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Hospital Medicine: Current Concepts

Scott A. Flanders and Sanjay Saint • Series Editors

HOSPITALISTS' GUIDE TO

THE CARE OF OLDER PATIENTS

EDITED BY

BRENT C. WILLIAMS • PREETI N. MALANI
DAVID H. WESORICK

WILEY Blackwell

*HOSPITALISTS' GUIDE
TO THE CARE OF
OLDER PATIENTS*

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INTRODUCTION AND OVERVIEW

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Approximately one in three hospitalized adults in the United States is over 65 years of age [1]. With multiple comorbidities and limited physiological and functional reserve, hospitalization inherently represents a period of heightened vulnerability for this population [2]. The risks are clear: falls, delirium, healthcare-associated infections, and adverse effects of drug–drug interactions are common. Even a relatively short period of bed rest can result in profound deconditioning and loss of muscle mass. Between admission and discharge, more than a third of older hospitalized patients experience a decline in activities of daily living (ADLs). Overall, about a quarter of older adults require post-acute care due to loss of independence in basic ADLs and impaired mobility, and a remarkable one-third are rehospitalized within 90 days of discharge [3].

While the risks associated with hospitalization among older patients have been recognized for some time, in recent years significant progress has been made in identifying older patients at highest risk for adverse outcomes, and in structuring interventions to avoid or ameliorate morbidity. Although there is a paucity of research surrounding interventions that improve outcomes in older patients hospitalized on general wards, there is much information from trials among special hospital units (acute care of the elderly, or ACE units), geriatric assessment programs, as well as through intervention programs directed at specific outcomes, such as falls and delirium. A primary purpose of this text is to summarize recent research among hospitalized older patients in a single source, to facilitate incorporation of these findings into hospital practice.

The field of Hospital Medicine has experienced unprecedented growth over the last decade, and hospitalists now provide care for a substantial portion of all hospitalized patients [4]. Although hospitalists treat older

patients routinely, most have received little or no specific training in the care of older adults. This book attempts to present relevant scientific information about the care of older adults in a way that will be useful to a practicing hospitalist.

INTENDED AUDIENCE AND USE

This book is written for hospitalists—busy clinicians caring for acutely ill patients who need practical, evidence-based information and recommendations to improve the care of the vulnerable elderly. However, we believe other healthcare providers, including nurses, pharmacists, nutrition counselors, and physical and occupational therapists, will find several chapters germane to their work as well.

We also envision this book as a teaching tool, for use especially by hospitalists, medical students, and house officers seeking deeper and more comprehensive assessment and care plans for individual patients, and then embedding new practices into their daily routine.

Each chapter is intended to summarize “best practices”—that is, to provide concise, practical recommendations to hospitalists in the assessment and care of older hospitalized patients based on the most recent scientific evidence. In areas where evidence is scant, authors were encouraged to give practical advice based on their own experience. Topics were selected that addressed areas of high morbidity (e.g., falls, delirium, and medications), controversy (e.g., psychopharmacy and nutrition), or that are particularly difficult to “get right” in a busy hospital practice (e.g., informed decision-making and caring for patients with limited prognosis). Topics for which information and practice recommendations are readily available through other sources, such as management of medical conditions common among older hospitalized patients (e.g., atrial fibrillation, congestive heart failure, and pneumonia) were not included.

We hope hospitalists will use the text in several ways:

- *To build a systematic approach to older patients.* Chapters 2 (Communication and Physical Examination), 3 (Geriatric Assessment for the Hospitalist), 5 (Informed Decision Making), and 13 (Transitional Care Planning) address issues relevant to virtually all older patients, and are applicable in any clinical context.
- *To improve practice in specific contexts.* Many of the chapters address specific clinical contexts (Chapter 9 Hip Fracture, Chapter 10 Falls, and Chapter 11 Pressure Ulcers), and help inform the care of specific types of patients.

- *As a teaching resource.* The chapters in this book are up-to-date, and written by experts in their fields. They are a good starting point for clinical teaching on these topics, and they provide key references that can be used to foster additional reading and discussions.
- *To improve work flow among healthcare team members.* Although our primary audience is hospitalists, in order to be effective, many (if not most) of the recommended practices described in the book require collaborative interactions among physicians, nurses, pharmacists, therapists, social workers, and others. The practice recommendations offered readily lend themselves as a basis to review and redesign local practice with other health team members. Hospitalists who are already involved in quality improvement activities are encouraged to look for specific ideas and practice recommendations to discuss with administrators and other healthcare providers that are most relevant to their own practice environment.

As editors, we learned much from the many talented authors who willingly provided their time and insights to bring this book to fruition. We hope hospitalists and other hospital-based health care providers and administrators will find it equally valuable.

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THE HOSPITALIZED OLDER ADULT: COMMUNICATION AND PHYSICAL EXAMINATION

Mark E. Williams

INTRODUCTION

Effective interpersonal communication among hospitalists and patients and their families throughout the hospital stay is critical to high-quality care. Good communication can enhance the patient's overall experience, prevent avoidable mishaps and complications, improve diagnostic accuracy and therapeutic efficacy, and foster professional satisfaction. However, the hospital setting is not inherently conducive to effective communication; frequent interruptions, competing demands for physicians' attention, simultaneous tasking, and background distractions of noise and activity are among the myriad barriers. Patients and their caregivers are often anxious and worried about poor outcomes. They feel uncertain about the future and are often groping for some combination of information and assurance that everything will be okay. Despite these challenges, hospitalists can substantially improve communication with patients and their caregivers by applying a few simple principles along with some habits of mind and behavior.

The basic premises of effective clinical care are that clinicians treat individuals not diseases and that the relationship between the doctor and patient is the conduit through which all therapeutic benefits flow. The experienced physician can perceptively gather and integrate clinical information, understand how people behave when they are ill, and develop a plan of care in the patient's best interest. Truly superlative clinical care also requires communicating the necessary therapeutic interventions in a way that maintains and even strengthens the patient–physician relationship. The expert clinician appreciates that he or she is an essential component of the healing

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intervention. Plato stated: “You ought not attempt to cure the eyes without the head, or the head without the body, so neither should you attempt to cure the body without the soul. And this . . . is the reason why the cure of many diseases is unknown to the physicians of Hellas, because they disregard the whole, which ought to be studied also, for the part can never be well unless the whole is well.”

PEARLS FOR COMMUNICATING WITH OLDER PATIENTS

Make It a Habit to Demonstrate Reverence for Older Patients

In his classic 1927 *Journal of the American Medical Association* monograph, Francis Ward Peabody said the art of caring for the patient is to care for the patient. He also wrote “The treatment of a disease may be entirely impersonal; the care of a patient must be completely personal.” This succinct advice epitomizes the need for craftsmanship in caring.

Caring for patients goes far beyond the important but superficial actions of shaking hands and introducing yourself. For example, we can observe the reverence in how people handle objects they perceive to be extremely valuable. There is a precious delicacy of the touch, with attention to each nuance in movement. The pottery bowl or rare book commands total concentration with an obvious appreciation for the material or artistic value. In the same way, it is easy to identify the clinician who is “caring for the patient” by *how* he or she takes the patient’s hand for the initial handshake or to begin the physical examination. Again, there is a sense of conscious appreciation, respect, and reverence.

Control the Environment to Facilitate Communication

Conscientious information gathering requires awareness of the dynamics of the clinical encounter and structuring both the internal and external environment to facilitate communication. This can be particularly challenging in the emergency department or a typical inpatient room. The attitudes and habits of physicians and other healthcare personnel strongly influence the quality of information available from the patient history. In particular, two factors can make all the difference. First, it is important to keep in mind that the overall goals of care are to reduce morbidity and improve function and quality of life by whatever means possible, not necessarily eliminating the cause of the distress (which may be impossible in many circumstances). Second, during the few minutes of each clinical encounter, the hospitalist

should develop the habit of clearing clear his/her mind, quieting internal distractors, and paying full attention to the patient through empathic listening. Inattentiveness leads to erosion of the therapeutic relationship and compromises the quality of observations.

Attention to a few specific external environmental considerations can also help by facilitating sensory input to the older person and putting them at ease. Because some older people have visual impairments, techniques to improve nonverbal cues become useful. For example, physicians should avoid having a strong light behind them (such as a window or halogen lamp) because it puts the face in silhouette. Another useful technique is to reduce the distance between participants. As a rule of thumb, the optimal distance is that at which the interviewer begins to feel uncomfortably close. For individuals with hearing impairment, the volume of the voice must be raised without raising the pitch. Shouting, which raises the pitch, defeats the purpose because high-frequency sounds are affected more profoundly than lower-frequency sounds in the aging ear. In fact, shouting can also produce significant discomfort because the failing ear may become more sensitive to loud sounds.

Sit Down and Listen to the Patient

Environmental conditions can improve communication by helping the older patient relax and feel comfortable. One important way to facilitate communication is to sit down. The importance of sitting is inversely proportional to the time available for the encounter; the less the time available, the greater the importance of sitting. Besides providing a common level for eye contact, sitting helps to neutralize the appearance of impatience and haste. The appearance of impatience inhibits communication by magnifying a hierarchical relationship (physician over patient), rather than establishing a partnership to solve problems collaboratively. Sitting down also helps physicians establish the desired internal environment described earlier.

PERFORMING THE GERIATRIC PHYSICAL EXAMINATION

Geriatric assessment begins from the moment the clinician sees the patient and continues until the clinical encounter is complete. The way we wear our hair, the fit of our clothing, what we choose to show off about ourselves and those things we wish to hide are not random. Normally, this self-expression is congruent, and in day-to-day life, we subliminally make a value judgment about the person (pleasant, eccentric, attention seeking, kind, self-centered,

etc.) and continue our personal or professional interaction. Incongruities in this self-presentation are important diagnostic clues that require further inquiry. Patients expect to be touched during the physical examination and they are usually acutely aware of the physician's skill, discipline, and thoroughness in gathering clinical data. The importance of this clinical ritual cannot be overstated as an essential part of the therapeutic relationship.

Appearance

The initial appreciation of the patient derives from a broad impression of their body as well as specific features of the individual's uniqueness. These identifying characteristics form the observational basis of our individuality and provide essential clues of the person's inner and outer health. A fundamental question is whether the patient looks acutely ill, chronically ill, or generally well. Does the apparent age (how old the patients looks) match the chronological age? The apparent age may reflect overall health and well-being more accurately than the chronological age. Some nonagenarians look decades younger than their years, and their life expectancy seems to correlate with their apparent age.

The observant clinician notes the patient's body size, shape, and proportions. For example, is the patient overweight or are there signs of weight loss such as temporal wasting or, if more severe, loss of the buccal fat pad? Increases in abdominal fat may suggest the metabolic syndrome with increased risk of diabetes mellitus and premature vascular disease. Skin findings may be obvious over the face, arms, legs, or other areas of exposed skin. Is there the pallor of anemia, the bronze tone of jaundice, the lemon yellow tint of pernicious anemia, the hyperpigmentation of Addison's disease, the ruddy complexion of hypertension or alcoholism, the ecchymosed arm of a recent fall or possible physical abuse? Fresh scars or burns on the upper extremity may be clues to dementia or substance abuse.

No part of the human body is more closely examined than the roughly 25 in² that comprise the face. Faces are a central focus of our attention, and we are innately attuned to the nuances of those expressions (like joy, fear, pain, anger, sadness, and surprise) that can change with the subtlest movements of the facial muscles. The basic challenge for clinicians is to be able to transcend our usual and preconditioned way of looking at a patient's face to appreciate the individual's nature, as well as their inner state of health. In addition, specific conditions may alter the head and face in characteristic ways (Table 2.1). Pay careful attention to the eyes, the periorbital tissues, and the mouth and surrounding muscles. These parts of the face participate disproportionately in facial expression and communication. Disease predilection also seems to favor these areas.

TABLE 2.1 The Findings of Classic Facies

Condition	Description of facial findings	Other visible clues to the diagnosis
Acromegaly	Prominent jaw; enlarged facial features, especially lips and nose that project away from the head	Large hands with enveloping, pillow-like feel to the handshake
Amyloidosis	Periorbital purpura (raccoon eyes) just after rapid increase in venous pressure from coughing, for example, or, classically, after proctoscopy	Note: raccoon eyes can also be a sign of basilar skull fracture
Cushing's syndrome	Moon face where the buccal fat pads obscure the ears from the front view	Red cheeks
Depression	Worn, weary look; poor eye contact; smile, if present, is forced	Appearance of sadness, loss of pleasure
Klippel–Feil syndrome	Exaggerated forward head position from congenital abnormalities of the cervical vertebrae	
Mitral stenosis	Flushed cheeks; drawn look to the face making nose seem prominent	Exertional dyspnea, atrial fibrillation
Myxedema	Coarse facial features; full, coarse, dry, brittle hair; periorbital edema with little sacs of fluid; loss of the lateral eyebrow; facial puffiness; dull, lethargic expression may be present	Slow movements; large tongue; elbows with dirty-appearing hyperkeratosis
Nephrotic syndrome	Periorbital puffiness; dullness; lassitude	Grayish, sallow pallor if renal failure is present
Paget's disease	Bossing of the forehead causing a large, "Mr. Magoo"-shaped head	Possible hearing aids from deafness
Parkinson's disease	Expressionless, mask-like; slow facial movements, dull eyes peering from upper half of the orbit.	Bent posture; In men, several days of beard growth under the neck because of inability to see this area in the mirror
Polycythemia rubra vera	"Man in the moon face"—concave facial profile resembling a nutcracker doll	

(Continued)

TABLE 2.1 (*Continued*)

Condition	Description of facial findings	Other visible clues to the diagnosis
Scleroderma	Small, tight mouth that may not be fully closed; small oral opening; narrow, pinched nose; shiny skin with minimal wrinkles	Tightening of the fingers, loss of the finger pad
Seborrhea	May be evident in the eyebrows or across the bridge of the nose	Abrupt onset of severe disease suggests HIV infection
Smoking	Excessive facial wrinkles; thin, vertical cracks along the lips; hollow cheeks	Nicotine stains on fingernails
Stroke	Facial asymmetry; facial droop leading to loss of nasolabial fold; droop may include lip	Upper extremity hemiparesis may be present
Tuberculosis	Temporal wasting, malar sweat, loss of the buccal fat pad	Sunken yet bright-appearing eyes

Look carefully at the patient's overall habitus and posture. The hunched forward position of kyphosis reflects previous anterior vertebral compression fractures. The presence of assistive devices such as wheelchairs, canes, or walkers provides obvious clues of impaired ambulation. Musculoskeletal deformities, such as amputations, the arthritic changes of rheumatoid arthritis, the unilateral contractures of cerebrovascular disease, or the frontal bossing of Paget's disease, may be immediately visible.

Notice the presence of adventitious movements. Restlessness can be a worrisome sign in a bedfast or nursing home patient and suggests delirium until proven otherwise. In addition to restlessness, any stereotypic limb movements, such as tremor, chorea, or athetosis provide clues to the person's neurological or behavioral status. Head bobbing from side to side suggests tricuspid insufficiency, while forward and backward bobbing (de Musset's sign) reflects a wide pulse pressure usually from aortic insufficiency. Erratic head movements may suggest an essential tremor. Occasionally, elderly people with severe behavioral problems or psychiatric illness will quietly rock back and forth in their chair.

The presence of makeup in an older woman generally implies well-being or recent clinical improvement if the patient has been ill. Care in the application implies functionally adequate vision and reasonable upper extremity motor coordination. Overapplication may reflect vanity and a strong desire to look much younger. Heavy eyebrow pencil may be an

attempt to hide eyebrow hair loss perhaps due to hypothyroidism, systemic lupus erythematosus, syphilis, or heavy metal toxicity. The time of the last hairdo can imply the last time an older woman felt reasonably well. If the patient is wearing nail polish, the distance from the cuticle to the line of polish gives the approximate date of application since nails grow about 0.1 mm/day. Picked-at nail polish can reflect nervousness and agitation.

Dress

Observing the older person's choice of clothing helps in appreciating their state of health, as well as socioeconomic status, personality, culture, and interests. Regretfully, most people seen in the hospital setting are attired in a standard issue hospital gown and not their usual clothing. The interested physician can peruse the reference list for detailed discussions of diagnostic clues from clothing.

Language

The first part of the language assessment is called paralinguage, which deals with the rate and delivery of speech. In essence, paralinguage addresses the manner of speech. How does the patient say what they say? The strength of the person's voice is a useful marker of overall "vitality." This concept can be especially helpful in assessing a familiar patient over the telephone. Illness seems to compromise the patient's voice projection, providing a clue to a change in their status. Paralinguage also addresses the speech rate, pitch, volume, degree of articulation, and quality of the delivery. For example, anxious individuals may speak at a rapid rate at a higher than normal pitch. Soft speech may be a clue to parkinsonism. Another aspect of paralinguage concerns pauses and pause intervals. The pause interval is the time from the end of your utterance to the beginning of the person's response. Normally, this interval varies based on the content. Strong emotionally charged content tends to shorten the pause interval. Unfamiliar content lengthens the interval. If you were asked, "Give me a one sentence summary of the second law of thermodynamics," there might be a pause. If the pauses are always short, we might consider hyperthyroidism, autonomic overactivity, or anxiety. Excessive pause intervals might signify depression, parkinsonism, medication effect, or myxedema.

Another component of language assessment is whether the language makes sense. Can the person communicate a coherent flow of concepts or ideas? Some individuals show digressions from the main theme of the conversation, never returning to the main point. We all know people who communicate this way so a deviation from their normal communication pattern

is more revealing than a stable communication pattern. Incomplete thoughts reflect more significant communication difficulty. Does the patient show awareness of the implications of answers (insight), anticipation of an answer, or evidence of abstract thinking? These tend to reflect higher cortical function. Humor does not always indicate higher function unless it is spontaneous to the moment. In fact, some very demented older adults can relate extremely humorous stories from a well-practiced repertoire.

The person's choice of words may be a marker of intellectual vitality. The complexity of syntax also reflects overall education and mental capacity. Specific content issues include evidence or examples of dysfunction; rate of progression; and the nature of adaptations. In evaluating mental status it is useful to see if the person can take a "mental walk" and use their imagination to provide spatial information. For example, "Mrs. Smith, if you met me at the front door of your house and you invited me inside, tell me what we would see." People with dementia have trouble using their imagination and extreme difficulty with this task.

Behaviors

Observing behaviors is easy but interpreting behaviors is a challenge. Nonetheless, some emotions are clearly revealed in gestures. Context is critical in interpreting behaviors. The overall harmony and congruence of the observations are the keys to understanding the meaning of a behavior. Contradictions (apparent incongruities) are very revealing. For example, a nervous laugh can reflect both amusement and extreme discomfort.

The Face

The core of our emotional life is conveyed on the surface of our face. Most details of facial expression are comprised primarily of eye and mouth expressions.

Consider the overall facial expression:

- Is the face animated or flat and masked?
- Are the facial movements symmetric or asymmetric?
- Does the patient seem to be in pain?
- How does the patient use his or her eyes?

Normally, the forehead shows long wrinkles when the person looks up or when the eyebrows raise; absence of this forehead wrinkling suggests thyrotoxicosis or use of Botox. A distinct vertical wrinkle above the eyes in

a patient with axial rigidity suggests progressive supranuclear palsy (procerus sign). Cosmetic surgical scars may be visible behind the ear.

The Eyes

Eye movement sends a variety of emotion. For example, eyes that are down-cast with the face turned away shows low self-esteem. Gaze aversion can occur if the topic makes one feel uncomfortable or guilty. In grief, the brow is furrowed and the eyes are clenched. The eyes of depression may view the world through partially closed lids. Raised eyebrows suggest disbelief. A sideways glance reflects suspicion, uncertainty, or rejection. Limited eye contact implies the person is hiding something, or perhaps has a low sense of self-esteem. Eye contact can increase if one feels defensive, aggressive, or hostile. Bilateral proptosis suggests hyperthyroidism.

The Mouth

In sadness or depression, the mouth is often stretched and the lip margins may be thinned. The mouth tends to show anger by being tightly compressed. An open mouth with clenched teeth and tightly drawn eyes suggests significant pain. Frowns are easily recognized as signs of displeasure or confusion.

Interpreting smiles is a useful skill to cultivate. The simple smile is open and relaxed, with the mouth pulled up toward the ear and the eyes are slightly closed with a tight lower lid. False smiles tend to be less relaxed with eyes that are open and the corners of the mouth moved lateral rather than up toward the ear.

Arm and Hand Movements

Hand and arm movements are another core element of behavior. Gestures are hand signals that send visual signs of openness, doubt, frustration, inner conflict, and self-esteem. For example, a clenched fist shows determination or aggression.

Sitting and Standing Postures

Sitting on the edge of the bed may imply readiness and a person who is action oriented. Leaning back in a chair with crossed legs while making a kicking movement may reflect boredom and impatience.

A patient's pace, stride, length, and posture can signal emotions and overall vitality. Frail individuals tend to walk slower and without the usual rhythmic cadence. A rapid walk with free hand swing might mean the person

is goal oriented. Always walking with one's hands in his/her pockets suggests a person who is secretive, critical, and enjoys playing a devil's advocate role. The elderly person who scuffles with their head down may be signaling dejection. The individual who walks with their hands on their hips denotes sudden bursts of energy. Walking with one's hands behind the back with head bowed and at a slow pace suggests that one is preoccupied. Jangling money in pockets may also reflect preoccupation.

PUTTING IT ALL TOGETHER

The approach to the older adult in the hospital setting requires a different perspective from that needed for the medical evaluation of younger persons. The spectrum of complaints is different; the manifestations of distress are more subtle; the implications for function are more important; and clinical improvements are sometimes less dramatic and slower to appear. The differential diagnosis of common problems is often not the same. Presentations are frequently nonspecific, such as mental status changes, behavioral changes, urinary incontinence, gait disturbance, or weight loss.

Illness versus Disease

Understanding the difference between illness (a person's experience of negative health status) and disease (pathophysiological disorder of one or more organ systems) is a prerequisite to the care of patients affected by incurable disorders. Because older adult patients often present with several chronic diseases, many of which are irreversible, cure-oriented physicians are especially vulnerable to frequent disappointments. The crucial issue is the elderly person's ability to function. Even though many chronic conditions are incurable, the discomfort or disability they produce may be substantially modified. If these concepts are not realized and addressed, elderly patients with irreversible chronic diseases may receive less than optimal care from physicians seeking cures. If we maintain a purely disease-specific focus, we may have difficulty thinking about strategies to best serve the whole patient. Although defining pathological entities may be less complicated than intervening in the illness of the patient, the latter is what constitutes healing.

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GERIATRIC ASSESSMENT FOR THE HOSPITALIST

Brent C. Williams

INTRODUCTION

Two 80-year-old women are admitted to your service one evening to adjacent rooms. Each has had 3 weeks of progressive fatigue and dyspnea on exertion and a chest x-ray showing right middle lobe pneumonia. On admitting examination, each is resting comfortably on 2L/min O₂ per nasal cannula; pulse oximetry shows 96% oxygen saturation. History reveals that they have had well-controlled diabetes and hypertension for 10 years, but no other ongoing medical problems. Physical examination shows findings consistent with pneumonia; you continue oxygen therapy and initiate antibiotic treatment. On the second hospital day, one of the women becomes acutely agitated and confused and falls while attempting to get out of bed, and remains mildly confused throughout her hospital stay, while the second patient has an uneventful admission.

These two patients likely had very different risk profiles for adverse events during their hospital stays, yet had similar medical conditions and presentations. How could the hospitalist have identified the key differences through information gathered at admission? Perhaps more importantly, how can hospitalists approach *all* older patients to: (a) identify the *subset* of patients likely to benefit from additional data gathering (the so-called geriatric review of systems), and (b) gather standardized information for those patients in an efficient manner that is integrated into the standard workflow?

These two questions—how to identify “at-risk” older patients most likely benefit from assessment of domains other than biomedical conditions, such as functional status, caregiver support, and living environment; and how to efficiently gather information most useful in care planning to prevent avoidable morbidity—have been the focus of a broad array of investigations

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