The woman just moaned. “Have you thought about taking her to a nursing home?” I asked. “I understand how difficult it can be to care for someone who is chronically ill.”

“Her doctor talked to me about that a while back but I swore as long as I could, I would take care of her myself. We have been married for 42 years. I didn’t want to put her into a home unless I had to.”

“You have to, sir,” I said. “It’s time.”

He sat down in a chair beside her bed with a blank expression on his face. Looking at this couple, I felt sorry for both parties. Whatever suffering this man may have inflicted on his wife, either through commission or omission, they were obviously both in pain. A major change was needed in their living situation. I left the room to make that happen. Before returning to the patient’s bedside, I called adult protective services and arranged to have her admitted to the hospital.

When I entered the room this time, the woman had stopped howling. The nursing staff had cleaned her up and she was lying peacefully on the bed. I explained to the patient and her husband what was going to happen. I do not know how much of it she understood, but her expression led me to believe that she comprehended at least some of what I was saying. The husband asked how long this was going to take and what he should do. Taking into consideration his intoxicated state, I told him it could be a while before she got a bed assignment and that it might be a good idea for him to go home and rest. He put up less resistance to this suggestion than any family member I had ever talked to.

He quickly stood up to leave and call a friend for a ride home. On his way out through the curtain, he shook my hand. “Thanks for your help. This is the most peaceful I’ve seen her look in a long time,” he said.

“That’s because I’m taking her away from you,” I thought. And that is exactly what I did.

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Commentary: Thoughtful Practice and the Older Emergency Department Patient

One characteristic that I believe is important for emergency physicians is thoughtful practice. One might think that thoughtful, in this context, refers to being “considerate of the well being of others.” While being considerate is an important trait, this is not what I mean by thoughtful practice. Rather, thoughtful in this context refers to “occupied with or given to thought; contemplative; meditative; reflective.” Thoughtful practice is important while providing patient care, because it allows one to avoid failed heuristics (abbreviated thinking strategies) that contribute to cognitive errors. Thoughtful practice extends beyond the bedside, though, when we reflect on patients we have seen and our practice patterns, and this leads us to change our practice. The Resident Portfolio “Elder Abuse: Keeping the Unthinkable in the Differential” is an excellent example of thoughtful practice and how it can improve the care of difficult patients. It also provides us the opportunity to discuss elder abuse, a poorly recognized but serious issue.

Dr. Heyborne rightly notes that elder abuse is more prevalent than many realize, and it takes many forms. Broadly defined, elder abuse is “any knowing, intentional, or negligent act by a caregiver or any other person that causes harm or a serious risk of harm to a vulnerable adult.” Elder abuse may include physical, emotional, or sexual abuse, exploitation, neglect, or abandonment. Emergency physicians should expect that they will increasingly be called upon to evaluate victims of such abuse. The prevalence of elder abuse has been increasing, and it is estimated that the occurrence and severity of abuse will increase markedly over the next several decades. Recognizing and dealing appropriately with suspected abuse may be difficult for residents and attending physicians alike. Fortunately, these skills can be improved through thoughtful practice.

The patient Dr. Heyborne describes displays many of the risk factors associated with elder abuse. Those with shared living arrangements are more likely to be abused than those living alone. Those with social isolation are more likely to be abused; the fact that this patient had limited contact with the hospital system and there were no other emergency department (ED) visitors suggest this social isolation. Demented individuals are more likely to be abused, and their abusers are more likely to abuse alcohol.
One interesting aspect of this case that deserves comment is the interaction with emergency medical services (EMS). Dr. Heyborne tells us that the EMS providers were called to the residence about 30 times in the prior month and that “they have refused transport.” Even if the patient had previously been more alert and conversant, was she able to make an informed decision to refuse treatment? Or did the EMS providers allow the husband to make the decision to refuse transport each of the prior times? Out-of-hospital refusals of transport in older patients are a difficult issue. On one hand, it is ethically inappropriate to transport a patient against his or her will, and the decision to allow a patient to refuse transport should not be made solely on age. However, studies show that emergency physicians often fail to recognize cognitive impairment in older patients. If we cannot identify cognitive impairment in the ED, can we expect EMS providers to identify who is impaired and who is competent to refuse transport in the out-of-hospital setting? While this issue is subject to debate, prudence would suggest erring on the side of transporting older patients to the ED if there is any question about their competence.

Emergency medical services providers receive little direct education on geriatrics in their training. However, EMS providers have a unique role to play in the care of older patients, because they often are the only providers who assess patients in their home environments. Educating EMS providers on the signs and symptoms of abuse, and involving them in the referral process to adult protective services, may have allowed this case to be addressed days or weeks earlier.

A number of additional points about general geriatric emergency medicine are emphasized in this portfolio. It is critically important that emergency medicine educators prepare their residents to care for the older patient. These patients will increase in proportion for their entire career in emergency medicine, rising from about 15% of ED visits now to about 25% of ED visits in 30 years. First, this case illustrates the importance of assessing older patients’ function. This patient has lost the ability to transfer, which results in the need for extensive, 24-hour care to prevent skin breakdown due to incontinence, as described in this case. Often, an older spouse cannot adequately provide this care. It is important to recognize functional limitations in older patients and to incorporate these limitations into disposition planning.

Second, Dr. Heyborne was able to make this diagnosis, in part, due to his thorough examination of the patient. When busy, it is easy to leave older patients with limited mobility dressed in their nightgowns, making it impossible to perform a complete examination. Failure to note the skin breakdown, multiple bruises, and contractures may have resulted in misdiagnosis.

Finally, Dr. Heyborne describes the “shotgun pattern” of test ordering that is commonly used for these patients. I believe that his test ordering was more than just “shotgunning” and was likely derived from his (or his attending physicians’) thoughtful practice. I am sure that, on reflection, he could provide a rationale for each of the tests ordered. In this case, we have an older patient with impaired cognition and an intoxicated husband who could not provide a helpful history. While abuse or neglect may be the reason for her condition, many coexisting conditions may exist. These could include sepsis from a skin infection, urinary tract infection, or pneumonia (complete blood count, urinary analysis, chest radiograph); dehydration with hypernatremia and prerenal azotemia (chemistry panel); or acute myocardial infarction (electrocardiogram). Therefore, the process of “shotgunning” laboratory tests, in fact, generally represents a thoughtful approach to complex older patients with geriatric syndromes.

In conclusion, Dr. Heyborne’s thoughtful practice during the care of this patient in the ED prevented the cognitive errors that may have negatively affected her care. His thoughtful practice also allowed him to reflect on this patient after her ED stay, which “forever changed the way” he will approach older patients. Such thoughtful practice allows us, as emergency physicians, to improve the care of the older patients we see today and in the future.

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