



Tor Atle Rosness (born 1976), editor of the Journal of the Norwegian Medical Association, nursing-home doctor in Bærum municipality and associate professor at Lovisenberg Diaconal University College.

Photo: Sivert Almvik

Working with elderly people is a privilege, but to do a good job, nursing-home doctors need to collaborate well with their colleagues

The lonely doctors

Nursing-home employees in general, be they doctors or other health workers, need more competence. In 2011 the national board of the Norwegian Medical Association therefore decided to establish geriatric and nursing-home care as a specialty competence (1). The background for this decision was the need to ensure better healthcare services for patients in nursing homes and draw attention to nursing-home medicine. Given the large number of doctors working in this field throughout the country's municipalities, it is dispiriting to see that as of October 2015 only 27 doctors had been approved in this specialty, and that all of these approvals were granted in 2013 and 2014 (1). There is much to indicate that the status of this specialty remains low among doctors, as has been noted earlier (2). Also, the Norwegian Medical Association is often told that doctors do not want to work in nursing homes (3). Fortunately, however, there are some enthusiasts who describe their work in nursing homes as rewarding and inspiring (4).

Elderly people in nursing homes are actually in need of dedicated, skilled and committed doctors – as they are in need of advanced skills from *all* groups of professionals. If the other staff members have few qualifications, are unskilled or speak little Norwegian (5–7), this will make it even less attractive to be a nursing-home doctor. Despite the fact that a job in a nursing home means flexible working hours, little or no on-call duty and a good salary, it is unsurprising that doctors consider other career options.

The nursing-home doctor's working day may well be lonely, for several reasons. It is a strain to be the only doctor in the house, often employed in a short full-time equivalent and with medical responsibility for frail elderly people. Having only little time for each of them adds to the pressure. According to a Norwegian study undertaken in Bergen, nursing-home patients have seven different diagnoses on average, all of which require close follow-up and well-considered treatment (8). When patients are admitted to nursing homes with a long list of diagnoses, such as heart failure, severe renal failure, hypertension, atrial fibrillation, COPD, unspecific cognitive impairment, diabetes and colon cancer, great demands are placed on the person who will be medically responsible for them.

Provision of optimal treatment in nursing homes helps raise the patients' quality of life and may provide a dignified end to life. However, since elderly people in nursing homes often are subject to falls, infections, delirium and exacerbation of chronic diseases, such a goal can be difficult to achieve (8). On a regular basis, nursing-home doctors must decide whether patients with heart or renal failure should be sent to hospital or remain in their familiar surroundings to receive palliative care. Or, whether patients with severe dementia who have difficulty swallowing should have anti-

biotics administered intravenously for pneumonia. It is crucial to discuss such issues with hospital colleagues, to ensure that a correct decision is made, as well as to have someone with which to share the responsibility for the further course of treatment. In many places patients are relocated from hospital to nursing home with virtually no prior warning, in a marginal state and with little information in their medical history. In such cases, the nursing-home doctor is completely at a loss – not knowing how other colleagues have assessed the situation. A potentially fruitful cooperation between the primary and specialist health services remains unexploited.

The nursing-home doctor will often be responsible for sitting down with the patient and the next of kin to inform them of the long-term prognosis in a way that inspires confidence. Predicting the course of illness in a patient, be it for the next week, month or year, is a complicated medical task, but especially for the nursing-home doctor it is essential to have the ability to think in a long-term perspective and avoid engaging in drug-based firefighting (9, 10). A good, but seemingly underused aid in maintaining a long-term perspective is to use a simple graph. The x-axis represents time and the y-axis describes a total clinical assessment of the patient's somatic and cognitive level of functioning. The curve will slope downwards with rising age, but is not equally steep for everybody. Maintenance of quality of life and dignity, combined with necessary medication and appropriate nursing and care, will all make for a flatter curve.

Enhanced competence in nursing-home doctors alone will not necessarily result in better care for each individual patient. The doctor depends on observations made by the other members of the nursing home's staff. It is therefore essential that these have sufficient competence to be able to report any changes in the patient's condition. Appropriate interdisciplinary collaboration between doctors, nurses, occupational therapists and physiotherapists, who sit down to discuss short-term and long-term treatment strategies during the doctor's round, is a productive use of the nursing home's resources. After such a joint review of the patient's condition, the nursing-home doctor can establish a solid base for requests for further advice from the specialist health services.

Better health services for elderly people in nursing homes cannot be achieved by the nursing-home doctors alone. Good collegial collaboration with hospital doctors and other health professionals in nursing homes is essential for success. No doctor wants to be held responsible when the life of an elderly nursing-home patient ends with indignity or to feel pangs of conscience when providing optimal treatment was impossible. Loneliness in nursing homes must be prevented. Nursing-home medicine needs more enthusiasts – take this as a request!

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