



Center on Aging

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**Buehler Center on Aging
McGaw Medical Center
Northwestern University**

New Light on Lasting Questions

Why should we study aging? This is a key question here at the Buehler Center on Aging. The answer is one you've heard before. There are seventy-seven million of us baby boomers and we are all actively aging. There are already more elderly than there are children, and projections suggest that, depending on how successful we are in medicine, that trend will continue into the foreseeable future. So we have a problem, and we should think about how to deal with it in a fashion that is positive for all concerned. I would like to talk about the possibility of shedding new light on these lasting questions when it comes to the care of elders. I wanted to share with you two dreams: the story of a dream come true, and a dream for our future here together at the Buehler Center on Aging.

The dream that has come true is The EPEC Project, that is, Education for Physicians on End of Life Care. It came about because, simply, it was needed. There was needless physical suffering associated with end-of-life care. In addition, there was psychosocial suffering and social burden. Above all, people were fearful of being a burden to those they loved, and fearful of indignity and suffering. They were fearful of being abandoned in their dying days.

There was a huge gap between research and practice. We had excellent science, but we had lost our professional competence to care for people who were inevitably going to face dying, so much so that we were facing a movement for physician-assisted suicide that arose, I think, out of a despairing desire for care and dignity. I was at the time in the Ivory Tower, and I felt the need to leave the

Ivory Tower to see if we couldn't narrow that gap between research and practice even a little. So as we created The EPEC Project, we based our program on strong empirical research. After interviewing a thousand patients and their caregivers across the country, we came up with a model quite different from the one that I'd been raised on in the Ivory Tower.

Keep in mind that dying people present us with conditions that we cannot change, yet they also come to us with conditions that they want us to change. Our subjects told us that improving their physical symptoms was one thing that they wanted us to help them with. They also wanted us to help with their caregiving needs and with the psychological worries that went along with their illness. Their social relationships were changing as a result of the illness; there were challenges to spiritual and existential aspects of their lives. The economic demands consequent on the illness were huge as well. Their hopes and expectations were challenged. In short, we started to hear a much fuller story than anything we had learned in medical school.



Linda L. Emanuel, MD, PhD

They told us something else that made us rethink our practice of caring for them: they told us that we health professionals were only a part of their stories. They told us that our institutions could be their friends or could impose barriers. They told us that their families and friends and communities were at least as important as the professionals in caring for their illnesses and for them—the whole person—when they were in need. All these forms of care together provided the symptom relief, the satisfaction with their lives, and the overall quality of life that they were looking for.

It seemed to us that they were saying that they should not have to choose between a cure model excluding comfort and a comfort model excluding cure. Rather, they should be able to be comfortable from the point of their diagnosis and as their needs changed over the course of their illness. As time progressed, we should be able to blend the ways in which we provide for comfort and the ways in which we try to go for cure, according to their needs. If we could blend this kind of palliative care with curative care in just the right way, then the goal that these patients described to us perhaps would be attainable. They would be able to function in society until their illness was such a burden that there's only time to say goodbye. Their caregivers, instead of being burdened by economic problems and caregiving needs, would be able to be supportive in such a way that the caregiver too can have a meaningful relationship with the person who is ill and continue to function in society even during and after bereavement.

This is a different model, a different way of thinking about care than anything that we had been taught before, but it was one that was already actively being used in the hospice and palliative

care movement. Our dawning realization was that palliative care is not—according to our original assumption—for those who are actively dying alone. Instead, it is something much bigger. It's the care of the whole person and the family. It's attention to the relief of suffering from the point of diagnosis on, not only near the end. And it's for people who are young as well as old, for people who are curable or not.

We started our program with this model in mind. We were fortunate to obtain funding from the Robert Wood Johnson Foundation. We decided to target practicing physicians, not specialists, because our goal was to change the norms of practice at the grassroots so that the dream that those patients had told us about could become a reality. We aimed at nationwide scope. We created a program that had leadership from above and from the professional grassroots. And we made a program that is a train-the-trainer program. Physicians learn in ways that are unique; we are taught and we teach one another in ways that do not in fact comply with adult learning theory. So we adapted adult learning theory to physician culture.

Over the years since 1996, we've trained 1,300 physicians. We built state-of-the-art audiovisual content; and we provide all our materials to all the people we train. We give them a participants' guide, an instructor's guide, slides, tapes, CD-ROM's, all sorts of resource materials, and we give them everything from the EPEC web site as well. We give them all these materials in a modular format so that they can use them in units of a size that work for them. We give them permission to use all the materials we give them to teach the people that they are training. We train them in small group settings. After we train them, we follow them and we support them as they in turn train other people. We stay in touch with them on a regular basis through a listserv and by telephone and other ways.

We ended up with something—as we have begun to realize—that is a virtual college. We have the core team here at Northwestern, and we have a corps of master facilitators who were selected for their extreme talent as teachers and as palliative care physicians. They in turn train the EPEC trainers, and the EPEC trainers in turn train others. We also make sure we provide them with the

most up-to-date technical information. Among some physician subcultures, palliative care is thought of as an easy discipline, but it's actually one of the hardest, because clinically a lot of things are going on at once and patients are very frail—small errors can lead to disastrous outcomes. So we give EPEC trainers technical information in this growing discipline, but we also give them a full humanistic content. We try to make it very practical. We use language that could be understood by eighth graders. We approach controversy with purely practical approaches: we do not take positions, we say only that if the patient is suffering, that's what matters. The other thing that we do is encourage our participants to tell us how to change the curriculum, so that they feel this curriculum is their own.

Another thing that we do that seems to help is to reveal our very humble beginnings. Charles Von Gunten, who is originally from Northwestern, once spoke about the patient who inspired him to go into the palliative care field. And he said of this person, "They said there was nothing to do for this young man who was 'end stage.' He was restless and short of breath, he couldn't talk and looked terrified, and I didn't know what to do. So I patted him on the shoulder, said something inane, and left. At 7 a.m., he died. The memory haunts me. I failed to care for him properly because I was ignorant." Now this is a confession indeed. Dr. Von Gunten is probably the best palliative care physician I know, but this is where he began, and to the best of our knowledge this patient could not have been cared for better under the circumstances that were then available. But the experience began something wonderful that grew and grew and grew.

The last ingredient that can't be overstated is the importance of our team: a team that is committed, that brings diverse skills, incredible teamwork, reliability, and a loving approach to all our failures. We are led by a common mission, nothing more, just a common mission. We have had some surprises. One of our surprises was that the EPEC physicians began to declare that they needed self-care, that they and we needed to grow in our own relational maturity and in our own coping with the fact that we are mortal. The EPEC-trained physicians have discovered a community with a

common discipline and have experienced some professional renewal. They realize that palliative care is in a sense a return to the professional roots of medicine. It's all about care; it's all about the whole person.

So the EPEC project rolled on. In our first year or so, we trained 555 EPEC trainers, and they in turn trained 121,000 health professionals, 51,000 of whom were physicians, and 24,000 of whom were residents and interns. The project is now in its sixth year: we have trained 1,300 trainers, and we now estimate that we've reached about half the physicians in the United States, either directly or through our EPEC trainers. We also provide long-distance training, and we've mailed 200,000 CD-ROM's containing the project materials. So our influence seems to be growing. I think that the tide is turning for people who work in palliative care and, moreover, that the experience of people who need palliative care is different now than it used to be. People now expect the kind of care that we would like for them to have, and more often than not, they get it. So the EPEC Project is the dream that's come true. It's moving now to an independent stage, where we hope it will continue for the indefinite future. It's been picked up and applied within medical specialty associations. Professionals are coming for training from other countries and taking the training back to their home countries.

The EPEC dream came from a problem. Most dreams come from a problem. Most dreams require bricks and mortar to become real—as well as hard work, love, and labor—but they start from a problem. So here's our new problem: we all want to live to a ripe old age, but none of us wants to be old. Jonathan Swift said that. My "modest proposal" is that perhaps we all can live longer without being old. It is well accepted that sixty-five just isn't old anymore. When Medicare began, sixty-five was old. When Medicare began, life expectancy was only sixty. In 1900, even though most people were already gone by sixty, two-thirds of those who were sixty-five and older were working. Today, by contrast, only one-tenth of men who are over sixty-five are working, even though our life expectancy is seventy-five, and three-quarters of men over sixty-five rate their health as better than fair. So what's going on here? We have a very healthy older population that doesn't feel old, but indeed feels very

well; and, as best as we can tell, many people who are over sixty-five would like to work. They don't want to be a burden. They want to be integral members of society just as they have been all their lives before.

So how can we think about flexible options to bring that about? We've begun a project here at the Buehler Center—we call it Elderflex—in which we are thinking about healthy role transitions that can happen either late or early. Perhaps with modified work roles people can stay in the workforce in the just the right way, depending on the capacity that is still with them at sixty-five, at seventy-five, and at eighty-five. If we get it right—with employer and employee options for salary and benefits to suit these modified roles—perhaps we can reduce the strain on Medicare and Medicaid. Perhaps we can do that with the assistance of moving palliative care upstream to where people have received a diagnosis but have plenty of time and are not thinking about departing this world at all. In order to do that, though, we have to be very realistic. The number of people over seventy who are seen in a hospital is very significant. Here at Northwestern Memorial Hospital, 21 percent of our patients are over seventy. Because older people have a greater burden of illness, we have to think about how to bring them the kind of care that will allow them to function well as long as possible. Instead of education for physicians in palliative care, we would like to develop education for physicians in elder care, or EPEC Mark II. How can we provide the kind of elder care that we're looking for? We've got the model. We can provide geriatrics and gerontology core competence for all physicians in just the same way that we did with our EPEC Mark I program. We can bring together expert panels of people to write curriculum materials or adapt those that already exist for such a program, set about with train-the-trainer implementation all over again, and have a virtual college of people who are experts in geriatrics and gerontology. We think that those programming goals are achievable in about six years and that the program can become self-sustaining after those six years just like The EPEC Project has done.

So that's our dream for our future. How are we going to make that happen here at the Buehler Center? Coming to the Buehler Center reminded me of moving into a wonderful house where we have the opportunity to do some renovation. We have a lot of work to do. We've engaged in some blue sky strategic planning and some recruitment. In our strategic planning we have been able to articulate this vision of advancing aging-related research, education, health care, and policy at Northwestern University, within its affiliated institutions and across local, national, and international communities. We've been able to come up with our tag line, "New Light on Lasting Questions." Our theme is to improve the experience of aging for all of us, those who are aging and those around people who are aging.

Among the achievements toward this vision in my first nine months on the job:

- We have hired a new administrative director, Christine Powell, and have been working to bring in methodological expertise and research support.
- The social science and behavioral research section is involved in projects designed to evaluate a health and wellness outreach project, to discover how people find their way into care at the onset of Alzheimer's disease, to figure out support needs of caregivers, and to provide support in education and research for aging services institutions. Other researchers in the section are studying adaptation in elders who have schizophrenia and language changes in Alzheimer's disease, developing specialized ways of evaluating people who suffer from Alzheimer's, especially those who are bilingual or immigrants.
- The education section is run by Dr. Joshua Hauser. This section is where The EPEC Project finds a home. Dr. Hauser is also running the certificate program in aging services. We will have an annual conference in clinical geriatrics and residency training, and medical student training programs as well.
- In clinical research we've got projects launched and additional proposals in to look at caregiver burden and com-

munication and different ways of assessing whether we're providing that kind of whole-person care to which we're committed. We've also been successful in starting a new fellowship program that brings together oncology and geriatrics. In the service evaluation and policy section, there is the Elderflex program I already described. We've also been running a policy seminar series with a number of colleagues from around Northwestern. Finally, we don't want to give up on the idea of having a basic research section; although we don't have wet lab space, we will collaborate with our colleagues in basic research around the university.

Our vision for the Buehler Center is grounded in the same professional values that created The EPEC Project, the same values that created the atmosphere in which this can be done at Northwestern and that clearly motivated the ways in which Dr. Eckenhoff led his life. Our foundations are complete. Our recruiting has been excellent and our programs are already strong. The question is, can we do it? Aging is certainly a worthy problem, a demographic challenge to our relatives and friends and society at large. A few years hence, in a future Eckenhoff Lecture, I hope to be able to address you on how our "New Light on Lasting Questions" has taken us to a new era in elder care.



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This editorial is adapted from Dr. Emanuel's remarks at the Eighth Eckenhoff Lecture, delivered in Chicago in May, 2002. The Lecture is named in honor of James E. Eckenhoff, MD, the late distinguished anesthesiologist and dean of Northwestern's Feinberg School of Medicine.

The ASSERT Project: Meeting the Research Needs of Service Providers by Building Research Capacity

by Rebecca L.H. Berman, PhD,
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For many years the Buehler Center has collaborated with local aging service organizations to conduct numerous program evaluations and needs assessments. Through these experiences we have identified prevalent and ongoing needs for research and research skills within such organizations. To take the first steps toward meeting these needs, in September 2001 we initiated a pilot project called ASSERT (Aging Services Support for Evaluation and Research Training), funded by a grant from the Retirement Research Foundation.

ASSERT's goal is to strengthen the ability of agencies to identify and meet needs for information by building capacity for conducting, understanding, and using research to better assess services, improve programs, and become learning organizations. To achieve this goal, we have developed partnerships with eleven Chicago-area organizations that provide services or programs for older people. For the past year, we have been working closely with these "Agency Partners", as well as with local foundations and government agencies to identify the research priorities, information needs, and research skills needs at organizations that serve or care for older people. ASSERT will offer Agency Partners a variety of training and other supportive resources via a network of research and evaluation specialists at Northwestern University and linkages to student researchers from Chicago-area colleges and universities.

Why ASSERT?

Over the past decade or more, organizations that provide services, care, and opportunities for older people are facing

increasingly stringent demands for accountability. They frequently find themselves in the awkward position of balancing their own needs for learning about and improving what they do against the needs of policy makers and foundations for documenting or measuring "need," "performance," and "outcomes." In extreme instances, the political and moral legitimacy of the programs offered are at risk when agencies cannot systematically document the impact of their programs and comply with institutional rules and societal expectations (Fine, Thayer, and Coghlan, 1998; Hasenfeld, 1992).

Social services to the elderly are particularly likely to be under scrutiny in today's cost-conscious environment, especially when older people are perceived as being less-deserving yet receiving more than their fair share of government resources than in earlier policy contexts (Hudson, 1997; Silverstein, Angelelli, and Parrott, 2001). In response, service providers and nonprofit organizations are more often engaging in research and evaluation studies.

However, these agencies and service-providing organizations frequently do not have staff or resources to conduct or contract out for such research (Centers for Disease Control, 1999; Fine et al., 1998). One strategy for overcoming these deficits is to build the research capacity of such agencies internally, thereby improving their ability to understand, develop, conduct, and use research more effectively and routinely. Efforts to build capacity are rapidly emerging in the field of evaluation (Hueftle Stockdill, Baizerman, and Compton, 2002). But any effort to build research capacity must be enacted within and be relevant to each agency's setting, clientele, and goals. In addition, research and evaluation capacity-building efforts must be implemented in ongoing and routine ways so that the thinking and doing of research become part of that agency's culture.

The ASSERT Philosophy

ASSERT's aim of building research capacity is contingent on the development of ongoing partnerships between university and agency researchers. To facilitate such partnerships, ASSERT's philosophy is grounded in a participatory (Schensul, 1999), utilization-focused (Patton, 1997), multidisciplinary

approach to research. ASSERT assumes that research is a form of inquiry that can facilitate organizational learning (Preskill and Torres, 1999). ASSERT's model of training and consultation places emphasis on identifying the primary users and the intended uses of research. Our partner agencies will work collaboratively with ASSERT staff and faculty as they engage in the conceptualization, design, implementation, interpretation, and/or dissemination of research and evaluation results. Our multidisciplinary team of faculty researchers will provide access to a variety of research methodologies and approaches. To ensure that research capacity remains in the organization, ASSERT targets agency leaders who are most likely to be the primary users of research and who have the capability of shaping the culture of the organization toward one that values learning through research.

ASSERT's Activities

To assist our Agency Partners in preparing for the workshops and to develop the most "user-friendly" curriculum possible, we have spent the past twelve months meeting with leadership staff and facilitating stakeholder brainstorming meetings at each agency. In these initial contacts with our Agency Partners, we have already learned an enormous amount about agency perceptions of research and needs for information.

On October 16, 2002, ASSERT will launch a yearlong series of research workshops called "Improving Outcomes Through Organizational Learning." Five hands-on workshops will be complemented by one-on-one research consultations with ASSERT faculty, an online listserv and blackboard, and, eventually, a take home "toolkit" focusing on the unique research needs of organizations working with older adults. In addition, we will host four open-invitation seminars on a variety of research and evaluation topics. ASSERT's first seminar, "Involving Stakeholders and Building Partnerships in Research," will be held on November 5, 2002; Jean Schensul, PhD, the executive director of the Institute for Community Research in Hartford, Connecticut, will be the keynote speaker. As we continue to work with our Agency Partners and others in

the aging network, we hope to identify key strategies and best practices for building research capacity through ongoing university/agency partnerships with ASSERT as a permanent program.

For more information about ASSERT's seminars and workshops, guidelines for using ASSERT resources, and links to online and other resources for anyone interested in agency-based research and evaluation, please visit our new website at <www.assertproject.org>.

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Research Report: Asthma and the Elderly

Asthma is a common respiratory disease in children; however, it is also common in the elderly for whom it is often undiagnosed and undertreated. The Division of Allergy-Immunology and the Department of Medicine of Northwestern University's Feinberg School of Medicine undertook a study of asthma in the elderly with the support of the Otho S. A. Sprague Memorial Institute and the Ernest S. Bazley Asthma and Allergic Diseases Center. The study had several aspects:

- In the first part of the study, researchers wished to estimate the prevalence of obstructive airways disease in a disadvantaged elderly population. Investigators Aarti Malik, MD, Carol Saltoun, MD, Paul Yarnold, PhD, Leslie Grammer, MD, and Paul A. Greenberger, MD, interviewed older adults at three senior centers in Chicago. Subjects also underwent spirometry and skin testing and completed a health questionnaire. The investigators found that 23 percent of the sample had asthma, bronchitis, or emphysema previously diagnosed by a doctor, and another 10 percent had symptoms of these conditions that had not been evaluated. A key finding was that even those who had a diagnosis and prescriptions often did not take the medication on a regular basis.
- In a second part of the study, Investigators Daryn Abraham, MD, Leslie Grammer, MD, Carol A. Saltoun, MD, Paul Yarnold, PhD, and Aarti Malik, MD, examined the differences in health demographics and quality-of-life measures between those elderly who had asthma diagnosed by a doctor and those who did not. They found that elderly with doctor-diagnosed asthma more frequently became short of breath, evaluated their health as significantly poorer, were more limited in carrying out vigorous activities, and were also more frequently depressed. This part of the study was presented at the annual meeting of the American Academy of Allergy, Asthma, and Immunology in March.

- A third part of the study dealt with compliance with taking prescribed medications; the team compared subjects who take their asthma, bronchitis, or emphysema medicine as prescribed with those who take it only when they feel ill, or not as often as they should, or not at all. When they compared subjects who were compliant with those who were not, the compliant group had fewer emergency room visits and fewer nebulizer treatments in a physician's office.

Moreover, those who complied with medication regimen had had asthma for a longer period of time and were more likely to think of their asthma as a serious problem. Team members Leslie Grammer, MD, Carol Saltoun, MD, James R. Webster Jr., MD, Daryn Abraham, MD, Paul Yarnold, PhD, and Paul A. Greenberger, MD, reported these results at the annual meeting of the Central Society for Clinical Research.

- A fourth and final part of the study delivered an educational intervention, a presentation called "How to Find an Asthma Doctor," to seventeen elderly persons diagnosed with asthma. These subjects were followed up at two and four months after the presentation to determine if they had sought any additional health care or experienced any change in their condition related to asthma. By four months, nearly 50 percent reported a change in medication consistent with clinical guidelines and an improvement in condition.

The investigators, particularly Drs. Grammer and Saltoun, are pursuing additional funding for research on improving asthma care in the low-income elderly.

Buehler Center on Aging News

The Buehler Center on Aging is pleased to announce that James R. Webster Jr., MD, has agreed to serve as chairman of its newly constituted board of directors. The board and faculty also welcome several new members:

- **Whitney Addington**, MD, senior executive and visiting professor, Chicago Metropolitan/London School of Hygiene and Tropical Medicine;
 - **Jeffrey C. Miller**, MGA, chief operating officer and senior executive associate dean, Dean's Administration, Northwestern University's Feinberg School of Medicine;
 - **M. Catherine Ryan**, senior vice president, Bank of America;
 - **Mary Smart**, trustee, Smart Family Foundation; and
 - **Howard J. Trienens**, JD, partner, Sidley, Austin, Brown and Wood.
- Continuing members of the board include **Bernard H. Adelson**, MD, PhD (Evanston Northwestern Healthcare); **Henry B. Betts**, MD (Rehabilitation Foundation, Rehabilitation Institute of Chicago); **Peter P. Budetti**, MD, JD (NU Institute for Health Services Research and Policy Studies); **Fay Lomax Cook**, PhD (NU Institute for Policy Research); **John F. Disterhoft**, PhD (NU Physiology); **Howard C. Eglit**, JD (Chicago Kent College of Law); **Sanford I. Finkel**, MD (Council for Jewish Elderly); **Philip Greenland**, MD (NU Preventive Medicine); **David L. Gutmann**, PhD (NU Psychiatry and Behavioral Sciences); **Janardan Khandekar**, MD (Evanston Northwestern Healthcare); **Monte J. Levinson**, MD (Presbyterian Homes); **David A. Lindeman**, PhD (Mather Institute on Aging); **William C. McGaghie**, PhD (NU Medical Education); **M.-Marsel Mesulam**, MD (NU Cognitive Neurology and Alzheimer's Disease Center); **Elliot J. Roth**, MD (Rehabilitation Institute of Chicago); **Aryeh Routtenberg**, PhD (NU Psychology and Neurobiology); **Margo E. Schreiber** (Illinois Department on Aging); **Joanne G. Schwartzberg**, MD (American Medical Association); **Daniel Silverstein**, MSSA (Council for Jewish Elderly); and **Anna L. Willis** (City of Chicago Department on Aging).

The Buehler Center on Aging is pleased to announce the arrival of

Ramon A. Durazo-Arvizu, PhD, who will serve as associate professor at the Medical School's Division of General Internal Medicine and will be located at the Center for Healthcare Studies and the Buehler Center on Aging. Dr. Durazo-Arvizu brings expertise in statistics and research design to the two centers. He obtained a master's degree in statistics in 1987 from the University of Texas at El Paso and his doctorate in applied mathematics in 1994 from the University of Arizona. Since then he has served as research associate and lead statistician in the Department of Health Sciences Research in the Cancer Center of the Mayo Clinic and as assistant professor in the Department of Preventive Medicine and Epidemiology at Loyola University, Chicago. Most recently, he was associate professor in Department of Biometry and Epidemiology at the Medical University of South Carolina, where he directed the Office of Statistics and Data Management in the Alcohol Research Center within the Institute of Psychiatry. He is a member of the American Statistical Association, the International Biometry Society, and the Society for the Advancement of Chicanos and Native Americans in Science. Dr. Durazo-Arvizu has been a co-investigator on numerous NIH- or foundation-funded research projects, on topics such as prostate cancer, cardiovascular disease, alcohol consumption, and causes of death. Dr. Durazo-Arvizu can be reached at the Center for Healthcare Studies, 676 North St. Clair Street, Suite 200, Chicago, Illinois 60611; phone 312 695-0458.

Linda L. Emanuel, MD, PhD, director, is the recipient of two unrestricted grants from Pfizer, Inc. The first, for \$25,000, will support the development of the international component of The EPEC Project. The other, for \$10,000, will support the Certificate in Aging Services Project. Dr. Emanuel has been named a fellow of the Institute of Medicine of Chicago. Dr. Emanuel also recently joined the Board of Directors of the Rehabilitation Institute of Chicago. **Madelyn A. Iris**, PhD, was recently awarded a grant by the Illinois Department of Public Health Alzheimer's Research Fund, for which she will study "Los Caminos: Pathways to Alzheimer's Disease—Identifying Factors That Promote or Inhibit Early Detection in Hispanic Elders." In another study, funded by the Suburban Area Agency on

Aging, she will perform a needs assessment program review of five congregate dining programs in the suburban Cook County area. Dr. Iris has been promoted to associate professor and she was recently elected president-elect of the National Association for the Practice of Anthropology. Dr. Iris chaired the first annual conference of the Association for Anthropology and Gerontology, held at the Buehler Center on Aging.

Joshua Hauser, MD, and co-investigator **Linda L. Emanuel**, MD, PhD, have been awarded a grant of \$8,000 under a grant from the National Cancer Institute to Northwestern University's Lurie Cancer Center for a Specialized Program of Research Excellence (SPORE). Dr. Hauser will undertake a project entitled "Intercalating Palliative Care into Pancreatic Cancer Guidelines: The Impact of Patients' Experience of Care." The project will draft palliative-care-enhanced care guidelines for pancreatic cancer based on existing guidelines; it will also draft an educational intervention to introduce the guidelines, identify outcome measures to assess the impact of the guidelines, and assess the feasibility of using the guidelines among patients and professionals.

Robert W. Schrauf, PhD, research associate, is the recipient of a \$92,909 grant from the Alzheimer's Association for an eighteen-month project, beginning in September 2002, to develop a test of premorbid intelligence for neuropsychological assessment of Spanish-speaking elderly. His co-investigators are **William Revelle**, PhD (Department of Psychology, Northwestern University) and Dr. Raphael Nuñez-Cedeño (Department of Spanish, French, Italian, and Portuguese, University of Illinois-Chicago). The project will investigate how a clinician can tell if a Spanish-dominant patient's poor performance on cognitive tests is due to dementia or a lower level of intelligence. This research will adapt the Word Accentuation Test (WAT) to the United States by examining: (a) feasibility and adaptation to the Spanish spoken in the United States, (b) validation via the Bateria Woodcock-Muñoz—an intelligence test normed in the United States, and (c) cross-validation of the adapted version's ability to predict premorbid intelligence of Alzheimer's patients and matched healthy controls.

Geriatrics Summer Program for Medical Students

Ten sophomore medical students participated in the 15th Geriatrics Summer Program for Medical Students this past summer. They worked with faculty members on research projects; participated in weekly didactic sessions on aging, geriatrics, and research skills; and visited sites where the elderly receive care. The group included students from The Feinberg School of Medicine, Northwestern University, as well as from the University of Chicago. The medical students, their preceptors, and their projects were as follows:

- Peter Adamczyk (preceptor: Lesley Blake, MD, NU) worked on “differences in cortisol measurements in a geriatric psychiatry inpatient unit.”
- Chris Anderson (preceptor: Linda J. Van Eldik, PhD, NU) studied “S100 β transgenic and knockout mice in a hypoxia-ischemia model of neuroinflammation.”
- Laura Frehlich (preceptor: Greg Sachs, MD, University of Chicago) worked on a project examining “dementia, caregiving, and a palliative care approach.”
- Jonathan Hsu (preceptor: Solomon Aronson, MD, University of Chicago) worked on “biventricular pacing during cardiac surgery.”
- Sara Lee (preceptor: Don Scott, MD, University of Chicago) studied “how older adults respond to a computerized survey of sensitive health issues.”
- Michael Levine (preceptor: Mary M. McDermott, MD, NU) worked on “inflammatory and demostatic markers and lower extremity function in peripheral artery disease.”
- Anna Porter (preceptor: Christopher Beach, MD, NU) worked on “noncompliance in the elderly.”
- Mallik Tella (preceptor: Joe Feinglass, PhD, NU) worked on a review of “cost-effectiveness, cost-utility, and cost-benefit studies in rheumatology.”
- Alisha Thomas (preceptor: Kristi L. Kirschner, MD, NU) worked on “evaluation and design of teaching materials to aid healthcare professionals in the treatment of women with disabilities.”
- Robert Yenchek (preceptor: Joshua Hauser, MD, NU) worked on “spirituality in palliative care.”

Joshua Hauser, MD, and James R. Webster Jr., MD, assumed leadership of the summer student program this year, after many years of development under the leadership of Madelyn Iris, PhD. “The medical students this summer worked with their individual mentors on projects ranging from laboratory research to clinical interventions to educational projects,” said Dr. Hauser. “The time and energy devoted to this program by the students, mentors, seminar presenters, and clinical sites made this a successful summer.”

In other medical student news, two participants in the 2001 Summer Program, Katherine Butler and Paul R. Crisostomo (with James R. Webster, Jr., MD, and Maureen B. Moran, MPH) published the results of their research in a letter to the *Journal of the American Geriatrics Society*: “Validating the Time and Change Test to Screen for Dementia in an Older Hispanic Population,” Volume 50, Number 2, pages 397-8, 2002. From administering the Time and Change Test in Spanish to 222 community residents aged fifty-five and older who self-identified as Hispanic, these researchers found that low scores on the Time and Change Test were correlated significantly with scores on the Mini-Mental State Exam.

People, Programs, and Projects

Northwestern University School of Education and Social Policy, Human Development and Social Policy Program

The text of the inaugural Bernice L. Neugarten Lecture on Human Development and Social Policy is now available. The lecture, “Getting Our Act Together: The Challenge to Human Development and Social Policy of a Fast Changing World,” was delivered in May by Alice S. Rossi, PhD, Harriet Martineau Professor Emerita of Sociology at the University of Massachusetts, Amherst. Copies may be obtained from Mary Lou Manning, Program Assistant, Human Developmental and Social Policy Program, School of Education and Social Policy, 2115 North Campus Drive (Annenberg Hall), Evanston, IL 60208.

Northwestern University, The Feinberg School of Medicine, Division of Geriatric Medicine Beatrice J. Edwards, MD, FACP, presented a paper on her osteoporosis research at the American Society for Bone and Mineral Research’s annual meeting in September. “Wrist, spine and lower extremity fractures predict hip fractures,” was co-authored by Edwards and Andrew Bunta (from Northwestern), and L. Fitzpatrick, M. Bolander, C. Simonelli, and J. Kauffman (from the Mayo Clinic, Rochester, Minnesota, and Health East, Minneapolis, Minnesota).

Adnan Arseven, MD, is working with Linda Emanuel, MD, PhD, of the Buehler Center on Aging to create the “Excellence in Academic Geriatric Medicine Project.” The goal of the project is to establish a coordinated multi-site educational resource center to facilitate the educational efforts of the Division to improve the health care of the growing elderly population, reduce medical costs, and collaborate with other departments on the Northwestern campuses in aging-related research.

John T. Clarke, MD, has been named a fellow of the Institute of Medicine of Chicago. An article about Dr. Clarke was featured in the Summer 2002 issue of *Ward Rounds*, the magazine of Northwestern University’s Feinberg School of Medicine.

June McKoy, MD, MPH, JD, has been appointed to an advisory group of the American Medical Directors Association to assist in the planning of education in long-term care for fellows in geriatric medicine.

Northwestern University Department of Sociology

Eric Klinenberg, PhD, is the author of the just-issued *Heat Wave: A Social Autopsy of Disaster in Chicago*. The book, which deals with the July, 1995, heat wave that cost more than seven hundred Chicagoans—many of them elderly—their lives, is published by the University of Chicago Press. Chapter I, “Dying Alone: The Social Production of Isolation,” deals with how social conditions have increased the likelihood and the dangers of living alone or being isolated in old age. The book (and its author) are featured on the front page of the University of Chicago Press web site <<http://www.press.uchicago.edu>>.

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