Beyond polemic

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In *The Burden of Responsibility* Tony Judt describes the failure of most intellectuals in France from about 1930 to 1970 to engage in the important debates of their day.[1] That failure, he argued, stemmed from many sources, but perhaps the most important was a tendency to polemicize every dispute. Intellectual leaders widened the political and cultural fissures around them rather than redirecting national attention on to more promising tracks. The result was not just a loss of options from public discussion, but widespread public cynicism and a marginalization of the very people who might otherwise have contributed to the important issues of their day. Although Judt describes issues from another country, and of generations ago, his analysis will resonate with many Canadian physicians who have tried to voice dissenting views on health care policy.

It's not that there aren't physicians out there criticizing health policy. Should that effort go any further, it is likely to get its own line in the ledger-book of our national productivity. But the debate is both highly polemical and disappointingly conventional. On the one hand are analysts for whom the answer, no matter what the question, is fewer doctors — or, at least, fewer well-paid ones. On the other are the "bigger-Buick-than-thou" physicians, for whom the answer, no matter what the question, is better-paid doctors — or, at least, more of them. In such an environment the middle ground is an uncomfortable place. Not only is each side well armed to attack, but also — as Judt anticipated — support from either side can sometimes be alarming. The transient media frenzy over long emergency department line-ups is a good example. Last year, as the influenza season wore on, the "less is more" and "more is more" camps found themselves in agreement about a common enemy: the "bed blockers," a term reported by the *Globe and Mail* as having the official sanction of "industry insiders."[2] This term is used to describe patients, most of them elderly, whose acute care is over but who can't — or, one might be led to believe, *won't* — go home.

Such patients are sometimes exhorted to "learn to live with their chronic conditions." There is a feeling that the beds are wasted on them, compared with those who are more seriously ill. Whatever truth there may be in these statements, their emphasis is inappropriate. A better starting place for the acute care hospital interested in the "bed blocker" problem is to evaluate its role in creating blocked beds. This would be novel: my geriatrician colleagues across the country agree that hospitals rarely acknowledge their role in turning acutely ill frail elderly patients, whose care is complex and challenging, into the much maligned bed blocker.

Lacking insight into this hospital-induced dependency, reform advocates propose such demonstrably silly ideas as direct admission from emergency departments to nursing homes. Such proposals assume that most elderly people who wind up in nursing homes could not have avoided being there. This is sometimes the case, but we need to correct some of the mistakes that acute care hospitals make in the care of frail old people who become acutely ill.

As I've argued in these pages before,[3] this is the real "insider" story. We often get the initial diagnosis wrong by assuming that our patients have only one thing wrong with them at a time and that this one illness should look like it does in textbooks. Instead, we need to realize that most frail elderly people who get sick often become confused, or fall, or just take to their beds. No family member would fail to recognize that someone who was walking around last week and is not getting out of bed this week is probably ill, even if that person can't say why, and even if the results of a neurological exam are normal. So while it may sound incredible to a lay person, many doctors and nurses need to be persuaded that old people who suddenly become confused or begin to fall *are* sick, and not just old.

We often act in isolation without realizing the interdependence between organ systems and between the person and his or her environment. A patient whose arthritis medication should allow him to walk more finds that he can't get any farther because he is short of breath. Another with an elective hip replacement can't leave the hospital because there is no caregiver at home, and no provision was made to have one. It is insider information that few health care professionals pay any useful attention to function. Functional impairment is rarely noted, much less diagnosed. We often insist on addressing function and mobility in impersonal and curiously moral terms, without the precision needed to understand what is happening with the patient, as in "Twenty-four bed 2 is not too good," instead of "Mrs. Smith is becoming less mobile; she can't get out of bed without the help of two people."

We provide poor continuity of care at the bedside. Shift rotations that are baffling to patients provide an excuse for a lack of awareness of how exactly they are faring. And that is not to mention the physical restraints, the pressure sores, or the 4:45 supper hour. What many patients who come to need nursing homes would benefit from is not direct admission, but more responsive acute care.

Some of these problems reflect how busy the wards are, but that is not the whole story. We have done a poor job educating ourselves about what our patients with multiple, chronic illnesses and precarious social situations need, and need especially when they become acutely sick. Perhaps we use horrible terms like "bed blockers" to distance ourselves from the reality that we know is there. But in this faint realization lies a little hope — and a demand for a better standard of care.

If lay people can recognize when an elderly person is ill, so can we. If we put illness and its appropriate treatment at the centre, we may find that both sides in unnecessarily polarized debates about physician payment or the right number of beds can agree on the goals of care and the deficiencies of the current system in meeting these goals. This can provide us with a basis on which to test new approaches, and a reason to embrace — at least metaphorically — our patients and their needs.

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References

1. Judt T. *The burden of responsibility: Blum, Camus, Aron, and the French twentieth century*. Chicago: University of Chicago Press; 1998.
2. Coutts J. Hospital chaos: emergency rooms a symptom of deeper malaise. *Globe and Mail* [Toronto] 1999 Feb 13: Sect A:4.
3. Rockwood K. Medical management of frailty: confessions of a gnostic. *CMAJ* 1997;157(8):1081-4.

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