Interview with Dr. William Kane

On Elderly Health Care Stereotypes

by Claude Reed, Jr.

Dr. William Kane is a member of the Hartford Gereatric Project, in Hartford Connecticut. The project specializing in health care for the elderly. At present, they are waging a serious battle to reverse the stereotypical perception that is held regarding the elderly and their health concerns. In the following interview Dr. Kane explores these stereotypes and proposes solutions. He is also a member of the American Academy of Family Physicians.

NS: The Congressional Black Caucus Committee on Aging released a report which reflects a dramatic increase in poverty among Black elderly. The report states that over 1/3rd of the nation's Black elderly are living in dire poverty. Now that the government plans to cut medical services for the already financially burdened elderly, preventative care seems to be a viable alternative. Can you illustrate the concept and application of preventative care and how it can offset the expense of the elderly seeking professional help in later years?

KANE: I think there are a couple things you need to understand and your comment about the Federal funds being cut is one that I will expand on just briefly. Medicare and Medicade specifically as they have cut the budget or changed those programs actually pay for less and less preventative care. That's one of the major criticisms about those programs. They are much more likely to pay for acute care and not reimburse for doing certain things for patients ahead of time. I think as far as the elderly in trying to be preventative, you really are talking about not so much of treating the elderly person, but trying to get the person who's 40 or 50 to adopt life-styles that will insure that they will be healthier by the time they are 70 or 80. I am afraid sometimes people define preventative care in trying to do chest x-rays or other things. I am not sure that's what we are talking about. I think when you talk about preventative care for the elderly, you really are talking about trying to get rid of things that we know we can prevent. Healthy life styles, getting people to stop smoking, get them to exercise and stay active, getting them to control blood pressure and take medication as directed. I think all of those things create the big impact in preventative care. As far as the elderly people are concerned, when they do get old, some problems stem from non-medical things. Proper

nutrition, proper support services. Trying to keep the elderly active. Many times I think in our push to help the elderly, you make them dependent rather than independent. Many of our programs, again, require somebody to divest themselves of whatever independence they have before they are eligible for certain programs. We need to look at the incentives in our programs which are, I think, many times wrong.

NS: I've read an article on you in Patient Care magazine in which you mention that an objective of the Hartford Geriatric Project is to improve the education of family physicians in geriatric medicine. What is presently being done to arrive at that objective?

KANE: I think not only family physicians, but physicians and all health professionals need to understand a great deal more about the elderly. I make a distinction about what I would put out first and that is, a lot of people use the cut-off of 65 years of age and in this country that probably isn't the cut-off. That's a political-social security designation. What we're really talking about is changing and improving the knowledge and skills of health professionals, family physicians and other physicians to take care of those over 75. What is now being done, at least in my discipline of family practice, is a couple of things. The American Board of Family Doctors certifying exam now includes a segment on geriatric medicine as part of the questioning for board certification. The American Academy of Family Physicians has really stepped up its process of continuing education for family physicians already in practice. So a lot of our programs include material on geriatric medicine. And then finally the Society for Teaching Family Medicine has begun to look at issues of putting better education in our residency program. We met at a national conference in Philadelphia for Family Physician Educators (those who teach family doctors,) to improve their skills and organize their trade. I think we've started. We have a long way to go though to really make physicians appreciate the tremendous differences in care for the elderly people. The different way they present the disease, the different way they treat it, all of the different problems. Medical schools themselves are beginning to look hard at their problems. One of the difficulties you have right now is that in the current climate there is very little additional funding available to try to put these programs into our medical schools and into our residencies. I think we have to find some way to gain additional faculty and other things we need to put these educational programs into practice.

NS: Also, in that same article in Patient Care, you mentioned that financial barriers to provision of nutrition, home and health services and short term respite institutional care must be eliminated. Do you have any suggestions as to how this may come about?

KANE: In today's economic climate, I'm not sure how this may come about. We definitely have a problem because as the programs get cut certainly, Meals On Wheels, for instance (which is a nutritional project) is going to suffer as less people are going to receive that service. In terms of some of the other barriers, by "respite care" I mean in this country where