‘Cookbook medicine’ won’t do for the elderly

Just as children require specialized medical care, elderly adults have different needs than patients half their age

BY **JANE E. BRODY**
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ILLUSTRATION: NY TIMES NEWS SERVICE

The Martha Stewart Center for Living at Mount Sinai Medical Center in New York is like no medical clinic I’ve ever seen. It is brightly lighted and quiet — there is no television blasting. It has wide corridors and plenty of comfortable chairs with sturdy arms, and yet few people wait more than 10 minutes to see a doctor or nurse practitioner.

The center, which opened in 2007, was designed especially for primary care of older adults, many of whom have complex chronic medical problems like diabetes, heart disease and hypertension as well as debilitating conditions like arthritis and osteoporosis.

Just as a child is not a small adult and requires specialized care, adults over the age of, say, 65, are not just old adults and should not be treated like patients half their age.

The population of aging Americans is expected to mushroom in the years ahead. Geriatricians, the experts in elder care, are already in short supply, and their numbers will continue to shrink. But knowing the kind of care that these specialists provide may help older people and those who look after them learn to seek it out wherever they go.

“Cookbook medicine may be appropriate for younger people but is not always appropriate for older people,” Mark Lachs, a geriatrician at Weill-Cornell Medical Center in New York, said in an interview. He sees two dangers in how older adults are treated: overtreatment and undertreatment.

“If a high-functioning 80- or 90-year-old develops angina, aggressive treatment would be appropriate,” Lachs said. “Care should not be withheld solely on the basis of age.”

On the other hand, overtesting and overtreating older patients can result in debilitating side effects. Before deciding on tests and treatment, he said, “the doctor must take into account the whole picture of the patient, the patient’s family and life situation.”

SCREENING FOR LIFESTYLE

R. Sean Morrison is one of the geriatricians at Mount Sinai. “The overall goal is to help older adults achieve the best quality of life possible, given the limits of medical technology and knowledge,” he said.

When I asked how he would approach a new patient of 85, Morrison said he would start with a series of questions: “Tell me about yourself. What do you like to do? What are the things you would like to do that you cannot do anymore? What is your medical history? What medications do you currently take? What brings you here today?”

The geriatric exam itself would depend on the patient’s answers. “If the patient is a healthy 75-year-old who plays golf and tennis and has no functional limitations,” Morrison said, “the focus would be on preventive screening and advance care planning.

“But if the patient has functional limitations, the focus would be to restore and improve what can be restored and improved, such as reducing the risk of falls, addressing any acute medical conditions, and streamlining medications for chronic health problems so that the right drugs are taken for the right conditions.”

“You want a doctor who asks more than just about your medical conditions,” he added. The doctor should ask about the effect of medical conditions on quality of life, and then should explore what improvements are possible. “The focus of care should be on quality of life,” he said. “Too often, doctors lose sight of this goal when the focus is on treating specific diseases.”

The doctor should address a patient’s most serious health threats, of course, but also the patient’s most serious concerns. Is the patient troubled by problems like fatigue, pain or shortness of breath, or having problems with medications?

For example, he said, if a patient has serious arthritis and hypertension and cannot go to places without a readily accessible bathroom on the first floor because she takes a diuretic for high blood pressure, perhaps the blood pressure medication should be changed. The patient may prefer a different drug that carries a slightly greater risk of stroke if it means a better quality of life.

THE EXAM

“When going to a new doctor, an older patient should receive a comprehensive assessment, not just a physical exam,” Chad Boult, a geriatrician at the Johns Hopkins School of Public Health, said in an interview. “The patient should be asked, What is important to you about your health now? What is your life like — your exercise habits, diet, use of alcohol and tobacco? Is your environment safe and convenient?”

There are three areas that should be explored during a geriatric exam that are often missed if the doctor focuses on a specific illness, Morrison said:

— Dementia. He asks the patient: “Are you having trouble with your memory? Is it OK if I check with a family member about this?” He said there were often treatable causes for memory problems, like thyroid disease, medication side effects or depression.

— Risk of falls. Checking balance, gait and strength is easy, he said. “I would meet you in the waiting room, watch how you stand up from a chair and walk to the exam room. I’d throw a pen on the floor and ask you to pick it up. I’d ask you to sit in a chair and stand up three times as quickly as you can. Can you get up and down without using the arms of the chair? If the patient uses a cane, how is it used and is it the right height?”

— Incontinence. “There’s a tremendous social stigma associated with incontinence even when there are medical reasons for it,” Morrison said. It is as common as hypertension and diabetes among the elderly, but patients rarely discuss it with their doctors unless asked about it, he said.

Boult said that patients’ feet were often overlooked, leading to problems that can become life-limiting. Many older people cannot reach their feet to clean them and cut their toenails, and they develop painful sores.

OTHER CONSIDERATIONS

Morrison said that before recommending screening tests like mammograms for breast cancer and PSA tests for prostate cancer, the question to ask is, “What are we going to do with the test results? If we’re not going to act on them, screening should be stopped.” If a patient has chronic conditions that limit life expectancy, he said, there is no point in screening for most cancers.

On the other hand, he said, two medical procedures can greatly improve the quality of life for older adults: joint replacement and cataract surgery. Too often, patients think such surgeries aren’t worth the bother because they won’t be around much longer. He described a woman who at 82 was having trouble walking but chose not to have a knee replacement. Now 102, the patient told him, “I should have listened to you years ago.”

Like this woman at 82, many older people are quite healthy, Boult said.

But about one-quarter of the older population in the US has multiple chronic conditions and accounts for 80 percent of the country’s Medicare expenditures, he added. “These patients need coordinated care, a system of regular monitoring, and regular access to a primary care doctor who can detect problems early before they require expensive, dramatic treatments.”

[HEALTH]

Tainted honey, another Chinese food safety worry

Six years after the US Food and Drug Administration issued an alert, traces of a banned antibiotic continue to be found in honey exported from China

BY **ANDREW SCHNEIDER**
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The US imports most of its honey and for years China was the biggest supplier.

But in 1997, a contagious bacterial epidemic raced through hundreds of thousands of Chinese hives, infecting bee larvae and slashing the country’s honey production by two-thirds.

Chinese beekeepers had two choices: They could destroy infected hives or apply antibiotics. They chose to do the latter.

That was a mistake, said Michael Burkett, a professor emeritus at Oregon State University and an internationally known authority on bees and honey.

“You hear about people shooting themselves in the foot? Well, the Chinese honey-sellers shot themselves in the head,” he said.

The Chinese opted to use chloramphenicol, an inexpensive, broad-spectrum antibiotic that’s so toxic it’s used to treat only life-threatening infections in humans — and then only when other alternatives have been exhausted.

“That’s on the big no-no list,” Burkett said. “In the US, Canada and the European Union, chloramphenicol is on everyone’s zero-tolerance list.”

Now, 11 years later, some of the honey buyers who take the trouble to test for chloramphenicol still find the banned antibiotic in some of their imported honey.

The US Food and Drug Administration (FDA) says tainted honey from China is on top of its watch list and has been for six years — since the agency released the first of three “import alerts” targeted at banned substances in honey. The FDA considers a food adulterated if, among other reasons, it contains an animal drug deemed unsafe for unapproved uses. Chloramphenicol certainly meets that definition.

In 2005, China’s Ministry of Agriculture outlawed the use of chloramphenicol in food production, but there are reports that Chinese beekeepers are ignoring the ban.

A beekeeper from China’s Zhejiang Province examines honeycomb covered with some of his thousands of bees in Qingdao, Shandong Province, last May. Chinese beekeepers travel from place to place throughout the year to take advantage of the blossoming season in different parts of the country. PHOTO: EPA

Chloramphenicol is illegal for use in bees and other food-producing animals in the US because it is impossible to determine a safe residue level, said Steve Roach, public health director of Keep Antibiotics Working, a Chicago-based group raising awareness about the hazards of antibiotics in food.

“If the Chinese authorities are unable to keep this drug from being used, then no imports of honey from China should be allowed,” Roach said.

Chloramphenicol has never been officially found in honey produced in the US or Canada, and experts say honey containing traces of the antibiotic doesn’t pose a health risk to most people.

While the FDA says chloramphenicol has been linked to aplastic anemia, a rare but serious blood disorder, other food-safety agencies point out that two teaspoons of honey laced with chloramphenicol residue contain less than one ten-millionth of a treatment dose of the antibiotic.

Most properly labeled honey warns against feeding it in any form to infants younger than 1 because studies have shown it can cause sometimes fatal botulism.

Many health practitioners, though, consider honey a minor miracle drug. As the world’s oldest sweetener, the amber syrup has been heralded by grandmothers, nannies, nurses, medicine men and physicians around the globe.

Hippocrates, the father of medicine, prescribed honey for its nutritional and pharmaceutical value.

The index of medical and scientific journals at the National Medical Library in Bethesda, Maryland, lists hundreds of studies exploring honey’s value in treating, controlling or preventing diabetes, Alzheimer’s, osteoporosis, stress, skin conditions, sexual problems and scores of other maladies.

Honey makes a natural antibacterial agent, in part because of its high sugar content and acidity, and many developing countries still use it to treat burns and wounds.