The poet lyrically invites us to, “Grow old along with me! The best is yet to be.” In return, the cynic responds, “What damned fool said that?” Regardless of whether you are more of a poet or a cynic, it is doubtlessly clear to all of you that aging is not for sissies. The process of getting older, although inevitable, can be a difficult one both physically and mentally, but take heart because there are many things that you can do to keep yourself feeling and looking younger than you really are.

Our purpose in writing this book is to share with you ten simple, but critical, steps for maintaining an optimal quality of life throughout your lifetime, regardless of your current age and the genes that you inherited. In fact, if you start to follow the suggestions (continued on page 3)
OVER 300 TRAINED AT 18TH ANNUAL SUMMER GERIATRIC INSTITUTE

Three hundred and nineteen caregivers of geriatric medicine from over ten disciplines descended upon St. Louis this past June, to learn more about “Health and Wholeness in Body, Mind, and Spirit.”

Our keynote speaker on June 12 was Andrew V. Shally, Ph.D. and Nobel Prize winner, from the Miami VA Medical Center. He gave the Jim Flood Memorial Lecture: From Neuroendocrinology to Cancer Therapy: New Approaches to Therapy of Various Tumors Based in Peptide Analog. Dr. Schally was introduced by his research colleague, Dr. William Banks of the St. Louis VA Geriatric Research, Education, and Clinical Center (GRECC).

The June 13 keynote speaker was William J. Evans, Ph.D., a research scientist at the Little Rock, Arkansas GRECC. He gave the Max K. Horwitt Memorial Lecture: Nutrition and Exercise in the Elderly: New Approaches to Health Promotion.

HEALTH RESOURCES & SERVICES ADMINISTRATION (HRSA) RESTORES GERIATRIC FUNDING

Following the restoration of funds for geriatric education to the FY 2006 federal budget, Saint Louis University successfully applied for grants to provide geriatric training.

Julie K. Gammack, M.D., and Miguel Paniagua, M.D., assistant professors in the Division of Geriatric Medicine, Department of Internal Medicine, have both received Geriatric Academic Career Awards (GACA) from HRSA. These GACAs support the implementation of innovative geriatric teaching curricula.

Drs. John Morley and Nina Tumosa have been awarded three years of funding for the Gateway Geriatric Education Center, the purpose of which is to provide geriatric training to healthcare providers throughout Missouri and Southern Illinois.

DR. GAMMACK RECEIVES NEW GRANT FUNDING

Julie K. Gammack, M.D., assistant professor, Division of Geriatric Medicine, Department of Internal Medicine, received a three-year $21,384 grant from the Health Resources & Services Administration (HRSA), titled, “The Development of Standardized Assessments.”
in this book, within days and weeks you will likely experience the following, no matter how old you are:

- An upsurge in your energy levels
- An enhanced enjoyment of your life and daily activities
- A noticeable increase in the sharpness of your mind
- A stronger sex drive.

While these results will be more immediate, other benefits, like a fine wine, will take more time to fully appreciate—months, years, or even a lifetime.

This book is your passport to aging successfully and feeling your best at any age. Like anyone with a passport, however, you get to choose where you go with it. Throughout, we will point out the minimum that needs to be done at any particular stop along the way, as well as what we consider to be optimal. Wherever possible, we will also give you alternate choices since there is no single way to age gracefully. The path you choose to optimize your physical and mental journey through the rest of your life should be the one that works best for you.

What This Book Is Not About

At the outset, it is important to stress what this book is not about. First, we’re not here to promise you the impossible or to convince you to make sweeping and dramatic changes in your current lifestyle. Alternately, our goal is to help you to recognize where even small improvements can have the greatest impact on your overall health. For example, one of us (Dr. John) is inherently a physical sloth with an epicurean delight in gourmet food and wine, while the other (Dr. Sheri) is a more traditional believer in the physical and mental benefits of a healthy diet and regular physical activity. For her, exercise results more reliably in an endorphin “high,” while he questions whether exercise is anything more than “the ultimate experience in masochism.” Regardless of whose viewpoint you more closely identify with, accepting that participation in at least some exercise is essential will benefit you immensely.

The second thing that this book is not about is life extension—that is, increasing your longevity. We both fervently believe that enjoyment of life (by adding quality to your life) is far more important than simply racking up additional years. Living longer when plagued by debilitating illnesses, immobility, or a loss of independence is not necessarily a gift. Over a quarter of a century ago, Professor James Fries at Stanford University first suggested that each individual’s goal should not be an extension of life, but rather a higher quality. Living well and feeling good enough to do whatever you want to do throughout your lifetime, however, is priceless. If you follow our suggestions in this book, you will likely come closer to this optimal goal, and you may even end up with a better and a longer life.

Understanding How Your Body Changes over Time

The changes that your body undergoes over time are complex and involve both normal physiological and disease processes. In general, your body experiences very gradual and subtle alterations in how well its different systems—like breathing, digestion, and sexual ability—function over time. Human cells apparently have a limited number of times that they can split and reproduce. Once your cells slow their rate of turnover, these subtle changes start to accelerate. Unfortunately, such effects are often inseparable from (continued on page 4)
the onset of chronic diseases like heart disease and cancer.

Whether a true dichotomy exists between health problems caused by natural aging or by disease is largely irrelevant, though. If we could find a way to prevent all diseases from occurring, our lives would eventually end at some point when our cells have reached their maximal life span. Attempting to achieve greater longevity by preventing and effectively treating diseases that can shorten your life, though, is entirely relevant and a central purpose of this book. For example, the density of bones peaks somewhere around 25 years of age, after which time they may start to lose some stored calcium and other minerals over time. Muscle fibers, too, must be routinely used to prevent excess losses of muscle with each passing decade. However, here’s an area where regular physical activity will likely be beneficial and have an immediate effect. Likewise, a lesser ability to absorb adequate amounts of vitamins and minerals from foods may be almost entirely countered by dietary improvements that are easy to implement (as outlined in later steps of this book).

No Easy Fixes
The first best-selling book on aging was written in the 13th century by Roger Bacon, and it gave the following rules for success: controlled diet, proper rest, exercise, moderation in lifestyle, good hygiene, and inhalation of the breath of a virgin. We can attest to all of these recommendations—with the exception of the last one. However, virtually every best-selling book about aging written since that time has included one or more modern equivalents of the “breath of a virgin.”

By way of example, Dr. Deepak Chopra, one of America’s spiritual gurus with an interest in holistic healing, wrote a seemingly sensible book not long ago that time has included one or more modern equivalents of the “breath of a virgin.” Initially, Dr. John had been recommending Chopra’s book to his older patients. But he stopped doing so when they started complaining that he was holding out on them and asking if he would please tell them where to get these precious herbs. When asked if they were walking up ten flights of stairs a day or changing their diets for the better as Dr. John routinely recommends, they invariably replied, “No, doctor, that’s too hard. I just want the herb.”

What This Book Has to Offer
Our book has no virginal breath to offer you. We are alternately offering something even better, though: an innovative program with easily implemented steps that actually works to help you stay feeling, looking, and acting younger for longer. You may not be preventing, reversing, or even slowing your aging per se, but following the steps outlined in this book will invariably make your journey through the rest of your life from this point forward as enjoyable—and as disease-free—as humanly possible.

Our proactive approach to your successful aging contains ten easy-to-follow steps aimed at understanding, preventing, controlling, and/or reversing most health problems that can make you feel older or shorten your life. Our program explains the best foods to eat, why alcohol can be beneficial (and how much to drink), what types of exercise are important, which hormones are most likely to enhance your vigor, how to keep your mind sharp, and why weight loss may not be advisable at certain ages. It additionally gives you the knowledge to keep your heart healthy, prevent cancer, thicken up your bones, keep your joints limber, and stay on your feet.

Remarkably, your own fate has never been more in your own hands. We sincerely hope that you will choose to use this passport to immediate better health and a successful rest-of-your-life.

“"No, doctor, that’s too hard. I just want the herb."

(continued from page 3)
Chapter 1: Start on the Steps to Successful Aging

“To resist the frigidity of old age, one must combine the body, the mind, and the heart. And to keep these in parallel vigor one must exercise, study, and love.”

-Charles-Victor de Bonstettin (1867-1947)

How many times have you heard people blame all of their aches and pains on “getting old”? Both of us have heard it frequently even from people in their 30s and 40s. Maybe you have also used it as an explanation for why you feel achy when you stand up after sitting too long or for why you’re now experiencing a “middle-age spread” when you’ve never had problems keeping your weight down before. Many of these types of symptoms so commonly attributed to getting older may actually be reversible or preventable, meaning that they’re likely not inevitable consequences of aging at all.

Using Our 10-Step Program

Once you have read through all of the steps and begun implementing some of our suggestions into your daily life, you’re certain to start experiencing some noticeable health benefits, many of which will be readily apparent in six months or less. Whether you follow all of the steps depends on your own unique situation and your individual preferences. If nothing else, at least you will have gained the knowledge base to make informed decisions about what to do to optimize both your current health and how well you look and feel from here on out.

To make it easier to tell the difference between honest-to-goodness effects of getting older (that you can only minimally affect) and health problems resulting from other causes (that you may be able to do something about), we’re going to tell you some of the more important questions to ask about aging successfully and where to find the answers in the ten steps of this book:

• Why don’t French women get fat? (Step 1)
• How much fish should you eat, and when do you need fish oil? (Step 1)
• How much alcohol is good, and does it have to be red wine? (Step 1)
• Can a super-antioxidant supplement slow down aging? (Step 1)

• Is walking the only exercise you need to do? (Step 2)
• Why is it important to practice balancing on one leg? (Step 2)
• Can exercise really keep you from getting gray hairs? (Step 2)

• Is testosterone good for both men and women? (Step 3)
• Is estrogen really back in vogue again? (Step 3)
• Is it possible to reverse Alzheimer’s disease? (Step 4)
• Do crossword puzzles and Sudoku really keep your mind sharp? (Step 4)

• Why does attending church help you live longer when listening to a tele-evangelist doesn’t? (Step 4)
• Why is weight loss bad for you as you age? (Step 5)
• Can you still look muscular once you reach 50? (Step 5)

• Is it possible to lower your chances (continued on page 8)

Why does attending church help you live longer when listening to a tele-evangelist doesn’t?

Questions? FAX: 314-771-8575  email: aging@slu.edu
My name is Sue Brooks. On behalf of Dr. John Morley and the Division of Geriatric Medicine at Saint Louis University, we would like to honor Mrs. Leona Seals as one of the founders of the Health Resource Clinic, a free clinic run by SLU medical students established in 1994 through the BREM Catholic Social Ministries and held in St. Augustine’s church.

Dr. Morley is out of town and would have changed his schedule if it were at all possible. Earlier this week, as I walked into his office, I saw Dr. Morley sitting with a wistful, faraway look in his eyes, and I asked if anything was wrong. He told me he had just learned that Leona Seals had passed away. “She was a very kind and generous woman,” he told me. “All of us geriatricians loved her.” “As one of the founders of the HRC clinic,” he went on to explain, “Mrs. Seals not only supported the clinic’s ideas but supported them with her time and wisdom. She was extremely helpful to the medical students and the people who were seen at the clinic plus she sat on the Community Advisory Committee. We all greatly appreciated her then and grew to love her over the years as we worked with her and subsequently provided her health care. We are going to miss her dearly.”

So, on behalf of all of us from SLU, we honor you, Mrs. Leona Seals for your dedication to the community, your love of people, and for enriching all of our lives. May God use the foundation you set and your memory of a job well done to teach us to bless others as you have shown us to do.

“...I just wanted to thank you for the excellent care that you and your physician group arranged for Leona. She died peacefully on Friday. I talked to her at length about dying the Friday before she died. She was very much at peace, and ready to go to her God. She commented that she received excellent care in her final days at DesPeres Hospital. She was happy with the level of intervention, which respected her efforts to heal, and when she could no longer heal, supported her efforts to die with dignity. She died with dignity and much peace. Leona had the highest expectations of her health care providers, and it was wonderful that those expectations were met.”

- Dottie Kastigar
A Tribute to Mrs. Leona Perry Seals

My name is Daniel Johnson. I am a medical student, and I am here to represent the students of Saint Louis University. We would like, first and foremost, to thank and honor Leona Seals for all of the work that she has done in her life, as well as for the opportunity to have been able to work with and come to know her.

Mrs. Seals was one of the founding members of the Health Resource Center, which is a free clinic that is run in cooperation with St. Augustine Church and Saint Louis University’s Medical School. She helped with the birth of this clinic in the early 1990s, took an active role in patient care through the early years, and inspired many people to continue working into the future.

Unfortunately, I was never able to meet Mrs. Seals. I missed an opportunity to meet such an important leader in a clinic that became my own. I was part of a group of student leaders who were responsible for the operation of the clinic last year. From my time spent there, I can assure you that what we have today is a direct result of Leona Seals’ spirit and participation. The clinic is an organization that serves, each year, over 500 people who may have otherwise gone without healthcare. Mrs. Seals started down a brave path that has resulted in a vitally necessary and incredibly unique resource for the Saint Louis community. I stand here on behalf of my fellow students to thank Mrs. Seals and each of you for giving us the chance to help heal and learn.
for breast or prostate cancer? (Step 7)

- What type of dietary fiber is best for preventing colon cancer? (Step 7)
- Does tai chi prevent or reverse thinning bones? (Step 8)
- Can chondroitin and glucosamine make your arthritic joints feel like new? (Step 8)
- Can hip fractures resulting from falls be prevented? (Step 9)
- Why will SPA (i.e., spontaneous physical activity) help you live longer and better? (Step 9)
- Can taking too many medications cause more problems than it solves? (Step 10)
- When should you see a doctor who specializes in aging? (Step 10)

Our proactive approach to staying and feeling young longer is largely focused on preventing, controlling, and reversing many chronic conditions that can cause you to lose your vitality or your good health. These goals can largely be accomplished through a healthier lifestyle and earlier medical intervention, and the 10 simple steps, along with action steps given throughout the book, will help you easily implement changes into your life listed as “Action Steps for Better Health” in boxes in each chapter. As you read through this book, you can start implementing the suggestions given in each step as you go—without necessarily waiting until you reach the end. For example, once you learn how healthy fish is for both your heart and your brain, you can start eating more of it, while avoiding the types of fish with too much mercury in them.

Promoting good health is best when done over a lifetime, but you can still start implementing healthful practices at any time to increase your odds of longer survival and a stronger, healthier body. You can always gain some of the health promotion benefits, regardless of your current age, but the sooner you get started, the better your results will likely be.

It is important to note, however, that some guidelines change as time passes, and what is appropriate for you at 20 years of age may not be when you reach 40, 60, or older. For general guidelines to optimal health at any age, consult pages 12-13 in this publication. You can learn more of the secrets in December when the book is published.
I recently returned from an Aging Meeting in Sicily where the young man, Aeneas, carried his father, Anchises, on his shoulders onto the beach at Ence after his father was expelled from home. While there, I received a number of calls from family members who were struggling with the day-to-day needs of their frail parents. This caused me to ponder the key role that family support networks play in allowing vulnerable elders to function in the community.

The interaction between aging physiology and disease often makes it impossible for older persons to see to their own care. They become dependent on others to organize their care and help them get to innumerable appointments with various health care providers. Family members dealing for the first time with the complexities of the health care system desperately need simple answers of what to do. Rarely do I see an older patient without a family member in attendance. In delivering care, I am as much responsible for helping the family member as I am for administering care to my patient.

In reflecting on this, I realize my dream of retiring to the California coast is a fantasy. My children and grandchildren all live in St. Louis. As I age, they become more my strength and my reason for existence. In Ence, my spare time was spent shopping for my grandchildren. During the tour of the Greek ruins, my mind consistently wished that my grandchildren were there to marvel at this conundrum of history, the Ruined Greek Temples in Italy.

As we age, I often talk to my wife of how we need to move somewhere where we can walk to stores, restaurants, movies, and, most importantly, a bookstore. Always a terrible driver, I realize it will not be long before my driving skills are nonexistent, and I observe that my wife, who has always been an outstanding driver, is now not quite as good. I recognize now that in my life course I am slowly entering that time when I will need my children’s support. This is terrifying, but in its own way strangely comforting. It is family, in the end, who are our legacy, and it is our family ties that allow us to age successfully. I remain in awe of how wonderful the children of my patients are at caring and desperately seeking help for their parents. It is they who usually recognize their parents’ need for a geriatrician. Most internists and family practitioners seem blissfully and arrogantly unaware of the special medical needs of the aging person.

All of this leads me to recognize the need to redouble our efforts to educate health professionals about aging. We also need to greatly increase the numbers of geriatricians, or the aging baby boomers will find that their medical care will be incredibly inappropriate. It is time to increase respect for those who care for elders, be it the CNA in the nursing home, the academic geriatrician in the office, or the network of family caregivers in the community. Only when we recognize the importance of what these people do and place them on the same pedestal as the neurosurgeon or the cardiologist will we eventually attract more young people to this field.

It is time to develop a global society where caring for the most vulnerable in society is considered worthy of the same rewards (both in respect and income) as are the high-technology medical fields.
1. What day of the week is it?
2. What is the year?
3. What state are we in?
4. Please remember these five objects. I will ask you what they are later.
   Apple     Pen     Tie     House     Car
5. You have $100 and you go to the store and buy a dozen apples for $3 and a tricycle for $20.
   How much did you spend?
   How much do you have left?
6. Please name as many animals as you can in one minute.
   0-4 animals  5-9 animals  10-14 animals  15+ animals
7. What were the five objects I asked you to remember? I point for each one correct.
8. I am going to give you a series of numbers and I would like you to give them to me backwards.
   For example, if I say 42, you would say 24.
   87    649    8537
9. This is a clock face. Please put in the hour markers and the time at ten minutes to eleven o'clock.
   Hour markers okay
   Time correct
10. Please place an X in the triangle.
    Which of the above figures is largest?
11. I am going to tell you a story. Please listen carefully because afterwards, I'm going to ask you some questions about it.
    Jill was a very successful stockbroker. She made a lot of money on the stock market. She then met Jack, a devastatingly handsome man. She married him and had three children. They lived in Chicago. She then stopped work and stayed at home to bring up her children. When they were teenagers, she went back to work. She and Jack lived happily ever after.
    What was the female's name?
    What work did she do?
    When did she go back to work?
    What state did she live in?

TOTAL SCORE

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<th>un-scored</th>
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SCORING

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</tr>
<tr>
<td>21-26</td>
<td>MNCD*</td>
<td>20-24</td>
</tr>
<tr>
<td>1-20</td>
<td>Dementia</td>
<td>1-19</td>
</tr>
<tr>
<td>* Mild Neurocognitive Disorder</td>
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The Joint Commission on Accreditation of Healthcare Organizations (JCAHO) approved new pain assessment and management standards in 1999 citing, “Unrelieved pain has enormous physiological effects on patients. Effective pain management is a crucial component of good care.”

With increasing life expectancy and the incidence of chronic illness, along with the increased potential of dementia during the aging process, the need for accurate pain assessment and care is imperative. Pain robs our elderly patients of their quality of life, limits their functional capabilities and leads to the challenges of caring for some of life’s most precious commodities – our patients, someone’s mother, father, or loved one.

PAIN BEFORE BEHAVIORS

“Although chronic pain has not thus far invaded my body, it has pried its way into my soul.”

— Arthur Rosenfeld

After all, the topic of pain is far less about nerve cells and neurotransmitters than it is about the nightmare of unbearable suffering from which there is no awakening. The passion to care for our patients with pain has indeed pried its way into MY soul.

HUMAN EXPERIENCE

Pain is indeed a natural part of our human experience. Pain begins at birth and continues along life’s journey coming to us in many forms: physical, emotional, spiritual, and relational.

It is the goal of our NHC Health Care Teams to work together to assist in relieving each patient’s pain. In the process, we will hope it often does not present itself in a visible fashion – caregivers can assess and treat the things they can see, yet we tend to allow our own perceptions to intervene with the unseen. The question then becomes, how can we make pain visible? How do we reverse a culture of healthcare that depends on clear-cut physical symptoms to assess the patient? And that often can’t see the need for care and attention beyond the medical?

LISTENING

“Nobody wanted to help me with my pain.”

— Hal E. Garner, Jr. Professional Football Player

“There is a stigma...they didn’t believe I was in pain.”

— Hertz Nazaire Adult Survivor of Sickle Cell

These quotes are taken from Arthur Rosenfeld’s book, “The Truth About Chronic Pain.” They tell the story of individuals who are able to speak their fears and frustrations about the invisible symptoms that plagued them. Concerns and fears with stigmas...with helplessness and hopelessness.

THE GREATEST EVIL IS PHYSICAL PAIN.

— Saint Augustine

Questions? FAX: 314-771-8575

email: aging@slu.edu

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**PRIOR TO BIRTH**

1. Choose long-lived parents
2. Have your mother get regular check-ups during pregnancy
3. Have your mother not smoke or drink alcohol
4. Have your mother take pre-natal vitamins including folate.

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**0-20 YEARS**

1. Exercise regularly
2. Avoid obesity
3. Ingest adequate calcium
4. Eat nutritious foods
5. Wear your seatbelt
6. Do not smoke or drink
7. Get your vaccinations
8. Avoid violence and illicit drugs

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**20-40 YEARS**

1. Exercise regularly
2. Avoid obesity
3. Ingest adequate calcium
4. Eat fish
5. Wear your seatbelt
6. Drink in moderation and do not smoke
7. Drive at a safe speed
8. Avoid violence and illicit drugs
8. Check your breasts regularly (females)
A GUIDE TO HEALTH PROMOTION OVER THE LIFESPAN

40-60 YEARS
1. Exercise regularly
2. Avoid obesity
3. Ingest adequate calcium and vitamin D
4. Eat fish
5. Wear your seatbelt
6. Avoid weight loss
7. Ingest adequate calcium and vitamin D
8. Drink in moderation and do not smoke
9. Have your blood pressure checked
10. Have your cholesterol and glucose checked
11. Screen for breast and colon cancer, high blood pressure, and diabetes
12. Have Pap smears (females)
13. Have regular mental activity and socialize!
14. Avoid taking too many medicines
15. Consider hormone replacement (men)

60-80 YEARS
1. Exercise regularly, including balance and resistance exercises
2. Avoid weight loss
3. Ingest adequate calcium and vitamin D
4. Eat fish
5. Wear your seatbelt
6. Drink in moderation and do not smoke
7. Have your blood pressure checked
8. Do monthly breast self-exams
9. Have flu and pneumococcal vaccinations
10. Have Pap smears (females)
11. Have your cholesterol checked
12. Have flu and pneumococcal vaccinations
13. Have Pap smears (females)
14. Have regular mental activity and socialize!
15. Avoid taking too many medicines

80+
1. Exercise regularly, including balance and resistance exercises
2. Avoid weight loss
3. Ingest adequate calcium and vitamin D
4. Be screened for osteoporosis
5. Wear your seatbelt
6. Drink in moderation and do not smoke
7. Have your blood pressure checked
8. Do monthly breast self-exams
9. Have flu and pneumococcal vaccinations
10. Have Pap smears (females)
11. Have regular mental activity and socialize!
12. Avoid taking too many medicines
13. Keep doing what you are doing.
14. Remember, most of your physicians won’t reach your age!

See ya later, Doc!

Questions? FAX: 314-771-8575 email: aging@slu.edu
HEARING THE PATIENT

“You don’t even know what pain is until it happens to you...Until it is actually you and yours, you can’t understand it.”

— Mary Vargus, JD, survivor, automobile accident

“(They tell me it can’t hurt anymore, the leg was cut off) there are 50 staples in her leg. When was the last time you had your leg cut off?”

— Allyson Gabry, pain patient

It is when we as caregivers begin to accept the patient’s perception of what pain is that we can begin to effect change. And yet the greatest challenge we face in our centers is being able to address the pain of those who cannot speak for themselves.

RESPONDING TO THE PATIENT

“The most common thing is that other folks think you are a drug addict if you are taking narcotics, and why on earth would you let someone give you those drugs.”

— Susan Shinagawa, breast cancer survivor

NHC patients, families, caregivers, and physicians deal with these perceptions everyday. So how do we make pain VISIBLE for our caregivers?

ACKNOWLEDGING PAIN

We must acknowledge that the best measure of healthcare providers is in the way they care for their patients with pain. They must:

1) Affirm each patient’s perception of his/her pain
2) Identify obstacles, for example, family perception, education of all who come in contact with the patient, as well as local and cultural differences in perspectives about their perception of pain
3) Identify systems that recognize analgesic pharmacology as only one aspect of pain management, and
4) Commit to a comprehensive pain management program that is tailored to each patient.

INTERVENTIONS

One of the ways NHC is attempting to change the perception and treatment of pain is using a training DVD that directly focuses on helping CNAs identify and report possible symptoms of pain. This DVD from the University of Wisconsin helps CNAs and other daily caregivers in the center identify and report their observations, and then provides them with the tools to be able to assist the patient by intervening with non-pharmacological interventions such as massage, warm towels or blankets, as well as items that the patient identifies as comforting or distracting — music, religious material, and other items suggested by the patient or family members.

Obviously, CNAs are only a part of the overall picture. We at NHC are committed to seeing that all staff who interact with the patient in any way have been educated in what to look for in a patient who cannot or will not offer complaints of pain.

(continued on page 15)
Many of our centers have compiled pain/comfort kits that provide non-pharmacological interventions for families and partners to offer the patient.

**Barriers to Assessing Pain**

**For the Patient:**
- Pride
- Cognitive status
- Fear of not being believed
- Fear of cost – financial, addition/control
- Imposition of family/caregivers' beliefs or values on the patient

This list is not an exhaustive list of obstacles that caregivers deal with every day. Families, physicians, and caregivers struggle with patients who have difficulty organizing their thoughts, finding their words, or who may rely more on gestures than speaking and often end up expressing themselves through behaviors.

**For the Caregiver:**
- Not recognizing other symptoms of pain, e.g., weight loss, decline in ADLs, falls, etc.
- Pain management may be a low priority (for the team or caregiver)
- Fragmentation of care
- Few role models

We, as leaders of care in our centers, can be the examples of setting standards and expectations to help the nursing partners begin to see pain as our first priority in care. Beginning with the interview process, and continuing with our orientation and inservice training, and our standards and expectations, we can affect the culture of our centers and begin to erase these barriers.

**System Barriers**
- Lack of practical treatment protocols
- Failure to routinely assess and document pain
- Perception that pain is an insignificant symptom
- No accountability for poor pain management

*(K. Stevenson, RN, MS, Pain Improvement Partnership, Univ. of Wisconsin – Madison, 2006)*

An evaluation of center systems and communication will ensure that the patient receives the comfort measures and this will increase both cognitive and physical function. It will benefit the center in increased patient and family satisfaction, and will decrease the cost of care when we consider issues related to patients with decreased mobility and (continued on page 20)
Increasing Awareness of Dehydration

A Dehydration Council has been formed under the leadership of David Thomas and John Morley, with the purpose of increasing the awareness of elderly individuals’ vulnerability to develop dehydration.

The first meeting of the Dehydration Council was held in Boston in October. The members of the council are Todd Cote (Lexington), Larry Lawthorne (Wright State University), Steven Levenson (Baltimore), John Morley (Saint Louis University), Laurence Rubenstein (UCLA), David Smith (Texas A&M), Richard Stefanacci (Philadelphia), Eric Tangalos (Mayo Clinic), and David Thomas (Saint Louis University).

Among the first agenda items of the council was to develop a screening tool for persons at risk for dehydration. This was done by creating a DEHYDRATION mnemonic. The Council stressed that dehydration is due to diseases which occur in the background of a physiological loss of thirst reflex. They stressed that dehydration is rarely due to neglect. In the end, the diagnosis of dehydration is dependent on laboratory testing. While a person with dehydration usually has an elevated blood urea nitrogen (BUN) to creatinine ratio, the multiple other factors that elevate this ratio make it a poor diagnostic test for dehydration.

The Council is sponsored by Baxter Healthcare Corporation.

Aging and its causes represent a complex area that does not lend itself easily to statistical analysis. Despite this, most large aging studies continue to use classical statistics. These statistics tend to focus on the mean or median and assume a homogenous distribution of the population. In reality, rarely is the population normally distributed and this leads to statistical aberrations due to two point phenomena. Further, many variables are hometically distributed rather than following the classical continuous variable mode. While these points can be detected visually, most epidemiologists do not generate graphics to allow this and with large numbers it is often difficult to discern even simple patterns. These patterns would be much better analyzed using fractal mathematics.

A second problem is the analysis of longitudinal data where statistical methods fail to recognize multiple patterns of disability progression and, by using a single statistic, provide an erroneous picture of the factors affecting progression. Finally, much can be learned from the true outliers, i.e., persons who are highly successful at aging and those who are extremely poor at aging. These can be better handled with long tail statistics. In addition, the recognition of “Black Swans” (totally unexpected patterns of good occurrences producing bad results and vice versa) represents another fertile area to allow us to better understand the aging process.

For these reasons, we believe that a new aging statistics field utilizing chaos mathematics needs to be developed. It is only when this happens that we will be able to recognize the truly beautiful patterns that comprise the aging process.
As I Recall
By William A. Clark, Xlibris Corporation 2003
orders@xlibris.com

As a geriatrician, I occasionally come across a book that speaks to the core of why I became a geriatrician. William Clark has written such a book. In a hundred essays written in the form of letters to his grandchildren, he has encapsulated the breadth of experience that our older friends bring with them every time we see them. While he claims his favorite tense is the future, he has brilliantly portrayed the wonders of living through the twentieth century and captured the immense changes that occurred in his lifetime.

He provides a very realistic image of war, which should greatly help all of us who work with older veterans. I particularly enjoyed his essay on dirt which as a kid he was on very good terms with and his certainty that dirt likes kids. On aging, he points out that oldsters can be eccentric; folks are often nice to them but sometimes too nice, as older persons often would prefer to do for themselves. He concludes by pointing out that the three enduring things to do in life are to plant a tree, write a book, and have a child.

This is a marvelous “feel good” book that I recommend to all persons who work with older people. This book is a model of aging successfully.

As I Recall...
WILLIAM A. CLARK

FRAIL: A SIMPLE TOOL TO IDENTIFY FRAIL PERSONS

The International Academy of Evaluation and Health, under the leadership of Professor Bruno Vellass, has created a new tool to allow the rapid identification of frailty by health care professionals. This is the FRAIL mnemonic:

- Fatigue
- Resistance (cannot walk up one flight of stairs)
- Aerobic capacity (cannot walk one block)
- Illnesses (more than 5)
- Loss of weight (>5% of body weight in one year or less)

Frailty should be considered a pre-disability state and thus should exclude persons with basic functional impairment.
A diagnosis of early Alzheimer’s Disease (AD) fills the patient with loss and inability. Everyday something else is a challenge, or not do-able anymore. Being a participant in RESEARCH is something that a person with Alzheimer’s disease can do! That is the lesson my husband taught our family and me in 2001.

Ted’s participation in early trials was easy. We participated in a long-term research project at the Aging and Memory Program at Washington University, where Ted originally found out that he had Alzheimer’s disease. In order for Ted to be a part of this project, I had to sign on too. With mixed feelings, I did.

Ted also decided we needed to be a part of Project Esteem, an Alzheimer’s Association program at the St. Louis AD chapter, which is for patients in the early stages of AD and their families. The program consists of two support groups, one for the patients and the other for the caregivers. These support groups met monthly and we began to attend. I was surprised how much Ted loved it…I think he felt compelled to “help” the people in his support group. I attended my support group and tried to listen and learn. This was all so new and overwhelming for me.

Ted began his medications in hopes of slowing the progression of this disease. Months passed and each day was a challenge. Ted’s actions were often unpredictable and inconsistent. Through a pharmacy friend, I learned about a new medication, not yet available here, but being used in Germany. I asked our doctor to look into it and give me a prescription, but he refused to deal
with a drug that was not approved by the Food and Drug Administration. All right, I thought. I will get the drug and go from there. We were desperate to take action in the early stages. I called our long time family internist, who also refused to help. We heard of a great doctor at Saint Louis University and I made an appointment for Ted to see him. After we met and talked, I asked him to help. He agreed to monitor Ted on this new medication. My son, who lived in Europe at the time, was able to get several months of medications through a friend. To continue to get more, I needed a prescription, and our SLU doctor agreed to do that. As he managed Ted’s medications, he showed great compassion for our family. We continued regular visits and always talked about current research and trials. Ted told him emphatically, “I want to do whatever I can.” So, when a new trial came up, the CogniShunt, and SLU was announced as a trial center, the doctor started talking to Ted and me about joined the study. This project meant brain surgery…anything could happen. And Ted was in!

The study required hours and hours and hours of post-surgery meetings and additional tests were required. Finally, after so many evaluations and surveys, etc. we got to see if there were any results. After 18 months, we found out that Ted’s shunt was not open, he was in that part of the research that was the control population. He had to undergo another surgery to open the shunt.

Ted has to undergo painful spinal taps. The wonderful researcher showed such warmth and compassion. He himself did every spinal tap. The researcher was so appreciative of Ted’s dedication and courage.

We continued with the trial. And then, suddenly, we found out that the trial was terminated. They had run out of funding. Now what would happen? Nothing ever came of it. After another few months the whole project was scrapped. There was no empirical evidence of the shunt being helpful.

Ted continued to take his regular Alzheimer medications and was on the German medication, Memantine, which, one year later, became approved in the U.S. and is now a commonly prescribed medication for some patients with AD.

Ted continued to stay involved in research in several other projects. One of these projects involved meetings with interviewers about some specific topic.

As his disease progressed, Ted continued to show diminished cognitive abilities. His many volunteer projects became overwhelming and we had to leave a few. He could no longer drive, or even take a taxi. It became time for me to get full time help for Ted. He continued to be active and useful as long as he could. I had to take over more and more and more.

Even as the disease progressed, Ted still felt the need to give back and continued to do so as long as he could. One year ago, Ted had to go to a long time care facility because I could no longer care for him and keep him safe. We told him that he had a job again…to help the others in the facility to adjust and accept and he still tries to do that.

So the moral of our story is: Ted needed to find ways to be productive and useful. Even as his abilities diminished, he was able to make his contribution to society. He always approached every research project with a full and optimistic outlook. As family, we walked with him on this journey and supported him as much as we could, not always wanting him to be so brave, but always so proud of him. He never was afraid…he could and did make a difference.
the complicating issues of debilitation related to discomfort.

**PAIN ASSESSMENT IN THE COGNITIVELY IMPAIRED**

Difficulty in treatment/assessment of patients with dementia is related to:

- Reluctance of providers to use opioids
- Inability of patients to articulate pain
- Psychotropics that are being taken masking pain symptoms
- Desensitization of the care provider (*e.g.*, “she is always like that”)
- Behaviors stemming from emotional and psychological distress, fatigue, infection, and pain, can all look the same.

(continued from page 15)

and guides us on how to utilize our quality assurance (QA) and quality improvement (QI) processes, and how to become involved in state pain initiatives.

**DISCOMFORT BEHAVIORS**

The University of Wisconsin Pain Improvement Partnership notes the areas (listed below) on the minimum data set (MDS) under Mood and Behavior that are often coded without first considering pain as a cause for these moods or behaviors – a symptom of pain that is unexpressed by patients who are either unable or unwilling to identify discomfort.

As we train, as we plan care, and as we interact as health care providers, we need to consider these areas as symptoms of pain before considering them as problem behaviors.

- Wandering
- Resists care
- Crying, tearfulness
- Repetitive verbalizations
- Reduced social interaction
- Repetitive physical movements
- Insomnia or a change in sleep patterns
- Sad, pained, worried facial expressions
- Withdrawal from activities of interest
- Verbally abusive behavioral symptoms

- Physically abusive behavioral symptoms
- Socially inappropriate/disruptive behavioral symptoms

**STUDIES BASED ON THE MDS**

Karen Stevenson, RN, MS, of the Pain Improvement Partnership, University of Wisconsin – Madison, 2006, reports that the University of Wisconsin has studied responses to the MDS which demonstrates that the data gathered from the MDS shows that, as dementia progresses, pain is coded less often, with less frequency, and with less intensity – yet behaviors are coded as occurring with greater frequency. Are we assessing pain as behaviors?

The greatest challenge as we step into patient-centered care is to see beyond the “no complaints of pain” and delve into seeing a patient’s behaviors as a way of communicating his or her suffering to us. I challenge each reader to evaluate what the perception of your patients with behaviors is.

Do we code pain less often as the patient is unable to articulate it to us?

(continued on page 22)
Dear Dr. Morley:

I have been reading, with great pleasure, your editorials in “Aging Successfully” for several years. The recent discussion of the proper pharmacopoeia for the treatment of elderly persons finally stimulated this oft thought about, but previously never written letter. It has probably been 10 years since I heard a speaker say that the problem in effective geriatric prescribing is that there was no real knowledge on which to base one’s decisions.

I am not a gerontologist as a result of any formal training. I do feel that my practice of medicine has, by its very nature, made me reasonably qualified to treat elderly people.

After graduating from Tulane Medical School in 1950, a year of rotating internship, a year of psychiatric fellowship, and a year of general practice residency, I opened an office here in the general/family practice of medicine on July 1, 1953. The office was closed 50 years later on June 30, 2003. As the years went by, many patients grew older along with their doctor. As an estimate, I would guess that 90 to 95 percent of my patients were on Medicare at the time of my retirement, making it inevitable that I would have a long experience treating geriatric patients. In addition, I have learned from readings and meetings. I have been a member of the American Geriatrics Society for many years. As you know, essentially no time was devoted to geriatrics as a discipline during my medical school years.

I do strongly feel that the emphasis on geriatrics as a special field in medicine is long overdue. People with vision, depth, and understanding shown by your work and your writings will be the catalyst.

Sincerely

S.I. Courtman, M.D.
Monroe, LA
Do we treat for pain first, before behaviors? If so, what can we do to educate our staff about what are the non-verbal cues for pain and how we can document and treat them?

**Pain is an Organization-AI ssue**

The costs of uncontrolled or mismanaged pain are indirect, often unrecognized, and cause a steady outflow of dollars from an organization. Pain is often the focus of survey and accreditation processes. (Stevenson, Pain Improvement Partnership, 2006).

Again, the consideration of patient and family satisfaction with the care that we provide speaks to our community and can directly affect the perception of patient care – which affects our marketability. The focus on pain relief can reduce costs when we are able to meet the needs of our patient’s comfort and reduce the effects of behavioral outbursts (and subsequent hospitalization to gero-psych units). Treatment of pain decreases the cost of care in patients with decreased mobility and the complicating issues of debilitation related to discomfort. It also decreases the potential for survey and complaint issues.

All this being said, pain is now a focus of survey agencies – and though we all live by the survey process – we at NHC see that as our second priority – we are always looking to the patient needs as our first objective.

**Where to Begin**

*This checklist from the University of Wisconsin is a good place to start.*

- Can you go to any chart and accurately find out whether a patient is experiencing pain?
- If the patient is in pain, is there an assessment? Is it complete?
- If a resident has moderate to severe pain, is there evidence of timely follow-up?
- Is there evidence of patient/family education on pain issues? Is it comprehensive?

**Pain Improvement Partnership**

*University of Wisconsin – Madison, 2006*

It is important that we commit, upon inquiry and admission, to work together with the patient and family to establish an individualized comprehensive pain management program. We must:

- Follow essential practices
- Screen for pain
- Assess pain often
- Provide patient, family, and partner education
- Set standards for monitoring and intervention, and
- Evaluate pain assessment and treatment procedures often.

As we implement systems, we must re-evaluate center standards and practices both daily and in our QA/QI meetings. The pain care that NHC provides is an ongoing process. We continue to assess, to set the standards of care based on the patient need, to educate, and to evaluate, evaluate, evaluate!

“It is something to be able to paint a picture, or carve a statue, and so to make a few objects beautiful. But it is far more glorious to carve and paint the atmosphere in which we work, to affect the quality of the day – this is the highest of the arts.” *Thoreau*

**Resources**

Pain Improvement Process – University of Wisconsin, Madison, 2006

Palliative Excellence in Alzheimer’s Care Efforts (PEACE) – University of Chicago


**Articles:**

The utility of pain assessment for analgesic use in persons with dementia. Jiska Cohen-Mansfield, PhD, Research Institute on Aging, Rockville, MD.


Dementia and Serious Coexisting Medical Conditions: A Double Whammy, Katie Maslow, MSW, Alzheimer’s Association.
For more information about these conferences, contact 314-894-6560.
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