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# PROFESSIONAL PERSPECTIVES ON PREVENTION FOR THE ELDERLY: COLLABORATION AND ROLE DIVISION

Rosalie A. Kane



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# PROFESSIONAL PERSPECTIVES ON PREVENTION FOR THE ELDERLY: COLLABORATION AND ROLE DIVISION

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Abstract

Every profession giving health or social services claims prevention as a goal. Physicians and nurses want to prevent disease and disability; pharmacists want to prevent drug misuse; physiotherapists want to prevent immobility; social workers hope to prevent family conflict, social disruption and isolation. Each profession respects prevention as a sensible, humane, and perhaps cost-effective approach to human problems.

Even though theoretical enthusiasm is high, practicing professionals tend to leave the operational part of prevention to others. When health care professionals and social service workers do address prevention, they tend to do so in a haphazard manner.

Professional Perspectives on Prevention for the Elderly, a paper first delivered at the 6th National Conference of the Israel Gerontological Society, suggests that while multidisciplinary, prevention-oriented teams of experts might provide an effective approach to the medical and psycho-social problems of the elderly, there are a number of pitfalls that need to be addressed.

After reviewing various models and theories of prevention, the paper outlines the nature and difficulties of cross-professional participation in preventive care. Alternative forms of teamwork are discussed, including referral, consultation and case management. Finally, emphasis is laid on consultation with the views of the elderly themselves in the process of setting preventive goals.

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## Introduction

Every profession giving health or social services claims prevention as a goal. Physicians and nurses want to prevent disease and disability; pharmacists want to prevent drug misuse; physiotherapists want to prevent immobility; dentists work to prevent tooth decay and gum disease; mental health workers strive to prevent mental illness and promote positive mental health; social workers hope to prevent family conflict, social disruption, and social isolation. Each respects prevention as a sensible, humane, and perhaps cost-effective approach to human problems. My perspective on this topic, therefore, is not that of a social worker, but that of one interested in the organization of services and care.

Even though theoretical enthusiasm is high, practicing professionals tend to leave the operational part of prevention to specialized units or organizations that are expected to do something about. In the United States, major reponsibilities fall to local public departments, especially for disease screening, immunization, environmental surveillance, and the cluster of programs loosely called "health education". School health programs are well-established and are perceived as an investment because they socialize youngsters into better health habits. Various federal and state agencies also have responsibility for promulgating accurate information on matters of significance to health - although their messages sometimes are scarcely heard amid the more conspicuous messages of those who sell and advertise products.

When health care providers and social service workers address prevention, they tend to do so in a haphazard manner. Some doctors warn patients about the evils of smoking; some social workers develop

classes in parenting; most dentists instruct their patients in the intricacies of dental flossing. Still, it is fair to say that prevention tends to be everybody's business and, therefore, nobody's business.

People who regularly encounter the problems of older people naturally formulate ideas and hypotheses about how these problems might be prevented, postponed, or at least minimized. The physician who sees the havoc that can be created by a broken hip, the social worker who notices an alarming increase in abuse and neglect of the elderly by their relatives; the hospital official who notices that many elderly people seek institutional care because their homes are unsuited to an invalid - all such professionals are bound to think wistfully of a preventive effort. Undoubtedly, cross-professional efforts are necessary to examine the problems properly, to test likely points of intervention, and to establish some coordinated and consistent priorities. In fact, the kind of expertise needed for a long-range preventive approach to the problems of older people - at least in the United States - may go far beyond conventional health and social service providers to include builders and architects, communication and media specialists, city planners, recreation personnel, and so on.

Professionals tend, probably correctly, to assume that preventive approaches are good. We tend, also probably correctly, to assume that multiple professional perspectives and involvement are helpful in solving problems. Following this reasoning, what could be better than a multiprofessional team approach to the prevention of health and social problems for the elderly? However, both prevention and

teamwork require cautious advocacy. A preventive strategy can be futile and wasteful of resources if it is targeted to the wrong people, if it is too slight and infrequent an intervention to be expected to make much difference, or if it is based on unsound information about risk factors. And a team strategy can also be ill-advised unless clearly dictated by the nature of the work to be done. As one moves to a coordinated strategy for prevention for the elderly, it is indeed important to involve a wide range of professions; but both the prevention and the collaboration should be carefully planned.

I have organized my comments into three general sections. First, I shall discuss prevention in the elderly in order to highlight the necessity of multiple perspectives; second, I shall discuss cross-professional activity in general, laying out a variety of modes and suggesting the advantages and disadvantages of each; and I conclude with specific multiprofessional approaches to prevention for the elderly.

## Prevention for the Elderly

Prevention, of course, is not a term that stands alone. There must be an object of prevention - one can only consider prevention in the light of the particular problems or conditions that one tries to prevent. This statement is trite and obvious, yet it is necessary in order to counter the general and vague rhetoric about prevention. It is no more feasible to take a general approach to prevention in the elderly than a general approach to cure.

What do we want to prevent in older people? Without repeating Robert Kane's discussion about risk factors in the elderly, it might be useful to list some principles that can be extrapolated from his

earlier talk at this conference:

- The World Health Organization's classification of disease, disability, and handicap is particularly pertinent to the elderly. With many older people, useful efforts can be directed toward preventing disability, secondary to disease, and to creating conditions that promote independence, despite handicaps.
- Social, psychological, and medical factors are involved both as problems to be prevented and as risk factors. We are interested in preventing stroke, depression, and social isolation, to take examples in each category. Physical factors can increase risks for social problems (e.g., deafness may be a risk factor for social isolation) and similarly, social factors may add to the risk of physical problems (e.g., social isolation may be a risk factor for early detection of cancer). With the physical, psychological, and social so intertwined, prevention is necessarily a multidisciplinary affair.
- Prevention requires attitudinal and behavioral change on the part of older people themselves. It is the older person whom we expect to stop smoking, comply with antihypertensive regimens, remain socially active, and generally behave in a healthy manner - and that older person has the last word about implementing many prevention strategies.
- Prevention may require attitudinal and behavioral change in family members of older people and in the general public. Disability, handicap, and dependence can be created by low expectations and overly protective attitudes in persons who

are influential in the lives of older people.

- Prevention also requires attitudinal and behavioral changes in those who provide health and social services. Some preventable problems of older people are created by the very service systems that are designed to treat them. Medical treatments are expected to have side-effects and, because calculated risks must be taken, not all iatrogenic problems are preventable. However, much disability secondary to drug use, surgery, and bedrest is preventable. More subtle iatrogenesis is caused by missed or incorrect diagnoses; if an elderly person is mislabelled demented or hopelessly incontinent, a chain of undesirable events may be set in motion.
- Social service personnel can also create iatrogenic problems - iatrogenesis is not the sole prerogative of the powerful physician. Social service programs can disrupt natural support systems, foster dependency, and hasten institutional care. We in the United States are chastened by a 1971 study in Cleveland to test the effect of a preventive approach to the frail elderly at home. The experimental group that received the ongoing help of a specially qualified team was more likely to end up in institutions and had higher mortality rates than the control group whose services were gathered on a catch-as-catch-can basis (Blenkner et al., 1971).

What do we want to prevent in older people? Certainly, it is good to prevent disease when possible. An obvious example of primary

prevention in this regard is an immunization campaign for influenza. We also hope to reduce risk factors for diseases such as stroke, hypertension, osteoporosis, heart disease, and cancer. This will require behavioral change by the elderly (cessation of smoking, perhaps modification of diet or exercise, bringing certain conditions to medical attention, and complying with preventive regimens). Simultaneously, it may require change on the part of the providers, who will need to conduct new kinds of educational and health promotion efforts. Disease prevention can also be undertaken in the form of secondary prevention, that is, screening and early detection. For example, pap smears, breast exams and self-exams, and glaucoma tests all fall in this category.

We also hope to prevent a variety of conditions and problems that have social and psychological elements. Certainly, one wishes to prevent accidents that lead to fractures and other disabilities. One wants to prevent mental health problems such as depression. In the United States, we know that men over age 65 constitute the highest risk group for successfully completed suicides. We are also painfully aware that we have created an institution - the nursing home - which seems a guaranteed formula for causing its residents to be depressed. We want to prevent, if possible, loneliness, lack of meaningful roles, and loss of independence. Most health and social service professionals concur that they would like to prevent institutional care whenever possible.

Above all, a preventive strategy for the elderly must include, almost as its centerpiece, prevention of disability and disfunction itself, including its iatrogenic manifestations. This is an effort that requires many professions to come together, to solve problems and

to avoid creating them. I will illustrate what I mean by offering a brief formula for looking at functioning in older people.

Functioning in Older People

It is almost a cliche to say that the way an older person functions is the product of physical, mental, and social factors. When an older person presents himself to a professional, it may be hard to unravel the interrelated factors causing the problem. Consider an elderly man living alone who does not eat. He could be physically ill and therefore unable to cook, or perhaps he has no appetite for food. He may be depressed. He may be cognitively impaired and forget to eat. He may have no money to purchase food or may be unable to go out to shop. He may have never learned to cook. In this example, it may be relatively easy to ferret out the actual problem; but, if the combinations of factors are subtle, the cause may not be clear.

Consider the following equation:

$$\text{Functioning} = \frac{\text{physical ability} + \text{cognitive ability} + \text{motivation (emotional state)}}{\text{social environment, resources, and expectations}}$$

Functional ability is obviously related to physical and mental capacities, and if those capactiies can be directly improved, functional ability will also improve. Therefore, one preventive strategy concentrates on strengthening abilities and minimizing disabilities. It could include screening and correction of vision, or care for hearing, dental, and foot problems. It could include exercise and strength-building regimens, or review and reduction of medications. Another strategy directly addresses emotional states; it

may be possible to directly influence emotional wellbeing through psychological treatments.

But functioning is clearly a social phenomenon as well. Social factors dictate the type and complexity of performance required and the amount of help that can be mustered. The presence or absence of stairs, chairs, the number of modern conveniences, and the size of a house all help determine whether or not a person with a specific amount of disability will be able to function. So too does the social situation, including the number of relatives and friends nearby, the amount of help they offer, and the income available to purchase help. Another more subtle social factor is expectations for performance. Here professionals may add to the problem by exacting a higher standard than the older person ever considered necessary in a lifetime. Those working to prevent dysfunction must also consider the denominator of the equation - what can be done to modify the environment, to simplify the task, to get some human help for the individual, or to change the nature of the expectations for task performance?

Although professions tend to be identified with individual components of the functional equation, obvious areas of overlap can be identified. Paraprofessionals are also becoming more specialized; but ideally the home care attendant or care giver in an old age home should have a generalist perspective and should serve to facilitate a total program to improve functional status.

## Medical Versus Social Models

In the United States, we have been plagued by artificial distinctions between a "medical model" of care for the elderly (which

these days is a pejorative term) and a "social model", which is vague but is supposed to be an improvement. Such distinctions should be avoided because they foster a counterproductive divisiveness. Older people need timely diagnostic and medical interventions of high quality. We hardly want to discourage the practice of the precise science and art of geriatric medicine. At the same time, the functional equation we presented emphasizes that social factors are intertwined with health problems and with recovery from them. More important, social wellbeing is the paramount objective of all human service professions - one does not live to be healthy, but one strives for health to live fully. Therefore, the social implications of the remedies proposed for health problems and for disabilities must be kept uppermost in mind. For example, some therapeutic diets or suggested safety restrictions may exact too high a social toll.

It would be a shame to perpetuate an artificial dichotomy between medical and social models as we explore prevention for the elderly. It is also important to refrain from "medicalizing" every aspect of the social wellbeing of older people. For example, it would be good to prevent boredom (a dread disease), loneliness, isolation, and depression; but one would hope that physicians, nurses, hospital personnel and social workers in health settings will not translate these goals into an array of stress-management programs and therapeutic formulas. Other organizations in the community - such as recreational facilities, libraries, universities, or civic clubs - can probably better contribute to making life interesting and meaningful for older people than any health care organization, no matter how socially sensitive. Putting such niceties of society into the health

sphere increases the social distance between old and young and makes everyday life artificial.

On the other hand, health and social service personnel have enormous potential for preventive activity in the course of ordinary service delivery. Most older people are under regular medical care, particularly those who have one or more chronic conditions. In the course of this medical care, it should be possible to screen for other remediable conditions, to be alert to possibilities of medication misuse, to give careful, clear, and consistent advice about health behavior, to reassure those who might be catapulted into greater dependency through anxiety, and to make appropriate referrals on behalf of those who seem unduly isolated and unrelated to human activity.

My points may at first appear contradictory; but the two messages are compatible. On the one hand, it would be a mistake to launch into expanded programs of prevention directed toward improving the general wellbeing of older persons under health auspices. Making life worth living is not the proper sphere of the health professional. On the other hand, for health matters specifically, it would be counterproductive to set up mechanisms for prevention and health promotion parallel to health care delivery. Older people are already linked to physicians and care givers, and they generally have the greatest respect for this sort of authority.

Just as the places where care is given - the doctor's office, the hospital, the home care unit, the day care center - are the most reasonable places to focus a preventive strategy, they are also the loci of iatrogenic problems. We find, at least in the United States, that older persons themselves are well advised to develop some

preventive strategies for their use of health care services. We have called this "defensive health behavior" (Kane et al., 1985). An older person using defensive health behavior knows how to ask questions and receive information from physicians, becomes aware of the medications he or she takes, comes to physicians with well-prepared questions to make the best use of short encounters, knows how to describe symptoms, seeks second opinions, and so on. An overall preventive strategy should contain a plan for helping the older person become an effective user of health and social services.

In summary, the following points pertain particularly to prevention in the elderly. First, although classic primary and secondary prevention of diseases is possible, much of the feasible prevention for the elderly (especially the frail elderly) is prevention of dysfunction. Second, some dysfunction of older people is actually caused or exacerbated by the activities of the professionals who are trying to help - and this includes both medical and social service personnel. Third, the strategies for preventing dysfunction in any given instance can be multifocal- aimed at improving physical or mental capacities, improving motivation or emotional states, and/or changing social conditions in a way that allows a person to function adequately despite limitation. Fourth, some social problems of older people which may be eminently preventable fall outside the health sphere; addressing these requires meaningful social roles and pleasant social activities for the elderly in the community. Fifth, much preventive activity can and should be intertwined with the delivery of health and social services to the frail elderly. And finally, at least as an interim solution, it is

useful for the elderly to develop defensive behavior in relation to health and social service providers. Many wellness programs targeted for the elderly emphasize diet, exercise, and stress reduction; but information and skill in using the service system may have an even more direct connection with the wellbeing of old people.

## Professional Perspectives

Now let us consider the world of professions, each with its own knowledge, skills, values, ethics, and general way of looking at the world. How can they and should they work together on behalf of prevention for the elderly?

The proliferation of professions and occupations in health and social services is a by-product of urban, industrialized societies and technological development. More and more specialized division of labor seems necessary.

However, the division of labor that facilitates an assembly for industrial production works poorly when the workers are human service professionals and the raw material is other human beings, and the products desired are healthy, well-adjusted, well-served people. Sometimes the person being served gets lost somewhere on the conveyor belt and fails to reach the next work station - the familiar problem of the unrealized referral. And too often, the various professionals have different ideas about the product, thereby giving conflicting advice and working at cross-purposes. At best, the burden of gathering up the services needed for oneself and one's family often fell inappropriately on the user of the service, who needed to be aware of the universe of services available, as well as his/her own needs and eligibilities, and then go on an exhuasting quest among

fragmented resources. At worst, professionals communicated poorly and failed to draw upon each other's skills appropriately, leaving clientele insufficiently or ineffectively served. The answer to this dilemma one that burst on the American scene with the force of a social movement - was the multidisciplinary team.

In America - and possibly in Israel as well - the multidisciplinary team has almost become a panacea. The preferred form of serving people is to get representatives of as many disciplines as possible together in a cohesive working group and to make sure they appreciate each other and know how to work together. In theory, the team then makes the plan for and on behalf of individual clients, using the expertise of each member as needed and assuring the commitment of all. For the patients or clients, this form of service delivery means that the whole person is being treated, that the burden of assessment and provision of relevant services is carried by the the professional group, rather than by the client. For those disciplines or functions considered ancillary, participation on a team means access to clientele.

Despite good intentions, the emphasis on teams can create as well as solve problems. Proponents often stress team processes rather than outcomes. In the U.S., team training is popular and usually includes discussions about conflict resolution, leadership styles, and consensual decision-making. In all this, the client's wellbeing can get lost - professionals can derive a sense of satisfaction just because they work well together. Indeed, some forms of teamwork are extraordinarily expensive. Resources used to assemble a large team where a smaller one was sufficient, or to conduct unnecessarily long team discussions to plan an approach to care, diminish the total

resource pool of available services. So some principle of parsimony should apply to cross-disciplinary work and cross-disciplinary communication.

Definition of a Team

Multidisciplinary teamwork imposes requirements inherent in its definition: A team is a working group with a common purpose, distinct roles, and some method of communicating together (Kane, 1975). A multidisciplinary team includes people with differing educational backgrounds and perspectives. Teams may operate within a single organization (where everyone has the same boss) or may be composed of people from different organizations, wherein jurisdictions, responsibilities, and loyalties become even more complicated, as does communication. However, teamwork need not involve multiple disciplines to create problems; teamwork across organizations is difficult even when the communication is nurse-to-nurse, social worker-to-social worker, or physician-to-physician (as exemplified by relationships between representatives of hospitals, rehabilitation centers, nursing homes, primary care clinics, and home care units).

Most problems with teamwork, whether multidisciplinary or intradisciplinary, can be traced to one or more of the three elements in the definition - that is, the common purpose, the role division, and the communication. Quite often the purpose of the team is unstated, or is declared in vague terms like "promote mental health" or "help old people become independent". Similarly, each member's contribution to the common purpose and how that contribution will be measured is often unclear. Team members may have difficulty describing their own expertise straightforwardly, and may have equal

difficulty describing what others do. Professional jargon adds to the obscurity. Written and verbal channels of communication may be ineffective. All team members need to know and endorse the team's overall purpose to understand their own contribution to that purpose, and know how to give to and receive information from each other. It is important that the team be no larger than necessary to get the job done. Some of the role demarcation will be as much a function of individual skills, interests, and personalities as professional background. Considerable role overlap and redundancy is built into our professions. Consider, for example, the plethora of professionals that are equipped to do psychotherapy, or patient education, or multidimensional function assessments.

Other Forms of Cross-Professional Work

Teamwork is not the only way that professionals interact. There are various other forms of interchange, all of which work better if there is an understanding of each other's skills, a clear sense of role, and a good way of communicating. Among these other forms are referral, consultation, coordination, and joint planning.

Referral involves knowledge of another profession's abilities and also another agency's portfolio; it also involves processes of preparing the client, following up to see that the referral takes place, and occasionally sending information to a professional colleague. Often, these functions are done only haphazardly, and the referring agent hopes for the best.

Consultation involves an exchange of expertise around a specific question or problem, where the consultant seeks but is not obliged to use advice. Again, it works best if there is an understanding of what

other professions have to offer, if the request is specific and clear, and if the advice is specific, clear, and responsive to the question asked. Much multidisciplinary input can be applied to problems through processes of referral and consultation, without ever forming a team- and this is true both at the individual and community levels. Sometimes built-in coordination is needed, either within organizations or across them, to make sure that the mechanisms are in place to help people recieve the services they need as expeditiously as possible, and to avoid gaps or duplication. Representatives of different organizations and/or professions come together and work out such mechanisms, which then need to be monitored and updated to make sure they continue to serve their purpose.

In geriatric care in the United States, case management is also developing as a preferred process (Kane, 1984). This might be seen as a variant of teamwork or even a substitute for teamwork. A case manager is someone vested with the responsibility of ensuring that a client receives the services to which he or she is entitled and needs. The case manager - who is usually a nurse, social worker, or sometimes a nurse/social worker team - is responsible for drawing on specialized resources and for creating ad hoc teams when needed. The case manager draws not only on specialized professional services but also on specialized organizational services.

## Professional Collaboration, Role Division and Prevention

This paper began with a discussion of the particular challenges of prevention on behalf of the elderly. It then discussed the various ways that professionals can and do work together, and the possibilities for inefficiency or ineffectiveness unless service

providers are fairly conscious of what they are doing. We now turn to the question of the organization of preventive services for the elderly. What sort of collaboration works best? What sorts of role divisions make sense?

As already indicated, prevention tends to everybody's and nobody's business. Therefore, if certain preventive activities are deemed worth undertaking, there need to be clearly designated authorities to do it, and these persons need the resources to back up the task. This is particularly true of a general health education and promotion effort geared at changing the minds and hearts of the elderly and their families or the general public. And if a concerted effort is to be made to inform older people about appropriate health related behavior, including defensive use of the health and social welfare system, some organization needs to be empowered to do the job.

Preventive activities have considerable range. Not all of them require multidisciplinary implementation, and some do not even require multidisciplinary input into planning. For example, immunization is a straightforward activity that can be performed in physicians' offices, hospitals, health departments, and at home by nurses. Planners of specially targeted immunization campaigns need access to media for announcements and need to deliver services in convenient locations at convenient times.

Consider screening programs for early detection of various diseases, conditions, or problems. If screening were to be developed beyond the sort that is included in routine physical care, it should be well thought-out and targeted to groups believed to be at risk for the conditions sought. Multidisciplinary planning is needed to

determine the useful elements to include in screening and to design the appropriate follow-up actions if positive results are found. However, it would not be necessary to assemble a multidisciplinary team to do the actual screening. Vision, hearing, blood pressure, emotional wellbeing, for example, can all be incorporated into a screening procedure that can be implemented by a nurse, a social worker, or, for that matter, by any well-trained, intelligent person. Most importantly, the procedure should be carefully considered so that screening be done only when (a) there is reason to believe that there is an unidentified problem to be detected, (b) there is something that can be done about that problem, and (c) a plan for action is developed in the event that the screening yields positive results. It is hardly helpful, for example, to diagnose the same case of hypertension over and over again; there is some evidence in the United States that people found to be hypertensive at screening already knew about their high blood pressure (and perhaps their doctors did too).

The screening strategy must also be designed to identify the appropriate populations. On social dimensions, for example, one probably will not identify many isolated elderly people with tenuous social connections by conducting screening programs at shopping centers, synagogues, or older people's clubs. A different strategy is needed, perhaps one that involves public health nurses or health visitors (along the British model) who go into homes, or an outreach strategy wherein social workers follow up on referrals by community members.

What about bringing about behavioral change in older people - for example, promoting smoking cessation, weight loss, and exercise? Again, although a team may not be required to undertake the activity,

multidisciplinary dialogue is needed to determine the changes that are most likely to lead to improved health and wellbeing. Behavioral change is difficult to bring about, as any teacher can attest. The activity should be directed by a person with special knowledge and skills in just that process - influencing people. The plan needs to take into account the need for reinforcement and follow-up; "one-shot" lectures on health are rarely helpful. Sometimes small group activities in which participants make mutual commitments and influence each other are very successful. (In parts of the United States, neighborhood walking groups of elderly persons have been formed as a spin-off of local health education activities). Of course, it is difficult for any health education program to get its messages across if contradictory messages are given by health care providers or other authorities.

If professional providers demand behavioral changes of their clients, they need to develop practical strategies in order to get the desired results. Education and exhortation are rarely effective. It may be necessary to create tools, develop procedures and forms, or perhaps designate personnel (for example, in a physicians's clinic) to perform specified functions. Approval and encouragement of the desired behavior is needed at the highest organizational level, and strategists must try to eliminate all disincentives toward the desired behavioral change.

What about prevention of <u>dysfunction</u>? Here is where team work and case management come to the fore. An organized, coordinated effort is needed in which members of various disciplines must agree on the definition of the problems and on how they can work, each in his

or her own way, to promote maximum functioning. Methods of referring people to appropriate resources are crucial; professionals need to deliberate about what they consider important and identify common ground. One way of preventing dysfunction is to improve the conditions under which old people make personal decisions about their health and their care. Although the topic of old age homes arises at natural points in the lives of old people and their families, decisions are often made under enormous pressure and with little information or opportunity to choose. Caregiving organizations can greatly exacerbate the aura of crisis by placing a premium on moving persons rapidly out of acute hospitals, or by transmitting misinformation or incomplete information about options and choices. This issue clearly requires multidisciplinary cooperation and commitment. A subtle but crucial form of prevention is to discover and eliminate the ways that the service system exacerbates this aura of crisis.

A few years ago, professionals interested in aging in Los Angeles started meeting together. The group included geriatric personnel - social workers, recreationists, nutritionists, and family experts affiliated with a university-based gerontological center and various social agencies, such as senior centers. The participants held markedly different views of prevention. At one extreme were those who believed that vigorous health education on such topics as nutrition, exercise, and stress-reduction would keep people healthy into old age; with proper prevention people would die healthy and happy at an advanced old age. At the other extreme were the cynics - those who believed that most preventive activities were short on evidence and full of futile hopes.

The truth lies somewhere in-between. An unreasoned suspicion of preventive efforts is not more helpful than an unreasoned suspicion of physicians and "medical models". It is crucial to bring the two extreme views closer together. The preventive efforts of a health educator are undermined by physicians who "don't believe in that stuff". Conversely, a determined advocate of nutritional approaches may suggest a combination of minerals, vitamins, and natural foods long after a visit to the doctor. The range of perspectives on potentially preventable outcomes must be considered, and some effort to reach a consensus attempted.

Because social and psychological factors are intertwined with physical factors, prevention is a fertile field for multidisciplinary research. It is useful to know in a more certain way what social behavior will follow when an older person becomes aware, for example, of urinary incontinence or a hearing problem. How will it affect his social activities and relationships? When are people so isolated from social contact that they lack a network through which to seek help for a health problem? If social researchers ignore medical variables, and vice versa, information on which to base preventive efforts will be incomplete. But the perspective of older persons must also be included. Paternalism is always a danger in professional work. The better a team of professionals functions, the more danger there is that the client (on whose behalf all the work is being done) will have no voice. Highly effective teamwork may increase the power of professionals over their clients, surely a step in the wrong direction for the frail elderly.

To counteract the paternalism of benevolent teams, there needs to

be a deliberate effort to understand health-related problems and their social consequences as experienced by older people, and to discover the preferences of various subgroups of older people. Some might prefer to take greater risks rather than be protected from accidents and harm. Others might prefer less household independence and responsibility in their later years in exchange for a residential setting where they can enjoy privacy and freedom of movement. (In many countries, we jump to the conclusion that all people in all circumstances prefer their own homes, based on evidence that they prefer to avoid all kinds of institutions that have been created).

And if we wish to prevent psychological depression and social problems such as social withdrawal of the elderly, we need to ask them what makes them depressed, why they decide to withdraw, and what would make their lives more meaningful. It would be a serious mistake to ignore the views of the elderly themselves in the process of creating preventive goals and strategies.

# גישות מקצועיות לטיפול מובע בקשישים:
# שיתוף פעולה וחלוקת תפקידים

רוזלי א. קיין

פורום בינלאומי

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והתפתחות אדם וחברה בישראל

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## המכון

הוא מכון ארצי למחקר, לניסוי ולחינוך בגרונטולוגיה והתפתחות אדם וחברה. הוא נוסד ב-1974 ופועל במסגרת הג'וינט האמריקאי (ועד הסיוע המאוחד של יהודי אמריקה), בעזרתן של קרן ברוקדייל בניו-יורק וממשלת ישראל.

בפעולתו מנסה המכון לזהות בעיות חברתיות ולהציב להן פתרונות חילופיים בשירותי הבריאות והשירותים הסוציאליים בכללם. אחד מיעדיו הוא להגביר שיתוף הפעולה של מומחים מהאקדמיות והממשלה, עובדי ציבור ופעילים בקהילה כדי לגשר בין מחקר לבין מימוש מסקנות מחקר הלכה למעשה.

## סידרה בינלאומית

המאמרים מציגים מימצאי מחקר והשקפות מקצועיות של מלומדים אורחים מחו"ל, של אנשי אקדמיה בארץ ושל חברי סגל המכון. המאמרים בסידרה מציגים דיונים החורגים מעבר להקשר האמפירי הישראלי, או עוסקים בסוגיות מושגיות ומתודולוגיות בעלות ענין בינלאומי כללי. בכך משמשת הסידרה במה שבה נבחנים בפרספקטיבה בינלאומית ההלכה והמעשה של נושאי ההזדקנות.

הממצאים והמסקנות המוצגים הם של המחבר או המחברים וללא כוונה ליצג את אלה של המכון או של פרטים וגופים אחרים הקשורים למכון.

# גישות מקצועיות לטיפול מונע בקשישים:

## שיתוף פעולה וחלוקת תפקידים

רוזלי א. קיין
פרופסור, ביה"ס לעבודה סוציאלית
אוניברסיטת מינסוטה

מבוסס על הרצאה שהוגשה בכנס הארצי השישי של האגודה הישראלית לגרונטולוגיה
דצמבר, 1984

ירושלים ספטמבר, 1985

## תקציר

כל מקצוע המספק שירותים בריאותיים או סוציאליים רואה במניעה את אחת ממטרותיו. רופאים ואחיות שואפים למנוע מחלות ונכויות; רוקחים שואפים למנוע שימוש לרעה בתרופות; פיזיותרפיסטים שואפים למנוע שיתוק; עובדים סוציאלים שואפים למנוע סכסוכים משפחתיים, בעיות חברתיות ובדידות. כל מקצוע מכבד את המניעה כגישה הגיונית, אנושית ואולי גם חסכונית לבעיות אנוש.

אם כי בתיאוריה קיימת התלהבות מן הנושא, הרי במסגרת עבודתם נוטים אנשי המקצוע להשאיר את ההפעלה המעשית של המניעה לאחרים. כאשר קיימת התייחסות של עובדים סוציאליים ושל אנשי מקצוע בתחום הבריאות לנושא המניעה, היא נעשית באורח מקרי ובלתי מסודר.

<u>גישות מקצועיות לטיפול מונע בקשישים</u>, מאמר שהוצג בתחילה במסגרת הכנס הארצי השישי של האגודה הישראלית לגרונטולוגיה, טוען שצוותים רב-מקצועיים של מומחים בנושאי מניעה עשויים, אמנם, להוות גישה מועילה לבעיות רפואיות ופסיכו-סוציאליות של הקשישים, אך קיימים מספר מכשולים שיש לתת עליהם את הדעת.

לאחר סקירה של מספר מודלים ותיאוריות המתייחסים למניעה, המאמר עומד על טיבה של ההשתתפות הבין-מקצועית בטיפול מניעתי, ועל הקשיים שמעלה טיפול זה. נדונות צורות שונות של עבודת צוות, כולל הפניה, התייעצות וניהול טיפול. לבסוף, מושם דגש על התחשבות בדעותיהם של הקשישים עצמם, במסגרת התהליך של קביעת מטרות הקשורות במניעה.

תוכן העניינים