Second Thoughts

OLD PEOPLE IN HOSPITALS

JAMES S. GOODWIN*
Department of Medicine, University of New Mexico, School of Medicine,
Albuquerque, NM 87131, U.S.A.

(Received 25 October 1982)

Abstract—This article is a personal tale of one geriatrician's struggle to integrate good medical care of hospitalized old people with the intellectual rigor of an academic medical center.

I was called to do a geriatric consultation on a patient on five-south the other day. It was my first request for an inpatient consultation this year. I don't think my consultations are considered very useful—my diagnostic impression is frequently something like "this man is very sick and may very well die" and my recommendations tend to be similarly nebulous championings of vitamins and frequent visitors. The internal medicine residents here learn quickly to avoid me. I must admit that I feel uncomfortable doing inpatient consultations. I never quite feel certain that I am communicating, and I am not sure how I should change so that I can get across my ideas. I suppose there are other more charismatic, certainly less acerbic, geriatricians out there who successfully influence the treatment of elderly patients at their institutions. Perhaps if I were less ambivalent about trading time in research for time doing inpatient consultations I might be viewed more favorably.

But the problem is more basic than charisma, or time conflicts. The problem seems to be that good medical care for the elderly is not something that teaching hospitals are very good at. Part of the problem is facts. Medical residents and medical students love them. Geriatricians have very few to dispense. A factual textbook of geriatrics would take up perhaps 100 pages. After that limit facts cease and opinions flourish. Medical residents do not like opinions. Another part of the problem is that geriatricians rarely recommend additional diagnostic procedures and novel therapeutic approaches. To the contrary, we question and whine about the necessity of the most basic procedures and are always telling people to stop this or that medication.

All of this brings me back to the man I was called to see the other day. Perhaps if I go over the consultation I can better relate the problem I have been trying to describe. They called me because the man had had an appointment to see me in my geriatric evaluation outpatient clinic but got hospitalized before I could get to him. He was an 83-yr-old Spanish speaking man who was in good health all his life and was not taking any medicines. His daughter made an appointment for him to see me because he began acting senile and he stopped eating. Pretty soon he wouldn't eat or drink anything, and he didn't recognize anybody; so they brought him to the emergency room. He was admitted because he was dehydrated and because it was the second week in July and the new intern didn't know any better. All of this was told to me the next afternoon by the fourth

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*Request for reprints should be addressed to Dr James Goodwin at the Department of Medicine, University of New Mexico School of Medicine, Albuquerque, NM 87131, U.S.A.
year student charged with this man’s care. In a dispirited but not unfeeling fashion, he avowed that in the workup they had found nothing but vitiligo and an erythrocyte mean corpuscular volume of 114. This started an interaction between me and the ward team that I still do not understand. I said to the student, “this is marvelous; the man has pernicious anemia, a wonderfully reversible cause of dementia. Draw blood for vitamin B12 and folate and then give him lots of both.” I thought the student, as well as the unseen intern and resident, would be as excited as I was at uncovering a treatable cause of dementia. I erred. In the first place, they looked askance on my jumping to a diagnosis and actually recommending treatment on such flimsy evidence—one physical finding and one laboratory test. They wanted a hematology consult who wanted a bone marrow and a Schilling test; he thought that pernicious anemia was a possibility. Meanwhile, the demented man was not getting any B12, and he truely was not eating or drinking. The daughters did not want to sign consent for the bone marrow. I was confused. Here was a man with an illness (severe dementia) as life threatening as pneumonia, and there was an excellent chance he could be cured. When I went to see this man, he was clearly dying, lying in his bed taking neither food nor water. Yet what was clear to me was not clear to others. The ward team, the medical attending, and the hematology consultant saw an incomplete evaluation upon which no treatment plan could be scientifically based. In their eyes I was a mindless, anti-intellectual practitioner—the reviled “LMD” of the CPC. I tried to explain that whether the bone marrow got done or not was of little consequence—that it was important to start potentially highly therapeutic treatment. I raised the possibility that the man might even have an occult gastric cancer accounting for his anorexia, but I did not want to look for one in his present condition. My note in the chart was followed by one from the medical attending rueing that I would recommend any course of action that would deny to the students and housestaff valuable teaching experience. That infuriated me. One does not provide students and housestaff valuable teaching experience by improperly treating a demented old man. By this time it was hospital day five, and the B12 value came back very, very low. At this the ward team grudgingly agreed to give him a shot of B12. And then they discharged him. He could not get out of bed. He lived in a trailer by himself. He drank and ate nothing. But he was discharged. Why? Because the ward team said he did not need to be in the hospital. He was not getting a bone marrow or an upper gastrointestinal series; he was merely trying to decide whether or not to die.

I would have liked to have kept him in the hospital. I would have enjoyed the suspense each day of visiting him to see if the B12 was beginning to work. I would have liked to have him around to show off to my colleagues. The ward team or perhaps the medical attending mumbled something about the hospital being full and trouble with justifying continued hospitalization to medicare. The part about medicare was wrong, but correcting facts doesn’t change attitudes. Insecure physicians still mumble “medico legal” to justify thoughtless diagnostic procedures long after the inutility of such procedures has been demonstrated.

The man is living with his daughter now. He is coming to see me this Friday. It will be exciting to see him. I would not miss that clinic appointment with him for anything.