An ER is never a great place to hang out especially if you're elderly. Welcome to SBH Bronx Health Talk produced by SBH Health System and broadcast from the beautiful studios at St. Barnabas Hospital in the Bronx. I'm Stephen Clark. Elderly patients comprise a significant and growing percentage of ER patients. Recent data shows that the incidence of older patients who sought emergency care in recent years was 12 per 100 persons for injury and 36 per 100 for illness and according to the CDC, visits to ER's by people over 65 rose by more than 27 percent over the past decade. With us today is Dr. Ernest Patti, a senior emergency physician with SBH Health System. Dr. Patti has been a familiar figure to patients at St. Barnabas Hospital for literally generations having first come to the hospital as a resident in the early 1990s. He's often been called the mayor of Arthur Avenue. Welcome Dr. Patti.

Thank you Steve. Thanks for having me.

So before you tell us where you can find the best linguini with clam sauce or Fettuccine Alfredo, let's talk about the problems faced by many older patients in the ER. I would guess that the reason you see so many elderly patient is an obvious one- that they're more vulnerable to injury and chronic disease right?

That's definitely true. We do get a large percentage of elderly patients so if we could use the term geriatrics I guess the geriatric population. And one of the things that's obvious when they first hit the door for many of them, you know don't forget a lot of these folks don't normally visit the doctor, or the clinic, or have any regular medical care. So to be brought in say on an ambulance stretcher, strapped to a

backboard because of some suspected injuries with a cervical collar on, and basically made totally immobile with little seat belt straps that EMS uses to keep the patient from sliding. Getting brought into a busy emergency department, lots of noise, lots of sounds, lots of- you know, confusion and many, many different people touching you, all of which you can't see any of these folks. So it's- it's very overwhelming. I recall vividly a case from a number of years ago where you know, we live close to some universities. We had a well-known person who had been in an accident brought into the hospital and I realized she was elderly- that I realized that she was terrified. And despite all the injuries that she could have sustained, I was more concerned about her having a coronary event just from the excitement and sheer terror of being there. So I positioned myself at the head of the bed where she could see and hear me, and you have to remember that many of these folks are hard of hearing so you have to speak loudly. And I told her, introduced myself, told her where she was, explained what was going on, and gave her a blow-by-blow while it was happening. And I could immediately see the blood pressure and the pulse rate come down a little bit when she realized that, you know, not everybody there was just you know in a state of confusion.

Right.

It's- it can be overwhelming I try to put myself in their- in there; and throw in a language barrier? And forget it, you know then all bets are off.

Dr. Patti, what are some of the most common complaints of elderly patients when they come to the ER?

Lots of times we get uh- dizziness, inability to perform their normal activities of daily life, we get chest pain, we get abdominal pain, shortness of breath is a common one, and we also get a large percentage of folks who come in who are basically a little anxious, and/or possibly depressed as well because of their living situations. You know, small things that when you're younger, don't affect you as well mean a tremendous amount to the elderly. Whether they're family, you know, forgets to keep in touch with them on a regular basis, whether they have an- a neighbor or a friend, a contemporary of theirs who passes on; all of these things are life changing for the elderly. It sort of reminds them of their own mortality so, many times these folk well come in with not just one complaint but a few of them. We also get folks who- who don't eat and drink as much so, they lose weight, they get weaker, and a lot of this is can be also be traced back to maybe them having some level of depression.

I know you touched on it earlier, but I would guess that you treat an elderly or a geriatric patient differently than you would treat a younger patient. What comes into play?

Well the prudent doctor would definitely treat them differently. You have to pay attention to their, you know, there may be decreased senses. Some of them have really bad eyesight as well as hearing, and both of these may not be evident when you first encounter the patient, because some of them are very crafty and have developed real good, you know, compensatory mechanisms to deal with that. They might be reading your lips, maybe you speak very fast and they can't keep up with

your lip reading. Sometimes they also come in and they have different types of visual aids to help them see you, so you have to be perceptive to that. Maybe they can't see me that well, maybe they can't hear me. And also, some of them come in and, you know, maybe say that they speak English but maybe it's just basic conversational and it's not easy for them to understand sometimes when we want to ask questions in a medical nature or explain different processes to them, that maybe they're unable to understand because of their rudimentary understanding of the English language.

How do you deal with cognitive shortcomings?

Well that's- that's also a huge, huge part of our difficulty that we face with elderly folks. Many times we will try to have our ancillary staff help us and some of our ancillary staff are experts with the- the elderly and the geriatrics, meaning they will spend a little more time with them; maybe sit down next to them, stroke their hand, hold their hand, sort of comfort them. Don't forget, when you come into an emergency department, especially one like ours, there are very few visual cues that you could relate to if you're an elderly person who lives in an apartment with pictures of loved ones on the walls, maybe a pet is around as well to keep you company. You see different things in your apartment or your surroundings that sort of come- may give you a certain sense of comfort. Coming into sterile environment of a hospital, especially emergency department at a busy time, you lose all those visual cues, so many times these people get disoriented. The other aspect is, we don't have any windows in the emergency department, so people lose track of hours, days you know days versus nights. So we'll have staff members remind them

what time it is, sometimes tell them which meal they're bringing over, and- and- and try to get them to enjoy some of it so that we can keep them on a somewhat regular schedule. Unfortunately, there are other times where we have to use certain soft restraints and maybe a little vests to keep them from wandering, but usually we-we limit that in extreme cases and we just like to have one person, an ancillary staff member, sit and baby- basically babysit them until we get them treated, and then disposition.

I know research has shown that a visit to the ER for a geriatric patient can be almost a sentinel event, so I know you teach. So I'm assuming that when you teach medical students at CUNY School of Medicine or residents at SBH, that's something that you discuss with them right?

Oh definitely. When we are preparing them for their clinical rotations, we definitely talk to them about the special populations, and one of those special populations is obviously geriatrics and the elderly. The other end would be pediatrics, and the- and the infants and- and very young. They also have their challenges as well, and you know there are other populations as well we enlighten them on but we want to make them aware of the different needs. You can't approach each patient exactly the same. You have to be able to understand what extra things you may need to go overboard with on them and what other things may be you can use like you would in a normal encounter.

Should a trip to the ER serve as a wake-up call for relatives and caregivers, that geriatric patient may have a problem?

I think it does serve as a wake-up call, you know in speaking with lots of the families from the community. Don't forget you did mention I was sort of well-known in the community. Lots of these families will call us and say, you know, "we've been taking care aunt Tillie for the past four or five years. We can't do it anymore. What's the next step?" And unfortunately, many times, it turns out to be an ER visit because they've fallen, you know, cut their- their scalp or broken a hip, God forbid, and they wind up in the ER. That's the wake-up call, just like you said Steve. But at that point, they really need to start to have some difficult conversations because you really need to prepare yourself for when this starts to- when the decline starts to occur. And I'll be honest with you; I'm having these conversations with my own parents right now. They're both- my dad's gonna be 80 in September and fortunately he's still totally with it. My mom, the same; she's a year behind. But we have- I've already started bro- broaching this subject with them which is not an easy subject to talk to- to talk about with your parents. Something that- like most parents- they don't want to talk about it right now. So- but my siblings and I have started the dialogue. If you can start the dialogue early, before you have the catastrophic event, many times it makes it easier for both the patient and the caregivers.

If you're a caregiver and you have an elderly loved one who's going to the ER, say they fell or say they have chest pains or something, what should you do in preparation?

You should definitely, if you have- if time permits, bring all their medications with

them. You should also pack a small little bag with clean undergarments, maybe a pair of pajamas, slippers, eyeglasses if they don't have them. They need their eyeglasses, and maybe some small, just very small toiletries that they might want; their toothbrush, or maybe their denture case for their dentures if they should have them. And it's also a good idea to bring a-an item that they're sort of attached to from home as sort of a tool to help them remember that, you know, that there is some comfort around; whether it's a photo of the family they can put it on the bedside table in the hospital room, or maybe it's a favorite pair of rosary beads, or something. Each person will have something different, maybe that they're sort of attached to. One or two of those items that you- if you can throw it in the bag and bring it with them, or bring it once they're settled in the hospital, sort of to remind them that yes eventually they will make it back home hopefully. It keeps them also optimistic and it sort of can keep them grounded and maybe less disoriented when they're in the sterile hospital environment.

And I guess the list of medications.

No I said if you can bring their medication.

Okay yeah.

Definitely, if they have a list and bring the list but usually most folks because, they don't have a-an updated list, will just put all the prescriptions in a bag and bring them in a brown bag. Whatever works is fine for us as long as we can see what they're currently taking. That really helps us because many times the- the lists are

inaccurate, or they're incomplete, or maybe the patient has visited an urgent care center somewhere else where they've sort of duplicate medications.

As an ER physician, do you try to keep the patient from being admitted into the hospital? Because I guess that brings in another potential problem.

That's a really good question Steve. When I first started in training- when I first started training, the focus in medical care was you know there was no-no real discussion about admission. When someone came in, if they were sick and you felt they needed further care than you can deliver to them, you admitted them to the hospital. Today, yes the goal is to, if we can, and obviously when appropriate, to deliver care, hopefully stabilize the patient, and then try to get them to do things as an outpatient. Because don't forget, despite all of our best efforts, in ha- in the hospital, hospitals are full of people who are sick, where other bacteria, viruses, and other, you know illnesses, can circulate. Sometimes bringing an elderly patient in whose immune system may not be as robust as we'd like it to be, may actually put them at risk for obtaining hospital-acquired infections, which can make it more difficult to treat them. So when appropriate, yes we like to get them stabilized, and then we like to get them home. Sometimes, we'll send them home with an indwelling line so they can get antibiotics as an outpatient, and we'll have visiting nurse come in and check on them regularly. Those are all good social programs that we've worked with for many years that do help us with our geriatrics population.

So you do work with I guess, social workers, geriatric professionals, so when they

leave the hospital, they're not on their own if they live by themselves correct?

Exactly. Exactly. You know, we were blessed that we have Dr. Joel Sender here, one of you know our geriatrician, because Dr. Senders and his PA's that he's been working with have- have been from the beginning when he started, just phenomenal resources for us. I can't tell you how many times you know, I would call I remember one of the guys that was here years ago, Francisco and then Sherry who's still with him, she- she's been around a very long time. I can call either one of them up and say, "Listen, we have your patient." They always know the patients. They always know their- their needs and many times they have a good way to contact the family and/or give us advice as to how best to deal with families because don't forget, not every family is equipped to be able to handle the challenges faced by them when their elders age and now maybe become very difficult to handle. So the- the geriatric service has been tremendous with us and a huge asset for our care in the emergency department so that we don't just get these folks in and patch them up and send them home without the proper follow-up. Many times that's the most important thing because then they'll bounce back in 24-48 hours and basically we're repeating what we just did and sort of you know behind the eight-ball.

I know we're talking about some of the negatives about geriatric patients coming to the ER but by the same context, conversely they shouldn't avoid the ER when necessary correct?

No of course not. They shouldn't avoid the ER or emergency department. I- I finally

remember Dr. Spivak yelling at us many times when we used to use the moniker ER and the only reason I say that is during my residency in the early 90s as you said, I'm glad you didn't say the 1890s it's actually the 1990s. But during the early 90s the show ER was popular on television right while we were in our residency so, many times, we would use the term ER and he would say "Guys, we're one of the biggest departments in the hospital." He said "It's a department, not a room." It used to be a room many years ago. Anyway, I just wanted to mention that. I'll give Dr. Spivak a shout out there- him and Dr. Kachinsky, our founders here. Anyway, you were asking me about they shouldn't avoid the ER no- the emergency department- they shouldn't. And you know it's amazing. When you get a geriatrics patient who still has all their faculties Steven, I always tell the students this: enjoy the interactions with them. Many times, if they still have their faculties and they can converse with you, they are walking history books. I mean, it's amazing when you get somebody who grew up before airplanes were popular you know? And- and they've in their lifetime have now gotten electricity in their home and a- some folks have grown up with outdoor plumbing still and you can chat with these people and see what it was like, get a little sliver of insight into how life was back in the early 1900s. It's amazing where before people were flying, and using cell phones, and everything, and computers. It's really an amazing encounter. I've had some really great conversations with many of the geriatrics folks. Obviously, sometimes time is tough. You don't have the time to sit and chat with them. But it's not unusual for myself or for many of my colleagues, to run upstairs you know at the end of a shift or before another one to check on somebody who you were concerned about and maybe just have a conversation with them because some of them were just truly delightful.

Yes, well you know we're running short on time and I'd be remiss if I didn't go back to the original question.

I was hoping you're gonna forget.

I know you're gonna get in trouble but where do you go if you want really good Italian food on Arthur Avenue?

Right, basically try to go all around so I can keep everybody happy. Don't forget, we have our standards on Arthur Avenue. Mario's is a standard place that's been around forever- I think he just celebrated an anniversary- Enzo's is another great place, Amelia's. Those are all the- the tried and true folks. I'm also very fond of going to Roberto Paciullo's restaurants. He has a number of restaurants on Arthur Avenue. He has Roberto which is on Crescent, he has Zero Otto Nove which is on Arthur, as well as Arthur Avenue Fiasco, or Fiasco Arthur Avenue- I forget how we use it. All of them- all of them have wonderful Italian food. Pasquale's Rigoletto, the one right here closest to St. Barnabas, they have great food as well and- and a lot of entertainment on the weekends.

What's your favorite dish?

What's my favorite dish? I have to say I'm still really fond of- if you want pa- if you're asking me about pasta, I'm gonna have to give you, I can't pick between these two, but I love like a linguine with pesto- fresh pesto sauce. I do love the

white clam sauce that you mentioned, that's also a favorite, as well as there is during the particular time of year, they do the fettuccine with the truffles, the- the truffles that they import from Italy which is just an amazing pasta dish as well. Basically, I've never met a pasta I didn't like so we'll stick with that.

When we have you back on again, we'll talk more about it.

Okay.

But thank you Dr. Ernest Patti for joining us at SBH Bronx Health Talk. Again, for more information on services available at SBH Health System visit www.sbhny.org and thank you for joining us.

Thank you, Steve.