Complementary Medicine
The Good, the Bad, and the Ugly

“An old woman in Shropshire who sometimes made cures after the more regular practitioners failed…This medicine was composed of twenty or more different herbs; but it was not difficult to perceive that the active herb cannot be no other than foxglove.”

-William Withering
1741-1799

Modern medicine has developed out of the alternative medicines of traditional healers from the past. In addition, we continue to see the enormous power of the placebo effect. Often the modern physician is rushed, spending little time dealing with the person’s fears and psychic needs. The importance of addressing the patient’s concerns and needs was first recognized by Hippocrates who said “It is more important to know the person that has the disease than the disease the person has.” Thus, it is not surprising that many persons seek out complementary medical systems when mainstream medicine appears to fail them. Up to 90% of older persons use complementary medicine. The major conditions for which persons turn to complementary (or alternative) medicine (continued on page 2)
Complementary Medicine

(continued from page 1)

Modern alternative medicine were codified in the principles of the ancient Indian medicine system, Ayurveda. Developed around 6000 B.C., Ayurveda literally means “Life-knowledge.” It is based on the principle that all diseases are due to an interaction of mind, soul (prana), senses, and body and that attention to each component is important for a cure. The illnesses are due to the “doshas” which disturb the constitution (pakhrite). The three doshas are VATA (air, which is energetic and leads to gas and arthritis); FITA (fire, which is emotional and leads to ulcers and diseases of the liver); and KAPHA (earth, which results in respiratory diseases). The treatment modalities include diet, herbs, massage, breathing, and detoxification (panchakarma). Ayurveda is the basis of the books and lectures of Dr. Deepak Chopra.

It should be pointed out that a good geriatrician needs to incorporate many alternative therapy tenets into his/her practice if (s)he is to be successful. Examples include the importance of spirituality in healing and end-of-life care and the use of massage, e.g., neck muscle massage to cure temporal headaches. Therapeutic touch such as hugging can work wonders. Smile and laughter therapies go a long way towards alleviating anxiety and depression. Norman Cousins popularized the role of distraction techniques to diminish pain. Ta’i Chi (the ancient Chinese exercise form) is, today, an excellent therapy for persons at risk of falling. Relaxation techniques play a key role in treating psychosomatic disorders. Both herbal medicines and some hormonal therapies, e.g., testosterone, have a role in the management of our patients.

Other areas of alternative medicine are of questionable value but certainly can be fun and relaxing. In this class, aromatherapy (“Flower Power”) is the leader. Examples of this include the use of tarragon to treat the menopause; rosemary to treat dyspepsia; bay laurel to treat anorexia; and lavender to treat headaches and insomnia.

The use of vitamins is a therapy that moves itself back and forth between mainstream and alternative therapy. Vitamin B₁₂ therapy provides such an example. It is clear that vitamin B₁₂ deficiency can occur as a disease when it leads to anemia, dementia, and peripheral neuropathy. Modern medicine often recommends high doses of vitamin B₁₂, folate, and pyridoxine to lower homocysteine, and recently it has been suggested that low vitamin B₁₂ levels may lead to hip fracture. Physicians have long recognized the powerful placebo effect of monthly vitamin B₁₂ injections. Those who used this approach were derided in the past by academic physicians as “The B12 Bombers.”

Other vitamins and free radical scavengers also have many proponents in mainstream medicine. Vitamin E is used as a treatment of Alzheimer’s disease and as an anti-aging medicine. Its role in atherosclerosis remains controversial. (continued on page 14)
I’m NOT Going to Fall Again

Carolyn Philpot, GNP-BC

Falls are an important marker of frailty. They frequently play a role in accelerating the loss of health and independence of a frail elder. Falls can lead to decreased activity, depression, social isolation, functional decline, and a diminished quality of life. About 95% of all hip fractures result from falls, resulting in over 332,000 hospital admissions each year. In addition, “the fear of falling” can lead to social isolation, depression, and impaired activities of daily living.

GOALS

Falls are inevitable. Active persons fall more often than inactive ones. Therefore, it is essential to set goals designed to minimize the impact of falls when they do occur rather than to eliminate falls by forcing elders to become inactive. Two such goals are:

1. to decrease the number of falls a person experiences, and
2. to limit the injuries that the falls cause.

RISK FACTORS

Both intrinsic and extrinsic factors must be considered when determining how to reduce the number of falls or limit the injuries that result from those falls. Environmental factors affect the number of falls that occur. Every year about one of every three community-dwelling elders experiences a fall. Most falls occur indoors, mainly in the bathroom, bedroom, and kitchen. Ten percent of falls occur on the stairs, particularly during descent. The first and last steps on stairs are the most dangerous. Nursing home residents fall approximately three times more often than those who live in the community. In institutions, the most common sites for falls are at the bedside during transfers and in the bathroom.

Intrinsic factors include a person’s disease status. For example, people are at increased risk for falls whenever they develop a new disease. Delirium often accompanies the onset of a new disease and delirium is a risk factor for falls. Whenever elderly persons have a new onset of falls, they should be worked up for the reversible causes of delirium. Older persons with dementia are twice as likely to experience a fall compared to cognitively intact people of the same age. For persons with Alzheimer’s disease, this increased fall risk is most likely due to disturbance of gait and balance with shorter step length, increased sway, and greater step-to-step variability. Incontinence, which can be used as a marker for frailty, is commonly associated with falls. People who are rushing to the bathroom are more prone to falls, probably due, in large part, to altered gait and an abnormally rapid pace. Bunions, calluses, and deformed toes also can modify gait or inhibit adequate movement. High heels are a key preventable cause of falls.

(continued on page 5)
Ageism is as old as aging itself. From the beginning of time, younger persons have often given older persons unfavorable characteristics. Yet at the same time, those who have aged successfully are venerated by the young. The conundrum of the love-hate relationship that youth have for the aged is one of fear for the aging process juxtaposed to hope that they will themselves age successfully and have a long life.

Our ageist attitudes are best displayed when we talk of the elderly as “they” thus magically separating “them” from “us.” It should be obvious that “the elderly” are just “us” separated only by the passage of time. Dissociating ourselves from “them” allows us to treat “them” differently from how we would treat ourselves. This is a ploy used by human beings to remove themselves from a group that they do not want to help or worse still, wish to harm. For example, we often believe that the “Other Group” (i.e., any group that is not “us”) is somehow unworthy and therefore they deserve what happens to them.” Thus it absolves us from the commandment to honor our fathers and mothers.

A recent example of veneration for old age was seen in the adulation of the American public at the funeral of President Reagan. Despite the fact that history may well categorize Reagan as an inept, but lucky, President, all this was set aside to honor a man who had bravely battled Alzheimer’s disease. Who could fail to be moved by Nancy Reagan as she stroked the coffin, fighting back tears for her departed husband? As such, she epitomized the heroism of millions of caregivers who daily provide loving care for those of us who have grown frail.

It is important that we recognize that but for time, old persons are us. However, it is equally important that we recognize that old age is not for sissies. The travails of aging are easy to recognize: it is the awakening with pain in our hip or back; it is finding that as the light fails we can no longer read without glasses; it is struggling to follow a conversation in a noisy room. Those of us who have chosen a career path of working with older persons are trail-blazing a future for ourselves which will hopefully make our own aging process less of a trial. As such, I consider us to be extraordinarily lucky to have older friends who are acting as our guides along the path to the future. It is these friends that are showing us the roads less traveled. They are showing us, as we embark on the same journey, how to choose an inviting path through the garden of our old age. They are enticing us at the different branches in the road with a tempting invitation to explore a new pathway in our life which allows us to discover the secrets of aging successfully.
Immobility is also associated with an increased fall risk. Studies have shown that a reduction in the use of restraints in nursing homes results in fewer serious injuries. Restraint reduction from 41% to 4% over 3 months reduced injuries from 7.5% to 4.4%. Sometimes a person may fall without a loss of consciousness. These drop attacks are due to decreased perfusion of the posterior cerebral blood supply. The person does not lose consciousness but falls to the ground and cannot move his or her legs. Syncope results in falls associated with a loss of consciousness. About one-quarter of institutionalized patients has had a syncopal episode in the last decade and 6 to 7% of institutionalized persons will have a syncopal event during the next year. Causes of syncope include:

- Orthostasis (can be associated with falls without loss of consciousness)
- Postprandial hypotension (can be associated with falls without loss of consciousness)
- Prolonged QTc on EKG
- Anemia
- Straining while urinating or defecating
- Seizure disorders (associated with incontinence)
- Abrupt reduction in cardiac output
- Carotid sinus pressure
- Arrhythmias
- Drugs

Drugs associated with falls include:
- Diuretics
- Antihypertensives
- Psychoactive drugs
- SSRIs
- NSAIDs
- Hypoglycemic agents
- Antiarrhythmic agents

To prevent injuries, helmets and hip pads can be very useful. Intrinsic factors must be considered also. The major risk factors associated with falls are quadriceps weakness, balance problems, gait disorders, sensory loss, dizziness, recent change(s) in medication, orthostasis, and a history of falls. The risk factors for falls can be remembered by the SAFE AND SOUND mnemonic (see box).

Osteopenia is often neither recognized nor treated by physicians. Thus frail older persons who are at risk for falling must at the least receive vitamin D and calcium. Bone mineral density should be done to determine the need for bisphosphonates.

In conclusion, attention to simple points such as monitoring orthostasis, appropriate use of canes and walkers, no restraints, identifying and treating delirium, treating osteopenia, monitoring drug usage, and utilizing hip pads and helmets for frequent fallers can reduce injurious falls.

Carolyn Philpot is a Geriatric Nurse Practitioner in the Division of Geriatric Medicine at Saint Louis University Health Sciences Center.
News at SLU

John E. Morley Appointed To Executive Board

At a meeting in Prague this spring, John E. Morley was appointed to the executive board of the International Society for the Aging Male. This society, founded by Bruno Lunenfeld of Israel, has played a major role in developing increased awareness of the unique needs of aging males. He also was appointed to the editorial board of the society’s journal, The Aging Male. The Society works closely with the World Health Organization in Geneva.

Division of Geriatric Medicine Faculty Promoted

Dr. Susan A. Farr has been promoted to Associate Professor of Internal Medicine at Saint Louis University. She joined the Division of Geriatric Medicine in 1998 as an Assistant Professor. She is also a Research Scientist at the St. Louis Veterans Administration Medical Center (VAMC) at the John Cochran Division. Her research interests include the behavioral assessment of impaired learning and memory in Senescence Accelerated Mouse subline P8 (SAMP8), which is a mouse model of Alzheimer’s disease.

Dr. Wilson Receives Award

Dr. Margaret M.G. Wilson of the Division of Geriatric Medicine at Saint Louis University has been awarded the Osler Award this year. This award is presented annually to the physician voted as the best teacher of the year by his or her students, the residents, and the interns. Named after perhaps the most important figure in medical education in the United States, Sir William Osler, the award is given to one who knows and teaches that “medicine is learned by the bedside and not in the classroom.” Osler was a common-sense teacher; he loved books and emphasized that a patient, a library, and a notebook were the best tools of medical education.

Dr. Nina Tumosa has been promoted to Professor of Internal Medicine. She joined the faculty as an Associate Professor in 1997. She is also the Co-Director of the Gateway Geriatric Education Center and a Health Education Officer at the VISN 15 GRECC at the Jefferson Barracks Division of the VAMC. Her research interests include assessing the progression of cognitive impairment in humans. She is editor of the Aging Successfully newsletter and currently serves as President of the Breakthrough Coalition, a group of organizations, companies, and individuals in the St. Louis Metropolitan area that is working together to improve the lives of seniors in the region. Dr. Tumosa is also Secretary of the National Association for Geriatric Education Centers.
In order to develop quality of care in nursing homes, there must be a focus on all three customer groups: families, residents, and partners (staff). Continuous ongoing evaluation is essential if quality is to be maintained. All of our customers have to be made aware of the fact that “we care what you think.”

The key to good care is to train partners in the importance of customer satisfaction. We treat our partners with respect so they will treat our customers with respect. Ongoing education is an important tool. It should be based on the evolving needs of our customers. Where possible, we attempt to make education fun.

Our partners are empowered to make changes in several ways. A suggestion box is made available, and partners whose suggestions are used are rewarded with gift certificates. Non-managers are included in the Continuous Quality Improvement (CQI) meetings and encouraged to present their projects. This includes CNA participation. We believe that active medical director participation is important in the CQI process. We stress that the CQI process requires follow-through and once a problem is fixed, it needs continuous follow-up to prevent recurrence. The ultimate goal of this empowerment of our partners is to reduce staff turnover. Staff turnover needs to be kept at a minimum. Not only is training of new staff expensive, but also it has a marked effect on resident perception of care.

Food is another key to happiness in the nursing home. Novel approaches we use include: a free ice cream parlor; a snack cart (see photo) that travels the halls between meals providing not only food but also fluids to maintain hydration (a bell on the snack cart is rung to remind the residents of its presence); baking bread on the Special Needs Units that creates an aroma that stimulates the need to eat; and enhancing the dining room atmosphere by placing flowers on the tables. Care is taken to place compatible residents at the same table. Soft music in the background and no television during mealtimes are useful in promoting a friendly atmosphere. Food presentation with clear choices displayed suggests a fine restaurant atmosphere. We have found that buffet dining, which allows residents to choose their own food and interact with staff while they do it, leads to a very successful dining experience.

End of life care is particularly important to create a hospitable environment. It is essential to have a compassionate approach to end of life care. Family involvement is crucial to ensure that the resident’s wishes are respected. It is important to provide ongoing education to the staff on end of life care to ensure that they are equipped to provide quality care in these situations.

Dr. Carl Adams, founder of NHC, says: “Nobody knows the quantity of their life. I don’t know how many days you have on earth, nor does anyone else except God. What I’m most interested in is the quality of life while they are here. That’s the business I am in.”

Putting the “Home” Back in Nursing Home

By Susan Taylor, Nursing Home Administrator

Snack cart at NHC
ating a caring environment in our nursing homes. Good deaths are a key to the quality of life of residents, family, and staff. To help make deaths as natural and non-stressful as possible, we place soothing pictures inside and outside the room to act as a reminder for all to be respectful of family during the dying process of their loved one. We also provide books on death and dying to help the family understand the process more easily. We offer comfort foods to the family members as well. After death occurs, families receive a sympathy card signed by those who cared for their loved ones and we encourage our partners to attend memorial services. We also hold memorial services within the facility at suitable intervals for departed residents.

The development of an Eden Alternative has been a major commitment to our customers. The introduction of a variety of animals, both indoors and outdoors, is another key element to making people feel at home. At present, we have sheep, a Shetland pony, hens, and rabbits outdoors; and dogs, cats, a rabbit, and birds indoors. Cockatiels make ideal pets for nursing home residents and we always have one or more on hand. Besides pets, we also have a gardening project and a Japanese garden. These areas include specially constructed gardens for those in wheelchairs. A wander garden is available for those in the special needs unit.

Contact with people from outside the home is encouraged. A computer is available for residents to use. Individualized tutoring on the use of the computer is available for the residents. We also provide intergenerational programs where junior high school children come into the facility and as a school project, record oral histories from our residents. The resident animals represent an extra attraction for younger children while they visit their grandparents. During summer months, the activities department and a number of residents run a summer camp for children 5-13 years of age. At Easter, the residents organize an Easter egg hunt for neighborhood children. At Halloween, the residents dress up and the facility provides candy for children who come and “trick or treat.” At Christmas, residents man the phone and play the role of Mr. and Mrs. Claus on the “Santa Hotline.” The phone number is advertised in local newspapers. We have a fireworks display for the residents and members of the community on July 4th.

Residents are empowered to play a role in improving the facility. Resident mentors are assigned to welcome new residents and introduce them to other residents. Residents also do fund-raising by holding raffles, etc. The resident council is encouraged to help find solutions for problems in the facilities. Families are encouraged to visit and play an active role in helping residents. Both family members and residents can give to individual partners Pep cards to acknowledge that the family has noticed that those partners have provided especially good care by their loved ones. These Pep cards are then aggregated towards an end-of-year bonus.

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This year’s Saint Louis University Summer Geriatric Institute was attended by more than 300 persons. The Institute began with a provocative talk by Robert Heaney from Creighton University who discussed the importance of vitamin D for older persons. Not only is vitamin D important for bone maintenance, but it also has effects on muscle strength, function, and falls. Low levels of vitamin D are associated with prostate cancer, multiple sclerosis, and fibromyalgia. He pointed out that the original RDA for vitamin D was set at 400 I.U. because that was the amount in one tablespoon of cod liver oil. He provided evidence that this amount of vitamin D was too low to maintain adequate calcium absorption and suppress PTH in older individuals. This is, in part, due to the decreased production of vitamin D precursors in the skin of older persons.

Thomas Edes highlighted the leadership role the Department of Veterans Affairs has played in developing geriatrics in the United States. He pointed out that it was the VA that originally developed and validated the Geriatric Evaluation and Management Units. He demonstrated that the VA hospital-based primary care program dramatically saved costs predominantly by reducing hospital admissions (see figure below). He stressed that the VA had developed a new initiative in end-of-life care with the mission “to honor veteran’s preferences for care at the end of life.” Finally, he delineated an exciting new program at the Little Rock VAMC where foster home care is being provided for veterans who would otherwise need to be hospitalized or placed in nursing homes.

Joseph Flaherty discussed the difficulty physicians have in estimating when a person will die at the end of life. He quoted Joanne Lynn who said, “...[there is an] irresolvable uncertainty of time of death for many illnesses.” Ninety-four percent of patients have problems with hunger and thirst in the last 12 months of life, necessitating a more aggressive approach to nutrition management and perhaps the use of orexigenics at the end of life. Morphine is

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not only key to managing pain, but nebulized morphine can be used to treat terminal dyspnea. He stressed that a spiritual history – one that examines beliefs and values regardless of whomever or whatever gives one meaning in life – is an important key to a good death.

Julie Gammack pointed out the well-demonstrated benefits of a comprehensive geriatric assessment including identification of unrecognized conditions in over a third of patients, changes in medications (40%), and improved referral to home care, psychosocial needs, and community service. A meta-analysis has demonstrated that comprehensive geriatric assessment reduces mortality and decreases nursing home placement. She stressed the need for an interdisciplinary team to carry out the focus on functional, social, and cognitive domains.

Robin McFee discussed the special needs of the geriatric population when developing preparedness in healthcare delivery against the effects of weapons of mass destruction (WMD). The importance of atypical presentations in older persons, such as failure to mount an adequate febrile response, may limit the ability to make an early diagnosis of a bioterrorism attack. Conditions that commonly alert the physician to an unusual infection in young persons, e.g., relative bradycardia, delirium, echymosis, and skin conditions, are commonly not present in older persons, making the diagnosis of the “sentinel zebra” much more challenging. The importance of behavioral trauma (“how to feel safe again”) following a WMD attack cannot be overlooked.

Ramzi Hajjar reviewed the evidence for the aggressive management of hypertension in the elderly. He concluded that there was little evidence to lower blood pressure below 160/90 mmHg and that further lowering might be dangerous. Before treating older persons, the presence or absence of orthostasis, postprandial hypotension, pseudohypertension, and white coat hypertension needs to be ascertained.

George Grossberg discussed the findings of clinically significant depressive symptoms that occur in 8 to 15% of older persons. The health care costs of the depressed patient are twice that of non-depressed patients with similar levels of co-morbidity. Older persons with depression have markedly increased death rates and poorer responses to rehabilitation. He highlighted that older persons have a 30 to 40% placebo response, suggesting the importance of psy-
Kastin and Keller Receive James Flood and Max Horwitt Awards

Abba J. Kastin from the New Orleans VA Medical Center received the James Flood Award for his lifetime achievement in developing the field of neuropeptides and behavior and the scientific evidence for a body-mind communication. Dr. Kastin has previously won the VA’s prestigious Middleton Award. He was the mentor of Dr. William Banks, the leading research scientist in Saint Louis University’s Geriatric Program. Dr. Morley also paid tribute to Dr. Kastin as a person who played a major role in the early development of his career.

Dr. Heather Keller, a dietitian from the University of Guelph, received the Max Horwitt Award for her work in developing a nutrition screening tool (SCREEN©) for seniors. SCREEN© (Seniors in the Community: Risk Evaluation for Eating and Nutrition) is a simple, questionnaire-type tool for assessing nutritional risk. It can be self- or interviewer-administered and can be used in a variety of settings: epidemiological studies, nutrition education, and for monitoring change in behaviour as a result of intervention. SCREEN© was developed using an interactive process that involved researchers, practitioners, and seniors and is based on a combined psychometric and clinimetric approach to tool development. Developmental analyses demonstrated that the tool has content validity and internal reliability.

This tool is now being widely used throughout Canada.
Falls are a Marker of Frailty

- Social isolation
- Depression
- Hip fracture
- Decreased activity
- Fear of Falling
- Functional decline
- Decreased quality of life
- Death

NEW ONSET FALLS ARE A DELIRIUM EQUIVALENT

Environmental Hazards Commonly Cause Falls

from the Saint Louis University “Safe and Sound” program
Fall Assessment

- Did the patient trip?
  - Yes
    - Environmental assessment
      - Mobility assessment
      - Strength assessment
      - Balance assessment
  - No
    - Did the patient experience a loss of consciousness?
      - No
        - Rule out delirium
      - Yes
        - Did incontinence play a role in the fall?
          - Yes
            - Seizure
          - No
            - Syncope
              - No
                - Previous syncope
      - Yes
        - Syncope
          - No
            - Previous syncope

- Orthostasis
- Postprandial hypotension
- Medication review
- Mobility assessment
- Strength assessment
- Balance assessment
- Visual function
- Anemia

- Ambulatory cardiac monitor
- Carotid sinus pressure
- Echocardiogram
- EKG
- Cardiac exam
- Cardiac enzymes
- Orthostasis
Complementary Medicine
(continued from page 2)

Alpha-lipoic acid is a strong free radical scavenger that has now clearly been shown to be an excellent treatment for diabetic neuropathy. Studies in animal models of Alzheimer’s disease suggest that alpha-lipoic acid can reverse memory dysfunction. Vitamin D clearly protects bones yet physicians have been quicker to adopt the therapeutic effect of expensive bisphosphonates while often failing to remind their patients to take calcium and vitamin D as a preventive measure. Vitamin C can often alleviate the occurrence of “senile” purpura. On the negative side, vitamin A in high doses can result in hypercalcemia.

Numerous other herbal medicines are effective in the treatment of disease but have not necessarily been incorporated into the physician’s armamentarium (see box below). Studies to discredit these cheaper alternatives are often sponsored by the pharmaceutical industry.

Many non-pharmacological methods are also useful in treating disease and disability. Some of these methods have been shown to be effective; others have not. A variety of bodywork techniques such as Feldenkrais, Reiki, Rolfing, and Trager Psychophysical Integration have flirted with being incorporated into the physician’s armamentarium (see box below). Studies to discredit these cheaper alternatives are often sponsored by the pharmaceutical industry.

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Herbal Medicines That Do Work

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<tr>
<td>Valerian</td>
<td>Sleep</td>
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<td>Gingko biloba</td>
<td>Dementia</td>
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<td>Feverfew (parthenolde 0.2%)</td>
<td>Migraine</td>
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<td>Saw palmetto</td>
<td>Benign prostatic hypertrophy</td>
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<td>Alpha-lipoic acid</td>
<td>Diabetic neuropathy</td>
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<td>Glucosamine</td>
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<td>Ginger</td>
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Paul Niehans
A Medical Student Workshop in Geriatric Assessment

By Julie Gammack, MD

During the spring semester 2004, fourteen medical students at Saint Louis University School of Medicine participated in a new elective course. The “Geriatric Skills Workshop” introduced first and second year students to communication techniques and assessment tools used in evaluating older adults. Each two-hour session included an introductory lecture on the clinical topic, followed by a hands-on skill session that allowed students to practice the assessment technique.

The topics for the Workshop course included: History and Physical Exam of the Elderly, Functional Assessment, Gait and Balance Assessment, Mental Status Evaluation, Skin and Wound Care, Challenging Communication Scenarios, Sensory Assessment, and Breaking Bad News.

This 8-session course was held at Life Care Center of St. Louis, a 100-bed skilled and long-term care facility. Many of the residents at Life Care participated in this course by volunteering to be examined by the medical students and to talk about their medical conditions. The Life Care Center therapists and nutritionists also assisted Dr. Gammack during several of the sessions.

Students completed a 41-point geriatric knowledge pre- and post-test to evaluate the educational impact of this course. Pre-course and post-course scores were 21.8 (50%) and 27.99 (68%) respectively (p-value 0.003). For comparison, students not enrolled in the Workshop Course scored 24.4 points (60%). Student feedback on the course was extremely positive with the sessions receiving ratings of 7-8 (1=poor; 9=excellent).

Students found the practical, hands-on skill training and the use of volunteer patients to be the most beneficial aspects of the course. Some of the comments from the class included these:

“This is a stress-free opportunity to work and interact with patients and concentrate on geriatrics.”

“The videos were very helpful to observe [before] seeing a real patient later on in the evening.”

“I really enjoyed this course since it was one of the only times for us ‘first years’ to get to work with actual patients.”

The Geriatric Skills Workshop elective will be offered each spring for first and second year medical students at Saint Louis University. This course was developed by Dr. Gammack as part of a five-year career development award from the Health Resources and Services Administration for junior faculty in geriatric medicine who focus on medical education.

Aging Successfully is now on the web! Check us out!

Screening tools
Archived issues
Products
Conference Information

http://medschool.slu.edu/ agingsuccessfully/

Dr. Julie Gammack, one of the latest additions to the Saint Louis University faculty, is an Assistant Professor in the Division of Geriatric Medicine.
chosing social interventions. Electroconvulsive therapy is safe and effective in the elderly. Future antidepressants, such as duloxetine (a mixed serotonin, noradrenergic reuptake inhibitor) appear promising for the treatment of elders with depression.

Margaret Wilson provocatively suggested that males with incontinence are often ignored. She particularly highlighted the occurrence of urge incontinence occurring early during the process of prostate enlargement.

John Morley pointed out that from the beginning of time, humans have looked for anti-aging medicines. In Taoism, this was seen as magical foods such as ginseng, and ayurveda (ayur = life; veda = science) delineated a number of anti-aging herbs. The Babylonian demi-god, Gilgamesh, sought a plant found under the sea which would give him immortality.

In more recent times, the Nobel prize winner, Elie Metchnikoff, felt that eating yogurt would purge the gut of bacterial toxins and confer longevity. Ana Aslan in Romania sold Gerovital H3 (procainamide) as a cure for aging in the 1940s and 50s.

John Morley went on to give a brief history of geriatrics. Modern geriatrics was born with Ignatz Leo Nascher who coined the term in the early twentieth century. The basic principles of geriatrics were developed by Marjory Warren at the West Middlesex Hospital from 1935 onward. The modern scientific foundations of gerontology were codified by Edmund Vincent Cowdry in St. Louis in 1939. Modern academic geriatrics in the USA was developed by Les Libou in New York in 1966.

The meeting ended with Nina Tumosa demonstrating a prototype of the Disaster Preparedness computerized game that has been developed at Saint Louis University and the St. Louis VA Medical Center to educate health professionals concerning the unique needs of elders in preparing for disasters. A CD containing this game will be distributed free of charge to the first 500 people who request the CD. To receive your copy, please send a letter of request plus your complete mailing address to Nina Tumosa, 1402 S. Grand, Room M238, St. Louis, MO 63104.

**Recommended Reading**

For those of you who want to learn more about complementary and alternative medicine (CAM), we have just the book for you. We recommend that you read *Clinics in Geriatric Medicine*, Volume 20, Number 2, which was published in May, 2004. The topic of this volume is Anti-Aging.

The ISSN number of *Anti-Aging* is 0749-0690. This volume should be available in most medical libraries. The publisher, W.B. Saunders Company, may be contacted by calling 1-800-654-2452.
Dancer Inspires Poet

Many of you will remember the article from Aging Successfully, Fall 2003, which detailed the dancing abilities of Frances Wessells, aged 84. Our own Dr. Rafi Kevorkian was so moved by her presentation that he penned this poem.

There she was, standing on stage
Looking out at us with precision,
Whispering words of wisdom
Music began to play in the background
The beat, tantalizing everyone
Left us to our imagination
She jumped up in the air
Seemingly floating forever
To an everlasting harmony enchanting everyone
Her age insignificant
Her wrinkles smooth as silk
Her expression imprinted with history,
Brought a sense of rejuvenation
As she gyrated back and forth
A thread of hair fell to the ground,
Suddenly there was silence
We felt her energy radiating
As the sound of her heartbeat echoed
A glimmer of light reflected upon us
From a silver thread
Woven eternally into our soul

-Dr. Rafi Kevorkian
Saint Louis University Geriatrics Academy Evaluation Results

In January of 2004, 30 geriatricians received post-graduate education in geriatrics and leadership at the inaugural session of the Saint Louis University Geriatrics Academy (SLUGA). Four months after their training, these Scholars were asked how their training had affected their educational or clinical practices. The results below indicate that the Scholars put their training to good use. The next session of the SLUGA will take place July 12-16, 2004. For more information contact Nina Tumosa at tumosan@slu.edu.

![Effect of Training on Clinical Practice](image1)

![Effect of Training on Educational Practice](image2)

3rd International Meeting
International Academy on Nutrition and Aging
St. Louis, Missouri
May 6-8, 2005

To suggest ideas for symposia for this conference, please contact Pat Byrne-Mulligan at byrneplk@slu.edu by August 31, 2004.
Professor Joan Smith died on June 8, 2004. She remained active in the community even after her retirement from School of Social Service at Saint Louis University. In 1996 she became the founding member of the Saint Louis chapter of the University of the Third Age. Known for her quick wit and her unassuming demeanor, Professor Smith always felt that actions spoke louder than words. As our tribute to her, we offer you a picture of how we remember her best: as a teacher and a friend.

In Memory

Joan Smith introduces the concept of the University of the Third Age to Saint Louis University in 1996.
Complementary Medicine
(continued from page 14)

 rated into mainstream medicine. Homeopathy (the dilution of toxins to vanishingly small doses to fight the toxins producing disease) remains a common therapy in parts of Europe despite a total lack of evidence that it works. Light therapy has been shown to play a role in treating depression and in improving behavioral problems in dementia patients with a shift in circadian rhythm. Osteopathic medicine, which started in Kirksville, Missouri, is now totally accepted as one of the pathways to mainstream medical practice.

Some therapies are certainly highly questionable. For example, the concept of high colonics was developed in ancient Egypt when the pharaoh was constipated and his physician saw an Ibis (thought to be an incarnation of the god, Toth) squirt water from the Nile into its anus. While this is a useful treatment for fecal impaction, regular cleansing of the bowels this way is more fetishistic than therapeutic. Cell therapy to slow down aging (injection of fetal animal cells into the blood) was introduced by Paul Niehans in Switzerland. Among those who are purported to have tried it are Winston Churchill, Pope Pius XII, Dwight Eisenhower, Aristotle Onassis, and Christian Barnard. Clearly this is rejuvenation for the gullible rich, though some may see it as the precursor to stem cell therapy. As shown in the figure below, many alternative medicine techniques are at their best, foolish and at their worst, downright dangerous.

Dietary practice is another area in which the overlap between mainstream and alternative medicine is blurred. Mainstream nutrition has paid much attention to the development of probiotics to alter gut flora and improve health. This stretches from the unsubstantiated belief by Nobel prizewinner, Elie Metchnikoff, at the start of the twentieth century, that eating yogurt prolonged life in persons living in Bulgaria. Cholesterol-lowering diets are clearly mainstream though often ineffective. This has led to the recent introduction of phytosterols (e.g., Corowise™) into the food market. Numerous dietary fads, ranging from the Atkins diet to the South Beach diet, have been introduced to combat obesity. These diets have been marketed successfully to the public with little or no evidence of efficacy. Caloric restric-
In modern times, classic textbooks are a rare find. However, the Third Edition of the Comprehensive Textbook of Geriatric Psychiatry is an instant classic. This outstanding, comprehensive book is a joy to read.

This text focuses on disorders (e.g., late-life affective disorders and dementia), interventions (e.g., psychotherapy and psychopharmacology) and service settings (e.g., geriatric assessment and nursing homes) that are particularly relevant to later life. The text also examines the changes of normal aging and differentiates those changes from the ones caused by illness. The differences in presentation of late life psychiatric illness from presentation earlier in life are stressed. This book also provides remarkable insights into the capacity to change with aging.

The book begins with a review of the history of geriatric psychiatry from early times, where they point out that attempts to treat dementia were found in the Edwin Smith Papyrus and the Magical Papyri. The first clinical description of depression in old age is found in the Bible, when it describes an aging King David as follows:

“Be gracious unto me, O Lord, for I am in distress; Mine eye wasted away with vexation, yea, my soul and my body. For my life is spent in sorrow, and my years in sighing; My strength faileth because of mine iniquity, and my bones are wasted away. Because of all mine adversaries I am become a reproach, yea… I am forgotten as a dead man out of mind; I am like useless vessel.”

- Psalm 31:9-12

In 1805, Benjamin Rush wrote the first treatise on geriatric psychiatry entitled “An Account of the State of the Body.” Geriatric Psychiatry in the United States was formalized in the 1950’s and early 1960s when Ewald Busse formed the program at Duke University and began the Duke Longitudinal Studies on Aging. From this program came outstanding geriatric psychiatrists such as Carl Eisdorfer, Eric Pfeiffer, Adrian Verwoerd, Dan Blazer, Burton Reifler, and Murray Raskind. Other early programs were founded by Paul McHugh at Cornell, Lissy F. Jarvik at UCLA, and George T. Grossberg at Saint Louis University.

The book is divided into five sections viz. The Aging Process, Principles of Evaluation, Psychiatric Disorders of the Elderly, Treatment and Medical-Legal Ethical and Financial Issues. The authors of the various chapters are a Who’s Who of Geriatric Psychiatry.

This encyclopedic coverage of geriatric mental health care should be on the bookshelves of all persons interested in the care of older persons.

**“Home” in the Nursing Home**

(continued from page 8)

It is our belief that the more persons in the facility, the better the quality of care. Therefore, nursing and other students from local colleges are welcomed in the facility to learn. Students in gerontology, therapy and social work provide enthusiasm and joy to the residents while we educate them on special needs of our residents. In addition, the tone for a stay in a nursing home is set on admission day. Thus, all new residents are escorted to their room by a member of the administrative staff who attempts to answer their questions. The room is neatly prepared and an admission bouquet is in the room. The resident mentor also visits on admission day. A separate time is set aside for a family orientation appointment on that day. Finally, the family is given complementary meals and encouraged to eat with the resident on the first day. A social history is obtained from each resident and this is used to match him or her with residents of similar interests.

Quality care in the nursing home requires carefully listening to resident preferences and providing variety and choices. The residents need to be continuously exposed to and interact with multiple members of the managerial staff. The administrator has to care about the residents and their preferences and must be available to family, residents, and partners to discuss them. This needs to occur during evenings and weekends, when most families visit, as well as during normal business hours. Rapid complaint resolution is a key to satisfaction. It is important to remember that family members are conflicted at placing a loved one in a nursing home and that this internal conflict often causes misunderstandings that must be addressed immediately. A resident’s or family’s satisfaction is often predicated on a single adverse event – we are only as good as our weakest partner. Caring for seniors in nursing homes is a major challenge, but is worth it for every radiant smile and “thank you” we receive.

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**Complementary Medicine**

(continued from page 20)

tion, which in rodents increases life, has been pushed into the mainstream because the National Institute of Aging conducted short-term studies on dietary restriction. This has been done despite the overwhelming evidence that in older persons, weight loss leads to death.

The final area of complementary medicine that deserves our attention is spirituality. Clearly this stretches from the television preachers healing persons by the laying on of hands to mainstream religion. Most studies suggest that religious persons live longer and function better. The belief in a hereafter can play a key in promoting a “good death.”

Overall, the lines between mainstream and alternative medicine are extraordinarily blurred. In general, physicians have done a poor job in recognizing the good in alternative practices. Alternative medicine adherents often wildly overdo a practice that could, at the minimum, do no harm. The minimal regulatory oversight of alternative medical practices opens this area to the extremes of fraud and abuse. Only carefully controlled evidence-based studies can determine which approaches are appropriate.
Upcoming CME Programs

Multi-Disciplinary Certificate Program in Geriatrics for Non-Physicians

- Thursdays, September 9 and 16, October 7 and 21, and November 4 and 18, 2004 in Tinley Park, Illinois
- Fridays, September 10 and 24, October 8 and 22, November 5 and 19, 2004 in Rolling Meadows, Illinois
Call 217-265-0876 for more details.

Multi-Disciplinary Certificate Program in Long Term Care

- Wednesdays, September 22, October 6 and 20, November 3 and 17, and December 1, 2004 in Oak Brook, Illinois
Call 217-265-0876 for more details.

University of the Third Age Conference

(no CME)
- November 6, 2004
- For more information, call 314-977-8848.

Cachexia in Aging and Cancer Conference

- December 4-5, 2004 in Chicago, Illinois
- For more information, go to http://www.ualberta.ca/~oncology

24th Annual GRECC Conference

Community Emergency Responses: Focus on Nursing Homes and Hospitals
- December 10, 2004
- Call 314-977-8848 for more details.

16th Annual Symposium for Medical Directors

Nursing Home Issues
- December 11, 2004
- Call 314-977-8848 for more details.

Saint Louis University Geriatric Academy

- January 10-14, 2005
- Call 314-977-8848 for more details.

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3rd International Meeting

Saint Louis University Geriatric Academy
- January 10-14, 2005
- Call 314-977-8848 for more details.

3rd International Academy on Nutrition and Aging
- May 6-8, 2005
- Call 314-977-8848 for more information.

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

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This newsletter is a publication of:
Division of Geriatric Medicine
Department of Internal Medicine
Saint Louis University School of Medicine
Geriatric Research, Education, and Clinical Center (GRECC)
St. Louis Veterans Affairs Medical Center
Gateway Geriatric Education Center of Missouri and Illinois (Gateway GEC)
(supported by a grant from the Bureau of Health Professions, Health Resources and Services Administration)

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Please fax the mailing label below along with your new address to 314-771-8575 so you won’t miss an issue! If you prefer, you may email us at agingsuccess@slu.edu. Be sure to type the address exactly as it appears.