Social and Community Aspects of Aging

By Rodney M. Coe, John E. Morley, and Nina Tumosa

The interactions of social and community factors and aging are extraordinarily complex (see Figure 1 on page 4). It is important for the health care professional to be aware of the impact of social and community factors on the health and well-being of the older person.

Although the distinction is arbitrary, it is useful to try to separate the effects of the physical processes affecting persons as they grow older from the effects of the social consequences of attaining an advanced chronological age. Three of these physical processes — aging, disease, and disability — overlap with each other and with the social process which is often called growing old (see Figure 2 on page 14). Although it is more common for Aging Successfully to address medical issues about aging, disease, and disability, in this issue we will consider the social problems that occur as a result of growing old.

(continued on page 4)
The quote above is the logic used by a starving Chinese peasant girl of thirteen from Ningxia to spend her last five cents on buying a pear for an older woman, rather than food for herself. To see this level of devotion to older persons expressed by Ma Yan in a remote corner of China can give us all hope that globalization will eventually improve our positive attitudes to older persons.

Throughout the world, the most vulnerable people remain those at the end of life. While CNN beams pictures of young children starving to death in Darfur, Niger, or elsewhere into our living rooms, we know that they are accompanied by starving older people. Both groups are entitled to and need our support. For those aging in the developing world, it is time that we pressured the United States government to increase aid to the level that starvation and lack of vaccines and medicines are no longer the major causes of death for older persons.

However, even in the United States where “seventy may be the new fifty,” ageism remains clearly evident. There is a tendency to glamorize the aging process and to focus on those who have successfully aged. This allows us to forget that both in the United States and the rest of the world, there are many old persons who are aging less successfully. There are several things we can do to improve elder care. For example, it is time to look at new options for housing for seniors with disabilities. One such option is group housing, such as is available for developmentally disabled adults. This type of housing is being developed for rich seniors but should become a viable option for all seniors.

Also, we are coming close to being able to slow the progression of Alzheimer’s disease, if not totally cure this thief of the mind. It is time to reconsider incentives to encourage a full scale attack on this disease. Among these incentives should not only be money, but also a recognition that there is a need for relaxation of Institutional Review Board restrictions on human experimentation in this area. Persons with cancer regularly consent to therapies that are as likely to kill as to save them. We tend to be overprotective of persons with Alzheimer’s disease because they are a vulnerable population. Should I develop this dreaded disease, I would willingly be a human guinea pig in the hopes that my experience would lead to a cure for others. I am sure that many older persons would join me in this sentiment. Thus, I am proposing that any person over sixty years of age could sign a simple letter agreeing to be an experimental subject in a trial for Alzheimer’s disease if their closest relative also acquiesces. This would be a true “Bill of Liberation” for all of those who suffer from Alzheimer’s disease.

Finally, for good health care for all persons, we need a Universal Computerized Medical Record. I join with Secretary Leavitt and the Bush Administration in suggesting that we make this our number one health priority and realize that if we utilized the highly functional system developed by the Veterans Administration, the conversion would be easily affordable.

With little effort and a modicum of expense, we can greatly improve the future for those of us aging in the United States and also for those in the rest of the world.
In geriatrics, in order to be ranked by *U.S. News and World Report*, hospitals had to first meet at least one of three requirements: be a member of the Council of Teaching Hospitals, be affiliated with a medical school, or make available to patients at least 9 out of 18 technology-related services deemed worthwhile (such as positron emission tomography). This year, fewer than one-third of all hospitals made it through the first gate.

Then, a hospital had to perform a minimum number of specified procedures on Medicare patients in 2001, 2002, and 2003. Or the hospital had to have been recommended by at least one physician in a U.S. News survey in 2003, 2004, and 2005. The remaining hospitals got a numerical assessment (the U.S. News Score) made up of three equal parts: reputation, death rate, and care-related factors such as nursing and patient services. Here’s how each of the elements was ranked:

**Reputation.** For geriatrics, a sampling of board-certified physicians was randomly selected from the American Medical Association’s Masterfile of all 811,000 U.S. doctors and mailed a survey form. The number of physicians surveyed for geriatrics was 200 in 2005 and 150 in both 2004 and 2003. All physicians were asked to list the five hospitals they consider best in their specialty for difficult cases, without considering cost or location. The numbers in the “reputation” column are the percentages of responding physicians who cited the hospitals. SLU scored a reputational score of 11.4%.

**Mortality Ratio.** This number defines a hospital’s ability to keep patients alive. It is a ratio of how many Medicare patients with certain conditions died prior to discharge in 2001, 2002, and 2003 to how many deaths would have been expected after factoring in severity. If the number is below 1.00, the hospital did better than expected; if above 1.00, worse than expected. SLU Hospital received a ratio of 0.76.

**Other care-related factors.** This information comes from various sources, most prominently the American Hospital Association’s 2003 survey of its members. This year, some factors, including “technology index” and “patient/community services,” were updated.

SLU Hospital provides 7 out of 7 key technologies. SLU Hospital received a U.S. News Score of 45.4 in geriatrics. This score is the 8th best score in the country.

To make an appointment to see one of SLU Hospital’s geriatricians, call 314-977-6505.

Just 176 hospitals scored high enough this year to rank in even a single specialty out of all 6,007 U.S. medical centers.

By Susan Hakes, Director, Marketing and Public Relations, Saint Louis University
A Life Course Perspective on Age

Infancy, childhood and adolescence involve preparation for a job while living at home as a dependent. Adulthood and middle age bring with them increasing involvement in work, marriage, and creating a family in an independent setting. Persons in old age, however, will have experienced retirement, death of loved ones, and increasing dependency from functional health limitations. From a psychosocial perspective the transition from youth to adulthood may be seen as increasing attachment to one’s social groups through meaningful and productive roles. The transition from adulthood to old age may be seen as detachment from one’s social groups as these meaningful and productive roles are given up. This may help account for the reports that the very old are, or at least perceive themselves to be, isolated, a ‘burden to society’ and have feelings of unworthiness. In fact, clinical depression is a common problem for older people, which could be exacerbated by these perceptions.

Social Problems

Common social problems of elderly people include certain practical problems that occur more frequently among older people, such as housing problems, difficulties with transportation, and isolation. The reasons why older people suffer from these types of social problems more frequently than younger people include:

Poverty: The inability to purchase needed services to maintain an acceptable quality of life.

Inmobility: Due to the high prevalence of disabling disease combined with the difficulties with public transport, compounded by restricted use of cars and taxis.

Attitudes: Older people are generally not assertive because many were brought up in a culture in which the individual had fewer rights than s/he has today. Hence, few appeal against official decisions, seek help from elected representatives, or try to overcome bureaucratic inertia.

Poverty

Poverty threshold is defined by comparing a household’s income with the level of prices of the basic commodities necessary for life—the subsistence level, sometimes called the ‘poverty line.’ Those with incomes below the minimum level necessary for subsistence are deemed to be living in poverty. Relative poverty is defined by comparing a household’s income with the average level of incomes in society. J.K. Galbraith has described the condition of relative poverty eloquently: “People are poverty stricken when their income, even if it is adequate for survival, falls markedly below that of the community. Then they cannot have what the larger community regards as the minimum necessary for decency and they cannot wholly escape, therefore, the judgment of the larger community that they are indecent. They are degraded, for in the literal sense they live outside the grades or categories which the community regards as acceptable.”

In the United States, older persons now have similar poverty rates to those seen in working persons. Social Security provides 90% of income for one-third of Americans over 65. Other sources of income for retirees are assets (55% of Americans), private pensions (29%), government pensions (14%), and earnings (22%).

There is a wide range of wealth within the group of retiree households. In general, the older a person is,
The 16th Annual
Summer Geriatric Institute
at Saint Louis University

Over 300 participants from 22 states plus Puerto Rico attended the 16th Annual Saint Louis University Summer Geriatric Institute. Conference attendees enjoyed plenary sessions and workshops on the medical, social, and spiritual aspects of aging. Topics of discussion included incontinence, religion and spirituality, mental health, the genetics of aging, chronic disease management, nursing home care, quality of care, and geriatric assessment. A series of workshops on emergency preparedness for the elderly across the continuum of care completed a two-year initiative supported by the Bureau of Health Professions.

Max K. Horwitt and James Flood Awards Presented

Ronni Chernoff, PhD, RD, FADA, is the Director of the Arkansas Geriatric Education Center, Director of Education at the Donald W. Reynolds Institute on Aging, UAMS; and Associate Director, Education at the Geriatric Research, Education, and Clinical Center at the Central Arkansas Veterans Healthcare System. A professor at the Donald W. Reynolds Department of Geriatrics, she is a past president of the American Dietetic Association. She received the Max K. Horwitt Award for her lifetime achievement in geriatric nutrition. Following the presentation of her award, she shared her wisdom about how hydration care has changed for elders across the continuum of care at the 16th Annual Saint Louis University Summer Geriatric Institute.

Keith W. Kelley, PhD, Professor of Immunophysiology in the Department of Animal Sciences at the University of Illinois at Urbana-Champaign, received the James Flood Award for his remarkable contributions to the understanding of how health is affected by hormones and immunology. He spoke to the audience on how the brain and the immune system interact, with particular emphasis on intracellular signaling molecules that are activated by the insulin-like growth factor (IGF)-I receptor in promyeloid cells and neurons and on the role of pro-inflammatory cytokines as communication molecules between the immune and central nervous systems.

Questions? FAX: (314) 771-8575 • email: agingsuccess@slu.edu
Saint Louis University Geriatricians
Best in St. Louis

Of all the doctors in St. Louis, only those at Saint Louis University were named in St. Louis Magazine’s ranking of Best Doctors in Geriatric Medicine.

The August 2005 issue of St. Louis Magazine’s cover story lists 592 physicians in 39 specialties. These physicians are considered the best in their field.

Joseph H. Flaherty, MD, John E. Morley, MB, BCh, and David R. Thomas, MD, comprised the entire list of Geriatricians in the St. Louis region. They join 101 SLUCare physicians from other specialties chosen for the 2005 list.

The list is based on the annual “Best Doctors in America” database, which considers more than one million peer evaluations to create a directory of approximately 30,000 doctors.

To see one of these physicians, call 314-977-6055 for an appointment at Saint Louis University or 314-966-9313 for an appointment at Des Peres Hospital.

July 11-15, 2005 marked the fourth meeting of the Saint Louis University (SLU) Geriatric Leadership Academy in the SLU Division of Geriatrics. Thirty-two physicians, pharmacists, and nurses met with 15 faculty members to discuss geriatrics, literature, business, education, and leadership skills. Guest lectures included Strategic Planning by Dr. Timothy Hickman, Capacity Building with Janet Frank, DrPH, Supporting Clinical Geriatric Programs and How to Write an Introduction with Dr. James Goodwin, Cardiovascular Aging by Dr. Michael Rich, and Infectious Diseases and Geriatric Leadership with Dr. Stefan Gravenstein.

In light of the recent increased workload at Veterans Affairs Hospitals around the country due to the extensive nature of wounds suffered in the Middle East, an entire afternoon was devoted to two workshops on Clinical Assessment of Gait and Balance and on Prosthetic and Orthotic Care.

Five physicians have now completed the 160-hour Geriatric Leadership training program. Three of them are Veterans Administration physicians: Asif Ali from the Hollidaysburg, Pennsylvania VA Medical Center (VAMC), James Stauffer from the Lebanon, Pennsylvania VAMC, and Rafi Kevorkian from the St. Louis, Missouri VAMC. The other two are Maria Hansberry from Rush Medical Center in Chicago, Illinois, and Julie Gammack from Saint Louis University.

The next SLUGA is scheduled for January 9-13, 2006. We are currently accepting registrations. Contact Nina Tumosa, PhD, at 314-894-6560 for more details.
New Nursing Education Program Set to Debut

Dr. Julie K. Gammack is the Principal Investigator of a Department of Health and Human Services, Health Resources and Services Administration (HRSA), Comprehensive Geriatric Education Program Award. This one-year award supports the development and implementation of new programs that provide training for nurses who provide geriatric care for the elderly. In partnership with the Saint Louis University (SLU) School of Nursing and Co-investigator Dr. Helen Lach, three new nursing educational activities will be implemented in 2005-6.

Faculty and Staff Development

A four-hour train-the-trainer course will be offered for nurses and nursing faculty who plan to teach geriatric assessment skills to nursing trainees. Detailed instruction and classroom demonstrations will prepare course participants to implement geriatric skills workshop sessions at their home institutions. Workshop topics included in the curriculum include: Sensory Impairment, Gait and Balance Training, Wound Care Management, Therapy and Dietary Support, History and Examination of the Elderly, Mental Status Evaluation, Breaking Bad News, and Challenging Communication Scenarios. Participants will be provided with the Geriatric Skills Workshop curriculum and materials needed to implement this course at a hospital, academic program, nursing facility or other organization. This training course will be offered at the June 6-8, 2006 Geriatric Summer Institute hosted by SLU’s Division of Geriatric Medicine in St. Louis, Missouri. Course fees are covered through Summer Institute registration. Continuing Nursing Education credits will be available for the training.

Nursing Trainee Education

During the 2005-6 academic year, all SLU nursing students will receive a four-hour orientation to geriatrics. As an introduction to clinical training, this module will cover geriatric syndromes, geriatric assessment, and common disorders in the older adult.

After completing the first year of training, undergraduate and graduate level nursing students at SLU will be eligible to elect a two-credit Geriatric Skills Workshop Course. A series of eight hands-on workshops introduces students to the common clinical screening and assessment tools used in evaluating the older adult. Students will practice these skills on volunteer elders.

For more information on these opportunities, contact Dr. Gammack at 314-977-8457; or by email at gammackj@slu.edu or Dr. Helen Lach at 314-977-8939; lachh@slu.edu.
John Morley Winner of Award for Excellence
Dr. John E. Morley has been selected from a group of outstanding nominees as the first winner of the Marsha Goodwin-Beck Excellence in Geriatric Leadership Award. Dr. Morley contributes significantly to clinical care of the patients in the VA and he has pioneered the medication reduction approach of the GRECC clinics. Dr. Morley received the award at the National Leadership Board Meeting in June 2005.

Dr. Wilson Awarded Tenure
Margaret-Mary Wilson, M.B.B.S, has been awarded tenure as an Associate Professor of Medicine in the Division of Geriatric Medicine at Saint Louis University.

Dr. Flaherty Administers Oath
Dr. Joseph Flaherty was granted the honor of administering the Hippocratic Oath at the 2005 Saint Louis University School of Medicine graduation ceremony.

Two Awards for Dr. Gammack
Dr. Julie K. Gammack received a 2005 Pfizer Quality Improvement Award. The award is designed to encourage the development of innovative projects that will help to make a distinct impact on the quality of long term care. This $7000 award supports research, education, health literacy, and quality improvement to enhance patient care in the nursing home setting. Dr. Gammack’s project is titled “Effects of Natural Light Therapy on Sleep in the Elderly.”

Additionally, Dr. Gammack is one of two recipients of the 2005 Saint Louis University Department of Internal Medicine Faculty Career Development Award. This $2500 award supports junior faculty who participate in accredited educational programs to enhance career competency in teaching, clinical care, biomedical research, or community service. Dr. Gammack will attend the European Academy for Medicine and Ageing (EAMA). The aim of EAMA is to improve knowledge and skills in geriatric medicine. The course was developed in 1995 by the Group of European Professors in Medical Gerontology and is held each year at the Institut Kurt Bösch in Sion, Switzerland.

Seema Joshi, MD, Joins Faculty
Dr. Seema Joshi joined the division of Geriatric Medicine at Saint Louis University as an Assistant Professor of Medicine in August 2005. She recently completed her fellowship training in Geriatric Medicine at Saint Louis University. She attended medical school at King George’s Medical College in Lucknow, India and completed her residency in internal medicine at St. Luke’s Hospital in St. Louis, Missouri. She will be pursuing her interests in memory impairment, dementia, and associated caregiver burden.

Dr. Joshi is married with two children, ages 4 and 4 months. In her free time, she likes to work in her garden, read a good novel, or attempt the occasional home improvement project. Welcome, Dr. Joshi!
The Ride of Her Lifetime

Twenty years ago, I drove a cab for a living. When I arrived at 2:30 a.m., the building was dark except for a single light in a ground floor window. Under these circumstances, many drivers would just honk once or twice, wait a minute, then drive away. But, I had seen too many impoverished people who depended on taxis as their only means of transportation. Unless a situation smelled of danger, I always went to the door. This passenger might be someone who needs my assistance, I reasoned to myself. So I walked to the door and knocked.

“Just a minute,” answered a frail, elderly voice. I could hear something being dragged across the floor. After a long pause, the door opened. A small woman in her 80s stood before me. She was wearing a print dress and a pillbox hat with a veil pinned on it, like somebody out of a 1940s movie. By her side was a small nylon suitcase. The house looked as if no one had lived in it for years. All the furniture was covered with sheets. There were no clocks on the walls, no knickknacks or utensils on the counters. In the corner was a cardboard box filled with photos and glassware.

“Would you carry my bag out to the car?” she said. I took the suitcase to the cab, then returned to assist the woman. She took my arm and we walked slowly toward the curb. She kept thanking me for my kindness. “It’s nothing,” I told her. “I just try to treat my passengers the way I would want my mother treated.”

“Oh, you’re such a good boy,” she said.

When we got in the cab, she gave me an address, then asked, “Could you drive through downtown?”

“It’s not the shortest way,” I answered quickly. “Oh, I don’t mind,” she said. “I’m in no hurry. I’m on my way to a hospice.”

I looked in the rear-view mirror. Her eyes were glistening. “I don’t have any family left,” she continued. “The doctor says I don’t have very long.”

I quietly reached over and shut off the meter. “What route would you like me to take?” I asked. For the next two hours, we drove through the city. She showed me the building where she had once worked as an elevator operator. We drove through the neighborhood where she and her husband had lived when they were newlyweds. She had me pull up in front of a furniture warehouse that had once been a ballroom where she had gone dancing as a girl. Sometimes she’d ask me to slow in front of a particular building or corner and would sit staring into the darkness, saying nothing.

As the first hint of sun was creasing the horizon, she suddenly said, “I’m tired. Let’s go now.” We drove in silence to the address she had given me. It was a low building, like a small convalescent home, with a driveway that passed under a portico.

Two orderlies came out to the cab as soon as we pulled up. They were solicitous and intent.

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PRODUCTS from the Gateway GEC

GEROPADY
ACE Unit Video
Crossword Puzzle Book
Challenges and Choices
Aging Successfully Newsletter
SLU GEMS
Emergency Preparedness CD
Books

Call 314-977-8848 for more information about these products.

SERVICES
Services of the Division of Geriatric Medicine, Saint Louis University Health Sciences Center include clinics at two locations in the following areas:

- Aging and Developmental Disabilities
- Bone Metabolism
- Falls: Assessment and Prevention
- General Geriatric Assessment
- Geriatric Diabetes
- Medication Reduction
- Menopause
- Nutrition
- Podiatry
- Rheumatology
- Sexual Dysfunction
- Urinary Incontinence

For an appointment, call
314-977-6055
(at Saint Louis University)
or
314-966-9313
(at Des Peres Hospital)

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“Those the gods love die young” is an often quoted cliché, presumably intended to convince the gullible that the only alternative to aging is the frightening concept of death. In the Western world, idealistic notions of aging lull us into forgetting that in poor countries, aging is a cynical game in which ‘survival of the fittest’ is frequently rewarded by death. As a Nigerian-born geriatrician, trained and practicing in the United States, I have often wondered what becomes of the frail elderly in Nigeria, a country where geriatric medicine is a little known specialty. How do the elderly survive in a country where national and international healthcare assistance is directed almost exclusively toward children and young adults?

Perhaps, “the village that raises a family” that widely publicized Clintonian African health insurance system also caters to the frail elderly in Nigeria, a country where geriatric medicine is a little known specialty. How do the elderly survive in a country where national and international healthcare assistance is directed almost exclusively toward children and young adults?

Permitting the unknown and the daunting crime statistics was the first challenge. Janice Della Hicks, a disillusioned and happily retired registered nurse, now a part-time medical education consultant, volunteered her services. Brenda McCrimon, an administrative assistant, was coerced into accompanying us. We set off to Nigeria.

Catholicism is one of the oldest religions in Nigeria with century-old parishes, schools, and mission hospitals extending far into the rural areas. Other than the churches, which have an attendance paralleled only by evangelical revival meetings in the United States, the schools and hospitals have been reduced to pathetic vestiges of their former selves. Father (continued on page 17)
LE = Life Expectancy
% = percent of population over the age of 60
HLE = healthy life expectancy (disability-free years)
SR = Sex ratio (percent of males to females over the age of 60)
Aspects of Aging
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the poorer that person is. The disparity is due to the fact that the proportion of people in each age group who have an occupational pension decreases the older the age group considered. The difference between the income of different age groups of retired people is accentuated because men die younger than women, on average, so that the older groups consist of relatively more women, many of whom are ineligible for national insurance or occupational pensions and depend on a supplementary pension which is set at the lowest social security rate. Poverty is most common, therefore, among elderly women, particularly those who never married.

Housing Problems

Environmental Problems:
For some older people the cause of their housing problem is not their dwelling but its environment. Many either cannot afford to, or do not wish to, move even when new neighbors do not share their cultural or social values.

Structural Problems:
Often the dwelling has deteriorated. Common problems and their solutions are presented in Table 1. The services listed are not universally available and where such services exist older people often have difficulty accessing them. Every health professional can help by being aware of the range of services available, suggesting ways to improve the dwelling and helping the person to contact the appropriate services.

Difficulties Caused by Disability:
Sometimes the dwelling is unsuitable after the onset of disability. Disabilities can affect the person’s ability to climb the stairs, access the bathroom, do the laundry, or enter the dwelling. Sometimes the circulation space within the house is too small to allow easy movement for a person using a wheelchair or walking aid.

One solution is adaptation of the dwelling, and domiciliary occupational therapists have the skill to do this. Solutions include the installation of ramps and indoor elevators. Adaptation of the kitchen and bathroom and addition of handrails can dramatically increase the safety of the house.

Making a Move:
The decision about when to move into a less independent environment represents one of the hardest decisions associated with aging for both the older person and the caregiver. The development of “smart homes,” lifeline alarms, etc. are delaying the time to when that decision has to be made. Each case is unique but possible guidelines for decision-making are listed in Table 2 on page 15.

Figure 2. The social consequences of growing old
Senior apartment buildings or assisted living facilities are the types of housing which most people think of when new housing for elderly people is mentioned, although many move to independent flats or villas. Such congregate housing offers security and reassurance to elderly people and thus meets the needs of many frail elderly people, particularly those who are:
- Nervous about living alone
- Anxious that they could not call anyone if they should fall ill
- At risk of hypothermia or hyperthermia
- Isolated (although some people feel just as isolated in congregate housing as in an independent dwelling).

### Table 2. Good Reasons for Moving

- To move nearer a son, daughter, or other relative who is willing and able to offer care
- To move away from a dwelling that is impossible to repair, improve, or adapt
- To move away from an environment that is causing severe depression or anxiety
- To move to sheltered housing if living alone is no longer safe

Assisted living is not always suitable for antisocial or very confused persons because staff members are often not trained to cope with excessively dependent people. People requiring individual attention by dedicated staff may require the level of assistance best provided by nursing homes. However, it is important to remember that the majority of disabled elderly people live, and will continue to live, in independent dwellings.

### Retirement

Retirement became a reality for older Americans with the introduction of Social Security. For many, pensions from employers and personal investments supplement that retirement. At present, insecurity about the ability of the government to fund Social Security and health plans for the old (Medicare) and the poor (Medicaid) is creating fear, especially among the poor elderly.

### The ‘Golden Age’ Myth

The ‘Golden Age’ myth states that there used to be a time when it was good to be old because all elderly people were loved and respected. Some believe that the Golden Age was destroyed by the industrial revolution when the traditional skills of elderly men and women, which they passed on to the younger generations by the fireside, were rendered irrelevant. However, that myth is false. Although rich elderly people were treated respectfully, poor elderly people usually finished up in a workhouse. The proportion of elderly people living in this situation was higher in times past than today. The quality of care in modern institutions far surpasses that seen even a quarter of a century ago. If ever there was a ‘Golden Age’ for older persons, it is now.

### Ageism

‘Ageism,’ like ‘racism’ and ‘sexism,’ is a prejudice. People who hold ageist views believe that all people over the age of 65 are of declining intelligence, rigid, conservative, dull, and unable to change or learn. They assume that physical or mental changes are due to the aging process and are untreatable. They also have expectations about the way older people should behave, e.g., that it is not normal for older people to drink to excess, show an interest in sex, or even to argue forcibly.

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New Pharmacy Resident Joins Saint Louis VA GRECC

Erin Thomas, PharmD is the 2005-2006 Geriatric Pharmacy Practice Resident at the St. Louis VA Medical Center GRECC, under the direction of Myra Belgeri, PharmD, CGP, BCPS, FASCP. Dr. Thomas graduated from St. Louis College of Pharmacy with her BS in Pharmacy in 2004 and her PharmD in 2005. As part of her 12-month ASHP-Accredited Residency, Dr. Thomas will spend the majority of her time providing clinical pharmacy services in the GRECC and Hypertension clinics and participating in interdisciplinary team rounds on the GEMU at the VA. She will also gain clinical pharmacy experience at the PACE program, which she will learn the principles of abilities-based education and will have the opportunity to apply these principles in several spring College of Pharmacy courses. Dr. Thomas will also be conducting presentations at multiple medical and pharmacy conferences, including St. Louis area pharmacy residents seminar series this fall, Saint Louis University Geriatric Medicine Grand Rounds in the spring, Midwest Pharmacy Residents Conference in May 2006, and the Summer Geriatric Institute in June 2006. St. Louis College of Pharmacy and St. Louis VA Medical Center are proud to have Dr. Thomas as a part of our team – Welcome, Erin!

The Ride of Her Lifetime

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watching her every move. They must have been expecting her. I opened the trunk and took the small suitcase to the door. The woman was already seated in a wheelchair. “How much do I owe you?” she asked, reaching into her purse. “Nothing,” I said. “You have to make a living,” she answered. “There are other passengers,” I responded. Almost without thinking, I bent and gave her a hug. She held onto me tightly. “You gave an old woman a little moment of joy,” she said. “Thank you.”

I squeezed her hand, then walked into the dim morning light. Behind me, a door shut. It was the sound of the closing of a life. I didn’t pick up any more passengers that shift. I drove aimlessly, lost in thought. For the rest of that day, I could hardly talk. What if that woman had gotten an angry driver, or one who was impatient to end his shift? What if I had refused to take the run, or had honked once, then driven away? On a quick review, I don’t think that I have done anything more important in my life.

that our lives revolve around great moments. But great moments often catch us unaware-beautifully wrapped in what others may consider a small one.

This article is reprinted with the permission of The Humor Network. Submitted by one of their readers, the author is unknown. While many of the articles on The Humor Network are light-hearted and humorous, others, like this one, are poignant, bittersweet, and thought-provoking.
Boniko, the spiritual director of the Divine Mercy Prayer Group of the Port-Harcourt Catholic Diocese in Eastern Nigeria, offered to guide us on our tour. He is also the parish priest of St. Patrick’s Parish in Bodo, a nearby village. Our first encounter with life on the other side of the geriatric divide was at the Port Harcourt “Home for the Elderly.” This is one of only two long term care facilities in Nigeria. This facility, run by the Catholic diocese, was established to care for sick, poor, abandoned, and rejected elders. The facility houses twenty-nine residents, only one of whom is a man. Incidentally he also doubles as the facility gardener. On arrival, we were met by the entire workforce, Pauline the middle-aged supervisor and five teenage girls. Attempting to define the specific responsibilities of each employee soon proved impossible. There were no departments or disciplines. Care plans and standards of care did not exist. Apparently, the only qualifications necessary were a cheerful disposition, the ability to work hard, and a crucifix worn around the neck. The home is comprised of three buildings that could easily be mistaken for warehouses. Residents are housed in a dormitory-like style, with beds arranged along each wall in a Florence Nightingale fashion. Faded and well-worn bed linens stood in stark contrast to the cold concrete floors. Beside each bed was a small cabinet that housed each resident’s entire worldly possessions.

Shouts of jubilation erupted when the residents were told that a medical team from the United States was here to visit. We suddenly realized that we were expected to provide each resident with a comprehensive medical examination. This was not an unreasonable expectation considering a doctor had not visited the facility for at least fifteen years. We got to work; there were no laboratories, no X-ray facilities, no CAT scans, or ultrasounds. I had to rely on the Livingstone approach: “My little black bag and I!” All the residents were hypertensive, seven of them had dementia, several had major depression, and one lady who roamed freely through the facility had full blown tuberculosis. Most of the residents were just lonely. A really withdrawn woman was so malnourished and wasted that I thought at first glance she must have cancer. Examination revealed several decaying teeth and a mouth full of pus making it almost impossible for her to eat. After we had finished with the residents, the staff demanded an examination! One young teenage employee had a nasopharyngeal tumor, another teenager had severe hypertension. With all the ‘patients’ seen and all the prescriptions written, the only thing left to do was order the medication. At this point we realized the obvious—someone had to pay for the medicines. Peter-Anthony, the lay-diocesan leader of the Divine Mercy Group, and our three-person team pooled funds to buy the medicines. (continued on page 22)
Aspects of Aging
(continued from page 14)

with people with whose views they disagree. Both old and young people hold ageist views and may assume that all physical and mental changes are due to the aging process, rather than to disease. The two main effects of ageist beliefs among older persons are:

1. Failure to seek help for treatable medical problems—“What else can you expect at my age,” and
2. Failure to comply with medical advice—“It was kind of the doctor to give me tablets but there’s no point in taking them; it’s just old age that’s the problem.”

Ageist beliefs lead to undervaluing the contributions of older persons and providing inadequate societal resources for them. Political activism is needed to combat ageism. Persons at all levels of the community and health professions often pay lip service to the aging demographic imperative, but fail to provide the financial and social supports needed to overcome ageist policies.

The Effect of Social Factors on the Aging Process

George Valiant (2003) studied aging in Harvard graduates and inner city persons living in Boston and found that not smoking, exercise, not drinking alcohol to excess, avoiding obesity, and a stable marriage were the factors that predicted successful aging. Social connection and perceived social support have an effect on health in persons facing crises, stressors and/or adversity (Johnson and Krueger, 2005) while social isolation or perceived lack of social support leads to more diseases and a higher mortality rate. When volunteers sat with recipients of home-delivered meals while they ate, the elders experienced decreased risk for poor nutrition and dysphoria (Suda et al. 2001). Allostatic load, an index of wear and tear on the physiological systems of the body that is related to heart disease, physical function, cognitive function and death can be significantly modulated in men, but not women, with strong emotional supports (Karlamangla et al., 2002).

The effect of social relationships on an older person developing and coping with disability depends not only on the strength of the relationship but also on the ability of the person to accept the relationship (e.g., are they depressed or did they have a lifelong inability to bond with others?) and their innate coping skills, as well as their economic status and the inherent severity of the disease process (Figure 3).

Endurance and resistance exercise can modulate disease processes and slow the development of frailty, disability and death. Exercise enhances frontal lobe cognitive function and may slow cerebral atrophy. Yet, over half of men and women over 65 years of age do not engage in physical activities. It is important that simple ways to improve physical fitness, e.g., climbing stairs rather than taking the elevator, can be as effective as organized activities. The importance of balance exercises, such as Tai Chi, to reduce falls needs also to be stressed.

Lifestyle, Nutrition and Healthy Aging: Lessons from the Seneca Study

The Survey in Europe on Nutrition and The Elderly: A Concerned Action (SENECA) examined how social factors modulate disability and mortality in 19 towns throughout Europe. The participants, born between 1913 and 1918, had a large variation in lifestyle factors such as alcohol consumption, smoking, and activity in sports (De Groot et al., 2004). Physical activity and smoking habits both predicted death and dependency.

Figure 3. Factors modulating the ability of social relationships to affect the aging process.
Another study examined the effects of social factors on aging in centenarians in Okinawa, Japan. This population has changed its diet from a calorie restricted, sweet potato base to a higher calorie, rice and meat base and, at the same time, has decreased its energy expenditure. Early reports suggest that these lifestyle changes may be deleterious as males in Okinawa now have a lifespan that has sunk from 1st to 26th among the prefectures in Japan.

Religion and Spirituality
An emerging literature recognizes the role of religion and spirituality in the preservation of psychological and physical health of older persons. Overall, religion and spirituality improve psychological health with a lesser effect on physical health, although not all forms of religion are positive. The role of religion and spirituality in health may be that it increases coping skills and enhances access to support groups. Health care professionals need to be aware of the religious and spiritual affiliations of their patients and, in appropriate cases, be prepared to incorporate them into a holistic model of health care. Prayer is a commonly used coping strategy for many older persons dealing with disability or life-threatening illnesses. Involvement of a person’s religious leader as part of the team approach to health care is important.

Anti-Aging Medicine
People have long sought the mythical fountain of youth (Fisher and Morley, 2002). This has lead to unscrupulous people selling their version of “snake oil” to vulnerable older persons. Within recent times, pseudoscientific claims associated with the growth hormone and dehydroepiandrosterone as agents that will “reverse the aging process” regularly appear in newspapers, magazines and books. Many of these claims are based on flawed studies originally published in mainstream medical journals. Others are based on hypotheses developed by scientists and published in mainstream literature and then translated as fact by the lay press. For example, the claim by Linus Pauling that megavitamins will protect cells from free radical damage remains alive today, despite studies suggesting that instead of prolonging life, they may shorten it.

Stem cells are a promising therapy that might reverse aging of muscle and cure Alzheimer’s disease. This research is accruing in Israel and South Korea, while under embargo in the United States. Such social factors will limit the rigor of scientific exploration into the role of stem cells and may eventually limit their use to the very rich.

The Environment and the Genome
Pharmacogenomics has shown that the efficacy and side effects of drugs are associated with specific alleles. For example, persons with the apolipoprotein E (APOE) allele have different responses to the antidepressant, paroxetine, depending on the allele (Shanahan and Hofer, 2005). Side effects from paroxetine are related to the number of C alleles of the HTR2A gene which codes for the serotonin receptor 2A.

The environment can modulate gene expression. Two examples have been found with the APOE4 gene: (i) Head injury accelerates Alzheimer’s disease in persons who have the APOE4 allele (Mayeux et al., 1995); (ii) APOE4 is a risk factor for ischemic heart disease predominantly in smokers (Humphries et al., 2001). The interaction of a major life event with a genetic predisposition increases the likelihood of major depression. Physical exercise produces different responses depending on the person’s angiotensin converting enzyme insertion deletion genotype.

These simple examples represent only the start of the exploration of gene/environment interactions. It is both the
genome and the environment that eventually determines the successful aging potential of a person. The new social science of aging in the 21st century will require the inclusion of the person’s genetic background to allow full interpretation of environmental affects.

**Elder Abuse**

Approximately 5% of older persons suffer elder abuse. In most cases this is due to neglect. Overall, persons who abuse older persons are more likely to have been abused when they were young and to have a mental illness. The solutions to elder abuse are complex, ranging from criminal prosecution and separation of the elder from the abuser to psychosocial therapies including such options as daycare, respite for the caregiver and increased home care.

**The Internet**

Although older persons are much less likely to use the Internet than are younger adults or children, many nursing homes offer Internet facilities for older persons to communicate with family, as well as to access the news. Older persons are also using the Internet to obtain healthcare information. With the movement of the “Baby Boomers” into the young-old cohort over the next decade, these uses are expected to increase exponentially. There will be increased communication between physicians and their patients via the Internet. We can expect to see an increase in telemedicine as a more technologically adept group of persons join the old cohorts.

**Cultural Competency**

Shifts in populations require that health professionals acquire cultural competency and that social policy adapts to create more health professionals from ethnic minorities. Throughout the United States, immigration of religiously and politically persecuted persons, many with war-time experiences of torture and displacement, are presenting healthcare professionals not only with new medical, but also with new social and cultural, challenges. Changes such as these require training programs for health professionals in the beliefs of different cultures and how they impact the interactions between older persons and their healthcare providers.

**Emergencies and Disasters**

In all emergencies and disasters, whether human-made or natural, older persons are disproportionately affected. Social interventions that healthcare professionals can use to improve the survival of elders were discussed in an earlier *Aging Successfully* (Vol. XIII (2), 2003). It is the responsibility of all to see that older persons are properly prepared for disasters, cared for during disasters, and returned to their homes after disasters.

**References**


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Saint Louis University Goes International

International Aging and Nutrition Meeting Held in St. Louis

Professor Bruno Vellas and Saint Louis University faculty organized the 3rd International Aging and Nutrition Meeting in St. Louis in May. Over 300 attendees heard presentations from 60 faculty. Plenary sessions, including talks on Nutrition and Alzheimer’s Disease by Professor Vellas, Cardiac Cachexia by Professor Stefan Anker, Nutrition in Europe by Professor Wija van Stavaren, Exercise in the Older Person by Professor William Evans, and Anorexia of Aging by Professor Ian Chapman.

Among the symposia, the problem of weight loss was highlighted. There were discussions on complementary medicine and nutrition education for older persons. The nutritional aspects of diabetes and osteoporosis were covered in detail. The role of free radicals and fruits and vegetables in dementia were highlighted. The InChianti group led by Luigi Ferrucci gave an outstanding series of presentations on the nutritional findings of this Italian Aging Study.

A highlight of the conference was an evening on a paddle steamer on the Mississippi River. The jazz band included a number of members over 80 years of age.

The next International Meeting will be held in Adelaide, Australia, under the organizational skills of Ian Chapman in September, 2007.

Saint Louis University Jointly Sponsors Aging Meeting in Bogota

Together with Fundacion Cardio-Infantil, Saint Louis University jointly sponsored the 2nd International Geriatric meeting in Bogota, Colombia. The meeting was attended by over 600 social workers, nurses, and physicians. The meeting was opened by the Minister of Health from Colombia, Dr. Diego Palacios, who highlighted the rapidly increasing older population in Colombia and the need for increasing the services available for the elderly. The organizers in Bogota were Professor Cabrera, Professor Dennis, and Dr. Silvia Cuenca. Presentations were made by Dr. David Thomas, Dr. John E. Morley, and Dr. Oscar Cepeda from Saint Louis University.
medication. We had a farewell party with meat patties and sodas. Passersby gawked as music blared and the sound of festivities emanated from the old peoples home.

Next, we traveled to Bodo to visit the old rural Nigerians in their natural habitat. We arrived at St. Patrick’s church on a Monday. Father Boniko had announced at Sunday mass that we would be arriving. We set up shop in the only available space, the church. As I sat facing the crucifix, preparing to minister to sick elders, I finally grasped the significance of the Jesuit ministry at Saint Louis University. I thought of Father Jim Baker and Father Boniko, worlds apart, so different and yet so alike. My philosophical musings were rudely interrupted by a flood of elders from villages far and near. The word had spread and they had made their way, walking several miles, some supported by young adults, others with canes; all eager to be seen by a physician, ready to take the time to hear the good news of Jesus.

Realizing that I had to keep track of my recommendations, we sent out for sheaves of paper and created a rough and ready medical records department to store our notes. This department is currently housed in a cardboard box in Father Boniko’s house. At the end of the day we were treated to cultural dances and an excellent meal prepared by the local villagers.

Exhausted, we set out for the long trip back to our air-conditioned hotel. As I waved goodbye to a rather motley crew of elders, I thought of Mrs. Williams at the home for the elderly, who was angry with God for keeping her alive for so long; I thought of the elderly lady who, after several strokes, could neither speak nor walk, so she grunted as she crawled. I thought of the old man who had walked several miles to see us in shoes that were held together with string and had no soles. I had met the poor, frail Nigerian elder…and now…what?

Brenda McCrimon writes as Dr. Wilson dictates the treatment plan for this elderly patient.

Margaret-Mary Wilson, Assistant Professor of Medicine at Saint Louis University in the Division of Geriatric Medicine, is the only daughter of Andrew Iyere Wilson and Victoria Arit Wilson. Andrew Wilson was the first Secretary of State to Mid-Western Nigeria following that country’s independence in 1960. He died in October 2003 from complications of a chronic illness. His death was the driving force behind this mission. Margaret-Mary’s mother and only surviving brother, Peter-Anthony, live in Nigeria.
Upcoming CME Programs

14th Annual Multi-Disciplinary Certificate Program in Geriatrics for Non-Physicians
In Bloomington, Illinois on Fridays, Sept. 16, 30, Oct. 14, 28, Nov. 11, and Dec. 2, 2005

Saint Louis University
Geriatric Academy (SLUGA)
January 9-13, 2006 on the Saint Louis University Campus

University of the Third Age Conference
November 5, 2005

17th Annual SLU School of Medicine Symposium for Medical Directors
NURSING HOME ISSUES
Saturday, Dec. 10, 2005

All of the conferences will be held at Saint Louis University, except as noted. For more information about any of these conferences, please call 314-977-8848.

Been Here? Done This?
Offering regular updates on geriatrics, Cyberounds, an internet-based educational program for physicians and other health providers, is edited by Dr. John E. Morley. The internet address for Cyberounds is: www.cyberounds.com

A cybersite for seniors has been developed in collaboration with Saint Louis University and the Gateway Geriatric Education Center. Besides articles written by geriatric experts, this site provides health updates and an interactive question and answer section. The address for this site is www.thedoctorwillseeyounow. See you in cyberspace!
Aging SUCCESSFULLY

Division of Geriatric Medicine
Saint Louis University School of Medicine
1402 South Grand Boulevard
St. Louis, Missouri  63104

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John E. Morley, M.B., B.Ch.
Dammert Professor of Gerontology and
Director, Division of Geriatric Medicine
Director, Gateway Geriatric Education Center
Department of Internal Medicine
Saint Louis University School of Medicine
and Director, GRECC, St. Louis Veterans Affairs Medical Center

Nina Tumosa, Ph.D.
Editor
Health Education Specialist, GRECC
St. Louis VAMC-Jefferson Barracks
and Executive Director, Gateway GEC
Professor
Division of Geriatric Medicine
Department of Internal Medicine
Saint Louis University School of Medicine

Carolyn E. Phelps
Assistant Editor

Please direct inquiries to:
Saint Louis University School of Medicine
Division of Geriatric Medicine
1402 S. Grand, Room M238
St. Louis, Missouri  63104
e-mail: agingsuccess@slu.edu

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