The Art and Science of Healing

Courtesy of Tak-Kwan Kong, Shun-Kai Tse, and Lily Chiu

The Princess Margaret Hospital in Hong Kong contains the Golden Art Gallery, in honor of the central theme of the Elderly Commission of Hong Kong which promotes “healthy aging.” Dr. Lily Chiu, the hospital’s chief executive, indicates that the Commission believes that, “although there is no magic pill to lengthen life indefinitely, activities in art is one potion that increases the depth of life.” The Geriatric Day Hospital within Princess Margaret Hospital offers a rehabilitation program to patients disabled by weakness resulting from stroke, Parkinson’s disease, falls and other diseases. Patients who have received rehabilitation there in the art classes have donated some of their works to the Gallery, which displays it proudly.

Dr. Tak-Kwan Kong, a geriatrician at the hospital, states that the Golden Art Gallery celebrates

A few individuals are fortunate enough to be born of long-lived parents and, thanks to their genetic make-up, experience successful aging. Most of us, however, will run into a number of obstacles along our life’s journey and how we handle them will decide whether or not we age successfully. One of the great examples of persons who aged successfully is Grandma Moses who, when she developed arthritis, gave up making quilts and took up painting miniatures. Many other older persons also have aged successfully, often having completed wonderful paintings following a stroke. Overcoming adversity is the secret of aging successfully.

(continued on page 12)
Terrorism has become a worldwide problem. Media coverage alerted Americans to a sarin gas attack in Japan, Irish terrorist bombings in London, and even a food poisoning case in the United States.

In the months following September 11th, terrorism in America continued. Anthrax spores were mailed to politicians and television personalities on the East Coast, resulting in documented infections in 18 people, with five deaths. One of these deaths was a 94-year-old woman.

Death is not the only effect of terrorism. International media attention, including almost continuous replaying of the planes flying into the twin towers, adversely affected the psyche of persons not only in the United States, but throughout the world. One study has demonstrated a decline in psychological well-being in individuals living in Italy following events of September 11th. In nursing homes, it has been noted that many older persons expressed a strong lack of desire to continue living - “It isn’t worth it” - and a few vocalized a desire to die or even to kill themselves.

The effects of terrorism on the individual are protean and can involve both those persons directly affected and persons at a distance who hear or see the events. Effects on persons directly affected by the events include:

**Physical**
- Injury
- Illness
- Death

**Psychological**
- Anxiety
- Isolation
- Insomnia
- Depression
- Bereavement
- Post-traumatic Stress Syndrome

**Indirect**
- Loss of home/place of work
- Loss of services, e.g., meals-on-wheels, senior centers, home health
- Loss of access to transportation
- Altered routines
- Financial repercussions
- Decreased access to emergency services, e.g., telephone to call for help
- Increased activity of confidence tricksters using the event to defraud persons.

Older persons appear to be more vulnerable to having their lives disrupted by these events and more likely to succumb to the effects of bioterrorism or injury if exposed.

(continued on page 16)
Physicians Named Best in Care for Older Adults

On the ACE (Acute Care of the Elderly) Unit at Saint Louis University Hospital, teams of multidisciplinary faculty members conduct research studies ranging in scope from molecular biology to epidemiology. As this knowledge builds, it is shared with colleagues around the world, influencing positive changes in the care of older adults.

ACE: Focus on Function

The 23-bed ACE Unit on SLU Hospital’s ninth floor puts older patients under the care of a specialized health care team devoted to preventing functional decline during their hospitalization.

“We know from previous studies that the longer the hospital stay, the greater the threat to an older patient’s functionality, independence, and survival,” says SLUCare geriatric medicine specialist Joseph H. Flaherty, MD. Dr. Flaherty is medical director of the ACE Unit at Saint Louis University Hospital and an assistant professor of internal medicine at Saint Louis University School of Medicine.

The interdisciplinary ACE team includes nurses, physicians, physical therapists, occupational therapists, pharmacists, social workers, quality improvement staff, dietitians, and pastoral care staff. Together they conduct daily medical reviews of every patient. Their vigilance helps to minimize adverse consequences of procedures, tests and medications and keeps the team moving toward the goal of discharging a functioning patient.

“One of the first tasks accomplished by the ACE team upon a patient’s admission is a discharge plan,” explains Michelle McGuire, RN, nurse specialist on the ACE Unit. “That way the patient, family and everyone on the ACE team can coordinate their efforts to ensure the patient regains and maintains good function while receiving the best possible, patient-specific care.”

Patients on the ACE Unit spend less time in bed and more time walking. The use of urinary catheters is discouraged to give patients one more reason to get out of bed. Many patients take their meals in a dining area. All are encouraged to maintain as many activities of daily living as possible. “By preventing our patients’ functional decline, we can shorten length of stay and return them to the life they led before they were hospitalized,” Dr. Flaherty says.

Acute confusion is a common condition of older patients and one that easily can be misunderstood and lead to longer hospital stays and rapid decline. On the SLU Hospital ACE Unit, patients suffering from acute confusion receive 24-hour observation and care in a four-bed, low-tech, high-touch room. On a traditional hospital floor, these patients might be restrained or heavily sedated, approaches that only serve to mask symptoms, lengthen hospital stay and...

(continued on page 4)
aggravate the underlying conditions causing their confusion. In the close observation room of the ACE Unit, no restraints or heavy sedation are used. Instead, nurses and aides keep careful watch of patients to document symptoms as well as prevent falls, malnutrition, and worsening of confusion and agitation.

“Through this approach, we have shown a decrease in the length of stay for patients who experience acute confusion while hospitalized,” Dr. Flaherty says. “We think that the special care we give ACE Unit patients helps extend their lives.”

Research and Renowned Physicians
Several SLUCare geriatric medicine specialists at Saint Louis University School of Medicine have gained international reputations for leadership in creating a better quality of life for older people. Their work translates into more than 100 papers a year and has influenced improved nursing home conditions, as well as how older adult patients are treated for diabetes, Alzheimer’s disease, osteoporosis, male sexual dysfunction and general frailty.

For example, Douglas K. Miller, MD, professor of internal medicine, is the principal investigator in a study that looks at the role socioeconomic status plays in the general health of African Americans.

David R. Thomas, MD, professor of internal medicine, is a leading expert on the prevention of pressure ulcers. William Banks, MD, professor of internal medicine, has studied innovative methods to deliver drugs that may be useful in the treatment of Alzheimer’s disease. Margaret Wilson, MB, BS, assistant professor of internal medicine, has developed exciting approaches to the management of nutritional problems in older people.

One of the world’s leading figures in gerontology is John E. Morley, MB, BCh, Dammert Professor of Gerontology and director of the Division of Geriatric Medicine. Dr. Morley was the recipient of the 2002 American Geriatric Society Nascher/Manning Award (see page 11 for more details).

Care Beyond the Hospital
SLUCare geriatric medicine specialists strive to ensure that the knowledge they gain translates into high-quality care accessible to every older person. They are pioneers in developing innovative subacute treatment techniques that are incorporated into nursing homes throughout the nation. They also have been one of the leaders in developing continuous quality improvement in nursing homes and were among the pioneers of the Eden Alternative. This revolutionary vision of long-term care promotes (continued on page 20)
New Screening Tool Detects Appetite Problems in Senior Adults

The Council for Nutritional Clinical Strategies in Long Term Care, a national nutrition group which is chaired by Dr. John E. Morley of Saint Louis University unveiled a simple questionnaire that detects appetite problems in older adults. Dr. Morley and David Thomas, M.D., both professors of geriatric medicine at Saint Louis University, discussed how changes in appetite among senior adults can be the first sign of potentially fatal problems at a meeting of the Council on Nutrition in San Diego.

Dr. Morley is very concerned about weight loss in seniors. “When people lose their appetite, they stop eating and lose weight. They can develop multiple infections, get sick, and die. If an older person manages to maintain weight or puts on weight, he or she stays alive longer. For senior adults, weight loss correlates with death.”

The simple, eight-question survey (shown here) is an effective tool to help identify the symptoms that could lead to weight loss. “Learning how to recognize the warning signs that lead to weight loss is a critical step in saving the lives of senior adults,” Dr. Morley said.

The questionnaire asks older adults to:

- Rank their appetite on a scale from very poor to very good
- Assess when they start to feel full from eating

(continued on page 21)

<table>
<thead>
<tr>
<th>Council on Nutrition Appetite Questionnaire</th>
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<tbody>
<tr>
<td><strong>A. My appetite is</strong></td>
</tr>
<tr>
<td>1. Very poor</td>
</tr>
<tr>
<td>2. Poor</td>
</tr>
<tr>
<td>3. Average</td>
</tr>
<tr>
<td>4. Good</td>
</tr>
<tr>
<td>5. Very good</td>
</tr>
</tbody>
</table>

| **B. When I eat, I feel full after**       |
| 1. Eating only a few mouthfuls             |
| 2. Eating about a third of a plate/meal    |
| 3. Eating over half of a plate/meal        |
| 4. Eating most of the food                 |
| 5. Hardly ever                             |

| **C. I feel hungry**                      |
| 1. Never                                  |
| 2. Occasionally                           |
| 3. Some of the time                       |
| 4. Most of the time                       |
| 5. All of the time                        |

| **D. Food tastes**                        |
| 1. Very bad                               |
| 2. Bad                                    |
| 3. Average                                |
| 4. Good                                   |
| 5. Very good                              |

| **E. Compared to when I was 50, food tastes** |
| 1. Much worse                             |
| 2. Worse                                  |
| 3. Just as good                           |
| 4. Better                                 |
| 5. Much better                            |

| **F. Normally, I eat**                    |
| 1. Less than one regular meal a day       |
| 2. One meal a day                         |
| 3. Two meals a day                        |
| 4. Three meals a day                      |
| 5. More than three meals a day (including snacks) |

| **G. I feel sick or nauseated when I eat** |
| 1. Most times                             |
| 2. Often                                  |
| 3. Sometimes                              |
| 4. Rarely                                 |
| 5. Never                                  |

| **H. Most of the time my mood is**        |
| 1. Very sad                               |
| 2. Sad                                    |
| 3. Neither sad nor happy                  |
| 4. Happy                                  |
| 5. Very happy                             |

**Scoring**

Total the score by adding the numbers associated with the patient’s response. A score of less than 24 is cause for concern. If the total is

- 8-16 The patient is at risk for anorexia and needs nutrition counseling.
- 17-24 The patient needs frequent reassessment.
- >24 The patient is not at risk at this time.

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5
One’s ability to overcome adversity always depends upon community support as well as that person’s inner strength. An organized social structure that prevents loneliness and provides support in times of need is one key to aging successfully. A person’s internal spirituality or inner peace is another key. Persons who become depressed when they develop disease have worse outcomes. This depression can lead to malnutrition and frailty.

For all of us, maintenance of function requires undergoing some form of regular exercise. This includes not only aerobic exercise but also resistance, balance, posture and stretching exercises. Resistance exercise has been shown to decrease depression and increase executive function. Exercise also can enhance immune function. Tai Chi remains, as it did in ancient China, an excellent exercise form for the older person.

For older persons to age successfully, we need to aggressively treat the reversible causes of malnutrition and to detect and treat cognitive impairment (delirium and dementia). These conditions require an equal investment in social, psychological and medical therapies. While pharmaceuticals can be powerful tools for good, they also can create havoc in an aging body. The art of geriatrics is to balance the “yin” and the “yang” of drug therapy in elders.

An organized social structure that prevents loneliness and provides support in times of need is key to aging successfully.

Pain is a potent reason for deterioration of function. No elder should be left to needlessly suffer.

Finally, we are learning the potential for hormonal therapy in improving quality of life. In particular, it would appear that many older men benefit from testosterone therapy.

The importance of the spirit in helping us age successfully is encapsulated with the words of Florida Scott-Maxwell at age 83: “We who are old know age is more than disability. It is an intense and varied experience, almost beyond our capacity at times but something to be carried high. If it is a long defeat, it is also a victory.”

George Valiant, the Harvard psychiatrist, in his wonderful book Aging Well beautifully demonstrates how it is the indomitable spirit that allows us to age successfully. Socrates is quoted as saying in Plato’s The Republic, “the secrets of aging successfully are to be learnt from our elders. I enjoy talking with very old people. They have gone before us on a road by which we, too, may have to travel and I think we do well to learn from them what it is like.”

It’s NEW! GEROPADY ON CD!

GEROPADY, the game that tests your knowledge in geriatrics and gerontology! The game uses the format of the popular television game show, Jeopardy. The GEROPADY kit includes loose-leaf notebook, instructions, questions and answers, five game board transparent overheads, a “Final GEROPADY” overhead, and materials. PLUS new questions are available on a new CD version of the game. $25 for the regular version or $30 for both.

ORDER INFO:
Make checks payable to: SLU-HSC – Geriatrics

GEROPADY is produced by the Missouri Gateway Geriatric Education Center, the Division of Geriatric Medicine at Saint Louis University, and the Geriatric Research, Education, and Clinical Center (GRECC), St. Louis Veterans Affairs Medical Center.

I can say with assurance that my hospice experience was not what I expected. Having attended several lectures about hospice in my third year, I knew the philosophy behind hospice and the variety of disciplines that are involved in care of the hospice patient. However, I was expecting to be dealing with mostly medical issues, e.g., Mr. X is in pain and needs a change in his medication. He is vomiting and needs compazine, etc. To my surprise, the medical issues were few, and I am happy that this was the case. I learned that hospice is mostly about talking and listening to patients and their families. It’s about helping the dying patient to retain dignity and humanity, and helping the family to make some sense of the dying process.

While working with the Visiting Nurse Association (VNA), I accompanied a different person every session. The nurses handled issues with pain medicine and other problems, but were mostly there to support the patients and their families. It was mostly pleasant conversation, and I almost felt guilty receiving elective credit for it! These were people that I would be glad to visit anytime. Then I realized that, although the conversation was pleasant for us, it was more than that for the patients and their families. It was a way to escape, to vent, and to feel that they were living a somewhat normal existence. In the nursing home, it was a rare opportunity to have some human contact, especially for patients who could not move around very well. I noticed that, in nursing homes, patients are often lined up in a row around the nurse’s station for social reasons. However, if they can’t turn their bodies very well to the person next to them, they are still just as isolated as they would have been if they had stayed in their rooms.

Conversation with the nurses was also a way to be supported unconditionally without judgment. Although we didn’t particularly agree with the 40-year-old woman with breast cancer who refused any treatment from the beginning because she felt that God would heal her if He chose to, who was paralyzed from the waist down as a consequence of her decision, it was not our job to disagree with her. It was our job to talk with her about her faith, her cats, and the crafts she made. It was our job to make her comfortable physically, emotionally, and spiritually.

It was often the nurse’s job to give hospice patients in the nursing home more individualized care than they might have received otherwise. The nurses also provided care that should have been done by the nursing home staff, but was neglected due to understaffing or other reasons. For example, a nursing home aide might give up on feeding Anna after five minutes, but the hospice nurse had the time to find something special that Anna liked and feed it to her as slowly as she needed to be fed; she had the time to find a syringe to feed Anna liquids when she could not longer use a cup or a straw. Another nurse, after continually finding her patient short of breath with an empty oxygen tank, might spend half of a day training the nursing home aides on how to use and fill the tanks. It is much easier to give a patient the care he or she needs when the other 49 patients down the hall don’t need to be looked after as much. With the patients who resided in their homes, we had time to clean a bit, or make the patient breakfast. I found myself wishing that non-hospice patients who are not dying, but are just as disabled, could be cared for this way as well.
Ten Ways to Cope with the Fear of Terrorism

Have a discussion. Encourage people to talk about their feelings.

Ask elders for advice. Have older people recount how they coped with their fears during wartime.

Volunteer. Everyone needs to feel useful.

Eat, exercise, and rest. The world is not so bad after a good meal, a brisk walk, and a night’s sleep.

No one should be alone. Spend time with family and friends.

OOO0000000000000. Relaxation techniques relieve stress.

Focus on daily life. Turn off the television and go smell the roses.

Evaluate regularly for depression. Depression can be treated, but first it has to be recognized.

Accept support. Allow yourself to be helped.

Remember that help is always there. Spiritual help is available 24/7.

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We have enough to go around!

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Dr. John Morley has been a long-time advocate of developing geriatric assessments that are easy to use and fun to perform. Perhaps his favorite assessment is one to determine gait and balance. Dr. Morley maintains that gait and balance can easily be assessed while dancing with an older person. Dancing is more fun for both the elder and him than administering a classical gait and balance test. At Saint Louis University and at the St. Louis VA Geriatric Research, Education, and Clinical Center (GRECC), we ask the yes/no questions listed below while dancing with the patient. This simple system demonstrates the degree of disability. Failure to perform any of these routines appropriately represents a problem with gait and balance. The greater the number of “no” responses corresponds with a greater degree of problem. The speed at which any of these dance steps are executed is dependent on the physical stamina of the patient, not the doctor. Dr. Morley assures us that he uses this test on men and women alike. He doesn’t tell us how he determines who gets to lead, but we suspect we know the answer.

We recommend that a simple circle dance with the two dancers holding hands is sufficient to answer these questions. We do not recommend the tango or the limbo!

1. Does the person follow the dance steps?

2. Is there a space between her/his feet as (s)he performs the steps?

3. Does (s)he lift her/his feet off the ground?

4. Does (s)he maintain her/his balance while dancing close?

5. Does (s)he maintain her/his balance during the turn?

6. Does (s)he turn appropriately?

Failure to perform any of these routines appropriately represents a problem with gait and/or balance.

Questions? FAX: (314) 771-8575 • email: agingsuccess@slu.edu
SLU School of Social Service Receives John A. Hartford Foundation Funding

The Saint Louis University School of Social Service, in collaboration with the Social Work Department at the University of Missouri-St. Louis, has been awarded a $60,000 grant from the Geriatric Enrichment in Social Work Education project. This project is funded by the Council on Social Work Education with support from the John A. Hartford Foundation with the aim to support social work educators in their efforts to provide enriched content in gerontology across the curricula. One of 67 social work programs to receive the funding, the SLU-UMSL collaborative will include innovations in the area of field education and classroom curriculum development.

As part of the GeroRich grant efforts, Drs. John Stretch (seated), Ellen Burkemper (center back) and Tina Timm (right) will attend a faculty development institute on infusing geriatric content into practice courses in July in Seattle. Dr. Marla Berg-Weger (left) is planning and coordinating grant activities for the School of Social Service.

Products

- GEROPADY
- Senior Safety Solitaire
- ACE Unit Video
- Crossword Puzzle Book
- Challenges & Choices
- Aging Successfully Newsletter
- Books

Call 314-577-8462 for more information about these products.

Services

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

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

Call 314-577-6055 to make an appointment.
Honors....and Mentions

SLU Geriatrician Recognized for Lifetime Achievements

John E. Morley, M.B., B.Ch., received the American Geriatrics Society’s (AGS) 2002 Nascher/Manning Award for lifelong achievement in clinical geriatrics.

Dr. Morley is the Dammert Professor of Gerontology at Saint Louis University School of Medicine and director of the Geriatric Research, Education and Clinical Center at the St. Louis VA Medical Center.

The Nascher/Manning Award was established in 1987 to honor the pioneering work in the field of geriatrics by the late Ignatz Leo Nascher, M.D. The award was presented to Dr. Morley at the annual meeting of the American Geriatrics Society on May 10th.

“Dr. Morley’s work as a leader in the field of geriatrics, an educator, author, and his significant contributions in the area of home health care represent outstanding qualities and skills the Society wishes to honor,” said Jerry C. Johnson, M.D., president of the AGS.

An expert in geriatric endocrinology, Dr. Morley has lectured around the world on aging, speaking about nutrition, sexual function, and psycho- and neuro-endocrinology, and pharmacology. He has written more than 850 research articles for a range of specialty and general medical journals.

Saint Louis University’s Center for Bioterrorism and Emerging Infections is One of Ten Sites in the United States

The Saint Louis University Center for Bioterrorism and Emerging Infections developed a curriculum that is being used nationwide to train health care providers and public health departments. In fact, the center’s training materials were used by the Centers for Disease Control and Prevention (CDC) to instruct emergency health personnel, health care providers, and other public health workers in New York City in how to respond to the September 11th attacks.

The Center for the Study of Bioterrorism and Emerging Infections at Saint Louis University School of Public Health provides a comprehensive and coordinated training and preparedness program across the full continuum of public health activities in the United States to protect Americans from both emerging infections and the intentional use of biological agents. The Center’s main task is to prepare emergency response teams, physicians, nurses, health administrators, and public health and community officials to respond effectively to emerging health threats.

In the fall of 2000, Saint Louis University School of Public Health was designated as one of ten Centers for Public Health Preparedness, a new national network formed by the CDC. Of the ten centers, Saint Louis University has the only center to focus solely on the study of bioterrorism and emerging infections.
The renaissance of the often-forgotten role of art and humanities in medicine. He feels he can learn more about the health status of a stroke victim by looking at the patient’s painting than he can learn from merely looking at the computerized image of that patient’s brain. He suggests that the answer to overcoming adverse medical incidents may lie in the integration across traditional boundaries. If enough effort is made to marry the knowledge and skill of science, medicine, and technology with the wisdom, attitude, and creativity of the humanities and art, then everyone will benefit.

Mr. Tse tells us that the elderly artists showed several common traits:

- Their work is without pretension
- It was easier for the artists to express themselves through writing than through painting
- Skills and creativity are inseparable in art

The Art of Golden Years. The editors, Dr. Kong and Shun-ki Tse, an artist and architect, have graciously allowed us to reproduce some of the artwork and their artists’ stories in this issue of Aging Successfully.

In appreciating the calligraphy, poems, and art we need to remember that these works are the product of the patients’ mind and body. Mr. Tse sees the patients following the old Chinese saying “extending our years while we live with our illness” by focusing on something artistic that motivates them to practice life.

Dr. Kong hopes that the works portray a positive image of aging and also encourage patients to create and connect through artistic activities for the betterment of their health. He also hopes it inspires those enthusiastic in using the arts and humanities to improve health and well-being.

Fish

Mr. Kwan painted this picture 3 weeks after the removal of a brain tumor. The picture indicates that his memory and orientation were returning. All of the fish are swimming in the same direction and the various profiles are recognizable as different species of fish.

Health

Mr. Wong suffered a left-side stroke. Rehabilitation did not allow him to recover much function but his bold use of color and pattern suggest an inner strength.

Horse

Mr. Leung has suffered multiple strokes and right-sided paralysis for several years. He attended painting class and painted this artistic rendition of the Chinese word for horse using a modified pen attached to his weak and spastic hand. Both technique and subject show strong character.

We thank the authors for allowing us to print excerpts and artwork from their book, “Potion for Life: The Art of Golden Years”
Night Pearl
Mr. Lau was an amateur photographer. This long-exposure photograph was produced when Mr. Lau was 77 and receiving rehabilitation for tremors produced by Parkinson’s disease. The resulting picture shows that the artist had good functional ability and dexterity.

Poem
Shortly after the picture Night Pearl was taken, Mr. Lau suffered from dizzy spells and falls, which soon led to a stroke. To show his gratitude for the rehabilitation he received because of this new disability, he wrote the poem above. The English translation follows here:

The scenery of Lai King Building is beautiful
A stay here will add years and life
Happy faces seen in young and old
Doctors and nurses work wonder
Let this be a blessed Building.

Yellow Flower
Mr. Lau also decided to paint as part of his rehabilitation. “Yellow Flower” is his offering to the Gallery in that medium. Rehabilitation received at the hospital was so successful that he was able to resume with his photography 3 months after his stroke.

Painting 1 and Painting 2
Ms. Lau became chair-bound at age 76, following a stroke that left her with left-sided weakness. At age 81 she is now painting playful abstracts. “Painting 1” and “Painting 2” are representative of her work.
Rodney M. Coe Distinguished Lectureships in Interdisciplinary Gerontology

Sandra H. Johnson, J.D., LL.M. delivered the Inaugural Rodney M. Coe Distinguished Lectureship in Interdisciplinary Gerontology. Her lecture reflected Rod’s unique gifts as well as his impact on Saint Louis University and the field of Gerontology. He had a vision for Saint Louis University and he worked tenaciously and tirelessly to make that vision a reality. All three of our speakers in this year’s Rodney M. Coe Distinguished Lectureship in Interdisciplinary Gerontology spoke of visions that have improved health care for the elderly. Excerpts and ideas from each talk are given here.

Improving Health Care For Elders: Vision and Persistence
Sandra H. Johnson, J.D., LL.M.

An average of 20% to 40% of nursing home residents in the United States were physically restrained prior to 1987. Some facilities had over 50% of their residents restrained. In retrospect, this was a public health disaster. The impact on the physical health of the elderly living in nursing homes was quite severe. Less studied, but no less real, was the impact on the caregivers.

Despite such adverse effects, physical restraints were the standard of care. Patients’ advocates felt that physical restraints were used because it was easy, and that administrators drove the practice. Administrators often said that regulators and lawyers made them restrain residents because the facility would be liable if a resident fell. Nurses were taught that the restraints were for the resident’s own good. The focus was on keeping nursing home residents “safe” and was supported by predominant family attitude: “We cannot do much for them, but at least we can keep them safe from harm - from falling, from wandering.” This deeply embedded practice was supported by what lawyers call “common knowledge.” Professional attitudes held safety as the standard of good care. However, these attitudes negated other values such as mobility and socialization.

Nothing less than a new vision of the obligations and purpose of nursing home care had to be articulated to improve the quality of care received by the elderly. The change in the use of restraints came with a change in vision. The new obligation is not solely to keep our elders safe, but to maximize the quality of their lives. Safety is not a minimal threshold indicator of quality, but may indeed be traded off for other values. This new vision gave us a basis on which to talk about the issue of restraints in a way that made the conversation not just a fad, not a scolding, but an improvement in care.

But the vision was not enough. Persistence was needed; and the persistence in this case was research and education and then regulatory change. The research documented the negative health impact of restraints. It was also necessary to document that the legal standard actually supported a reduction in restraints.

The revolutionary change in the common practice in the use of restraints and the resulting improvement in health care for the elderly happened because there was an alternative vision of what could be and because the tedious work was done to answer each concern as it was raised. It comes down to winning hearts and minds – the heart with the vision and the mind with the answers.

John Morley presents Sandra Johnson with a plaque in honor of her lecture at the Inaugural Rodney M. Coe Distinguished Lectureship in Interdisciplinary Gerontology. Rodney Coe is on the right.
Dr. Carol S. Aneshensel Gives Second Rodney M. Coe Lecture

The second Rodney M. Coe Distinguished Lectureship in Interdisciplinary Gerontology was held March 27, 2002 on the Saint Louis University campus.

Carol S. Aneshensel, Ph.D., professor in the department of community health sciences at the UCLA School of Public Health in Los Angeles, spoke on “Family Caregiving and Beyond.”

Dr. Aneshensel’s research interests include stress and mental health. She spoke about a longitudinal study that began in 1984, in which she and colleagues have been studying the effects of caregiving on family members who care for demented elders. This epidemiological study has followed caregivers throughout their caregiving career.

Research results show that a person’s commitment to caregiving does not change once the demented elder enters a nursing home. Caregivers continue to provide care at a level commensurate with the care provided before the institutionalization. The only, temporary, exception to that result is the caregiver who is physically worn out by the caregiving and who, therefore, needs a few weeks to recover physical strength. Once physical health is regained, these caregivers return to the role of active, though secondary, care provider, aiding the professional staff now in charge of their family member’s care. This is true regardless of whether the caregiver is a spouse, child, or sibling.

Thus, caregiving is a life-long commitment. In fact, Dr. Aneshensel expressed an interest in continuing to study caregivers after the death of their loved one.

Third Guest Lecturer, David A. Snowdon, Speaks About Alzheimer’s and the Nun Study

David A. Snowdon, Ph.D., professor of neurology at the University of Kentucky College of Medicine discussed his well-publicized research at the Third Rodney M. Coe Lecture on May 15, 2002.

Dr. Snowdon spent 15 years studying more than 600 nuns from seven convents to find out who is most susceptible to Alzheimer’s disease. He found that small strokes and head trauma can trigger symptoms of Alzheimer’s disease, while a rich intellectual life and college education can help prevent the illness.

Dr. Snowdon also learned that the early autobiographies of nuns provided important clues to aging. Those nuns whose early writings contained complicated sentence structures were less likely to suffer from Alzheimer’s disease. In addition, nuns whose entries reflected more positive emotions lived longer than their less positive peers. His work was published in the Journal of Personality and Social Psychology, in his book, “Aging with Grace” and in TIME magazine. One of his subjects appears on the TIME cover at the left.
Many older persons living in the Ground Zero area were forced to rely on the services of visiting nurses to survive as local services were disrupted, making the homebound and functionally impaired particularly vulnerable.

**Chemical Warfare**

Two major groups of chemical warfare agents exist. These are blistering agents or vesicants such as sulfur, mustard, and lewisite; and irreversible acetylcholinesterase inhibitors. These nerve gases were developed originally from the organophosphate insecticides in Germany in 1937. The most recent cases of nerve gas attacks against civilian populations were the use of sarin against Kurdish villages in 1988 and the Tokyo subway attack in 1995. The irreversible cholinesterase inhibitors are tabun (GA), sarin (GB), soman (GD), and VX. It is ironic that gerontologists commonly use reversible cholinesterase inhibitors to treat Alzheimer’s disease.

Chemical warfare affects people both in the short term and long term. The major acute effects of nerve gases are excessive salivation, miosis, vomiting, diarrhea, dyspnea, hypotension, fasciculations, paralysis, restlessness, tremors, and convulsions. Long-term effects include fatigue and defective vision.

Progression of the smallpox rash (left) compared to that of chickenpox (right). Photos courtesy World Health Organization.

Top: Cutaneous, or skin, anthrax lesion four days after exposure. The lesion is developing into an ulcer, and the arm is swelling.

Center: Cutaneous anthrax lesion seven days after exposure. The ulcer base is darker, and the swelling has decreased.

Bottom: Cutaneous anthrax lesion twelve days after exposure. The lesion is dry and black and will soon separate and fall off.

All photos courtesy of the Centers for Disease Control and Prevention.
Inpatient Geriatric Psychiatry Unit at Saint Louis University Newly Opened

When life throws a few too many curves, older adults often can feel overwhelmed by major life changes. Retirement, the death of a spouse, illness, even children growing up and leaving can trigger depression and mood or anxiety disorders that become serious enough for hospitalization. In addition to evaluation, the most up-to-date treatment, and intensive therapy, these patients need comfort, quiet, and the supportive environment of a hospital.

The decision to hospitalize an older loved one facing emotional problems can be difficult. In addition to a hospital that provides the best psychiatric care, it is important to find a facility that is designed to meet the individual needs of seniors - one that puts a premium on comfort and safety, and one where every medical need can be addressed.

Saint Louis University Hospital designed its Geriatric Psychiatry Unit in direct response to the emotional needs of older adults. By providing a wing for patients who have difficulty with memory, cognition, and severe behavioral disorders separate from those with problems, such as late-life depression and mood disorders, it is possible to better consider each patient's personal set of circumstances.

Older patients admitted to the Geriatric Psychiatry Unit receive care in a comfortable, home-like setting. Private rooms and cozy sitting areas blend with common rooms that encourage social interaction. The goal is to provide a safe and healthy environment that nurtures the healing process. Together with patients and their families, hospital staff help build on each person's current abilities and strengths to establish new behaviors.

Focused on restoring the older patient to good mental health and on regaining all of the activities of daily living, the individualized, multidisciplinary evaluation and treatment plans include:

- formal, comprehensive evaluations and medical management coordinated by a board-certified physician specializing in geriatric psychiatry, a fellow, and a resident
- pharmacotherapy
- individual and group therapy to improve coping, concentration, and cognition skills
- family therapy
- activities therapy
- patient and family education
- occupational therapy and physical therapy
- neuropsychological and behavioral therapy consultation
- social work assistance in planning appropriate outpatient treatments.

In this environment with skilled and caring professionals, medications and other treatments proven to be helpful in treating mental illnesses can be administered safely, effectively, and with compassion. 

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self wishing that non-hospice patients who are not dying but are just as disabled could be cared for this way as well.

The job of pastoral care was to offer spiritual support regardless of the religious beliefs of the patients. Betty did not believe in God or humanity. She looked at me and said, “I didn’t think young people cared about us. You never see them here [in the nursing home].” Yet she was comforted by the two of us and the cheesecake we brought her. Perhaps she revised her view of humanity after our visit. Our job was to accept her as she was and not to convert her. We merely listened and offered support. We talked to a lady with AIDS about life and what it had taught her. She said, “I used to worry about every detail and run myself ragged, and now I don’t have to worry about it anymore.” I was surprised at how much more wisdom the patients offered us than we offered them.

The pastoral care staff also ministered to those who were too demented to have a conversation. The chaplain would talk to them anyway, and pray with them if she knew what religion they were. I couldn’t help but think that they understood at least that someone cared enough to come and sit with them for an hour. I know that the families certainly appreciated it.

I went out three times with social workers one month. The social workers helped patients get access to supplies and services they couldn’t afford. They helped Emma, the sole caretaker of her husband, Charles, who has terminal chronic heart failure (CHF), get a few days off by putting him in respite care. More importantly though, she needed someone to talk to about how difficult it was for her to take care of her husband when it was so difficult to get around herself, how she could never visit her friends anymore, and how she couldn’t make it to church anymore. The brother of a man with AIDS needed to give up his job to take care of him. The daughter of a lady with cancer needed to talk about how the rest of the family wasn’t helping her with her mother. The daughter of a 98-year-old woman with general decline wanted to know how to feed all the relatives after the funeral. She needed to talk about how hard it was seeing her mother live on her own until recently, while she herself needed assisted living. All her friends who were joking about it didn’t seem to realize how much the jokes hurt. Social work, like nursing and pastoral care, was about listening and supporting entire families.

At Pathways Hospice, I mostly went out to see the same patients every week, and therefore developed more of a relationship with them than with the patients I saw with VNA. We followed Jane who conveniently turned off her hearing aid when she didn’t want to hear what a nurse was trying to tell her. It made me wish sometimes that I needed a hearing aid. She had some of the staff at the nursing home convinced that she was totally deaf!

I saw Charles quite a bit, a man with lung cancer and no family or friends in the area. We had quite a few good discussions about music, as we both liked the Blues, particularly B.B. King. Since the entire nursing home seemed to be bereft of music, I brought my CD player and a live B.B. King CD. He was so touched that he was in tears, a reaction that astonished me. He asked me to bring some Muddy Waters next time, and I told him about Annie, the lady downstairs who grew up with B.B. King in Mississippi.

Corinne was a 98-year-old woman with CHF. Several times in her life she has been given only a few weeks to live and surprised everyone by spiting death. She spent years working in the film industry looking for imperfections in the film and says she met many celebrities including Gene Kelly. She spent years traveling all around the world with her niece, outlived a few husbands and had a boyfriend in his 40’s when she was in her 80’s. (She outlived him.) She was often anxious, saying how afraid she was of dying and of being alone. Her niece had often taken her to the emergency room.

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Patients suffering from dementing illnesses, such as Alzheimer’s disease, often require an environment that puts a premium on security and safety without unnecessary restraint. The SLU Hospital Geriatric Psychiatry Unit physically separates these patients onto an area that includes:

- large and specially appointed private rooms
- uniquely designed “wandering” areas for patients who need to pace
- dining facilities and common areas that allow close observation from nursing staff
- appropriate lighting to minimize agitation.

All therapies are based on a philosophy of holistic health care. Therefore, treatments using proven non-medical approaches are often used. The SLU Hospital Pet Therapy Program, for example, puts geriatric psychiatry patients in contact with specially trained therapy dogs. Studies show that pet therapy helps lower blood pressure, decrease depression, improve communication skills, and generally improve the patient’s condition.

The Geriatric Psychiatry treatment team works closely with referring physicians to assist each older patient and his/her family in developing the multiple components of a plan for positive aging that encourages individual hopes and human growth. A comprehensive discharge plan, created upon admission, ensures the patient’s follow-up care. Depending on the patient’s needs, the Geriatric Psychiatry Treatment team can act as a liaison between families, physicians, and other care facilities.

To discuss admission or for more information on the Geriatric Psychiatry Unit at Saint Louis University Hospital, call (314) 580-2300.
making nursing homes more humane and receptive institutions by infusing them with elements of the natural world.

As faculty of Saint Louis University, geriatric medicine specialists send medical students into the community to operate free clinics and home-care programs that reach shut-ins and other older people who otherwise might not receive care. A specialty clinic they created provides care for developmentally disabled adults.

Widespread Education Efforts

The main mission of geriatric medicine specialists is to share the knowledge gained through research and clinical settings so that caregivers throughout the world can use best practices in the care of older people. Health care professionals in more than 20 disciplines gather for training conferences on the Saint Louis University Health Sciences Center Campus, such as The Geriatric Summer Institute and the Medical Directors of Nursing Homes Conference. These sessions provide opportunities for physicians and health care professionals to gain hands-on experience in caring for older people.

In the same information-sharing spirit, Dr. Morley has authored numerous papers and 18 books, including Geriatric Nutrition, Second Edition (1995); Memory Function and Aging Related Disorders (1992); Medical Care in the Nursing Home, Second Edition (1996); Frailty in Older Individuals (1993); and Endocrinology of Aging (2000). He serves on the editorial board of Peptides, Journal of Nutritional Medicine and Age & Nutrition, and he is editor of the Journal of Gerontology: Medical Sciences.

J.E. Morley, MB, BCh, H.J. Armbrecht, PhD, R.M Coe, PhD, and B. Vellas, MD, PhD, recently edited The Science of Geriatrics (2000). It covers the interface between the basic scientific knowledge of aging and clinical geriatric medicine. The two-volume set has 55 chapters containing a wealth of information on topics such as gender and longevity, the effect of vitamin E on infection and immunity, drug metabolism in older persons, male sexual function and aging.

Several articles by Dr. Morley can be found on a cybersite for seniors and their caregivers, www.thedoctorwillseeyounow.com, developed in collaboration with Saint Louis University and the Gateway GEC. In addition to articles written by geriatric medicine experts, this site provides health updates and an interactive question and answer session.

Dr. Morley also edits the geriatric medicine section of www.cyberounds.com, a Web-based educational program for physicians and other health professionals. Besides regular updates on geriatric medicine, www.cyberounds.com provides an opportunity to directly ask questions of Saint Louis University faculty concerning all areas of geriatric medicine and gerontology.

“If we have an international reputation, it is because we are grounded in the science of geriatric medicine. It is because we initiate basic and clinical research on senior care. It is because at any given time someone from our faculty is somewhere in the world teaching others how to treat older people. It is because we strive for continuous improvements in every avenue of health care. Everything we do contributes to our reputation,” Dr. Morley says.
New Screening Tool
(continued from page 5)

• Quantify when they feel hungry
• Describe how food tastes
• Compare how food tastes now to how it tasted at age 50
• Indicate how often they eat
• Assess how often they feel sick or nauseated when eating
• Describe their general mood.

Ninety percent of the diseases that cause weight loss in older adults are treatable. Older people need to pay attention to eating enough. Every older person should have his or her appetite checked regularly. If you’re caring for an older person, ask them regularly about their appetite using this tool.

While older adults lose weight for a variety of reasons – including problems with medicines, difficulties with their teeth and therapeutic diets – depression is the most common cause.

Research tells us that people who eat with others increase their food intake. Therefore, when an older adult receives home-delivered meals, he or she will eat more of it if the person delivering the meal can stay to visit while the elder eats.

Saint Louis University Hospital: Only Local Hospital Ranked on Modern Maturity’s “Top 50” List

Saint Louis University Hospital – and its physician partners at Saint Louis University School of Medicine – has been ranked by AARP’s Modern Maturity magazine as one of the Top 50 Hospitals in the United States. It is the only local hospital to make the list. Our Gateway Geriatric Education Center consortium partner, Rush-Presbyterian-St. Luke’s Hospital in Chicago, Illinois, also made the list.

Saint Louis University Hospital also was ranked by Modern Maturity as one of the top 10 leading renal care hospitals. The final list of 50 Top Hospitals was selected using criteria such as physician ratings, accreditation score, training programs for physicians, and death rates for various types of medical and surgical cases.

In July 2001, Saint Louis University Hospital also received the honor of being the only local hospital to be ranked among the top 10 Best Hospitals for geriatric care by U.S. News & World Report. The Modern Maturity and U.S. News rankings reflect the hospital’s strong emphasis upon caring for our nation’s seniors.

Challenges and Choices

The Gateway Geriatric Education Center is pleased to introduce a new game to its readership. “Challenges and Choices” was created by Dr. William Gingold at the GEC Consortium partner, the University of Illinois - Urbana-Champaign. This game presents care providers with an easy-to-use tool for identifying problems, concerns, and conflicts arising in caregiving. The magnetic game board and game pieces allow easy use and repeat evaluations of constantly changing caregiving situations. The game is available at a cost of $30.00 Direct inquiries to Ronna Rhodes at 314-268-5644.
autonomic regulation. Treatment includes the administration of atropine, and treatment for seizures and bronchospasm.

The blister agents cause edema, ulceration, and tissue necrosis. Bronchopneumonia, vomiting, fever, and blindness are all associated with vesicant exposure. These agents are spread by contact and medical personnel should not treat these patients without full body protection.

**Bioterrorism**

The agents which have been identified by the Centers for Disease Control and Prevention (CDC) as most likely to be used for bioterrorism are:
- Smallpox
- Anthrax
- Plague
- Botulism
- Tuleremia
- Salmonella
- Ricen
- Ebola
- Marburg hemorrhagic fevers
- Lassa fever
- Argentine hemorrhagic fever (Junin).

In 1984, salmonella sickened 751 people in a small Oregon town when a fringe community deliberately contaminated foods in a salad bar. Ricen is a cytotoxin from the castor plant bean that damages the lungs. Most agents used for bioterrorism cause the victim to present with either fever, cough, or skin rash.

It is important to realize that bioterrorism represents an unusual diagnosis. Despite the adage, “When a health professional hears hoofbeats, it is more likely to be a horse than a zebra!” health professionals today need to consider that victims of terrorism may be presenting with very common symptoms of many diseases seen every day by physicians.

Presentations of inhalation anthrax during the recent postal anthrax attack included fever, chills, drenching sweats, fatigue, minimal non-productive cough, nausea, chest discomfort, headaches, myalgias, and delirium. The chest x-ray showed a widened mediasternum (due to lung infiltrates and pleural effusions). Cutaneous anthrax presents with painless, pruritic papules with progression to vesicles and black scar tissue associated with regional lymphadenopathy and a low-grade fever.

**Concluding Comments**

Unfortunately, terrorism has become a fact of modern life. There is a suggestion that older persons may be more vulnerable to bioterrorism with an increased chance of becoming infected with low-dose exposures and having worse outcomes. In addition, during a major terrorist attack, essential medical and social services for older persons are liable to be disrupted. There is some suggestion that terrorist attacks such as 9/11 may increase suicidal ideation and depression among older persons. Fear induced by the multiple terrorist warnings we now receive may lead to increased isolation of older persons living in cities. Older persons are also particularly vulnerable to scam artists playing on their fears and defrauding them. Unfortunately, geriatricians, like all other health professionals, now have to include the effects and possibilities of terrorist attacks in their approach to comprehensive care for their patients.
Hospice  (continued from page 18)

Emergency room for pain, which was promptly relieved as soon as she was surrounded by doctors. She was happy just to have us sit near her.

I took this elective to learn more about hospice, as I would certainly be dealing with it as a family physician. I learned that hospice is invaluable to the dying patient and his or her family, especially in the nursing home, and that it would be valuable to those nursing home residents who are not dying as well. I asked several of the hospice staff what doctors needed to know about hospice. They said that doctors should accept earlier in the course of the illness that a patient is dying; they should refer the patient earlier, and help the patient prepare for death; that often the physician does not want to admit that the patient is, in fact, dying; that physicians should discuss with every patient his or her wishes regarding the dying process, not just those who are in immediate danger of death; that hospice is not a place patients go to die; and most importantly, that hospice is not giving up on the patient...it’s just moving on.

University of the Third Age Conference
Saturday, October 19, 2002
at Saint Louis University
(no CME)

14th Annual Saint Louis University Symposium for Medical Directors
Saturday, December 7, 2002
at Saint Louis University

22nd Annual Geriatric Research, Education, and Clinical Center Conference on Health Promotion and Disease Prevention
Thursday and Friday, December 5 and 6, 2002
at Saint Louis University

10th Annual Program in Geriatrics for Non-Physicians
On Fridays, 8:30 - 4:30
In Urbana, IL: 9/6, 9/20, 10/4, 10/18, 11/1, and 11/15.
In Springfield, IL: 9/27, 10/4, 10/11, 10/25, 11/8, and 11/22.

For more information about these conferences, please call 314-268-5644.

Questions? FAX: (314) 771-8575 •  email: agingsuccess@slu.edu

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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