

HUMANISIM IN MEDICINE

The Difficult Discharge

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Working as an intern at Boston Medical Center (BMC), formerly Boston City Hospital, I find that the “disposition” section of my progress note is, more often than not, a big question mark.

Mr. J was one such patient. He was a 74-year-old veteran who had been admitted with altered mental status, rhabdomyolysis, acute kidney injury, and possible herpes zoster ophthalmicus. He lived alone and rarely saw his two local children. He managed a myriad of health issues by himself, which meant he was not taking any of his prescribed medications for coronary artery disease, hypertension, hyperlipidemia, and vitamin B12 deficiency. Somehow he had already survived prostate cancer, bladder cancer, an NSTEMI, and a nephrectomy secondary to trauma—all the while abusing cocaine and alcohol.

The weeks leading up to his admission were truly a series of unfortunate events. At each stage, there was a fork in the path, and Mr. J always followed the one that led him to his inevitable admission. First, Mr. J saw an optometrist for conjunctivitis at the VA, where he received all his care. The conjunctivitis worsened despite treatment, and the optometrist became concerned about herpes zoster ophthalmicus. He pleaded with Mr. J to go to an emergency department (ED) for evaluation, and even called a taxi to Mr. J’s front door, but to no avail. Days later, when it became intolerable, Mr. J ended up at the BMC ED, which was closer to his apartment. Acyclovir was prescribed for his presumed herpes zoster ophthalmicus, but he did not pick up this prescription. A week went by. A friend be-

came worried about Mr. J, who seemed confused over the phone. The friend finally called 911 for Mr. J, who then arrived by ambulance at BMC for inpatient admission.

During his admission, Mr. J was seen by inpatient ophthalmology and neurology consultants and promptly received empiric IV acyclovir for presumed herpes zoster encephalitis. His rhabdomyolysis, thought to be due to a fall while altered, resolved with hydration. Cerebrospinal fluid analysis ultimately was inconsistent with herpes zoster encephalitis, so he was discharged on oral valacyclovir and ophthalmic antibiotic ointments. He had improved and wanted to leave the hospital, but it was never clear what his baseline functional status was, as his children did not see him often. What was evident was that he used to be an independent man, but it was unclear how long he had been declining prior to this acute illness.

Knowing Mr. J’s history, I was extremely worried about his discharge. This was a man who was stubborn enough to refuse help when ill, who did not take any of his prescribed medications, who missed multiple clinic visits, and who delayed taking any medications until his illness had progressed to the point of inpatient hospitalization. Moreover, on discharge, I discovered he had not filled out any of his insurance paperwork, so he could not afford the valacyclovir that had been prescribed on discharge, even though he was eligible for both Medicare and Medicaid. Essentially, he had been just barely independent enough to mislead his children into thinking he could take care of himself, until he fell off the precipice.

I did what I could to prepare for his discharge, which took hours. I set up a visiting nurse. I called his daughter to pick him up, despite the patient’s prideful protests that he wanted no one to be bothered. I walked him and his daughter to the BMC pharmacy to pick up his prescribed medications, which ultimately could not be filled due to his lack of insurance. I called the VA on-call nurse practitioner to fill the valacyclovir for him and called him to let him know. He said, “No problem. I’ll have my son pick it up for me.” I set up an appointment for him at the VA within a few days of discharge and faxed the discharge summary to the VA. All the while, I waited in dread, hoping in my heart of hearts that whatever I did would be enough.

And, not unexpectedly, less than a week after discharge, Mr. J’s primary care physician sent him to the VA ED. He had not filled any of his prescriptions. He had sepsis secondary to a urinary tract infection. During this next hospitalization, he constantly refused treatments. Psychiatry saw him and concluded that he did not have capacity to refuse. They diagnosed him with a form of cognitive impairment without evidence of mood disorder. Over a month later, he remains at a VA long-term care facility because of concerns for his capacity to perform his activities of daily living.

I have had many patients like Mr. J in my six months as an intern at BMC. Patients who have too many comorbidities to manage alone. Patients who do not have the mental capacity to understand the severity of their illness but have sufficient insight to want a better quality of life

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than a hospital can provide. Patients who are too poor to afford a good long-term care facility. Patients who have no one to help them manage their numerous health care issues.

Mr. J was lucky in a way. Although he did not have insurance, he was a veteran, and the VA has excellent resources for difficult discharges. He had children nearby who cared about him. He was not homeless or destitute. But now that he is ensconced in a long-term care facility, he has lost all semblance of independence, which is a heavy price to pay for health.

But what is the end point for Mr. J? He could not live alone any longer, but he did not want to live in a hospital setting for the rest of his life. He was growing older, with all the incumbent infirmities of old age. He

did not want to burden his children, and they had their own busy lives and jobs. In this day and age, we are all just trying to figure out “how ordinary people can age without having to choose between neglect and institutionalization,” as Atul Gawande insightfully writes in his new book *Being Mortal*.¹ This is made even more difficult when patients have limited financial resources, as do most of my patients at BMC.

There is no easy answer. We are entering the era of longevity and infirmity. We need more geriatricians at a time when fewer are being trained.² We need better assisted living facilities that can navigate the perilous path between inadequate support for independent living and institutionalization. We cannot force medications and check ups on pa-

tients like Mr. J, but we also cannot let them waste away due to stubborn self-neglect.

While Mr. J is no longer under my care, I have many more patients like him waiting for placement. This is not something medical school prepared me for, and I am learning slowly day by day. Medicine is an ever-changing landscape, and despite the frustrations and challenges, I am still grateful to be a part of it.

References

1. Gawande A. *Being mortal: medicine and what matters in the end*. New York: Metropolitan Books, 2014.
2. Span P. Even fewer geriatricians in training. *New York Times*, January 23, 2013.

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