Chapter 4
Meaningful Engagement: An Option or Not

Dr. Sarkar showed lots of inhibition when I asked him, “Sir, why don’t you resume your medical practice by starting a clinic?”

I had met Dr. Sarkar for the first time in my geriatric clinic in October 2012, when he came visiting me along with his wife and daughter-in-law. It was a Tuesday, and relatively fewer patients visited the outpatient department (OPD) on that day, so I had ample time to chat with him.

4.1 Difficulties in Visiting Tertiary Care Public Hospital

Elderly patients are often accompanied by their spouses or daughters-in-law when they come for a check-up in the OPD. There has been an increase in the awareness regarding the plight of parents/grandparents, which is also visible when sons, daughters, and grandchildren (14 years to 18 years old) are willing to step forward and take the responsibility of bringing their parents/grandparents to the public hospital. This is a frequent practice among those belonging to middle or lower socio-economic class. But many times, the son or the working member must compromise his/her daily wages to take their parents/grandparents to a doctor. Getting an appointment with a senior doctor in AIIMS or any tertiary care public hospital of the country is a time-consuming process and proves to be a costly affair, which is one of the reasons middle-income class patients are turning to private clinics or hospital [1].

4.2 Evolution of First Geriatric Clinic in North India

Departments specializing in Geriatric Medicine are still non-existent in most of the hospitals, even in metropolitan cities like Delhi. In October 2012, when Dr. Sarkar had visited us, our department was still in its infancy. We started our daily outpatient
care services in August 2010. A small ward with a capacity of 24 beds was set up in August 2012 under the guidance of Dr. A. B. Dey. He was sensitized towards this field during his Commonwealth Fellowship in England in 1995–1996.

Since the very inception of daily OPD, Dr. Dey established and maintained, “The goal of a separate geriatric clinic would be to smoothen the process of hospital visit for elderly, understand their health problems, which was of course over and above organ-specific problem, and give them comfort and care as and when it would be needed”. Being the first senior resident (SR) in the new department, I had the privilege to do lot of experimentation with my patients, like reducing medicine in the era of multimorbidity. My training in psychiatry definitely helped me to understand older patients better. I would spend hours examining the case history of most of my patients, in order to understand their psychology.

Dr. Sarkar was an alumnus of R.G. Kar Medical College, West Bengal—college from where I had completed my diploma training in chest medicine. We developed a rapport in a short span of time. Dr. Sarkar retired as Chief Medical Officer from Central Government at the age of 58 years in 1990.

He was staying in a joint family with his next two generations. Mrs. Kamala Sarkar had multiple diseases like uncontrolled diabetes, hypertension, coronary artery disease (which was probably the complication of the other two diseases), severe arthritis in the knee (a painful disease of knee joint in ageing population), and depression. Fortunately, they had a well-informed daughter-in-law, Mrs. Uma Sarkar, who was working with the Ministry of Defense. She would often encourage her mother-in-law to keep herself engaged in daily chores and also would care for her like her own mother.

### 4.3 Challenges of Multimorbidity and Polypharmacy in Older Adults

I wasn’t surprised to know that Mrs. Kamla had visited several doctors with her extensive list of complaints. She brought the prescription of 19 medicines (polypharmacy) along with her. Her medicine included three types of antihypertensive (drugs to lower blood pressure); three groups of drugs for lowering blood sugar levels; three medicines for managing arthritis; one multi-vitamin; one medicine each for calcium, vitamin D, vitamin B-12 and depression along with sleeping pills; and three medicines for coronary artery disease (heart problem) (Table 4.1).

Mrs. Kamla was on many hands, and each healthcare provider was prescribing medicines independently with focus on the organ-specific expertise. For example, a cardiologist for heart and high BP based on evidence-based guidelines, an endocrinologist for diabetes and osteoporosis, psychiatrist for depression and an orthopaedic surgeon for osteoarthritis.

Unfortunately, clinical practice is restricted to organ or disease-specific guidelines. Patients like Mrs. Kamala, suffering from multimorbidity, would visit multiple specialists for separate problems, ending up with multiple drugs, even if the specialist follows evidence-based medicine (EBM).
In EBM the foundational units of information come from trials carefully designed to isolate and measure the effect of a single treatment on a single disease. By force of parsimony, it may seem to follow that the optimal therapy for an individual with more than one disease, that is, with multimorbidity (MM), should be easily derived through the linear combination of recommended therapies for each component disease. Thus, if patient with Disease A (DA) generally benefit from Treatments 1 and 2 (T1,2), patient with DB from T3,4,5 and patient with DC from T6,7,8,9, then patient with DAB should be treated with Treatments 1–5 and those with DBC with Treatments 3–9 and those with DABC should receive all the nine therapies.

While this may seem a scientific parody of EBM, and the antithesis of what thoughtful EBM-practitioners promote, it is unfortunately not very far from the current state-of-the-practice as many of us would hope. Clinical practice guidelines focus on the management of single diseases and generally do not address how to optimally integrate care for individuals whose multiple problems can make guideline-recommended management impractical, irrelevant or even harmful [2].

A generalist, unlike a specialist, manages the patient as a whole “unit”, that is, not as an “organ system”. Generalists include family practitioners, internists, paediatricians and geriatrician. [3]

Doctors have to work within the existing framework of contemporary EBM, but they should also understand how this could be leveraged to create guidelines better fit to the needs of multimorbid patients.

Doctors’ knowledge should help them to balance the EBM for single diseases and combining essential drugs with minimum drug interactions and side effects with special consideration to functionality, life expectancy and expectation of the patient.

### Table 4.1 Mrs. Kamala Sarkar’s prescription

| Medical condition         | Medicine/dosage                                      |
|---------------------------|------------------------------------------------------|
| High blood pressure       | Telmisartan (20 mg) once in the morning (OD)         |
|                           | Amlodipine (5 mg) OD                                  |
|                           | Metoprolol (25 mg) OD                                 |
| High blood sugar          | Metformin (500 mg), twice a day (BD)                  |
|                           | Glimepiride (2 mg), BD                                |
|                           | Pioglitazone (30 mg), OD                              |
| Coronary artery disease   | Aspirin (75 mg) OD                                    |
|                           | Ranolazine (325 mg) BD                                |
|                           | Atorvastatin (10 mg)                                  |
| Arthritis of knee (SAM)   | Diacerein BD                                          |
|                           | Paracetamol (650) QID                                 |
|                           | Ibuprofen OD                                          |
| Osteoporosis              | Shelcal (500) OD                                      |
|                           | Calcirol sachet (60 K), once weekly                   |
| Peripheral neuropathy     | Pregaba (75 mg) HS (after dinner) Becosule BD         |
|                           | Tryptomer (25 mg) HS                                  |
| Depression                | Sertraline (50 mg) HS                                 |
| Sleeplessness             | Clonazepam (0.25 mg) HS                               |

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Clinical trials should be designed and conducted to maximize heterogeneity of multimorbidity among heterogeneous elderly participants. Analyses should be based on carefully considered ways to measure MM, heterogeneity of treatment effects (HTE) and carefully explored across different subgroups of interest defined by specific comorbidities [2].

Polypharmacy refers to intake of five or more medications concurrently daily to manage coexisting health problems or MM. Polypharmacy can be considered as a major geriatric issue, with prevalence 30–40% among the elderly [4].

Polypharmacy is common in the older population with MM and associated with adverse outcomes including mortality, falls, adverse drug reactions, increased length of stay in hospital and readmission to hospital soon after discharge [5]. The risk of adverse effects and harm increases with increasing numbers of medications and could be due to decreased renal and hepatic function, lower lean body mass, reduced mobility and drug-drug interaction [5].

Sometimes an unwanted side effect from one drug goes unrecognized or is misdiagnosed, leading to prescription of a new medication rather than discontinuation of the dosage of offending drug. For example, starting antihypertensive drug like enalapril may cause first dose hypotension and dizziness to the patient. The doctor may consider it as a problem related to ear and its internal structure thereby starting a new drug betahistine. This is referred to as the prescribing cascade.

Due to lack of time, the physician may many a times ignores complete documentation of reasons of prescribing a medicine. This missing piece of information could make the situation complicated for the future physician who would like to discontinue some medications to prevent polypharmacy.

Presently in India, there is a scarcity of doctors who can explain the MM to their patients and prescribe essential drugs in consultation with the patients. There is a dire need to train doctors to have a wholesome approach with adequate knowledge of disease and its management and simultaneously minimalistic medicine regime to prevent polypharmacy, both in undergraduate and postgraduate training curriculum.

Mrs. Uma came to know about our department from one of her ministry staff, Anju, whose mother had been our patient.

Elderly care physician must maintain a comprehensive review of all the medications a patient is taking at every visit, with proper documentation on why each medication was being prescribed.

I tried to curtail Mrs. Kamala’s medicines down to the essential and effective drugs in adequate dosage for hypertension and diabetes that were not the part of her earlier prescription.

I eventually stopped her drugs for insomnia, which was basically due to her anxiety and frustration because of her multiple uncontrolled diseases and her painful knee. I sent her to Professor Vinit Goel for knee replacement. I stopped her vitamins and minerals that were not required in her case. In day-to-day practice, senior citizens are keen on having vitamin and multi-vitamin capsules even if they do not have any biochemical deficiency of the same. Most of the elderly patient would ask “Doctor Saheb, taakat ki goli dedo” (Doctor, please prescribe me medicine for...
strength). Vitamin supplementation for long term should be discouraged; it simply increases the pill burden. Vitamins are only indicated when there is deficiency [6].

Dr. Sarkar was apparently fit with little botheration from arthritis in his knee and mild hypertension, which was well controlled by his self-medication. He retired 22 years ago and initially had tried to start a clinic in his own colony. But he neither had enough patience nor confidence to get his clinic running. He shut down the clinic within a year. But never had any regrets because medical science was not his passion.

He mentioned, “I was never a studious guy. Medical profession was the choice of my parents. I had good marks in my graduation. My dad had forced me to apply for graduation in medical science”.

4.4 Intergenerational Solidarity: A Fantastic Way of Meaningful Engagement

Life is the best example of dynamics. It keeps changing with time. One cannot predict what would happen next. In the words of Dr. Sarkar, “You know Dr. Chatterjee, time flies. I sometimes wonder about how I had spent the post retirement phase of my life after the birth of Surjya, my only grandson. It seems as I got a chance to revive my childhood with him. I was just like him and I feel that it was one of the best times of my life. Whenever Surjya would sit in his pram, I would spend hours looking at his divine face, his smile, his cries, his pain. I used to cry with him and felt his pain. When he grew up, I used to drop and pick him up from school, took him to the park and played with him just like the other kids around. We used to imagine ourselves to be characters from the Ramayana, Mahabharata and present generation superheroes like Spiderman and Superman. Surjya’s favorite character was Bajrangi and he used to make me play various demon characters and I was the one who always had to be content with defeat”.

With a reflective smile on his sombre face, Dr. Sarkar spoke, “I didn’t feel like working or going anywhere other than enjoying a child’s company. But once Surjya joined secondary school, his pressure to study and succeed increased. He had to complete multiple assignments and perform well in his class. He was also part of rat race just like the other kids of same age group, participating in music class, tuitions, school and sports etc. He is still my best friend, but we don’t, rather he does not get, quality time to spend with me. He is pursuing his engineering in architecture from a college in Gurgaon. I have learnt many things from him- from using smart phone to using skype, but most importantly the true meaning of love, life, attachment and detachment”. This is one of the best examples of intergenerational solidarity, which is the value and strength of our country, our ancient culture. But all the elderly are not lucky enough. Staying with their grandchildren is not always an option for them,
following disintegration of the joint family culture. But family and intergenerational empowerment are the primary fuel of active and graceful ageing in any society across the world [7]. At the family level, intergenerational solidarity is characterized by the behavioural and emotional dimensions of interaction, cohesion, sentiment and support between parents and children, grandparents and grandchildren, over the course of long-term relationships. While at the society level, it reflects the close interpersonal relationships across the generations. Bengtson and Oyama Intergenerational Solidarity: [8] Every generation holds their unique strengths and weaknesses depending on the life experiences. The unique historical circumstances that define the generations can also pose challenges within a working or learning environment. A recently published review article examined the benefit of intergenerational interactions between youth volunteers and residents of long-term care homes. The authors found that while this interaction resulted in the development of new communication and career-related skills, meaningful relationships and friendships and an improvement in the attitudes towards older adults among the youth, it benefited the older adults by meaningful engagement with the students, enhanced wellbeing and improved communication abilities for residents with aphasia [9].

Dr. Sarkar was a person with low aspiration index but with high life satisfaction. He believed that he had enough savings to live the rest of his life peacefully, he had a bungalow, and that his progeny will stand by him in the time of need, which is also a common belief among the older Indian like Dr. Sarkar. But the scenario is different in developed nations, where elderly people must rely on their own physical, cognitive and financial reserve. Joint family system is hardly noticed. Even though most of them would prefer to stay at their own place, once geriatric syndrome, like falls, frailty and dementia with impaired functionality, prevails, they had to shift to assisted living service [10].

4.5 Situation of Primary Care Physician in Metropolitan Cities

Dr. Sarkar continued, “I have done enough in my life. Medical Sciences has advanced far ahead from what I had learnt 50 years back. You know, a primary care physician (PCP) like me is not bound to be up to date with medical advancements in this country compared to many other countries like the UK or the USA where PCP has to update themselves on regular interval. I didn’t have that much patience to start from the scratch and read books at the age of 81. I am in this manner, backdated for recent generation practices. For the rest of my life, I will spend time in the park, with my walking sticks, watching T.V, chatting with Surjya and looking at my wife who is progressively deteriorating from semi-robust to pre-frailty”.

Again, I nudged “Sir, can you spend some time in practicing medicine even if you feel that you cannot be a full-time practitioner unlike present generation?” I continued, “I feel your understanding about basic medical science and treating common ailments with minimal investigation could help a lot of patients in this country where there is a dearth of PCP”.
“No No, Dr. Chatterjee”, Dr. Sarkar replied instantly, “You know I am staying in an elite colony where people believe only super specialists can treat. When they look at my MBBS degree, they think my knowledge even for common ailments is inadequate”.

Health system in India does not mandate the stepwise approach like many other western and European countries where a patient initially always has to visit PCP, followed by referral to secondary or tertiary care specialists depending on the needs. Thereby, primary care physicians are losing interest in practising in small colonies in this country. They are also struggling for regular update from their busy schedule.

In fact, there is a dire need of qualified PCP with regular updates to manage and treat most of the common ailments like fever, chest infection, urine infection, malaria, dengue and non-communicable diseases like hypertension, diabetes, heart problems, etc., which can be diagnosed and screened by them with occasional reference to specialists. Rather, they are the first point of contact to the healthcare system to address elderly issues. If adequately sensitized to multiple medical morbidity and geriatric specific issues like fall, frailty, depression, dementia, etc., they would able to manage most of the health issues in holistic way. They tend to be the best interface between informal caregiver, which is the family, and super specialist. It also creates space and opportunity for the health quacks, who have no formal training of medical sciences and have received some tips from the PCP under whom they have worked for few months or years, to occupy the role of PCP in a majority of rural India [11]. Nevertheless, these health quacks are the only respite for the majority of rural elderly, the situation was aptly quoted by one of my patients from a village of west Bengal “we get some health advice in times of need, sometimes it works too”.

Dr. Sarkar left my clinic that day with a promise to visit me after 3 months for follow-up.

4.6 Staring Second Innings

Dr. Sarkar entered my room with prior appointment and told me, “I am happy to share with you that as per your advice I have opened a small clinic and I work there every morning. My friends come there every day with great enthusiasm and get regular BP check-ups! They also bring along their family members”. I could feel the sense of pride in his voice.

I immediately responded with a great sense of joy “Please come in sir, this is great news!”

He continued, “As per your advice about social contribution, I am also teaching our maid’s son Ramu, 3 days in a week in the evening. He is a promising student in class V. Whatever I earn from the clinic, I am spending that on Ramu’s education”.

Mrs. Sarkar also entered the room with a smile, “Doctor, since the time you had reduced my medication, I am feeling much better, however my right knee continues to ache even after knee replacement”.

I decided to treat Ms. Kamala Devi first as I felt that her complaint needed to be addressed first. On questioning her further regarding pre- and post-operative exer-
cise, she said, “I did some physiotherapy at the hospital for 7 days and then 1 more week at home. But I am not able to do regular physiotherapy as my mobility has been restricted following weight gain”.

I enquired, “Why don’t you walk inside your house at least?”

I tried to explain to her the concept of life space mobility. It refers to the size of the spatial area that a person can access in his daily life and to the frequency of travel in a specific time and the need of assistance for this travel. Life space mobility mirrors the balance between internal physiological capacity and the environmental challenges faced by the older adults. Further, it helps to evaluate their abilities to lead an independent life. Restriction in life space mobility can result in the loss of various valued activities of personal life such as practising outdoor activities, hobbies and visiting friends [12] which has a direct implication on the quality of life of older adults [13].

She replied, “I don’t like walking, the only thing I truly like is to gossip, relax on my bed and watch movies and Bengali serials on my TV”.

Their next two visits were uneventful with minimal fluctuation of mood and blood sugar for Mrs. Sarkar.

Sometime in November of 2013, I got a phone call from Dr. Sarkar “Dr. Prasun, my wife is not doing well. Would like to meet you” then a silence.

I was inside a conference hall in Bengaluru with poor cellular reception.

For some reason I couldn’t connect with him again, no matter how much I try. I forgot the incident once I came back to Delhi.

4.7 Situational Challenges in Late Life

On March 2014, I heard a familiar voice in my OPD, “May I come in?” I realized instantly that it was Dr. Sarkar.

“Please come in” and with lot of enthusiasm I asked, “How is your practice sir?”

Ms. Uma followed him.

Dr. Sarkar had a gloomy and sad look on his face.

I asked, “Sir you came alone, where is madam?”

With a very heavy heart, Dr. Sarkar replied, “Dr. Chatterjee, Kamala has been diagnosed with cancer of buccal mucosa and it has already spread to the neck and lung”. Before he could finish his sentence, he broke down.

After a pause …

“You know she chewed beetle nut all her life, a customary practice among Bengali ladies. There was a small nodule in her left cheek, which progressed rapidly within three months to ulcerate. Initially we consulted our Central Government Health Scheme (CGHS) dermatologist who asked for biopsy. But Kamla was reluctant for invasive procedure. Ultimately Uma cajoled her to visit a pathologist at a 300-bedded multidisciplinary Private Hospital, CGHS empaneled. A team of doctors, including oncologist, ENT, surgeon, dermatologist, Internist and pathologist examined her at length”.

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“We had couple of sleepless nights during Diwali, when entire Delhi was brightly lit, there was darkness in our home. Unfortunately, Dr Shyam Chawbe, the medical oncologist from the hospital was on holiday that time. So, I called you, but you were also out of station. After a week, once he joined back, he ordered a CT Scan of the lung and abdomen”.

Again, a pause …

After a deep sigh, “There was metastasis, cancer had spread to other parts of the body, it spread to the right upper lobe of her lung”.

“I was almost collapsed after hearing that”. Dr. Sarkar put his head down on the table.

His pain and agony were palpable.

I took the thick file of medical records of Ms. Kamala and flipped through it.

It was stage IV squamous cell cancer (type of cancer diagnosed by the pathologist) on posterior aspect of the oral cavity with tumour size 4 cm with invasion to adjacent deep muscle of the tongue.

Her functional assessment ECOG score was 2, which means that she was capable of only limited self-care, thus confined to her bed/chair for more than 50% of the day hours [14].

In general, oral cavity cancer tends to spread primarily to the lymph nodes of the neck first before it spreads or metastasizes to other areas. The lung is a likely second level of metastasis, also called distant metastasis.

Dr. Sarkar continued, “Dr Chawbe, in consultation with the radiation oncologist, decided to treat her with palliative Chemotherapy and Radiotherapy”.

“We came home after one episode of chemotherapy. She tolerated it well but pain in the oral cavity was troubling her a lot. She continues to have major problems in speaking and swallowing solid food. Her life has become miserable, doctor”.

We had spent almost 20 min by that time, and other patients were getting anxious, but I continued to talk to Dr. Sarkar. I asked him, “Sir how is she doing now? May I help her anyway?”

“Yes doctor”, with lot of hope and despair he said, “Control her pain and treat her depression. She was otherwise fine with your minimalistic medication for her medical morbidities”.

I looked at her present prescription following her completion of palliative radiotherapy. She has been tried with Paracetamol and Tramadol in high doses.

“Have you tried morphine?” I asked.

Dr. Sarkar replied, “No”.

I called a nonprofit organization that helps in giving counselling services to the cancer patients at door step which includes even providing morphine.

I had increased the dose of Sertraline 50–100 mg and added Lonazep (0.5 mg) three times to relieve her anxiety.

Again Dr. Sarkar uttered, “It is a tough time for our family. She is not letting me leave her side even for a single minute. So, I was forced to stop my clinic again”.

I also noticed that Dr. Sarkar was in extremely low spirits today and I soon realized the hardships he must be facing and will have to face in the future.
Dr. Sarkar continued, “But I don’t feel like doing anything. I don’t feel that I will be able to resume my clinic again. Ramu is now studying in class VII and I have promised our maid that I will bear all his educational expenses till death”.

Since he was at my OPD, I decided to examine him as well for a while. I knew this was not the appropriate time or place to ask such a question, but still I asked after evaluating his knee and his gait “Sir, you should go for knee replacement. That will improve your mobility and you might be able to help madam in a better way”.

4.8 Ill Effects of Space and Time Restriction

“Do you think I have the capacity to survive a knee replacement surgery? And most importantly, I have lost all the motivation to walk. I am on antidepressants”. With a very lost expression he said, “Please just titrate my dose of HTN. The four walls of my bungalow have now become my world. I almost always feel tired and easily lose interest in any activity. Yes of course, I read newspapers everyday but that does not give me any extra energy or happiness”.

I felt helpless, one spouse affected by depression because of the other partner whom he had been supporting for 24 h. This is a challenging situation at the end of life for most of the couples where their entire world gets constricted to four walls. I explain this as a theory of “space, time and restriction” where a person who initially was very active, visited parks, banks and cinema halls, has now been restricted within four walls, confined sometimes just between the bedroom and the bathroom. Mobility restriction is the terminal event for rapid fall of physical, functional, cognitive capacity of a human being [15].

I tried to counsel and encourage Dr. Sarkar to strengthen himself mentally and increase mobility by at least visiting the park regularly.

When Dr. Sarkar left the room, Ms. Uma also described how her daily schedule has been very hectic. Juggling between work and family it is often hard for her to cater to the needs of her incapacitated mother-in-law. She also mentioned that they couldn’t tell her mother-in-law about the diagnosis of cancer, considering that she would be unable to accept the reality and might go in a state of shock.

In India, doctors as well as caregivers often hesitate to honestly disclose cancer diagnosis to the patients, considering that the acceptance will be very poor and their physical and mental health will deteriorate further. But studies suggested elderly people are more adaptable, acceptable and experienced. They have been witnessing to numerous ups and downs of life, and they know that the body is mortal. Only thing that they dislike is the process of death.

I pressed Ms. Uma that, “You must inform her about the disease and explain it in detail. She may cry, get angry and may get anxious but she must know about the diagnosis and prognosis of her disease which is cancer with advanced stage and her life expectancy is from few days to months”.

Ms. Uma left my clinic with misty eyes. Probably nobody had told her the truth about her mother-in-law’s life expectancy.
Ms. Uma came to see me after 3 months and informed me that Mrs. Kamala’s condition had deteriorated further.

She was also explaining how difficult it was for them to pass each day with increasing sufferings of Mrs. Kamla. She was on feeding tube, as she couldn’t swallow even liquid food comfortably. “Her Speech has become incomprehensible. She has lost all desire to live”.

Mrs. Kamala had lost significant weight of 20 kg in 6 months, as a side effect of her cancer. Uma asked me, “Doctor, is it mandatory to control her blood sugar so strictly? She is already on minimal food”.

I informed her, “Not at all”. I reduced her medicine to four essential drugs. For someone like Ms. Kamala, who is counting her days, suffering from end-stage cancer with gross cachexia, what is the role statin or cardioprotective drugs or calcium could play? Treating physician needs to be considerate about the same.

Dr. Sarkar did not accompany his daughter-in-law that time. He was probably in denial, contemplating how his 50 years of married life was coming towards an end. Unknowingly but inevitably, Dr. Sarkar was moving towards frailty with decreased mobility, depression, social isolation and withdrawal from the world.

It is very easy as a doctor, a reader, a writer and an audience to give suggestions to others on how to live their life meaningfully and contribute to the society.

I believe that my words of encouragement to my patients are helpful and welcomed by most of them and their families and probably aid in creating a positive attitude. But reality is different and far away from our limited knowledge of medical science. Defining meaningful engagement to an individual, who is aged 80 or more, is not only difficult but a mere foolishness. They are wise and experienced and can visualize their destiny. They are ready to accept everything, and most importantly, they are also suffering from situational challenge, be it internal or external.

But of course, a doctor or medical team should try to infuse a positive but realistic outlook to their elderly patients. In the end, what an elderly expects is a peaceful living and a painless exit from this world. As a specialist, one should empathize, listen and care for them. After all, who knows and understands the health of them better than a doctor. One should try to augment their positive thought, which helps them to willingly and happily be a part of the recovery process or help in dignifying fag end of life.

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