Nutrition.

Third track—administration of geriatric services.
- Policy and services for the aged
- Budgeting and finance
- Legal aspects
- Open versus closed care
- Dwelling models, architectural designs
- Implications of environmental changes
- Aging and mental health
- Administration in complex organizations
- Work, retirement, and leisure

A research thesis in basic, clinical, or applied research will be required of all candidates.

The educators in both institutions will be involved in the degree program. Participating from the Israel Institute of Technology will be the faculty of medicine, including its affiliated hospitals, with 300 beds in geriatric institutions and 600 beds in psychiatric hospitals, and the faculties of biology, biomedical engineering, architecture, materials, and computer sciences. Participating components of Haifa University will be the faculty of social work and its affiliated network of welfare and social services for the aged, the faculty of liberal arts, the school of education, and the school of occupational therapy.

There is no doubt, from our experience in Israel's geriatric institutions, that the quality of their medical and paramedical personnel, as well as social welfare personnel and top level administrative personnel, does not equal that of medicine in general in various Israeli institutions.

Primary care clinics, old age homes, nursing homes, and other community services urgently need a better formal program of education. We do not believe that it is really different in other parts of the world.

We strongly believe that, just as the master of public health degree has promoted understanding and expertise in public health, this unique bi-institutional, three-track program can reach out to medical and paramedical personnel working in geriatrics and gerontology and stimulate individual interest in care and research in the field of aging.

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The Challenge of Combining Clinical Approaches with Function in Treating the Elderly

Marian Rabinowitz, MD, Head, Division of Geriatric Medicine, Chaim Sheba Medical Center, Tel Hashomer, Tel Aviv

The clinical dilemmas that arise in the treatment of the aged may be considered in the form of seven main challenges.

1. To apply the nosological and semantic categories of clinical medicine, but not to overuse them in geriatric medicine.

These categories are only tools, and often they do not contribute to understanding. In geriatric medicine we are accustomed to emphasizing the characteristics of multiple pathology. We often find on one medical chart multiple diagnoses of congestive heart failure, Parkinson's disease, benign hypertrophy of prostate, degenerative joint disease, hypertension, and so on. And we even experience some pride in identifying so much morbidity, sometimes ignored or unmentioned by others. But what does all this inventorying mean? Does it reveal the real problem or help to mask it? Often we forget that we coin names and sometimes become prisoners of them.

Many textbooks of geriatric medicine are organized as, for example, cardiovascular diseases in the aged, gastro-intestinal disorders of the aged, and so forth. Besides being repetitive in the information they contain, the textbooks are constructed according to a decremental model or curve or according to statistical prevalence in a population that is presented as homogeneous, but in fact is very diversified. It is important to know the medical details, but all these nosological and semantic drawers do not differ much from conventional internal medicine for the elderly. After the inventory of multiple conditions has been completed, their combination and relationship should be emphasized, and therapy planned accordingly for the patient.

Parkinson's disease and osteoarthritis and an elevator out of order in a building—all these together create a new disease, unknown to textbooks. It is a SITUATION.

Bleeding hemorrhoids plus cognitive decline creates a new syndrome because the patient forgets to

take his iron pill. In fact, it is not a syndrome, but a situation.

That is why the postgraduate course in geriatrics that I am now conducting is entitled "Situations in Geriatrics"—combinations of usual diseases with usual symptoms leading to special situations, which need to be identified.

2. To introduce the functional, social, and psychological components in a new system of assessment and terminology in which the boundaries between pathological entities and situational realities are indistinct and not clear-cut.

Those who also have been trained in rehabilitation medicine and who use the team approach are accustomed to the separate assessments from the physician, nurse, medical social worker, liaison district nurse, psychologist, rehabilitation personnel, vocational counselor, recreational therapists, speech therapists, team coordinator, dietician, and so forth. Personally, I enjoy listening to all these in my daily noon team conferences. A great deal of information emerges, and I feel important presiding, omnipotently, over such a large and costly team. But where are the boundaries between a patient's social, psychological, functional, and medical aspects? Consider these examples.

Ability to walk contributes to socialization, but the drive to socialize stimulates the hemiplegic patient to walk, and proper transfer from bed to wheelchair increases the radius of exploration and knowledge.

Who will report on how a diuretic-induced weakness leads to social disengagement? Who will identify how a patient's vertebro-basilar insufficiency, through fear of falls, is conducive to sensory deprivation? Incontinence, shame, and a spouse tired of washing clothes and bedclothes—to which professional area do they belong? If we try to put cerebral cortex, urinary bladder (a common source of shame), and an exhausted wife in one diagnostic basket, the entire medical and scientific community will laugh at it.

Therefore, the answer to the second challenge, in my opinion, is to devise another system of assessment and terminology.

3. To adapt the assessment of function to the global assessment of the elderly and to diminish the importance of narrow, purpose-oriented, utilitarian goals in therapy.

The goal of restoring function to the elderly is different from working with younger people. An acute disabling event often occurs after a deterioration so slow that it has not been noticed. It is true that Mr. Kaufman walked normally before his stroke, but why did he cease all trips to the city that required him to change busses? And he was indeed independent in activities of daily living but, somehow, preferred to avoid taking a shower, which by the way, is very costly of energy.

There was, of course, no justification for measuring Mr. Kaufman's hip flexor when climbing the steps to the bus, or his cognitive abilities in coping with time-limiting tasks such as bus schedules, or determining his left ventricular ejection fraction before and during the shower; but the assumption is that Mr. Kaufman was functionally normal when he was not. Therefore, the assessment of function in the elderly should be more than an external photograph of a motor action, and rather different from matching two types of normality: the achieving-competitive related normalcy and the self-preservation related normalcy.

Concerning the utilitarian, purpose-oriented goals in the rehabilitation of function, one should not forget that a frozen shoulder in a bedridden patient has a much more ominous significance for his reach than the same limitation in an ambulatory elder who can substitute with walking. That particular clinical challenge might be met by establishing as a goal, for example, not simply movement in itself, but reach; not the 90 degrees of shoulder abduction, but as much as necessary in order to wash the axilla; and to respect Mr. Kaufman's wisdom in adapting his activities to his abilities.

4. To understand the clinical manifestations of chronic disease and disability in the context of cultural-ethnic background.

Yemenite, Moroccan, and Polish Jews are not the same in their responses. The recently arrived Ethiopians still puzzle us. In my dementia clinic, the reaction to memory loss in an old Yemenite is quite different from that of a German Jew. I continue to wonder why the cognitive decline in an old Talmud student, who studied for a lifespan in a noncompetitive ambience, is so different from that in a Western intellectual. And how do the Druze approach disability? And the Circassians? And the Bedouin? We might learn from them old-new ways of coping: all this natural human laboratory is, so far, practically unresearched and untapped.

5. To establish priorities in therapeutic intervention and restraint, but not according to the "glamour" of underlying scientific diagnoses.

From the long list of pathological conditions one

might build a scale of diagnoses according to their "glamour." A few examples follow.

- Inappropriate secretion of antidiuretic hormone sounds more "glamorous" than benign prostatic hypertrophy.
- Left anterior hemiblock sounds more "glamorous" than decubitus ulcer.
- Idiopathic hypertrophic subaortic stenosis sounds more "glamorous" than gonarthrosis.
- Problems related to major histocompatibility complex sounds more "glamorous" than insomnia, but the main reason for the disability may be the inappropriate use of valium for sleep.

The clinical art of what to treat first, and what not to treat, becomes of tremendous importance. Often, I do not treat hallucinations in a mentally deteriorated patient if they have a "good" content, and if, by resurrecting a long-dead husband, they help a hallucinating widow to populate her lonely world. In a moderately Parkinsonian patient, with good chances of further improvement, I often refuse to add L-Dopa, if he is alone and threatened by orthostatic hypotension when he gets up at night. And sometimes I have to oppose my devoted physiotherapists in order *not* to correct a knee flexion contracture which could help a bilaterally below-knee amputee to maintain his sitting balance. Therefore, we have to look behind and beyond the first and most resonant complaint.

6. To use a life history fruitfully for clinical understanding.

What does it mean: "He married at 22, he graduated in 1938, he was a chemical engineer, he retired at . . . ?" Does it have any impact on his hypertension or his chronic obstructive lung disease? What is the relationship between his biography and his illness? Probably very little, if we see biography as a sequence of conventional life events. A man does not have a past, he *is* his past. Life history is not only an accumulation of events, but a history of coping. The individual is the summation of coping and failures, and all of them are conducive to the totality of "I am."

That "I am" is, in my opinion, of major clinical significance. The "I am" in a wheelchair is the "I am" that is undesirable, the "I am" who takes his medicines or not, the "I am" who wants to be respected. In geriatric medicine we deal with an "I am" that took a long time to be built emotionally, and often it takes only one night of incontinence to put it in jeopardy.

This challenge should be, therefore, met by teaching ourselves and our pupils to approach the elderly patient as an individual and not as a cross-section of an amorphous population that has diseases. As Kierkegaard said, "Truth is the individual."

I shall summarize by conveying all the previous challenges in a final one.

7. Approach the elderly in a clinically existential way in the totality of his or her being, not with the traditional medical model.

What would happen if the existential-medical diagnosis were as follows? "A retired accountant, with a right hemispheric damage and severe sensory-spatial deficit, fell a few weeks after relocation." or "A recently widowed housekeeper, with severe degenerative joint disease and borderline cognitive functioning, living in her son's remodeled house, became incontinent."

To the possible opponents of such a long formulation, I can answer that a diagnosis should not necessarily be brief. Brevity and truth do not always get along well.

In conclusion, to meet the challenges that I was asked to deal with, I offer these principles:

1. Geriatric medicine should strive to create a somewhat different type of clinician, rehabilitation-oriented, with knowledge of several disciplines concentrated in the one-person care giver.
2. Clinical geriatric medicine, as it grows at the bedside, should focus on the person who has a face, a name, a uniqueness, and it should encourage him or her to resist classification.
3. Geriatric medicine, while remaining medicine, should come as close as possible to applied human anthropology.

Functional Assessment as a Model for Clinical Evaluation of Geriatric Patients

Richard W. Besdine, MD, Director, Travelers Center on Aging, University of Connecticut Medical Center, Farmington, CT

FUNCTIONAL ASSESSMENT may be defined as the systematic, multi-dimensional, detailed evaluation