Back to the future

In caring for the elderly, low-tech can be cutting edge

BY ADAM BURROWS

There are several ways to mark your way through Dorchester, Boston’s largest neighborhood. Savin Hill to Fields Corner to Codman Square. St. William’s to St. Ambrose to St. Matthew’s. Irish stout to Vietnamese pho to Trinidadian roti. Upham’s Corner Health Center to Dorchester House Multiservice Center to Codman Square Health Center.

I was explaining our route to two Boston University medical residents on an overcast Monday morning. Like nearly all the physicians-in-training who come to work with me, they were bright, enthusiastic, and bewildered. The pair had barely arrived at the day center, our base of operations, when I handed my brown leather home-care bag to one, a voluminous chart to the other, and hustled them into my 1996 Audi station wagon.

A call had been forwarded to me moments earlier from Azela, our receptionist. Mr. Monroe (not his real name) had blacked out again. Was it a seizure, a convulsion? Or syncope, a transient loss of consciousness due to a precipitous drop in blood pressure? Was it a manifestation of low blood sugar? He had a history of all three. Over the phone, I asked Loretta, his daughter-in-law, a few questions, established that Mr. Monroe was stable, gave some brief instructions, and assured her that we would be out shortly.

I’ve been Mr. Monroe’s physician for more than six years. He and his wife, born and wed on the Caribbean island of St. Kitts, are both enrolled in the Upham’s Elder Service Plan, a program of the Upham’s Corner Health Center. Mr. Monroe is 90 years old; his wife a few years younger. Regardless of the weather, Mr. Monroe wears a crushed felt fedora and a brown trench coat. He is strong-willed and unfailingly polite. Mr. Monroe suffers from the consequences of multiple chronic medical conditions, and, like all the patients I care for in the Elder Service Plan, requires assistance with activities of daily living. Despite his own disability, Mr. Monroe is vigilant in directing attention to the needs of his wife, who has Alzheimer’s disease and is prone to outbursts of belligerence when her mood sours.

As we trail the school buses and garbage trucks through the streets of Dorchester, I brief the residents on Loretta’s call and Mr. Monroe’s medical history. The residents, whose training is firmly rooted in the conventions and attitudes of the academic medical center, express surprise. Their training has taught them that nonagenarians who lose consciousness are the responsibility of the emergency room and the hospital ward, not the subject of a breakfast-hour home visit. This will not be the last time during the month, or even the day, that their assumptions are challenged.

We pull up in front of a large single-family home on a one-way street. Despite peeling clapboard and rusty chain-link fences, the neighborhood proclaims a proud message of hard-won habitation. Loretta greets us at the door and thanks us for coming. As we climb the broad staircase, I ask about her recent vacation, a much-deserved break from her responsibilities as wage earner, household manager, and caregiver for her father-in-law, mother-in-law, paraplegic son-in-law, and 4-year-old granddaughter. With a smile, she assures me that she enjoyed her holiday, which was made possible by a nursing-home respite stay for the Monroes, a benefit of the Elder Service Plan.

We find Mr. Monroe in the small, tidy room that he shares with his wife, twin beds lining opposite walls. Loretta has propped him up with pillows, and he leans forward to wish us good morning in a slightly muffled West Indian lilt. That initial encounter reveals much of what we need to know, but we continue our evaluation, obtaining a detailed account from Loretta of what transpired, conducting a thorough physical examination, and performing basic bedside laboratory tests, pulling equipment from the home-care bag like rabbits out of a hat. It’s not quite what would have taken place in an emergency room, but, with the advantage of having cared for Mr. Monroe through prior episodes, it is sufficient to make a provisional diagnosis of recurrent syncope and assure Mr. Monroe and Loretta that he’s safe. It’s happened before and is likely to happen again, but it’s been fully evaluated, and there’s nothing further that we need to do now. I leave Loretta with some instructions and let her know that I’ll call later to check up.

Home visits can be better than the emergency room.
When I was a medical student in New York City and a resident at Boston City Hospital, my peers marveled at the wonders of fiberoptics, balloon catheters, and magnetic resonance imaging, while I looked backward in time and outward in space. My heroes were rugged, self-reliant country doctors struggling to practice modern medicine in the small towns of rural America. I imagined settling with my wife in a splendid valley between snow-capped mountains, raising a family, hanging out a shingle, and weaving myself into the fabric of the community. But it was just a fantasy. I was a city boy, more comfortable on a darkened subway platform than a moonlit dirt road. I would have to fulfill my ambitions in a different way.

As we ride back to the center, the residents reflect on our home visit, describing the sequence of events they would have expected to flow from Mr. Monroe’s blackout: the worried call to 911, the paramedics, the emergency room, and the inevitable hospital stay. The consultants, CAT scans, monitoring, and procedures. I ask them: What would all that mobilization of institutional and technological resources have accomplished that our visit to Mr. Monroe’s bedside did not? And what would it have cost? I invite them to consider other ways those health care dollars could be spent. How many hours of home health—home health aides, personal care attendants, homemakers—would it purchase? How many trips to the day center, where the patient could get the benefit of fellowship as well as a watchful medical eye? How much availability of primary care providers, nurses, therapists, and social workers would it buy, allowing them to respond to needs as they arise, in familiar and less institutional settings? How many extra minutes for doctors to get to know their patients, to help them turn personal relationships into therapeutic alliances?

This calculus is the logic behind PACE, or Program of All-Inclusive Care for the Elderly, the model of care being implemented by the Elder Service Plan. PACE is the kind of program that gives managed care a good name. Focus on the most frail, complex, disabled, and vulnerable elderly patients. Develop interdisciplinary teams that are devoted exclusively to their care. Combine a fully integrated, capitated financing system—fixed dollar amounts per enrollee that cover everything—with a fully integrated, comprehensive care model. Grant the program total flexibility to allocate resources as needed to support function and well-being. Practice state-of-the-art, evidence-based medicine to control chronic medical conditions, like diabetes and heart failure. Prevent unnecessary emergency room visits, prolonged hospital stays, and premature nursing home placements. Take the savings and redirect them toward the community-based health, social, and rehabilitative interventions. Save money for Medicare and Medicaid, and provide the care that patients and families want in their homes and their neighborhoods.

Back at the day center, a renovated former warehouse on Dorchester Avenue, participants are arriving. Van drivers have returned from their morning runs and are wheeling, escorting, and guiding the participants into the center. Health aides are greeting people in four languages and serving coffee. The activities staff is leading exercises to a calypso beat. Nurses are circulating in the day room, checking vital signs and administering medications. I spot Mrs. Monroe, who’s concentrating on her buttered toast, and let her know I’ve been by her house to see her husband, who’s doing fine.

I check in with the day center manager and give her a report on Mr. Monroe. She’s already compiled a list of patients for me to see, filtering off-hours reports, telephone calls from...
caregivers, and observations from drivers and health aides. Over the next several hours, the two residents join me as I encounter the variety of problems and ailments that makes the medical specialty I practice so compelling, rewarding, and challenging to an intellectually peripatetic generalist. Geriatric medicine requires knowledge and skills from the domains of medicine, psychiatry, and neurology, as well as an awareness of the social environment. The patients are complex, and it takes a careful sifting through many layers of possibility to get to the root of their problems.

We first meet with Mrs. Grant, a former hairdresser who is tall and graceful even in her wheelchair. Since her stroke, Mrs. Grant has been hemiplegic, paralyzed on her right side, and aphasic, unable to speak except for a few monosyllables. Over the course of many encounters like these, however, she has found ways to communicate with me through signs, sounds, and facial expressions. Today she’s having chest pain. Is it her heart? A blood clot? Or acid reflux? Is it a muscle strain deriving from her exclusive reliance on her left arm for her mobility and functional needs? In the eight years I’ve known her, Mrs. Grant has had chest pain caused by each of these.

Doctors rely heavily on the history, the patient’s story about their pain or other symptoms. When it started, how it started. What makes it better, what makes it worse. Where it’s located and whether it moves. What other symptoms come along for the ride. Through a careful history, doctors can generate a hierarchy of diagnostic possibilities. The physical examination, lab tests, and imaging studies that follow merely confirm our diagnostic impression or allow us to distinguish between likely possibilities. In geriatric medicine, the capacity of patients to provide a complete history is often limited by cognitive impairment, and we must rely on surrogate informants. Mrs. Grant’s aphasia offers a different challenge. Fortunately, I’ve been through this before.

In the day center’s clinic, my residents and I evaluate Mrs. Grant. We obtain the history from the patient as best we can, question other staff, perform a detailed physical examination, and apply the technology available in the clinic—pulse oximetry, an electrocardiogram, blood tests. We suspect the pain is muscular, but we can’t entirely dismiss the possibility that it’s her heart. Fortunately, we’ll have all day to observe Mrs. Grant at the center, giving us plenty of opportunity to assess her response to treatment. Still steeped in their hospital training, my residents would be more comfortable if we immediately transferred her to the emergency room, but they agree to suspend judgment.

Next we see Mrs. Morse, blind and stooped over her
wooden cane, dressed sharply in a charcoal grey wool suit and cap. Her daughter is concerned about Mrs. Morse’s hallucinations, which have taken a nasty turn. In the past, Mrs. Morse has told me of the comfort these apparitions give her. She has proudly pointed to her dead sister swooping in through the window for a visit. Not this morning. Today Mrs. Morse is angry, guarded, and suspicious, and she thrusts her cane into the air as if to ward off threats.

What has caused this transformation in the character of her visions? Is it an expression of physical discomfort? Is there an acute medical problem? Is she depressed? We evaluate Mrs. Morse, enlisting the cooperation of her social worker, and begin to sort through the possibilities. I call her daughter and propose a treatment plan that includes pharmacologic and behavioral approaches, a low-dose antipsychotic accompanied by reassurance and redirection from the family and the team. The plan is designed to relieve Mrs. Morse’s distress and keep her safe, while we continue to look for an underlying cause.

As the day continues, the day center participants play bingo, make crafts, and watch a movie. They discuss the Bible and eat a hot lunch. We see a succession of patients, some for routine check-ups, some for follow-up of stable problems, others with new issues. I call Loretta to inquire about Mr. Monroe. He ate well and is listening to the radio. We check in on Mrs. Grant. The pain is gone, and she’s having her nails done. We join Mrs. Morse at her table. She’s still absorbed in her visions, but now quiet and more relaxed.

After the residents and the participants leave for the day, I return phone calls, fill out paperwork, then head out through a light rain. Meeting House Hill to Grove Hall to Egleston Square. St. Peter’s to St. John–St. Hugh’s to Our Lady of Lourdes. Upham’s Corner to Roxbury Comprehensive to Dimock Street.

I stop at a senior housing complex on a street of auto salvage yards to pay a final visit to Mrs. Grant. Her evening health aide opens the door to the small studio apartment, which is spare and uncluttered. Peering through the window and into the dusk, I can see all the way to a cluster of angled rooftops that marks the street where I live. Mrs. Grant smiles, gives me an OK sign with her thumb and forefinger, and manages to say, “all right.” I go over some instructions, remind her to press her Lifeline if she gets into trouble, and assure her that I’ll see her tomorrow at the day center.

Mrs. Grant’s health aide clears away her dinner, and I head home to mine.

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