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Primary Care Geriatrics: A Case–Based Approach

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In memory of my parents, John and Eileen Ham, and of Lawrence J Frankel, who died in 2004 at 100 years of age, pioneer of exercise in old age as the means to “be alive as long as you live”.

RJH

To my parents, Walter and Grace Heddesheimer, and my in-laws, Aaron and Janice Itkin, who have taught me much about what matters as one ages.

PDS

To my wife, Martha Capps Warshaw

GAW

To my children, Lisa Therese Jenkins and Michael Lee Jenkins

MAB

To my grandmothers, Gertrude Campbell Hain and Mary Mullane Flaherty.

EF

My thoughts on old age...

A gift for old age is to be able to delight in comfort.
Bed, bath, food, drink. To enjoy the simple and immediate.

Acknowledge one's disabilities—then try to forget them.

For our children we must be brave, happy–looking, and interesting.
They will never see you as you are but
as you were. It is only to old friends that one can speak
frankly.

Nothing works properly – our bodies are unreliable.

I just hope I die before I lose my independence.

If there is life after death, I shall be most interested.
I don't know what, if not. Well, I shall be happy to just finish.

Think of us sometimes (the best bits).
Think of us on our birthdays and play for me, Richard.

Eileen Ham (1920-2001), in a notebook found after her death

And death shall have no dominion.
Dead men naked they shall be one
With the man in the wind and the west moon;
When their bones are picked clean and the clean bones gone,
They shall have stars at elbow and foot;
Though they go mad they shall be sane,
Though they sink through the sea they shall rise again;
Though lovers be lost love shall not;
And death shall have no dominion.

Dylan Thomas (1914-1953), from And Death Shall Have No Dominion

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PREFACE

to the 5th Edition

Preparing this fifth edition has once again demonstrated how fast the field of geriatric medicine is moving forward. The basic purpose of the book remains the same: to teach those health professionals practicing primary care (physicians, nurse practitioners, physician assistants), the currently recommended approaches to the problems elders and their carers face, to disease prevention and health promotion, and to the reduction and postponement of morbidity and dependency, using a case-based text, with the patients and families cast in the settings of primary care - the office, the emergency room, the hospital, the nursing home, and the patient's own place: home, the best place to get a realistic impression of how the person's life really is, and how the patient, family and carers are handling the difficulties they face.

All the authors and editors in this new edition are, as before, experienced in clinical primary care, yet also prepared to take an evidence-based approach, utilizing the best possible evidence for all recommendations.

It is great to welcome two further editors to the team in Marie Bernard, whose enthusiasm for "our" book attracted us, and who has been zealous in keeping to deadlines and guidelines, and has shepherded in a large number of new authors and subjects, and Ellen Flaherty, our lively nursing colleague, who has similarly been responsible for new authors, new subjects and fresh approaches.

Recognizing that physician assistant and advance practice nursing students and practitioners have been using this book since its first edition, we made the decision this time to use the word "clinician" in the case materials and text, clarifying that it is not only physicians who practice primary care in our increasingly complex and diverse health care system, as we all attempt to make good health care accessible to all Americans.

Regarding terminology, it is possible that a few uses of the word "providers" have slipped through the editorial process, but we have tried to avoid that term. That it is useful, there is no doubt. But the concept of "providing" health care like a measured commodity, when in fact all realize that the interaction between clinician/prescriber and patient/family is far more complex than that—a negotiation of sorts, with recommendations made by one or more professionals and considered and acted upon (or not) by the other; a partnership devoted to the objective of improved health, bringing different perspectives and responsibilities to each situation.

Our patients are changing, as the cohorts we serve move forward in time. Our oldest patients experienced the Second World War and I still enjoy some reminiscences of the rather flatter areas of my home country where the "Yanks" came and helped us out with their planes, their enthusiasm, their supplies, and their lives. And I still treasure a few of the remaining "GI Brides" who fell for all of that American charm and immigrated (as, later, I did with my family) to a land with a very different set of opportunities than Europe presented at that time. For those of us who love old people because of the history they represent, this movement forward in time is very intriguing. The music and events of the past that evoke their youth and young adulthood, or their "best" time, is gradually moving forwards. And the expectations of younger family members (we Baby Boomers) are a powerful influence on changing the patterns of care, and the expectations of what medical care should be able to do, or should not attempt.

For me, the originator of this book, these last few years have been an immersion in the issues and challenges facing rural elders, now that I am relocated to West Virginia. I have come full circle: I was originally recruited to the Midwest, to Springfield, Illinois, to

a medical school founded in order to address the shortage of primary care physicians in rural southern Illinois, where many counties had no doctor, or, at best, had a doctor clearly destined to retire or die on the job imminently, and counties where the only primary health care professional was a chiropractor. Since the majority of us in medicine, nursing and all of the other professions that it takes to create comprehensive care of elders still tend to gather round hospitals and therefore in more urban settings (and certainly we academics do), it is too easy to assume the availability of services generally found in well organized urban and suburban settings (like meals on wheels, day care, respite services, visiting nurses). In rural America (and all states have some rural elders) such resources simply may be unavailable - out of the question for an individual who wants to stay in their own home in their own community. Also, Americans in general had barely begun to discover the "obesity epidemic" when the evidence became clearer and firmer that obesity predisposes not only to type 2 diabetes, the illness that accounts for so much of our health care spending, but also that obesity and diabetes between them represent risk factors for the illness that has dominated my life clinically: Alzheimer's disease and the other progressive dementias.

These past few years have continued to emphasize healthy lifestyles and preventive approaches, so that those of us who survive into old age will approach it in as good shape as we can. But we all know that we are more excited (at least the media make us more excited) about the dramatic interventions after the event than the more ordered, anticipatory and careful, but less exciting (more dull!) efforts that we must make to exercise right, eat right, and make a good social effort to have a network of people we care for and care about, and a sense of purpose to drive us and keep us going on our journey through life. The system we work in and its incentives, and we ourselves as individuals, must constantly look beyond the immediately presented situation to see the "big picture" of our patient's future, and recognize the often quite mundane or small-scale, individualized recommendations or interventions which will make a profound difference to that future.

In addressing rural health care, other issues like health literacy and the unique vocabulary, assumptions, expectations and so forth that characterize yet another culture that has not been incorporated into our medical education efforts, are becoming better defined. Cultural competency is seen to involve not only race, ethnicity, education, religion, language, communication etc, but also location and the history behind each and every individual's unique personality, knowledge and beliefs.

Those familiar with the book will note that we have retained the literary (and sometimes patient or family initiated) quotations at the start of each of the three units. We have encouraged the use by our authors of those short highlights and aphorisms that have the quality of "pearls", the pearls of wisdom that the pioneering teacher-clinicians like Osler used in teaching their accumulated clinical wisdom: ("Listen to the patient, he is telling you the diagnosis" - which I like to change to "Listen to the family, they are telling you the diagnosis" - and "pneumonia: the old man's friend").

Our publishers have once again risen to the challenge of implementing a book that is a bit more complex to assemble than more conventional texts. The intermingled cases and the pearls, boxes, tables and figures, the pre and post tests and the objectives, have - by adding color and using different fonts - become easier to differentiate from the text, so that the book can be used for reference as well as a programmed, self-paced, straight-through read and learning experience. As I wrote in the Preface to the last edition, we have tried to produce "not a biblical text with everything in it, but a practical clinical guide to the most germane issues and approaches, which, if well learned and consistently applied, would improve the *enjoyment* of geriatric medical practice by all clinicians, and would improve the care of the older patients and families whom we serve."

A significant change has been the addition of the CD, under the authoritative leadership of Phil Sloane, who has been editing this text almost as long as I have! The use of the CD enables us to access video and illustrative material, as well as more extensive references, guidelines and appendices than could be included in the book without excessively increasing its size and cost.

As before, our cases, most of them completely rewritten, continue to emphasize the relative passivity of the most needy of our patients, the ones who will *not* push forward and make an appointment and come and see us, but will worry their family, or possibly just neighbors and friends, good Samaritans and fellow church goers, enough to get them medical attention. The actual recognition of the insidiously progressive chronic problems of old age is still a "hit and miss" affair, and very often the route to a thorough investigation is in fact devastating illness which perhaps could have avoided (or at least its effects could have been minimized) if the person had already been established in the care of a primary clinician who knew how to "ask the right questions" and "watchfully wait."

The energy of all of our editors has resulted in a more sweeping revision to the text than ever before: we have still divided the book into three units, but with modified titles, allowing us to put some of the

major illnesses into that second unit with the "geriatric giants" – the syndromes that dominate the clinical picture and help to define the clinical approaches needed, and reserving the third section for (mostly) organ-system-specific issues, and discrete areas of care (such as chronic pain, the older adult driver, maltreatment). Of the fifty-two chapters, forty-five are complete rewrites with new authors. Syncope and delirium are now separated out into their own chapters.

It is always tempting, in the context of a Preface to a book like this, revised every few years as it is, to comment on the changes in the political scene. In view of public payment for health care services for the old and disabled, it is a public concern, and thus a political issue, as to who will pay for what and the priorities to be given to which aspects of health care. The American Geriatrics Society, of which we are all proud members, has been working hard on the CPT codes for the chronic care of the multiply ill complex patient, and we would urge all our colleagues to continue to support such efforts at making the Medicare system more reflective of the needs of our patients and of the efforts that all of us who specialize in providing health care for elders make every day. (One day, we may get paid for all that telephone - and now email - work!) The current fiscal and political crises challenge all of us to get involved and stay involved, to make our voices, knowledge and opinions heard by those who try to lead us. Decisions and policies still too often reflect the depth of ignorance of what it is like to be old, what the real needs are of our elders, and how to improve health and reduce dependency of "our" patients and their families, both right now and in the future as we Baby Boomers age - with our different expectations and demands!

For those new to this book, we have retained the "Introduction: How to use this book" section, and we hope that a new generation - and many returning visitors to our pages - will enjoy what we have written, and find it useful as they struggle to ensure that all their older patients get the best, most comprehensive and thoughtful management that can be achieved.

We are already thinking about the next edition. Let us know what you think - and please continue to enjoy the uniqeness and fascination of each and every one of the wonderful elders whom we all care about so much.

Richard J Ham MD

June 6, 2006