Letters to the Editor


To the Editor:

Several studies have shown that the majority of behavioral expressions (such as aggressive behaviors and resistance to care) among long term care residents with dementia are caused or triggered by an observable event in the social or physical environment.1–3 The guidelines for treatment of agitation in dementia are consistent with these findings: "Agitation may also emerge as a primary feature of a dementia syndrome, although in the majority of cases an explanation will be found in an examination of the patient's interactions with his environment."4

In addition, previous research indicates that a large portion of behavioral expressions among persons with dementia is caused by unmet physiological, psychological, and social needs.5,6

The clinical importance of the aforementioned findings and experts' opinion relates to the fact that understanding the "meaning of the sequence of events" and situational triggers leading to behavioral expressions2 and meeting the underlying needs are the primary keys to their prevention.

Based on these research findings and experts' opinions, it is suggested that the use of the term "behavioral symptoms" among persons with dementia should be considered as potentially inaccurate and misleading. This term is frequently used in dementia care settings, the gerontological literature, and the Minimum Data Set 3.0 (Section E—Behaviors). The time has come to examine the problematic nature of this term and consideration should be given to replace it with a more suitable one.

Using the word "symptoms" could imply that these behaviors are an inevitable and direct consequence of dementia, which in the majority of situations is not the case. Specifically, there is a great variability in the behavioral manifestations across individuals with dementia as well as within individuals over time. In addition, research has shown that the level of cognitive functioning accounts for only a small percentage of variance in behaviors, which suggests that other factors may play a larger role than cognitive impairment in predicting behaviors.8 In accordance, a study9 in 53 dementia special care units has found a substantial variability (0%–38%) in the levels of agitated behaviors across units. Specifically, the quality of the physical environment and the amount and quality of the interactions between staff and residents (including staff attitudes toward residents) were found to exert strong influences on unit agitation levels.

Perceiving behaviors as symptoms reflects and perpetuates the deterministic biomedical view of dementia that tends to place the origins of behavioral expressions inside the person with dementia and/or her/his brain pathology. Lyman,10 in her article Bringing the social back: A critique of the biomedicalization of dementia states, “Caregivers who interact daily with persons with dementia often attribute most of the person's behavior to the presumed clinical condition.” This author explains that “the problem with this misperception is that “many of the ‘behavior problems’ associated with dementia may be traced to problems in the caregiving relationship, which are overlooked if the behavior is attributed to the disease. The medicalization of dementia shifts attention from problems in the social situation of caregiving to locate problems in the pathophysiology and misbehavior of the person with dementia.” Attributing the ‘behavior problems’ predominantly to the disease runs the risk of excess disability and in certain situations use of blame-the-victim approach. As explained by Sabat,11 "From strict medical/technical approach, behavior problems have been viewed generally as caused by brain pathology alone and, as a result have been deemed to be symptoms of the disease, rather than reactions to the social milieu in which the afflicted person lives.”

The term “behavior symptoms” as it is currently used in practice, the literature, and in the Minimum Data Set 3.0 should be replaced by more suitable terms. The following terms, as reported in the literature, are suggested as candidates as they more accurately reflect the origins and true nature of these behaviors in persons with dementia. These include expressive behaviors,12 reactive behaviors,13 and responsive behaviors.14 These terms reflect and provide further support for a recent experts' recommendation for using the term “behavioral expressions” as outlined in the White Paper of the National Dementia Initiative.15

The recent national initiative of the Centers for Medicare and Medicaid Services to reduce the excessive and inappropriate use and negative consequences of antipsychotic medications in nursing homes further highlights the need to ensure that practitioners and researchers will use accurate terminology—one that reflects personalized practices that recognize and support the whole person.15 One potentially problematic consequence of classifying behavioral expressions as symptoms is that when such classification is made it may be more likely that interdisciplinary care teams and researchers will look for the solutions for these “symptoms” in pharmacologic treatment. This, while the first line of treatment for behavioral expressions and aggressive behaviors (that do not present immediate danger to the resident or others) in persons with dementia consists of nonpharmacologic interventions.4

References

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To the Editor:

Aging is becoming more of an impending challenge in current China than ever before. Clinical geriatric practices and geriatricians do not seem to be well prepared. Hence, the objective of our study was to disclose the current status of Chinese geriatricians and call for urgent reform in geriatric clinical practice.

A total of 98 geriatricians were recruited in 2011 at the 3 largest general hospitals in Chengdu, China. The survey was conducted using an anonymous questionnaire, which included information related to educational background, knowledge of the modern art of geriatrics, practice style, and self-estimations.

Most geriatricians are middle-aged, with more than two-thirds of physicians younger than 45 years. In terms of working years, most had not worked more than 5 to 10 years in the field of geriatrics.

Basically, 28.5% of the geriatricians surveyed have a PhD, and 37.1% and 34.3% have a Master’s Degree and Bachelor’s Degree of medicine, respectively. None of them received specialty training in geriatrics.

Based on the research, more than 90% of geriatricians believe that multiple comorbidities are a characteristic of elderly patients. Geriatricians with clear thoughts of their elderly patients of dysfunctions, high possibility of accidents, or multiple organ failure, and geriatric syndrome with its relevant problems account for 51.0%, 68.4%, and 61.2%, respectively.

Approximately 90.6% of geriatricians called for consultation at a frequency of 1 to 5 times per week in their daily work. The subdivision of internal medicine made up about 60% of all the departments consulted. Consultations from psychiatry and the nutrition department were only about 2.2%.

Of the geriatricians, 74.5% knew a little about the geriatric syndrome, whereas 11.2% were familiar with it. Surprisingly, 14.3% of geriatricians had never heard of the geriatric syndrome. In comparison, geriatricians who were not aware of the Comprehensive Geriatric Assessment (CGA) occupied approximately one fifth, whereas those who had some knowledge accounted for about 71.4%. Approximately 8.2% had attended training courses.

With regard to the application of CGA, 19.6% of geriatricians had never applied the CGA to their patients. Only 12.4% geriatricians regarded the CGA as a routine tool. Similarly, 14.4% of geriatricians often apply it to their elderly patients. In contrast, geriatricians who tried using the CGS accounted for, at the most, 53.6%.

Geriatricians who are satisfied with their job made up only 27.8% of those surveyed, and 40.8% of geriatricians thought their specialized skills and knowledge need improving. In addition, cooperation with other departments was the second most serious aspect that geriatricians thought needed enhancing (37%). Furthermore, 23.5% believed that practice style required mending and 10.2% noted that some other disadvantages need improvement, such as the systematization of work.

There is concern about geriatric medicine in current China because only a very few doctors are called geriatricians and they are mainly working in large general hospitals. Also, according to this survey, the work status of Chinese geriatricians is not as expected, which may result in insufficient clinical outcomes.

Setting up a nationwide educational program in geriatrics and a licensing system is urgently needed. This may improve the knowledge of geriatricians and help them to be more professional.

In addition, organizing multidisciplinary teams may benefit elderly patients. Through the cooperation of different occupations, doctors and nurses, as well as social workers, dieticians, physical therapists, pharmacists, and psychologists, will contribute to the whole recovery process for patients. The communication among various specialties can facilitate the development of interprofessional groups.

In summary, it is of crucial importance to improve specialty training of Chinese geriatricians and reform the clinical geriatric practice mode by setting up multiple disciplinary teams.

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