

Why the Elderly Can't Get Good Medical Care

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Doctors and Nurses Have Little or No Training in Geriatrics

As a physician and educator, (I teach at Brown University Medical School), I know better than most that it is no longer possible for families and caregivers to depend upon doctors and nurses to protect their elderly loved ones. Instead, families and caregivers themselves must work to maintain the elderly patient's good health. The problem? Doctors and nurses caring for the elderly have little or no training in geriatrics. The pharmacists who fill their prescriptions and who may recommend over-the-counter drugs to them likewise have little or no training in geriatrics.

For this reason, it is critical to the daily health and well-being of the elderly that their families and caregivers learn about the common diseases and conditions that are potentially fatal to them. Family caregivers must learn to communicate to doctors and nurses any changes in a patient's condition they see, for such changes signal what could become a serious crisis. They must also learn to assess what makes a loved one at risk for deadly conditions and how to reduce these risks as a preventative measure. They should strive for continuity of care so that her doctors and nurses will be more likely to perceive important status changes as a warning sign that the patient is experiencing a potentially deadly complication.

Because of their lack of knowledge, physicians, nurses, and other healthcare providers often fail to recognize the potential for drug interactions, symptoms of adverse drug reactions, or new disease processes and instead misunderstand these to be part of the natural aging process. As a result, experts say that millions of older Americans face greater risks of potentially fatal complications such as these:

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- getting the wrong diagnosis
- having a potentially fatal condition or disease go undiagnosed
- having the wrong medication prescribed for them
- not getting a proper and necessary medication prescribed for them
- being harmed by innocent misuse of prescription drugs and/or over-the-counter drugs
- having a drug-drug, drug-food, or drug-disease interaction that will be fatal if it goes undetected

These are only some of the things that can go wrong. In February 2002, the Alliance for Aging Research released a report documenting the grave shortage of trained healthcare workers called “Medical Never-Never Land: 10 Reasons Why America Is Not Ready for the Coming Age Boom.”¹ The report describes the magnitude of the crisis in healthcare for the elderly and also makes clear the lack of a reasonable prospect for a solution in the near future. As a result, your loved one may be at risk unless you are able and willing to learn about the diseases and conditions that pose the most serious threats and also are able and willing to be a member of her caregiving team.

If you wish to know why doctors, nurses, and other medical caregivers lack critical training in geriatrics, you can find a short summary of the Alliance for Aging Research report in the endnotes for this chapter. You can also read the entire report on the Internet or download it to your computer.² What you, as a family caregiver, must know is how much at risk your loved one is and how to protect her from potentially fatal complications. In fact, if you are a Baby Boomer yourself, as most caregivers are, what you learn in this book about common diseases and conditions affecting the elderly will help you to protect your own health!

I also hope this book will aid in your self-confidence: you are the individual most capable of observing and detecting the changes, even subtle changes, that tell you there is something very wrong with your loved one.

Finally, this book is intended to help you learn how to communicate your observations to doctors and nurses so that your loved one is properly diagnosed and treated. If you don’t, the possibilities are great that your elderly loved one will be marginalized, or essentially “written off.” This occurs far too often, particularly in the institutional setting.

How the Elderly Differ from the Population at Large

Because many, if not most, healthcare professionals are not trained in geriatrics, they often fail to recognize the health needs of older adults. Appropriate care for the elderly depends upon focusing on the unique way in which the elderly differ from younger patients, for a change in condition can signal a deadly disease or a drug interaction that, if not addressed, can prove fatal.

Specifically, the elderly often have symptoms that differ from those of younger persons with the same illness. For example, an older person who has a heart attack may not experience crushing chest pain but only dizziness and confusion. Or, an individual with hypothyroidism may appear to be suffering from dementia. Delirium, a sign of a life-threatening disease or condition that urgently needs treatment, is often mistaken by physicians and nurses as dementia. The result is that the elderly patient may not be diagnosed properly and treated appropriately, and death may result.

Elderly patients also face potentially hazardous interactions from drugs prescribed by different practitioners. Some doctors do not know that older people metabolize certain drugs differently from younger people, thus exposing elderly patients to inappropriate dosages that can cause harm and sometimes death.

The difficulties in managing and treating the elderly are made far more complex by the fact that the body's response to medications is markedly different among the various age groups within that group we refer to as "the elderly." You should look at your elderly loved one like this: age 65-75 is "young old," 75-85 is "older old," and 85 and older is "oldest old." When treating these patients with medications, the drugs must be carefully tailored, both in choice and dosage, to each individual, taking into consideration her health history, her known diseases, and also her existing drug regimen to avoid the medication errors and adverse drug reactions that will be discussed in detail in later chapters. These drugs should also be re-evaluated if the patient's kidneys begin to fail, as often occurs in the elderly either as a normal effect of aging or as the result of an emerging condition such as dehydration, so that dosages may be tapered or eliminated to protect the patient from toxicity and death.

Your Loved One Needn't Always See a Geriatrician

Most elderly are cared for by general internists and family physicians. Not every patient needs to be seen by a geriatrician, a specialist in aging-related health issues and gerontology. Whether a geriatrician is needed is based more on a patient's particular healthcare needs than on her chronological age. Two individuals both aged 65 may have very different degrees of disability or illness; one may have no problems at all while the other may have serious health concerns. Geriatricians frequently provide the primary care for older adults who have complicated medical and social problems. But for most elderly patients, an occasional consultation with a geriatrician who can then advise the primary care physician is sufficient.

If a patient becomes critically ill, a primary care physician may call in other specialists to consult. She may involve a geriatrician, whose major goal would be to coordinate the work of specialists and other healthcare providers such as social workers, nurses, and home health aides. The medical caregiving team may include, with or without a geriatrician, any or all of the following professionals:

- Nurse
- Social worker
- Nutritionist
- Physical therapist
- Occupational therapist
- Consultant pharmacist
- Geropsychiatrist

The members of this team look at each patient holistically. The team considers the patient's medical history and present health condition. The team also looks for the effects of past illnesses as well as "geriatric syndromes"—health problems frequently found in the frail elderly such as incontinence, frequent falls, depression, memory problems, and the side effects caused by multiple medications. The team's purpose is to detect, treat, and prevent the geriatric syndromes that are a direct threat to the elderly patient's ability to live independently. Again, while not all health professionals need to be certified in geriatric care and not every elderly person needs a geriatrician, a geriatrician should be consulted when:

- Your loved one's condition causes considerable impairment and frailty. For example, she may be over the age of 75 and coping with

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a number of diseases and disabilities, including cognitive problems such as dementia

- Use of numerous prescription drugs makes it unclear which drugs are appropriate and which may be causing additional problems
- Family members and friends are feeling considerable stress and strain as caregivers

Caregivers—an Essential Part of the Caregiving Team

As a family caregiver, you can be a valuable and effective member of the caregiving team. As you will read often in this book, the likelihood is great that you are the person who spends the most time with your elderly loved one and that you are the one in the best position to observe changes in her condition that indicate something is very wrong—that she's suffering from a disease process or condition that her physician needs to address right away.

Let me give you an example: much of what happened to Jeanne's mother resonates with experiences my patients have had, one of which I will describe because it illustrates a successful outcome of a determined daughter's intervention, a good resolution, quite different than Jeanne's. Mrs. Smith, like Jeanne's mother, had Parkinson's disease. It was so severe that her elderly husband and married-with-children daughter couldn't care for her adequately and she was admitted to a long-term care facility.

A month later the daughter called me. "Mom's doing terribly," she said. "When she went into the nursing home she could walk with a cane part of the day, feed herself all three meals, walk with a walker to the dining room all the time, and always assist in her care. Now she can't walk anytime, or feed herself. She can't do a thing, and I'm sure they screwed up her medication by giving her sustained release instead of immediate release medicine for her Parkinson's disease."

I assured her that such a change, while not endorsed by me, would not have made such a difference and that I would investigate. I telephoned the nursing home and had the charge nurse read the names, doses, and schedules of all the medications. I learned that a new medication had been started to treat the patient's chronic complaint of nausea. This medicine, unfortunately, causes PD patients to get stiffer and slower, a fact not well known to most doctors or nurses. I had the medicine stopped and, over the next few weeks, the patient's mobility returned to its previous level.

What struck me was partly the mistake of prescribing the drug in the

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first place, but mostly I was struck by the lack of recognition that something bad had happened to the patient. The nausea had improved and no side effects were observed. The nursing staff interpreted this as a success. The worsened motor function was interpreted as disease progression, the natural course of Mrs. Smith's Parkinson's disease. After all, that's why she came into the nursing home in the first place. What the staff failed to recognize was that the parkinsonism Mrs. Smith was exhibiting—increased tremor, stiffness, lack of mobility—was an adverse drug reaction. Here was an obvious, inadvertent, and correctable problem that occurred at a good nursing home with what passes for adequate staffing these days.

Fortunately, because of a vigilant advocate, a caring staff, and a doctor who had experience with the type of adverse drug reaction this patient suffered and who is committed to being available to his patients and their families, Mrs. Smith is still walking and feeding herself. But how often, I asked myself, is this happening where the family believes the staff's reassurances that this sudden worsening represents the disease's ceaseless progression? When family members hear comments like "It's so sad; we see this all the time. There's nothing you can do," most take them at face value.

It's important that you tell your loved one's doctor what you see—changes that may indicate a serious problem. Don't diagnose the problem yourself, because you may hinder the way her doctor analyzes the situation. Just make a list of all symptoms you observe and concerns you have and share them with the doctor either by telephone, telefax, or in person. Doctors rely upon checklists to help them assess and rule out the possible causes of such problems. They begin by considering the most common problems, and often find the answer they are looking at without having to complete an entire battery of tests. Then treatment of the emerging condition can begin promptly and often disaster can be averted. So if you learn more about the conditions Jeanne will address in this book, you will learn what to look for, how to communicate what you see to her doctors and nurses, and how to prevent these conditions from occurring so that your elderly loved one's life is longer, richer, safer, and more independent.

Conclusion

While I am no expert on nursing homes, I do know something about them. My grandmother suffered from Parkinson's disease when I was a child, before the development of L-Dopa, the main drug used for treating it. I clearly recall the nursing home she was in and the emotional problems her

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illness caused for the family. Likewise, I have a lot of patients who visit from nursing homes. I like to think I am observant, and I have a fair amount of common sense. As Yogi Berra reportedly said, "You can see a lot just by looking."

One reason Jeanne's mother was seen so little in the nursing home was that doctor payments are very low. My veterinarian receives more money for a routine evaluation of my healthy cat than I get for seeing people with Parkinson's disease, and she's not overpaid! For a time I "moonlighted" doing EMGs, a neurological test for diagnosing pinched nerves. I was paid approximately eight times, sometime ten times, as much as I would have been paid to spend an hour with a new PD patient. Seeing a patient with Alzheimer's disease and talking with her family about her myriad problems is getting to be a money-losing proposition. This translates into reduced time for interactions with the patient, reduced knowledge about the patient, reduced time to gather information from the nurses, reduced time to hear from the family, and less time or no time to actually talk with the family.

As Jeanne articulately explains in later chapters, the lack of contact between physicians, the patient, and family caregivers is frustrating, but it is also frustrating for the doctor. Between the frustration and the low reimbursements, it's no wonder that geriatrics is so under-subscribed.

What this means for you is that while you should try to seek out a geriatrician to care for your elderly loved one, you may not find one, even at a good nursing home. Even if you do find one who is good, you will still need to function as a patient advocate and inform the staff when you see worrisome changes that they don't. You may need, hopefully rarely, to go over the staff's head to the physician directly to communicate a concern. You can send a note or fax and/or request a phone call or a discussion. There is an advertising motto that a clothing store in the northeast has used for decades that I think applies in many situations. I invoke it frequently in my clinical research trials, and I think it applies to nursing homes as well: "An informed customer is our best client."

The nursing home, doctor, patient, and family are all on the same side. We all want what's best for the patient, keeping in mind certain resource limitations. The more informed the patient, staff, and family are, the better everyone can work together to improve the patient and staff's quality of life. Everyone does better when the patient does better. A happier patient makes for a happier family, a happier staff, and a better outcome. Being an advocate does not mean being a pain in the neck. In this book Jeanne tells her story in the hope that the reader will be better prepared to avoid similar problems and to better solve them, should they occur.