What is Geriatrics?

“Senility is a state of physiological valetudinarianism. It requires special study, not as a pathological condition of maturity, but as an entity entirely apart from maturity.” I.L. Nascher

With the advent of the aging of the baby boomers, the field of geriatrics represents one of the most exciting in modern medicine. Geriatricians are physicians who focus on the care of the aging population. Unlike many other physicians who have a high proportion of older patients in their practice, geriatricians place a high premium on improving the function of older persons and not just on treating diseases as they occur. Geriatricians are also aware of new advances that occur in longevity research and in minimizing the ravages of aging. However, unlike the anti-aging industry, the geriatrician avoids offering a dizzying array of hormones and supplements, most of which are risky and of unproven benefit. Geriatricians are specialists who can work closely with primary care physicians to improve our quality of life as we age.

The term geriatrics was coined by Ignatz Nascher, a New York physician, in the early part of the twentieth century. At about the same time, the term gerontol- (continued on page 12)
This edition of Aging Successfully is dedicated to our aging population and the people who are and will continue to look after us. The baby boomer cohort has totally changed the face of America. We have moved from an era when women had little place outside the home, minorities were denied their dignity, and it was considered un-American to disagree with the majority viewpoints to “a far more open, inclusive, tolerant, and equal America” (as characterized by Leonard Steinholm in “The Greater Generation: In Defense of the Baby Boom Legacy”). In addition, advances in science have greatly improved our quality of life, including medical care. Yet at this time, we are faced with the stirrings of a return of “ageism” because of the demographic imperative. It seems that daily we are bombarded by the news media about the future problems facing Social Security and Medicare, and the costs of a rapid graying of the world’s population. As a cost-cutting measure at the end of 2005, Congress ended funding for education of health professionals involved in the care of older persons. The specter of the Beatles song I grew up singing is now becoming a frightening reality.

“Will you still need me, will you still feed me, when I’m sixty-four?”
-The Beatles, “When I’m Sixty-Four” 1967

It is time that we affirm once again the fact that our success is built upon the shoulders of the giants that went before us—we all owe a debt of gratitude to our older population. But more than this, they remain a vibrant component of our population with much to teach and give. We need to recognize and proclaim that ageism is as ugly as racism and sexism!

So, what are we to do? As pointed out by Robert Pirsig in his best-selling book, Zen and the Art of Motorcycle Maintenance “the places to improve the world is first in one’s own heart and head and hands, and then work outward from there.” Thus, each of us, young or old, needs to begin a crusade against ageism and to demand adequate funding for the care of all older persons.

In this issue of Aging Successfully, we have attempted to provide a perspective on why it is necessary to grow the field of geriatrics. In the section on geriatric stories, we have attempted to put a human face on the practice of eldercare and to highlight the joys of working with older persons. Hopefully, this will help recruit more of our best health care professionals into the exciting and expanding field of geriatrics.

In particular, I would like to call on those of us in our sixties and beyond to become outspoken advocates for the improved care we deserve and have earned. Too often, as we age, we worry more about the needs of our grandchildren and children at the expense of our own needs. The concept that old age will only be respected when we demand respect is not a new one. Many eons ago, in Ancient Rome, Cicero wrote, “Old age will only be respected if it fights for itself, maintains its rights, avoids dependence on anyone, and asserts control over its own to its last breath.”

John E. Morley
It has been said that a simple story is worth more than thousands of learned words. Thus, this section tells the stories of older persons who have impacted our geriatricians most. These are not stories of great cures, but rather of the human side of medicine that makes the practice of geriatrics so special.

She lay in bed, demurely sticking an ankle out of one side of the sheet, to show her wound. A large, glaring, red wound presented on the side of her calf. “It just appeared one day,” she explained. No trauma. No pressure. No diabetes. An otherwise healthy 93 year old. As I bent over to examine the stigmata, she anxiously questioned, “It’s been there for months; do you think you can fix it?” “Sure,” I replied, although I was not so sure. A very funny wound – peculiar location, peculiar history, no infection, good pulses. Turns out she was a dancer. And back in her day, well before skirts rose with the stock market, a well-turned ankle was a source of pride and the only part of the leg allowed to be demonstrated to the world.

That began a relationship extending well over a year. We tried (and exhausted) nearly everything I knew. The wound remained defiant. Biopsies negative. Exotic work-up non-revealing. Consults with anybody I could think of – all not very helpful. It was some type of vascular wound, but I couldn’t pinpoint it. An humbling expe-

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I met George soon after I started working at Des Peres Senior Services. George made the trip from southern Illinois with his wife and two daughters. His family described the experience, this not knowing. Yet slowly, almost imperceptibly, the wound got a little better, a little smaller, at each visit.

She was always delightful. Since I didn’t have much to say intellectually about the wound, we spent some of our time talking about life. Gradually, she reversed the roles. I stared rather blankly at the wound and she consoled me. “I know you’re doing the best that you can. It’s OK. It’s getting a little smaller,” she reassured.

Finally, she was forced to increase the pressure. “I promised to dance at my last grandchild’s wedding (a date still a little distant). “I can’t go to the wedding with this wound. Do you think we can heal it by then?” We worked hard. She learned to do the dressings and to reach her ankle (not an easy task for a 93 year old, living alone). She became conversant in a great number of advanced wound dressings. Gradually, we coaxed a thick sheen of epithelial tissue over the wound, only to maddeningly have pinpoints of new tissue damage. Her fragile skin tried, but we were up against a lot of wear and tear.

She taught me a lot: Pervasive optimism in the face of the unknown. The impact of a chronic wound on a body’s self-image. How to simply be pleasant in adverse circumstances. How often in medicine we simply don’t know.

She did heal in time for the wedding. She did dance without a dressing on that well-turned ankle. And, having accomplished her goal, she died a little while later in her sleep, of unrelated causes. I miss her.

David Thomas, MD

My story is about Miss CS, a 48 year old nursing home resident who was admitted to the facility in May of 2005. She has had Type I Diabetes Mellitus for the last 33 years which was complicated by chronic renal failure, severe gastroparesis.

Gradual memory loss and search for a good doctor. Naturally outgoing and happy, George had become withdrawn and anxious. His family was grieving and frightened of the future.

George’s family was in the room when I asked him to write a sentence for the mental test I was doing. He printed in all capital letters: I LOVE HER and pointed to his wife. There are no bonus points for sentence content, but these three words define George. He told us what is most important to him; what hasn’t changed in his life.

It has been two years since I first met George. Every time he comes to clinic with his family he grins and says “I love my wife!” His mood is happy. His family is coping well. Recently his written sentence was in neat cursive lettering: I think that I am in fairly good health.

Success stories in geriatrics are not high tech dramas, but instead lessons in adapting to difficult situations.

Kathy Marren, RN, GNP

Kathy Marren, RN, GNP

Faheem Ahmad, MD

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and peripheral vascular disease requiring a below-knee amputation. She also has hypertension. She had a renal transplant 12 years ago.

I received a phone call on 1/18/06 from the nursing home requesting a transfer of Miss CS to the ER for uncontrollable nausea and vomiting. Nursing home staff informed me that this would not be the first transfer to ER for these symptoms. On my appeal, the patient decided to stay in the facility and be seen by me instead of going to the ER. She had severe gastroparesis and she had uncontrollable symptoms. She could not be given metoclopramide because she experienced extra pyramidal symptoms in the form of whole body muscle cramps. She was on Phenergan, Ativan, Zofran®, and a scopolamine patch for nausea and vomiting. Other medications she was receiving were Norvasc®, Catapress® patch, Cardura®, Imuran®, Prednisone, MS Contin®, and Humalog® insulin. She was given IV Ativan and Phenergan after I saw her. Also, she was started on erythromycin 250mg orally twice a day as a promotility drug.

She had had 26 ER visits for nausea and vomiting in the last six months, most recently on 12/22/05. When I saw her the second time in the nursing home on 2/3/06, she was not vomiting anymore and her nausea was better. Since January 18, 2006, we have not received any phone calls complaining of nausea or vomiting. I feel this is one of my successes.

“Life is what happens when you’re busy making other plans.”

Joyce Cary

“Birth and death are the two noblest expressions of bravery.”

Kahlil Gibran

Throughout the ages, medicine has always been seen as the art/science devoted to the restoration of a human being’s health. From Hippocrates to modern 21st century robotic telemedicine, healing has been the highest accomplishment of medicine, but somewhere in the middle of the road this objective has become misguided. For example, often physicians forget to think about death as an inevitable step during the cycle of life.

Modern lifestyles present physicians with multiple opportunities to face many complex, chronic diseases. Some of these diseases occur simultaneously in a single patient, making the introduction of curative therapies more difficult or even impossible. Scenarios such as these remind us that medical interventions have their greatest value when applied towards improving quality of life.

An example of this was a 78 year old dentist who was initially admitted to the hospital because of moderate back pain. He later developed nausea and vomiting. Prior to being admitted to the hospital, this gentleman had visited other doctors because of his back pain, and had been treated with conventional analgesics for several months. The work-up done at the hospital revealed a malignant pancreatic tumor with external compression of the duodenum.

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From the first moment that I talked with him about this diagnosis and condition, it was evident to me that he was at peace with life, family, and himself. He gathered his family to notify them about his diagnosis and about what his wishes were in terms of treatment options. The patient decided against both surgery and chemotherapy. Then he asked me to do everything possible to keep him free of pain and nausea, in order to allow him to be able to enjoy food and soft drinks. He also requested to be surrounded by his family and relatives until the very last moment.

He seemed to be pleased and in some way happy about being able to spend his last days with family, sharing thoughts, memories, and getting ready for the next step. During one short week, he taught us that life and death walk together and also what life is all about. It was a lesson of wisdom and bravery.

Oscar A. Cepeda, MD

Geriatrics is not one of the subspecialties that we are exposed to in India during our medical school. It is a field of medicine that I have grown to like over a period of time since I was first exposed to it here in the United States. The more I have practiced it, the more I have learned from it – not just about medicine, but also a great deal about life.

One of the things that I have discovered is that geriatrics is actually less medicine and more caring. It has also allowed me to get a deeper insight into how life is at the other end of the spectrum. Numerous interactions with the elderly have been very interesting for me and it is amazing how all these wonderful interactions leave me with indelible memories.

I had a patient who was 93 years old who had all the usual multitude of diseases, but mentally, she was very sound. She was wheelchair bound. I was a relatively new doctor to her and she had immense faith in her cardiologist who had followed her for a number of years prior. Every time she had chest pain, she wanted to go to her cardiologist as rapidly as possible for a check-up. The daughter would go to her mother in the nursing home no matter what she was doing or where she was, or what time of the day or night it was, in order to help her mother get to the hospital. Each time, I would discuss with her the risk and benefits of the hospitalization and she would say, “Doctor, I prefer to go to the hospital where my cardiologist is and see what is going on; I am terrified I am going to die.”

This happened three or four times after I took over her care as a primary care doctor – she would choose to be rushed from the nursing home to the hospital to see her cardiologist. She would then get some treatment, procedure, or test and come back to the nursing home exhausted. Although she would hurry to the hospital, she hated to stay there. She wanted to come back “home” (to the nursing home) as soon as she could. Nursing home staff had informed me that this had been the sequence of events for the last year or so prior to my becoming her primary care doctor.

Eventually, upon returning from her third or fourth trip in a span of eight months or so, she spoke in frustration with her weary voice: “Why am I alive? Why does God want me to go on and on despite all these medical problems? I don’t walk. I need help with almost everything I want to do. I am such a burden on others. Why does HE want me to go on? Why do I have to live? I really don’t want to go to the hospital this often.”

When I entered her room to check on her, I truly had not expected her to ask me such questions. She had impacted my life so much: Her daughter’s love...
HE HAS A PURPOSE – AS I SEE IT, YOU ARE THE SOURCE OF IMMENSE HAPPINESS FOR YOUR FAMILY.

of her mother was extraordinary. Her grandchildren loved her too, visited her often, and enjoyed her company very much. And I know God sees a purpose in everything that we observe.

So I replied to her “I am absolutely sure He has a purpose in keeping you alive no matter how you are. You may feel you are causing your children a lot of work and that you are a burden. However, to them, taking care of you is an opportunity to pay back for the love and affection you unconditionally showered on them while they were young. You are no more a burden to them than they were for you when they were growing up. The needs are quite similar. You are a wonderful source of happiness for them, a joy that your children and grandchildren come to experience even if you are not able to walk or do things for them except just be here. I don’t think He wants to take that away soon. Perhaps you might want to discuss with your family whether or not you actually want to pursue curative intent whenever you have chest pain versus comfort intent, especially since we do not seem to be achieving much with these burdensome trips to the hospital. We can optimize your medicine here and keep you pain free. You do not have to go to the hospital if you do not choose to and you can change your mind anytime you wish to. But remember, if He wants you to go on, He has a purpose – as I see it, you are the source of immense happiness for your family. You are still able to smile wonderfully and speak your mind clearly. It matters less if you cannot walk. You should go on.”

Three years later, she has had no further hospitalizations and the family has never seen her more pain free, more happy, and most importantly, more active. The guilt has gone. Purpose was found and conflicts were relieved. She taught me something for sure!

Devaraj Munikrishnappa, MD

In its intricate and mysterious ways, life gives us opportunities to grow and experience its fullest joys. I ask you to come up with an answer to this question. Please think carefully. If you are about to lose your vision and you had just a few minutes before you were about to lose your ability to see, what would be the last thing you would want to see? What have you cherished and loved so much that you would want it to be the last thing you remembered seeing?

I took care of an elderly patient four years ago who had been blind for the last 15 years. She was 72 years old. She had lost vision in her left eye as a child due to a traumatic eye injury and had a glass eye. She had been used to that all her life. Subsequently, she began to lose vision in the right eye and eventually, she lost all of her eyesight. Yet, she didn’t allow her disability to overcome her joy for life. She continued with her life because life had to continue.

When I first met her, I saw a sad woman with a small smile, hopeless, because she needed a doctor to tell her why her belly was getting bigger. I saw innocence on her face like a baby smiling at you. Her blood pressure was very elevated. She felt helpless because she couldn’t afford to pay for her medication. She had no insurance. She (continued on page 8)
was worried that a stroke or cancer might afflict her. In desperation, she turned to her Savior, and prayed that someone could help her.

While examining her, I noticed that she had a cataract in her right eye. I told her that the cataract could be removed. She was confused. She couldn’t afford to pay for the surgery. Here was her chance to be able to see again, yet there was no hope. I gave her samples to treat her blood pressure and referred her to an ophthalmologist at a local hospital that took care of uninsured patients.

She proceeded to have the cataract removed and subsequently returned to see me in the clinic. I have not forgotten the expression on her face when she first saw me. Her ability to see again was a true miracle. She wanted to see me, her doctor, and what I looked like when I smiled or when I was happy. She made me feel special and thanked me for what I had done.

The simple things in life, the “I love you,” the “thank you,” the “I miss you,” are all part of what we don’t do enough of in life.

*Rafi Kevorkian, MD*

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In the ten years that my father lived with me, he went to the emergency room (ER) at least once a year. Usually, he went because he was in cardiac distress, but the most memorable visits for me, even six years later, were the two ER visits he made because of falls.

Dad kept in good physical shape by walking 3 to 5 miles around the neighborhood every day. Then he fell on an ice patch at the end of the driveway. His son, John, who was caring for him while I was away, took him to the ER where Dad got his cuts glued together with Superglue. Once I returned home and heard the story, I bemoaned the fact that my brother got to have all the excitement and I actually voiced the wish that I had been able to see him glue Dad back together again.

Exactly one month later, I came home from work to find Dad standing in the kitchen with the lights off. I turned on the lights and saw that Dad’s face was covered with blood.

A quick call to the doctor’s office got me the assurance from the office staff that the doctor would call me right back to give me permission to take Dad to the ER. Twenty minutes later, when I called again, the office was closed and I was informed by the answering service that Dad’s doctor was no longer available.

Quickly deciding that I would pay for the ER visit myself because I could not get prior approval, I drove Dad to the hospital. I was so worried about Dad that I did not have any inkling that I was about to have even greater problems to worry about. When Dad walked into the ER, the admitting nurse greeted him by name. She had remembered him from his previous visit the month before.

The next thing I knew, I was looking at a police badge on the chest of the biggest State policeman I had ever seen. He was not mean, but he was not nice either. He asked Dad what happened. Dad told him to ask me. (Dad’s dementia was advanced enough that he always expected me to speak for him whenever he sought medical attention.) The policeman insisted on hearing the story from Dad so now I had to calm Dad down, all the while knowing I might soon be charged with elder abuse.

Two things finally worked in my favor. First, Dad’s dementia was not so far advanced that he couldn’t be coaxed into telling the policeman how he had tripped over a tree limb that had fallen across the sidewalk. I just needed to get him reassured and into his story-telling mode, a natural state for many World War II veterans. Second, the physician who examined Dad had attended Saint Louis University as a student and he had heard plenty on the special *(continued on page 9)*
Mr. M., a 69 year old man, arrived late one morning at the Geriatric Medicine Evaluation Clinic for a new patient appointment. “I don’t think our room is big enough,” the nurse noted. Mr. M. had arrived on a stretcher via an ambulance. He was too debilitated to transfer into a car and had no other means of transportation. He had not been out of his bed in over 6 months due to severe rheumatoid arthritis which had left most of his joints deformed and useless. He shared his home with his sister who was his caregiver and accompanied him to all doctor visits. “They said there was nothing else that could be done,” she reported to me. Mr. M. lay in pain on the stretcher. His joints were swollen and tender. Despite his physical limitations, he was mentally alert, pleasant, and most importantly, he wanted to get better. Mr. M. and his sister had only one expectation at this visit: that we could do “something” to help him feel better. Having been away from medical care for so long, there were many things that could be done for him.

With tears of gratitude, Mr. M. agreed to an immediate admission to the hospital in the Geriatric Evaluation and Management Unit. He was about to embark on a long and difficult path of rehabilitation. Pain medications allowed him to be comfortable enough to participate in therapy sessions. Splints and braces allowed him to have function of his arms and hands. New drugs controlled the inflammation of his arthritis. His physicians uncovered and treated a new medical problem, myasthenia gravis, which had contributed to his fatigue and weakness. Mr. M. was determined to get better and worked diligently with the multidisciplinary team. Although it took months of effort, Mr. M. made slow but steady progress. He began to feed himself and then dress. He became strong enough to sit in a chair for most of the day. At the time of discharge from the rehabilitation unit, he could transfer from the bed to a chair with only minor assistance. The next time Mr. M. came to the outpatient clinic, he arrived self-propelled in an electric wheelchair. He had purchased a handicap-equipped van with a specialized steering wheel and drove himself to the appointment. The change in his life was a miracle, medical needs of the demented elderly. He quickly confirmed that Dad was demented, that he was in shock from the blood loss from the cut over his eye, and that there was no other evidence that Dad was in any way abused. He left Dad with the nurse and came to rescue me, assuring the policeman that Dad had indeed had an accident and that he could go home with me without further risk.

As a caregiver caught between medicine, the law, and my father’s illness, sometimes it felt like the world was against me. Having a geriatrics-trained physician sure made a positive difference in my life that night.

Nina Tumosa, PhD

Julie Gammack, MD
“Hey Doc! What has two thumbs, speaks French, and loves sex?” Before I could even introduce myself, the energetic 84-year-old man bellowed “Moi!” pointing to himself with both thumbs. Such was my initial encounter with Mr. James who presented to the primary care clinic for the first time, after his 103-year-old mother insisted he take better care of himself. “I guess I’m here to make sure all my parts are working well.”

During the ensuing assessment, it quickly became apparent that Mr. James broke every rule of healthy living. “I have been smoking since I was 19, though I am down to 2 or 3 cigarettes a day,” the latter part of his statement intended to quiesce any reaction from me. “You are not going to ask me to quit smoking now?” he said, more with the intonation of a statement than a question.

Regarding nutrition, he followed a simple diet - “If you can fry it, I’ll eat it.” A typical breakfast consisted of fried eggs with bacon and sausages topped with fried scrapple, and four cups of coffee.

“Do you know what scrapple is, Doc?” Without waiting for a reply, he enthusiastically went on to explain “It is all the unusable parts left over from a butchered pig made into a mush; that includes the head, hoofs, snout … mmm, best thing I have ever had.”

Mr. James took no medications, not due to the lack of effort of physicians at rare previous encounters. He had been issued various prescriptions during his adult life for various conditions, including a serum cholesterol level of over 300 mg/dL, but he never filled any of them.

“Do you at least get some regular exercise or physical activity?” I asked, starting to lose hope of imparting any healthy habits on this decidedly engaged man. “I walk two miles a day, most days of the week” he replied. I was about to infuse a few words of encouragement and support into the conversation at that point when he continued “It’s the quickest way of getting to the liquor store.”

Despite the lack of routine medical care, or perhaps because of it, Mr. James had no serious health problems to speak of and appeared to be in excellent condition. His only complaint was of occasional joint pain. When asked if Tylenol eases the pain he gave me a feigned look of horror and said, “I never touch these things Doc; these things could kill you. They say you should never mix medications with alcohol.” Mr. James was like the man who read so much about the harmful effects of smoking that he finally quit reading.

Mr. James taught me a valuable lesson, best learned early. Against the assault of lifestyle decisions and preventive health care measures, genetic factors exert a great influence on health outcome. Modifiable risk factors must certainly be addressed, but by old age, one’s genetic makeup has determined the impact that risk factors will have on overall health. Despite less than optimal preventive care and a lifetime of poor health habits, Mr. James survived into old age without any discernable disease, as had his mother.

No intervention was necessary at that point, and Mr. James knew it.

Mr. James laughs aloud and often. He entertains the clinic staff and himself with his humor and enthusiasm. He often brings gifts to the clinic staff – chocolate for the nurses, scrapple for me. “The secret to doing well” he once told me, “is this,” and he pulled a well-worn Bible from his vest pocket. He uses an ABC liquor discount card for a book mark.

Mr. James was recently seen in clinic for a check-up prior to leaving to Hawaii to celebrate his 87th birthday. His goal is a similar trip for his 90th birthday. Before he left the clinic, I mentioned that we all hoped to be able to celebrate his 90th birthday and see the pictures of that trip. He took a quick glance at me from head to toe and replied, “Lose a few pounds around the waist, Doc, and I don’t see why you won’t make it.”

That evening, I jogged an extra mile beyond my routine.

Ramzi Hajjar, MD
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While you’re there, check out the screening tools, links to other useful sites, and information about our upcoming conferences.

SERVICES
Services of the Division of Geriatric Medicine at Saint Louis University Medical 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
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- Rheumatology
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ogy, which refers to the study of aging, was created by the Nobel prize winner, Elie Metchnikoff. It has been suggested that geratology is a more appropriate term to describe the study of aging individuals.

As already pointed out, geriatrics focuses on the maintenance of function. Function at its simplest level is the ability to get in and out of bed, wash, dress, feed, and toilet oneself. Dr. David Thomas and his colleagues at Saint Louis University showed that the absence of the ability to perform any of these very simple tasks was highly predictive as to whether an older person will die in the hospital or go to the nursing home (1). At the next highest level of function is the ability of a person to shop, prepare meals, look after personal finances, take medications, and use the telephone. It is a combination of these two sets of functions that determines the ability of a person to live at home without help.

There are many causes of declining function in old age, but in general, these can be divided into four major areas, namely cognitive problems, frailty, nutritional problems, and iatrogenesis (See graphic). All of these occur on a backdrop of inadequate social support.

The I’s of Geriatrics

Bernard Isaacs, a British geriatrician, created the concept of the Giants of Geriatrics. These are a set of conditions that are common and treatable in older persons and often poorly treated by general physicians. These conditions are also known as the I’s of Geriatrics and have been expanded from the original four to ten.

The common cognitive problems associated with aging are delirium, dementia, and depression. All of these are commonly missed by both family members and physicians. In a study of African Americans, we showed that the majority of elderly persons with depression were not being treated (2). Depression is a highly treatable condition and its presence is associated with poor outcomes in persons suffering from a myocardial infarction. It is also associated with poor rehabilitation outcomes. Delirium has multiple treatable causes (see DELIRIUMS mnemonic on page 13) and,

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when appropriately treated, as has been done at our hospitals with the creation of a 4-bed Delirium Unit directed by a geriatrician, has excellent outcomes (3).

Frailty occurs as age-related physiological decline interacts with disease to place the older person at risk of functional decline when exposed to an additional stress. Frailty has a number of causes (see figure above) including decline in executive function, visual problems, nutritional problems, polypharmacy, balance problems, many diseases (such as anemia - See Aging Successfully, Vol. XVI, No. 2), congestive heart failure, diabetes, osteoporosis (fractures), sarcopenia (age-related loss of muscle mass), decline in endurance (\(V_O^2\) max), and pain resulting in limitation of mobility.

Weight loss in older persons is a serious concern. There are five major causes of weight loss in older persons – protein energy undernutrition, dehydration, malabsorption, sarcopenia, and cachexia. Older persons develop a physiological anorexia of aging which places them at risk for developing severe anorexia when they become sick (4). The major reversible cause of anorexia in older persons is depression. The reversible causes of weight loss are easily remembered by the mnemonic MEALS-ON-WHEELS (see page 15).

The thirst drive often functions poorly as we age, placing older persons at major risk for developing dehydration. Older persons need at least 4 to 8 glasses of fluid each day. Vitamin deficiencies, caused by malabsorption, have been associated with the development of cognitive impairment (see Aging Successfully Vol. XIV No. 1). All older persons need a calcium and vitamin D supplement to prevent osteoporosis and hip fractures.

Unfortunately, iatrogenesis is extremely common as we age. All too often, an older patient has a Foley catheter inserted into the bladder during hospitalization and it is left in place when s/he returns home. This is a major cause of urinary tract infection, septicemia, and death in older persons. Foley catheters also represent a one-point restraint, hindering mobility in older persons. The available evidence suggests that physical restraints, which are still widely used in hospitals, increase injuries and can be associated with death. Nevertheless, this form of elder abuse remains in common practice.

Older persons are commonly allowed to languish in bed developing contractures and impaired mobility. The development of Acute Care for Elderly (ACE) Units is beginning to reverse this trend. The altered metabolism of drugs that occurs with aging can lead to older persons receiving too high...
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a dose of a drug. Older persons also tend to take large numbers of medications (polypharmacy), increasing the opportunity for drug-drug interactions. The appropriate management of medications in an older person is a cornerstone of the geriatric approach.

Geriatrics is an interdisciplinary field. This field recognizes and places high value on the skills of all health professionals. Because of the multiple problems that many older persons have, there is a need for more time to fully address their needs and this is more efficiently done in an interdisciplinary team setting. Teamwork has been proven to enhance the medical outcomes of the older person.

The efficaciousness of the geriatric assessment and management approach has been demonstrated in multiple studies and summarized in a meta-analysis (5). Very few medical subspecialties have as much data demonstrating their effectiveness as does geriatrics.

As geriatrics moves into the 21st century, geriatricians are taking on new roles. While geriatrics is classically a “high touch” field, geriatricians are also keeping abreast of the remarkable achievements in assistive devices and prostheses being developed. An example of this is the development of the “smart houses” that allow older persons to live longer (continued on page 15)
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at home alone. Geriatricians are also becoming experts on “anti-
aging” approaches and are among the best persons to ask about
whether these are “hype” or reality. Unfortunately, much of the
time, the answer will be that these are unproven, and unlikely to be
proven, approaches. However, following an appropriate preventive
and health promotion program as outlined in Aging Successfully,
Vol. XI, No. 1, will not only add life to your years, but most prob-
ably, also add years to your life.

WHEN SHOULD A GERIATRICIAN BE CONSULTED?

Certainly whenever a person over 70 years of age is deteriorating
either functionally or cognitively, s/he should be referred for a full
geriatric assessment to see if some simple interventions can reverse
or slow the process. Sometime at or near retirement, it is useful
to see a geriatrician to check that there are no early problems and to
discuss an individualized health promotion plan. Any older person
on more than seven medications should have a consultation with a geriatric
team. Older persons with memory problems often benefit from consultation with a geriatrician. It could be argued that all persons 70 years and older should have a geriatric consult at least once every five years.

Whether or not one should choose a geriatrician as one’s pri-
mary physician depends on the person. Very frail older persons often benefit by having a geriatrician as their primary care physician. In nurs-
ing homes, geriatricians and certified medical directors (CMD-AMDA)
appear to be more likely to provide state-of-the-art long term care.
Many geriatricians are experts in continuous quality improvement, making them ideal medical directors of nursing homes. Finally, many older persons find that geriatricians are kinder and gentler phys-
sicians who give them the time they need to discuss their concerns.
This discovery may well lead to a geriatrician becoming their primary care physician of choice. However, it needs to be stressed that the majority of older persons are best managed by primary care physicians who utilize the geriatrician as a consultant. When choosing a primary care

CONCLUSION

With the advent of the baby boomers, geriatrics is a field that will grow in stature. The geriatric team represents an important

MEALS ON WHEELS mnemonic
Common Causes of Malnutrition in Older Persons

- **M**edications
- **E**motion (i.e., depression)
- **A**noxia (nervosa or tardive)
- **L**ate-life paranoia or alcoholism
- **W**allowing disorders
- **O**ral factors
- **N**o money
- **W**andering and other dementia-related behaviors
- **H**yperthyroidism/hyperparathyroidism
- **E**ntery problems/malabsorption
- **E**ating problems
- **L**ow-salt or low-cholesterol diet
- **H**opping and food prep problems

1) Digoxin, theophylline, psychotropic drugs
2) Severe tremor, stroke, weakness

REFERENCES


The first Journal of Gerontology dates back to January 1946.
A Brief History

“History is the high point of advantage from which alone men can see the age in which they are living.”
-G.K. Chesterton

Origins of Elder Care: Ancient India

“abhivAdan shilasya nitya-vridh-upsevinah, chatvAtri tasya vrdhante Ayur-vidya-yasho-balam.”

“One who salutes and serves the elders, will get these four- long life, knowledge, fame and strength.”

Origins of Elder Care: Ancient Egypt

Edwin Smith Papyrus
1600 BC
The book for the transformation of an old man and a youth

Origins of Elder Care: Classical Times

“Man does not die. He kills himself.”
Seneca

“Old age is cold and dry.”
Galen

The Secrets to Longevity

Roger Bacon (c. 1214-1294)

- Controlled diet
- Proper rest
- Exercise
- Moderation in lifestyle
- Good hygiene
- Inhaling the breath of a young virgin

More Secrets to Longevity

The sins of the father are visited even unto the third generation.
Avoid alcohol, tobacco, tea, and coffee.
Clear the bowels every day.
Moderation of diet: little meat, much milk and vegetables.
Sound sleep.
Fight against our passions.
Cultivate hygiene of the mind (equanimity).
Exercise.

Nicholas of Cusa
Compared weight of blood and urine in young and old, healthy and sick.

Early nursing home in Holland

Old Age Deferred
Arnold Lorand, MD
Austria, 1910

Edwin Smith Papyrus
1600 BC
The book for the transformation of an old man and a youth
A Brief History of Geriatrics

“History is the high point of advantage from which alone men can see the age in which they are living.”
-G.K. Chesterton

The Father of Geriatrics
Ignatz Nascher
1863-1929

“Geriatrics, from geras, old age, and iatremics, relating to the physician, is a term I would suggest as an addition to our vocabulary, to cover the same field that is covered in old age that is covered by the term pediatrics in childhood, to emphasize the necessity of considering senility and its disease apart from maturity and to assign it a separate place in medicine.”

Geriatric “Greats”

E.V. Cowdry
1888-1975
Founder of modern geriatrics in the USA

Marjory Warren
1897-1960
“The Mother of Geriatrics”

Dietary Restriction

“Against the diseases known, the strongest fence is the defensive virtue - abstinence.”
-Benjamin Franklin

Louis Cornaro
1464-1566
“to eat only enough to sustain life”

Roy Walford, a modern proponent of dietary restriction.

The Cure for Parkinsons
A Nursing Home Success Story

Oleh Hornykiewicz gave L-dopa to Parkinson’s patients for the first time at the Lainz Nursing Home in Austria.

Other Anti-Aging Theories

“Good, Bad, and Ugly”

1889
Brown-Sequard Testicular extracts

1957
Denham Harman Free-radical theory

1969
Ana Aslan “Gerovital” anti-aging compound

1969
Paul Niehans Cellular therapy

1989
Elie Metchnikoff Bacterial toxins and invented Gerontology

Recent Developments

National Institute of Aging (NIA) 1974
www.nia.nih.gov

Dr. Les Libow
First Geriatric Fellowship, 1966

First GRECC, 1976

Geriatrics at Saint Louis University
Drs. Grossberg, Morley, and Coe
Geriatric Medicine, 1989
Occasionally, a coffee-table book of such beauty and soul comes along that one knows one will cherish it throughout his/her life. Pat Thane’s “A History of Old Age” is such a book. This book is incredibly illustrated (as shown by the pictures on this page). It brings home the beauty in older people as illustrated by examples of statues and paintings throughout the ages.

Among my favorites is Hyacinthe Rigaud’s double portrait of his mother, Marie Serre, which was painted in 1695. Another is the plate of the self-portraits by Leonardo da Vinci (1510, age 58), Titan (1562, in his 80s), Tintoretto (1589, aged about 70), and Lucas Cranach (1550, aged 77). The wonderful photographs of the sculptures of older Romans and Greeks, such as Homer and Seneca, are riveting. I particularly enjoyed the statue of the old shepherdess carrying a lamb as she seemed to walk out of the page, epitomizing the dignity of a person who has worked hard all her life.

I was struck by the drawing of the lavish 17th century “poorhouse” for old men and women in Amsterdam. Its gardens were a clear portend of the modern “Eden Alternative” concept. As a grandparent, I enjoyed the many portraits of grandparents with their grandchildren.

Self-portraits by women artists as they aged are particularly striking. For example, one must admire the incredible delineation of the aging process as shown in the self-portrait by Sofonisba Anguissola at age 78. Another beautiful example is the self-portrait by the German painter, Anna Dorothea Therbusch when she became a member of the French Academy.

From the twentieth century (1954) comes a delightful cartoon of the “ages of man” by Saul Steinberg. This shows the growth of man from infant through Boy Scout, college graduate, businessman, tycoon, to retirement on a beach in Florida.

The text of the book pales in comparison to the illustrations. It does, however, try to illustrate both the positives and the negatives of the aging process. It is peppered with historical quotes about aging. A few errors stand out, perhaps most prominently the continuation of the myth that Georgians (at that time, a part of Russia) lived for incredibly long times. Despite these occasional lapses, I have no hesitation in recommending this book to all of us who are either aging or care about the aging process.
Cochlear Implants in the Elderly: When Hearing Aids are Not Enough

by Stanton Jones, AuD, F-AAA

Hearing loss is one of those ailments with which the elderly have to contend on a daily basis. It is one of those complaints that affects every communication effort that the individual makes in a day, whether it be listening to a loved one, making a phone call, conversing with the teller at the bank, or trying to relax and listen to music or the television. More than 45% of adults over 60 years of age have hearing loss. New digital hearing aid technology can be useful while there is still enough usable hearing. But for many, even hearing aids are not enough to enable them to maintain adequate communication with their families or to continue to actively participate in their hobbies and everyday activities. This often leads to depression and withdrawal from social environments.

The advent of cochlear implants in the 1980’s has opened up a new world for many elderly who had lost the ability to hear. Even with the best hearing aids available, many patients are only able to hear sounds around them but cannot understand speech. This is not due to the inferior quality of the hearing aid, but is due to the inability of the inner ear (cochlea) to process complex sounds like speech. The loss of hair cells in the cochlea causes patients to lose the volume of speech. More importantly though is the loss of clarity that is experienced. The best hearing aid in the world could never compensate for the loss of these anatomical structures.

Cochlear implants are often able to restore a patient’s ability to understand speech. A cochlear implant consists of two parts. The first is a small electrode that is surgically implanted into the inner ear or cochlea, where the malfunctioning hair cells are situated. The electrode replaces the function of the hair cells, which is to stimulate the primary neurons of the auditory nerve. The second is an external speech processor that collects sound/speech from the environment and transmits it to the internal electrode, which in turn stimulates the auditory nerve.

Cochlear implant candidates are put through a series of medical and audiological investigations. This is to be sure that the (continued on page 20)
patient will benefit from this implantable device. If the patient meets the criteria for an implant, the chances of him/her being a successful user of the implant will be high. The assessment includes a series of hearing tests specifically designed for establishing candidacy. The patient is then seen by the otolaryngologist who will refer him/her for a CT scan. The purpose of this is to make sure that the cochlea is patent and able to accept an electrode. It also highlights anatomical landmarks used during the surgery. Patients are counseled extensively about expectations and fears.

The surgery is usually scheduled as outpatient or overnight. Two weeks after the surgery, the patient returns to the audiologist’s office to program or map the external processor. At the end of the session, the processor is switched on and speech is heard for the first time. For many this is a very emotional experience, and

This woman carries on a normal conversation with friends thanks to the cochlear implant device.

then seen by the otolaryngologist who will refer him/her for a CT scan. The purpose of this

family and friends are encouraged to attend this momentous occasion.

Depending on the duration and severity of the hearing loss, as well as a number of other factors, many patients leave the first session with the ability to hear and recognize some words or familiar sounds. Over the next few days and weeks, the implant stimulates the auditory nerve, which adapts to the implant. Adaptation of the nerve, together with aural rehabilitation, leads the patient to the best hearing that they can achieve. This level of functioning differs from one person to the next. Many people end up being able to speak on the phone, listen to television and participate in conversation that hearing aids would not have been able to facilitate. The other end of the spectrum is that the patient may be able to hear sounds at a normal volume as they did before their hearing deteriorated, but those sounds may not be clear. The majority of patients fall in the middle of this spectrum and are able to enjoy a lot more hearing and communication than their hearing aids could provide.

Cochlear implants do NOT give back normal hearing. Technology provides us with a tool to restore a measure of communication back to the patient that (s)he would not have if (s)he did not have an implant.

The Saint Louis University Department of Otolaryngology has a vibrant, up-and-coming cochlear implant program with audiologists and surgeons who specialize in cochlear implants. They have many years of experience between them and have had very high success rates within the geriatric population. If you are interested in more information, please contact me, Stanton Jones – Cochlear Implant Program Coordinator at (314) 977-2945. My e-mail address is sjones50@slu.edu.
Journey to China: Finding the Frail Elderly
by Joseph H. Flaherty, MD

All visitors to China will agree on one thing: it is crowded. One can only surmise the consequences, both positive and negative, this will have on its population of older people. Of the 1.3 billion people who live here, 10% are over the age of 60 years, about four times the number in the US.\textsuperscript{1,2,3} In less than 25 years, this number is expected to be 336 million, larger than the total current population of the United States.

In Beijing, it is common to find stereotypical older persons doing Tai Chi in the parks in the mornings, or playing Chinese chess or mahjong in the afternoon. Many older Chinese people can also be seen working hard jobs, or caring for their grandchildren.

But what about older people who are less functional, who need assistance with their “ADLs” (Activities of Daily Living - dressing, toileting, eating, transferring, and washing)? What about the “frail” elderly, the elderly with several chronic diseases, who require care typically seen in US nursing homes and hospitals? Although occasionally one can spot them out among the crowds, even in the middle of traffic (see photo on page 23), the observation that this group is much less visible than in the US makes one wonder: Is it that the population of frail older people in China are cared for in their home by their family and not in hospitals or nursing homes? Is it that life expectancy in China (72 years) is still below an age that might be associated with an increased risk of diseases or syndromes leading to frailty? Or is it that older Chinese maintain their health somehow to prevent the occurrence of frailty?

No matter which explanation or combination of explanations one chooses, it is clear, that in the future, (continued on page 23)
The James Flood Memorial Lecture will be given by Dr. Claudio Soto on June 6, during the 2006 Saint Louis University Summer Geriatric Institute. Dr. Soto is Professor in the Department of Neurology and Professor and Director, Mitchell Center for Alzheimer’s Disease Research at the University of Texas Medical Branch in Galveston, Texas. The title of his presentation is “Therapeutic Strategies in Alzheimer’s Disease”

The Max K. Horwitt Memorial Lecture will also be given during the Summer Institute. This lecture will be given by Dr. Connie Bales on June 7. Dr. Bales is the Associate Director for Education and Evaluation, GRECC, Durham VA Medical Center and Associate Research Professor of Medicine, and Senior Fellow at the Center for the Study of Aging, Duke University Medical Center. She will present “Nutrition for a Healthy Old Age: The Benefits and Risks of “Health-Promoting” Diets and Supplements.

To register to attend the 2006 Saint Louis University Summer Geriatric Institute, please visit http://aging.slu.edu. Click on the Summer Institute graphic on the left. Then click on the link to open the brochure. The registration form is on page 16 of the brochure.

SLU’s Geriatrics Ranks High

In it’s “Best Graduate Schools 2007” issue, U.S. News & World Report gave the geriatrics program in the Saint Louis University School of Medicine a ranking of 12th in the United States.

Donations and Bequests

The Geriatric Medicine Education and Research Fund at Saint Louis University School of Medicine welcomes contributions to further geriatric research, education, and training. If you wish to make a donation in honor of an individual, indicate this in your correspondence. An appropriate acknowledgment will be sent to the honoree or family in your name. Contributions are tax-deductible.

Donations and bequests should be directed to:

The Geriatric Education and Research Fund
Division of Geriatric Medicine
Saint Louis University School of Medicine
1402 South Grand Boulevard, Room M238
St. Louis, MO 63104
China will face increased challenges associated with an aging population, of which frailty, no matter how small a fraction, will need special attention.

The following story introduces an important aspect of aging in China: is China ready for the inevitable increase in frail elderly with chronic conditions? Future articles in Aging Successfully, based on my observations, experiences, data collection, and interviews of health care workers from October 2005 through March 2006, at four hospitals in Beijing will examine other issues such as: how China’s demographics, including the implications of the one-child policy, may impact the elderly; how rural and urban populations differ; the state of geriatrics at four hospitals in Beijing; hospitalization and hospital care, outpatient care and nursing home care; paying for health care; and education of physicians.

During lunch one day, I asked one of the residents if we could go to see a patient, Mrs. Li, together. I had already seen the patient with Dr. Ding (the attending) in the morning, but was interested in learning more about this older person because she seemed like one of our sicker patients that I might see on the ACE (Acute Care of the Elderly) Unit at Saint Louis University Hospital or Des Peres Hospital in St. Louis.

My initial intention was not to test the resident, but as I delved more into the history, my curiosity about the resident’s knowledge and attitudes toward the patient’s care grew. This resident is halfway through her residency, and has two years to go.

When we returned to the doctor’s room after lunch, I asked the resident if she knew the patient. “She’s always been here, …we all know her.” Mrs. Li had been in the hospital almost three months.

She did indeed know the patient because the residents divide the patients up much like we do in the US, each ‘carrying’ about 6 patients. Each of the four residents ‘cross cover’ for all the patients much like our residents do in the ICU, especially during their every-fourth-night call.

The patient was admitted with cough and fever of 39.3°C, and the chest X-ray showed an infiltrate. I found out from Dr. Ding earlier that the patient was diagnosed with aspiration pneumonia, not community-acquired pneumonia. The patient had been receiving (and continues to receive) tube feeding through what looks like our Dobhoff-style nasogastric tube for about a year. “She has many other diagnoses,” the resident told me...
went on. I waited to see which ones the resident would decide to tell me about. “She has coronary artery disease.” Pause, as another resident entered the room and added, “Oh yes, Mrs. Li. She also had upper intestinal bleed…. upper GI bleed.” Back to the first resident, “and pneumonia many times before.”

“What else?” I probed.

Silence. So I prompted, “I heard that she has (and I pulled out my cheat sheet of geriatric syndromes translated into Chinese) chi dai, ….dementia?”

“Uh...yes, she has had for four years.”

“Why does she have the catheter, the Foley catheter?”

The resident smiled, remembering my lecture from a week and a half ago. “She always has that.” There it was again, the word, “always.”

I did not pursue the temporal issue today, but I did ask the ‘why’ question. With a bit of an uncomfortable look, as if she was looking for an answer that would make sense, but not necessarily the actual reason, the resident responded, “Because she has a problem with urine.”

“I mean, did she live at home?” I asked.

Appearing a bit puzzled either at my English or that I had asked the question, she looked at the other resident who answered, “Yes, from her home.”

I pushed on. “Whom did she live with?”

The first resident was now feeling a bit more comfortable that she didn’t know all the answers, so in a question-like response, looking up again at the second resident, said “maybe husband?”

“No,” came the second resident’s answer, “her son… but I have not seen him the whole time.”

More information was on the way as I asked, “Can we go see the patient?”

“Sure.”

At the bedside, a caregiver who one would typically assume was a daughter, jumped up out of the chair as we entered the room.

(continued on page 25)
She was happy to see us, and gave us many compliments.

Earlier Dr. Ding had said that the patient “could not see or hear.” But later in our conversation, the caregiver said that when she does wake up at certain times, she understands better, and she proceeded to yell in the patient’s left ear, and did get the patient to rouse a bit. Apparently, she could hear up until about a month ago. I said, “I wonder why only a month ago?” but I don’t think the resident understood my English.

Who was this older lady, I kept wondering, so I asked, “does she have a husband?”

“MEI-you, MEI-you,” said the woman caregiver.

There are two very important words to know in Chinese, both of which basically mean “no” or “not” and both are pretty easy to hear and remember. It is also helpful that both usually are accompanied by some type of “no”-type hand gesture or a shake of the head. These two words are “BU” and “MEI.” It was pretty easy to understand that the patient did not have a living husband.

“What about a son?” I asked, already having heard from Dr. Ding the answer to this question.

With a surprised look on her face, the resident translated the caregiver’s response for me, “She has two sons in the United States.”

I was able to clarify a few other things. “When was the last time she ate by herself?”

“A year ago,” even surprised me a bit. Yes, nasogastric tubes do stay in that long. On average, they change them about every two months.

“How long has this catheter been in,” I asked, pointing to the Foley catheter.

The answer sounded familiar. Without a surprised look on her face (unfortunately), the resident translated, “a year ago.”

Before I could ask why, perhaps because of my facial expressions, the caregiver was starting to pull the covers from the rear of the patient (who was lying on her side) to show me that the patient no longer had a “ra chuang.” It almost sounds like the translation: “bed sore.”

This time it was the resident’s turn to read my face as I asked “why... still?”

“She cannot stay dry... and because it is convenient for caregivers.”

“Do you think she has pain?”

(continued on page 26)
I asked the caregiver.

The recognizable, “MEI” (she does not have) along with the wave of her hand and shake of her head came quickly from the caregiver.

I pressed on, “Does she get confused?”

I looked to the resident for help here, and again, either because she did not understand my English, or because she was surprised I asked the question, having just discussed the fact that Mrs. Li had dementia, she gave me a puzzled look as she turned and queried the caregiver.

“Sometimes,” came the translation, “sometimes she is able to understand things better, and sometimes she is very sleepy, like now.”

Having felt I had used up my welcome, I said my many Chinese “thank you’s” and headed for the door with the resident, as the caregiver ironically outnumbered my “thank you’s” for how much the doctors were doing for the patient. The “caregiver” was a hired person, who stays with the patient, like a nurse aide or tech, and is paid privately by the family. In this case, the two sons had hired her since they were not in Beijing. In general, hospitals do not have nurse aides or techs.

Outside in the hallway with the resident, I knew I had to curb my questioning because it was having a disquieting effect on her. However, I was still curious about her attitudes, her feelings, and her thoughts about this patient. Finally, having mercy and even feeling bad about asking too many questions, I merely was quiet, waiting to see if she would willingly offer me any insight about her attitude in these areas.

As we walked slowly back to the doctor’s room, she finally had a question for me, “Of all the patients on the ward….why are you interested …in this patient?”

References
A day on the General Medical Ward at Peking University First Hospital

Although a formal study would need to be done to verify this, it would seem that in cross-sectional observations on the severity of illness of hospitalized patients at Peking University First Hospital, only about one-fourth of patients are acutely ill by U.S. standards and qualify for hospitalization. The other three-fourths of patients would likely be cared for in outpatient clinics or nursing facilities if they were in the U.S. In February 2006, another tally of this type of observation at this hospital and another Beijing Hospital, confirmed this same observation: that about one-fourth of the hospitalized patients were acutely ill by U.S. standards.

Since this was a general ward, a variety of admission reasons were seen, the most common being GI and Respiratory (each 7/24, 29%). Diabetes as a primary reason for admission was more common than what one might see in the U.S., accounting for 25% of admissions. Hypertension was recorded along with diabetes as a reason for admission in some of these cases. Future articles will go into more detail about differences and similarities between the U.S. and China concerning hospital care for the elderly, including data on the length of stay, discharge locations, and costs.

<table>
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<th>Bed</th>
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<td>M</td>
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<td>3</td>
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<td>21</td>
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Table showing statistics of one ward of hospitalized patients at Peking University First Hospital. (LOS=length of stay).

During a recent visit to China, Dr. William Banks of Saint Louis University’s Division of Geriatric Medicine stands in front of the Peking University First Hospital.
Decades of isolationism and the current media portrayal of China as a communist state quickly rising in international prominence has made it easy to form opinions about the nation and its people without witnessing the reality firsthand. While China’s political system stands at odds with democratic Western ideals, my first visit to the Middle Kingdom a year and a half ago left me with the distinct impression that the socialist system of government did not significantly affect the daily lives of Chinese urbanites, contrary to my own preconceived notions. The opportunity to learn about the practice of medicine, both traditional and western, particularly from a geriatrics perspective, was a tantalizing prospect. This past February I returned to Beijing with this objective, and to see how much had changed in the short time I had been gone. My visit was limited to spending time in urban areas, even though the majority of Chinese continue to live in the countryside where access to public services such as healthcare and education is typically more limited. As such, my observations should not be considered conclusions or generalizations about the present state of the Chinese healthcare system.

Beijing was different in many ways than I remembered, but the economic developments belied a constancy of certain aspects of Chinese life. Confucian values remain central in all relationships, especially in the family. Chief among these is the responsibility children have for elderly parents. According to several physicians, nursing homes and home health aides are virtually non-existent, so the family remains crucial for long term care of these patients. With longer life spans and recent medical breakthroughs, the responsibility an adult child has over the well-being of an older parent now seems to encompass medical decision-making, in addition to financial and domestic support. It was common to meet a patient over the age of 65 - regardless of cognitive status - whose medical decisions were made by an adult child. While older Chinese individuals value independent living more than before, this is not (yet) a cultural priority. Nevertheless, the dynamics between the generations is slowly changing. Most young couples are now dual wage-earners, and it is harder to care for an elderly mother when you are at the office until late in the evening. The One Child Policy is also shifting priorities. The “burden” of caring for an older parent will no longer be shared between two or more siblings. It is a tricky situation if the parents of both the husband and wife require caregivers. It will be interesting to see how this generation and those that follow will balance the pressures of modern living with such strong cultural traditions.

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Certain aspects of inpatient geriatric medicine are highly favorable. Wards are typically peaceful and quiet, free from the commotion that characterizes many U.S. hospitals. Patients usually have someone watching over them for a large portion of the day. This is personal attention at its finest. Perhaps as an outgrowth of a type of social egalitarianism under which physicians and patients have the same status, sitters and family members freely walk into physician offices to ask questions or voice issues. In this way, physicians are viewed as public servants more so than in the United States, where the patient-physician relationship is typically more hierarchical.

Apparently it was not always this way. More than one Chinese physician admitted that the status of a physician has changed in recent times. Before the end of the Deng era, universal healthcare was the norm. The advent of private insurance and fee-for-service payment models changed this. At least one Chinese physician reported that the level of trust patients extend to their physicians has changed. During the severe acute respiratory syndrome (SARS) outbreak in 2002-2003, physicians played a prominent role in public health amidst fears of an impending pandemic. Since then, the consensus seems to be that the status of a physician has been slowly declining. The current fear of avian bird influenza has apparently done nothing to curb the trend. The specter of litigation looms over every medical decision, and newspapers frequently report cases of alleged malpractice.

The aspect I found most striking concerns disclosure of information to cancer patients. It is not customary to inform these patients of their diagnosis, let alone their prognosis. Physicians believe such knowledge would have a profoundly negative impact on a patient’s well-being. In the context of another conversation, one doctor said that Chinese people are “raised to be afraid.” Based on this generalization, it is understandable that disclosure of such a diagnosis may have unfavorable psychological and somatic effects. Moreover, family members of many cancer patients prefer to “protect” their loved ones from this information. The implications for patient autonomy and trust are far-reaching, particularly when patients ask their physicians about their health. The extent of this purported shift in the patient-physician relationship remains unclear to me. However, the interactions I observed, particularly among geriatric patients and their doctors, suggest it is not widespread. A tangible mutual respect between both sides is readily apparent. Patient compliance generally remains high, and management plans and treatments seem largely unaffected by any underlying changes in attitude or opinion.

The perception of mental illness in China is vastly different from that in the United States. Dementia is commonly considered a natural phenomenon of aging. Depression, especially in the elderly, is seen by some as a secondary manifestation of an underlying condition, rather than a primary diagnosis. It is a symptom, rather than an illness or disease. Consequently, there is less stigma associated with mental illness. One physician cited anecdotal data suggesting a lower rate of depression in China than in the United States. This may be due in part to better communication, she hypothesized; she feels that Americans are more stoic. Perhaps this is so. I am not so sure.

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China is a highly populated and socialist society, so one can imagine that the boundaries of public and private life are less rigid, making it easier to convey these feelings whereas the American ideals of individualism and self-reliance are very foreign concepts. Also, the Confucian model of relationships clearly delineates the connections between all parts of Chinese society, perhaps making it more acceptable for Chinese patients to talk about depression.

Other aspects of healthcare for the elderly are more similar to our system. Geriatricians agree that palliative care and social (in addition to family) support for older patients who are no longer able to look after themselves are important, although the infrastructure to provide these services remains sparse. Diagnoses such as coronary heart disease, congestive heart failure, chronic renal failure, chronic lung disease, and even diabetes, are common and, for the most part, managed in much the same way. However, traditional Chinese medicine is often utilized as adjuvant therapy (to improve circulation or promote bowel movements, for example) together with Western medication. In some cases, traditional remedies serve as first-line treatments for conditions like anemia and symptoms such as dizziness. Surgical masks are de rigueur; hand-washing somewhat less so. Overall, physicians are highly committed to the care of their patients and have (at least in Beijing) more than adequate resources to provide an excellent level of care.

For most Chinese, including the elderly, physical activity is more than a lifestyle choice - it is a necessity. For many, personal automobile and taxi transport is simply economically unfeasible and public transportation has limitations of convenience. With approximately 1,000 new cars vying for real estate on Beijing’s increasingly crowded roads, the bicycle has been largely banished from main streets and confined to the hutong neighborhoods. It is common to see elderly men and women walking on city streets and crossing perilous intersections, sometimes with the aid of a younger person. Elderly pedestrians carry grandchildren on their backs. They brave icy sidewalks to bring home bags of groceries. Some remain employed, presumably as municipal workers sweeping with brooms made from bundled branches, shoveling snow and collecting trash. In this nation without Social Security or Medicare, retirement at 65 is not an option for many, and seeing these individuals frequently conjures up a mixture of emotions. Despite the economic gains, life remains difficult for many Chinese people, even in the sprawling metropolises.

China has old traditions rooted in its history and culture that have become embedded in the national subconscious as well as in the tangible fabric of daily life. The more visible economic changes are undeniably occurring at a blistering pace. The Chinese culture, however, remains largely steadfast, although my most recent visit has me convinced that shifts are under way. When I return to China to witness the next developments firsthand, I hope to encounter a population reaping the benefits of modern living with its cultural integrity intact, balancing that delicate tightrope between the past and the future. It certainly will be interesting to see the effect this has on healthcare and the older population in general. The optimist in me believes that things will only get better.
BEEN HERE? DONE THIS?

Offering regular updates on geriatrics, Cyberounds, an Internet-based educational program for physicians and other health care 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.com.

See you in cyberspace!

Questions? FAX: 314-771-8575  email: aging@slu.edu
Moving?

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 aging@slu.edu. Be sure to type your address exactly as it appears on this label.