through training

The qualitative data cited in this article suggest that attitudes of staff greatly affect both the quality of treatment of older people and the regard given to maintaining their dignity and autonomy. This is a concept well supported by scientific literature: "A nurse's pessimistic viewpoint can translate into a loss of dignity, identity and decision-making power for seniors."[9] And indeed, the evidence suggests that a considerable proportion of medical professionals hold pessimistic views of older people. A survey of nurses and students working with older people in the clinical setting concluded that the sample "expressed stereotypical views about old people in general."[19] Such findings are supported by the recent report by the UK Health Advisory Service: "We did encounter examples of prejudiced attitudes towards older people and their care at almost every level of the service system."[1] Researchers conducting literature reviews have reached similar conclusions.[20] Alarmingly, some research has suggested that many professionals hold more ageist attitudes than the general population.[21]

The literature shows that a key means of tackling poor attitudes by staff towards older people is through extensive and continued training. One study reported that more positive attitudes towards older people were found among nurses working in elderly care than among those working in acute care (which covers all ages) and attributed this to a more specialised training in gerontology.[22] Swedish researchers reported that after a year of special education, medical trainees came to view older people with dementia as "unique human beings" rather than "a homogeneous group."[23] Another study reported more favourable attitudes towards the care of older people among students attached to a geriatric ward than among those attached to a general ward.[24] It seems, then, that training in geriatrics has a positive effect on the attitudes of staff. In fact, the evidence shows that mere exposure to certain groups of older people is beneficial. Older students and those with grandparents as role models have been found to have better attitudes towards older people.[25] Indeed, several authors have written about the importance of healthcare staff being exposed to older people who are healthy as well as to those who are patients.[9 19] Increased and improved training and exposure to older people is also likely to do much to raise the status of geriatrics.[24] Improved status is likely to have a positive impact on attitudes and encourage more individuals into the field,[26] which in turn will benefit older patients.[27]

Currently there is a "hotch-potch of training and qualifications,"[28] with many staff having received no specific training in the needs and care of older people.[1] Such training should be mandatory for all health service staff—not limited to those who work only with older people.[29] Staff who are trained and experienced in geriatrics will be not only better equipped to treat older patients but also more sensitive to issues surrounding an older person's dignity and autonomy.

Positive comments of older service users and their carers

"My consultant was excellent. He came in on a Saturday to do an operation which had been cancelled on Friday"[6]

"The ward was spotless; the staff were caring and attentive"[17]

"The doctors and the surgeon who performed the operation were caring and took time to explain the details to me and her in full"[17]

"I thought it was lovely how they discussed and told you everything, and the consultant drew a diagram to show me exactly what they were trying to do—sat on the end of the bed"[18]

"What I like—this is good—they said, 'What do you like to be called?' "[18]

Information provision

Older people and their carers need to be given adequate information to enable them to make informed choices about care. This is necessary at every stage of treatment, including "end of life" care.[30 31] The literature recognises that effective communication and information provision are fundamental principles of quality health care[15 32 33] but also highlights that these principles are often neglected.[7–13 34 35] The autonomy of older people (and their carers) from ethnic minority groups is further threatened by the fact that medical practitioners are often unaware of cultural sensitivities,[36–38] and information is rarely available in these patients' mother tongue.[39 40] Documents on good

practice suggest that when such barriers are overcome, the benefits are plentiful.[41] If patients' autonomy is to be maintained, information should be readily available in appropriate formats or languages, be provided in a supportive and sensitive manner, and be reinforced by staff throughout treatment or care.

The second article in this series will examine health promotion and disease prevention in old age; the third article will discuss quality in the care of older people with mental health problems; and the final article will examine physical frailty in old age, in particular the prevention and management of falls.

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One hundred years ago

"Kissing the book"

We are glad to see that some progress is being made towards the abolition of the uncleanly and dangerous English practice of administering the oath by requiring a witness to "kiss the Book." At first many judges appeared to be unaware of the existence of the Oaths Act, 1888, and often refused to allow witnesses to be sworn in what is called the Scotch fashion prescribed by that Act. From a note in the *Daily Mail* of March 15th we learn that Judge Bacon, in the Bloomsbury County Court has now advanced so far as to offer to have a witness sworn in the Scotch fashion. It is true he could not forbear a sneer at a witness who had made a pretence of kissing the Book, "That is too transparent;" said the judge, "if you have got a fad about microbes, you should say so, and I will swear you Scotch fashion." This offer marks a distinct advance, although it would have been more satisfactory had the judge set an example and carried out the law in a more gracious fashion. Possibly Judge Bacon is one of those people who have never seen a microbe through the microscope, and who have not taken the trouble to make themselves acquainted with the elementary facts of bacteriology. They are known to the man in the street, but the ignorance of judges with regard to matters of common knowledge is proverbial. The *City Press* is responsible for the statement that the two Testaments in the City of London Court are kissed by 30,000 persons annually, while a police-court usher is said to have stated that the covers of his New Testament had been worn smooth and well polished from the pressure "of numberless lips, bearded and beardless, blooming and faded, honest and lying, foul and sweet," as some 49,760 witnesses were sworn in that court annually. There can be no question whatever about the right to be sworn in the Scotch fashion, for Section v of the Oaths Act, 1888, runs as follows: "If any person to whom an oath is administered desires to swear with uplifted hand, in the form and manner in which an oath is usually administered in Scotland, he shall be permitted so to do, and the oath shall be administered to him in such form and manner without further question." We are informed that the members of the Leyton Medical Society have agreed invariably to adopt this form, and the matter is one upon which the medical profession might very well continue to preach by example. (*BMJ* 1901;i:726)