Geriatric Rehabilitation. 5. The Societal Aspects of Disability in the Older Adult

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This self-directed learning module highlights the societal aspects of disability and the older adult. It is part of the study guide on geriatric rehabilitation in the Self-Directed Physiatric Education Program for practitioners and trainees in physical medicine and rehabilitation and geriatric medicine. This article specifically focuses on ethical issues, including capacity, psychodynamics, sexuality, community integration, work, leisure skills, and the issue of driving a motor vehicle.

Overall Article Objective: To summarize the societal aspects of disability and the older adult.

Key Words: Automobile driving; Ethics; Geriatrics; Rehabilitation; Sexuality; Vocations.

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5.1 Clinical Activity: To justify your discussing care issues with the adult daughter of your 75-year-old outpatient who has decreased safety awareness.

The physician must be aware of changes in cognition and functional independence that may alter social roles. Adult children often assume a more parental role as their parents age, and these role reversals can cause conflict among family members. Many caregivers, whether children or spouses of an aging person, are concerned about safety, whereas that person may be more concerned with preserving his/her independence. This conflict may become apparent when the physician discusses driving, fall prevention, medication management, or continued independent living.

Driving a vehicle, in particular, may be an area in which family members may deny deficits. Denial is a common reaction to stress, and acknowledging the need to limit a family member’s driving translates into new family tasks and responsibilities. Driving is discussed in detail later.

Competency

Competency is a legal determination. In the United States, adults are competent unless a court judgment finds otherwise. If a court determines that a person is not competent, then a guardian must be appointed. A guardian, also called a conservator, custodian, or, in some states, curator, is frequently a family member. He/she has court-ordered authority to manage the incompetent adult’s finances and estate. A durable power of attorney (DPA) is a legal document that gives a named individual authority to manage someone’s financial affairs if the principal, the person who signed the document, becomes incapacitated. A DPA for finances or for health care can specify that it does not go into effect unless a doctor has certified incapacity. The attorney-in-fact, or named agent, must always act in the best interests of the principal, must maintain accurate records, must keep the principal’s property separate from his/her own, and must avoid conflicts of interest.

Most caregivers and family members are willing and able to make decisions in the best interests of their older relatives. Physicians should be aware of potential conflicts of interest between cognitively impaired individuals and their caregivers, especially when financial matters are involved.

Elder Abuse

Clinicians should actively screen for evidence of elder abuse, especially in vulnerable populations. Despite a prevalence estimated to be just slightly less than that of child abuse, elder abuse in its many forms (physical and sexual, 14.6%; financial exploitation, 12.3%; neglect, 55%) is seldom recognized or reported, especially by physicians (<2% of all reports). Every state has at least 1 statute providing immunity from civil or criminal liability to anyone who in good faith makes a report of abuse. Asking “Has anyone touched you without your permission?” or “Do you feel safe at home?” may uncover abuse.

Most elder abuse occurs in community residential settings, not institutions, and most often the perpetrator is the victim’s adult child or spouse. In 45% of cases, the abuse is categorized as neglect. Research has shown that the abusers are likely to have problems related to alcohol and drugs. The mnemonic SAVED can determine if a person is at risk for abuse: Stress, in the life of the caregiver; Alcoholism, or other substance abuse; Violence, domestic violence grown old; Emotions, ineffective coping strategies for emotions on the part of the abuser; and Dependency, particularly if either the victim or the abuser is financially, emotionally, or physically dependent.

5.2 Clinical Activity: To support the decision of a 75-year-old resident in an assisted-living facility to refuse rehabilitation intervention.

Aging is a process that encompasses emotional and physical changes. Although reactions to aging vary from person to person, the normal aging process includes integrating changes in one’s social roles, physical abilities, and appearance into one’s sense of self. Seniors’ reactions to aging are based not only on the medical and physical conditions that affect them as they age but also on their lifelong psychologic strategies for dealing with stress and life changes. For some, resistance to the changes of aging is primary, whereas to others acceptance and accommodation are key. Another coping strategy is to sidestep reaction to change and loss.
A key aspect of rehabilitation is to establish goals jointly with the patients. In many settings, the clinical and therapy staff may be several generations younger than the residents. The clinicians’ viewpoint concerning the benefits of therapy may include values the resident does not share. When offering interventions to meet the goals set by seniors, clinicians should be knowledgeable and forthright about the time, effort, and cost of achieving these goals. The MacArthur longitudinal study of successful aging of men and women between the ages of 70 and 79 years showed that self-efficacy beliefs have important impact on quality of life (QOL) independent of actual physical abilities.

For community-dwelling elderly persons, physical dependence on others may be a source of mutual growth for the extended family support structure. Culture, both societal and familial, may affect how seniors view changes in their present capacities. Clinicians should look for evidence of disinterest in participating in activities other than therapy to help distinguish acceptance of deficits from apathetic depression.

5.3 Clinical Activity: To counsel an 80-year-old couple who are experiencing sexual difficulty.

Sexual dysfunction is high in elderly persons of both genders, and it rapidly increases with age. Many causes are gender specific and can best be considered separately.

Male Sexual Issues

Erectile dysfunction affects 2 of every 3 men over age 50. A thorough medical evaluation is necessary to determine risk factors of hypertension, diabetes mellitus, cardiovascular disease (CVD), renal failure, and pharmacologic side effects, as well as obesity, tobacco, alcohol, and illicit drug use. A wide variety of treatment options are available, including management of medication side effects, pharmaceutical treatments, intracavernosal injections, testosterone replacement therapy, vacuum erection devices, and penile prostheses.

It is important to distinguish disease from the physiologic aging process. Serum levels of male hormones steadily decline as men age, resulting in a variety of changes. Hypogonadism, defined as less than 70ng/dl of bioavailable testosterone, is closely associated with decreased libido and may contribute to erectile dysfunction. Male hormone replacement therapy (HRT) for normal aging is still under investigation.

Female Sexual Issues

Libido changes and sexual activity must also be considered during a thorough psychosocial assessment on elderly women. In the Berman and Goldstein study, women under 60 complained of sexual dysfunction at a rate of 43%, and the incidence was much higher for the aged and medically at risk. The ideal approach to sexual dysfunction would be collaboration between therapist and physician and would include the partner, when appropriate. Recently, attention has focused on physiologic factors that affect female sexual function, although HRT is the only medical management currently beyond experimental phases. Use of testosterone in ovarian failure and sildenafil in various arousal dysfunctions shows promise. Many of the medical risk factors affecting male sexual function also affect females, such as aging, hypertension, cigarette smoking, pelvic surgeries, and medicine side effects (especially the selective serotonin reuptake inhibitors). Although the research in sexual dysfunction in women lags behind that for men, the effects of various medical conditions on female sexual health and function are under investigation in such areas as multiple sclerosis, spinal cord injury, and traumatic brain injury, among others.

5.4 Educational Activity: To discuss the rehabilitation and return to work considerations for a 78-year-old fast food worker 8 weeks after a 2-vessel coronary bypass graft.

CVD is a leading cause of death for Americans. It is the leading cause of death for both the over-65 and over-85-year-old age groups. The number of coronary artery bypass graft (CABG) surgeries performed on patients older than 65 years has risen over the past 10 years. These procedures, as well as postoperative exercise programs, have been reported to increase functional capacities in the elderly population. Premorbid functional capacity, concurrent morbidity, and postoperative exercise programs are associated with functional capacity at 1 year.

Before a CABG patient returns to work, his/her job demands and specific job requirements, such as bending, lifting, and standing, must be evaluated. To safely return to employment, the patient must have a current medical and functional status sufficient to meet his/her job demands. Perceived exertion scales or correlation of the patient’s metabolic equivalents (METS; 1 MET = 3.5 mL/kg·min−1 of oxygen consumed) tolerance to job requirements can serve as a guide. General guidelines for METS tolerance include those in table 1. If further evaluation is needed, a functional capacity evaluation can be obtained.

The American with Disabilities Act (ADA) of 1990 protects the patient’s right to pursue return to work when medically appropriate. A job offer may be conditioned on the results of a medical examination but only if the examination is required for 1% of all entering employees in a similar job. Age discrimination issues have been addressed at a federal level. The Age Discrimination and Employment Act of 1967 protects people who are 40 years of age or older. Title I and Title V of the ADA prohibit employment discrimination against qualified people with disabilities in the private sector and state and local governments. Specific ADA definitions for person with a disability, a qualified person with a disability, and reasonable accommodation can be found on the ADA website. Despite these laws and regulations, discrimination against the elderly and those with disabilities persists.

As age demographics of the United States change, more elderly people are staying active in the workforce after age 65. Industries such as fast food establishments and retail trade have had success in hiring retirees in part-time positions. These industries note the benefits of older workers, who have lower absentee rates and more reliability than their younger colleagues.

For the older worker, employment has a positive effect on their mental health, life satisfaction, and marital satisfaction. The largest factor affecting the decision to retire and a large determinant of perceived QOL is financial. The issues of medical status, job requirements, potential discrimination, and reason (financial or psychologic) to return to work all must be considered.
5.5 Educational Activity: To discuss opportunities to participate in community life for an 82-year-old woman with right hemiparesis.

Return to community life and social integration is an important goal of a comprehensive rehabilitation program. Successfully returning a patient to community life requires that the clinician understand his/her medical, functional, social, and financial status and to be aware of available community resources. A history of community activities, social involvement, and interests provides a basis for optimal individualized goal setting aimed toward return to the community.

Functional status and home structure guide the need for formal and informal care support. Nonpaid family and friends provide up to 80% of the needed assistance for persons in the community who would otherwise need long-term care. In 2000, an estimated $18 billion in Medicare resources were spent in home- and community-based settings to maintain the elderly population in those settings. This figure represents more than 25% of Medicare's long-term care dollar expenditure for the year. In addition to physical interventions and those based on adaptive equipment, the architectural structure of the dwelling must match individual needs. Information on housing (modifications, financing, home meals, apartments, assisted living, discrimination, in-home help) can be found at the US Housing and Urban Development website. Medicare provides limited to no reimbursement for these types of interventions.

Transportation services are a vital link to out-of-home activities (work and leisure). The US Division of Transportation is the designated agency with regulatory and enforcement responsibilities for people with impairments. All current and future fixed-rail and bus systems across the United States must be fully accessible. Further, supplemental paratransit services are required to be demand responsive for those who do not have access to a fixed-route service. Recreational facilities, such as amusement rides, boating facilities, miniature golf, fishing piers, golf courses, sporting facilities, and swimming pools, have accessibility guidelines that provide opportunities for the elderly or disabled persons. The United States Tennis Association, United States Golf Association, and multiple nongovernmental organizations have both competitive and recreational level opportunities to participate in sports, based on age groups, disabilities, or functional status. Equipment companies and industry have recognized this growing segment of the population and have begun manufacturing and marketing adaptive equipment targeted to disabled persons.

The benefits of leisure and community activity are both physical and cognitive. Participation in physical activities can improve a patient's balance, decrease anxiety and depression, assist with pain management, and increase one's ability to maintain functional independence. Recent research by Verghese et al and by Colye has shown that participation in leisure activities, such as reading, playing board games (chess, checkers, backgammon, cards), playing musical instruments, and dancing, are associated with a reduced risk of dementia. These findings add new meaning to the admonition "use it or lose it." Community integration has positive physical, cognitive, and psychosocial benefits for the individual and is an important and integral part of the rehabilitation process. The value of these issues is reflected in recent legislation, development of new products, and overall increased awareness of the elderly and disabled population.

5.6 Clinical Activity: To critique your decision to authorize a 73-year-old man who has had a stroke to resume driving.

In the United States, the ability to drive a motor vehicle is a crucial aspect of maintaining functional independence in the community. Assessing driving ability after a stroke is important for patient independence and community safety. Intact vision and attention are important factors for safe driving and are often impaired in stroke survivors. In the general geriatric population, heart disease, stroke, arthritis among women, dementia, diabetes, and multiple medications are associated with increased risk of vehicular accident. Accident rates for drivers age 80 to 85 are 4 times higher than those for persons 40 to 45 years. Drivers over age 85 are 10 times more prone to accidents. Of concern, adults with mild Alzheimer's disease, (clinical dementia rating [CDR], 0.5) have a risk of accidents similar to that of teenage drivers and that of alcohol-impaired drivers (blood alcohol concentration, <.08%). Doctors must render opinions on driving fitness, but their knowledge is very poor on current licensing policies and actions to be taken for potentially ineligible drivers who have epilepsy, myocardial infarction, stroke, or diabetes mellitus complications.

A thorough evaluation is suggested before releasing a patient to drive. A detailed driving history should include information about self-reported difficulty driving at night, accidents, and traffic violation tickets. It should also include driving-related information from observers. A review of medications should note those likely to impair driving, such as opioids, benzodiazepines, antidepressants, hypnotics, or antihistamines, some of which might be changed to non-sedating alternatives. Clinicians should consider illnesses that may cause sudden variability in levels of consciousness, particularly for persons with diabetes who are at high risk for hypoglycemic episodes. The CAGE questionnaire for alcoholism evaluation (C Have you ever felt the need to cut down on your drinking? A Have you ever felt guilty about your drinking? E Have you ever taken "eye-openers" drink first thing in the morning?) or a similar screening for alcohol use is indicated. Functional assessment should include vision, hearing, attention, visuospatial skills, judgment, muscle strength, and joint flexibility.

High-risk cases and complicated cases may require referral to psychiatry, neurology, neuropsychology, and/or occupational therapy for more intensive evaluation. Many driving skills tests have been devised to evaluate people for safe driving ability before road testing. Presently, the definitive assessment for stroke patients has not been determined. Some illnesses that impair driving have more defined criteria, such as an up to 1-year seizure-free period for epileptics, although state laws vary. Specific practice parameters exist for persons driving with Alzheimer's dementia. People with a CDR of 1 or greater have a substantially increased accident rate and driving performance errors and therefore should not drive an automobile. Those with a clinical CDR of 0.5 pose a significant traffic safety problem when compared with other older drivers and require referral for a driving performance evaluation by a qualified examiner with reexamination every 6 months.

Many impaired elder drivers voluntarily stop driving or adjust their driving to compensate successfully for their limitation. The Council on Ethical and Judicial Affairs of the American Medical Association concluded in 1999 that a "... tactful but candid discussion with the patient and family about the risks of driving is of primary importance..." and that "Efforts made by physicians to inform patients and their families, advise them of their options, and negotiate a workable
plan may render reporting unnecessary.** For those who refuse to stop driving when impaired, physicians should inform the department of motor vehicles (DMV) of their medical opinion. Many states require a medical release before a driver's license is provided, and some require physicians to report certain diagnoses (eg, Alzheimer's disease in California) to the DMV. Doctors should familiarize themselves with the medical regulations for driving in their state.

**References**


*Key references.*