

Conclusion

Among the 364 geriatric out-patients studied, 115 (31.6%) had polypharmacy (5 or more prescribed medications) and 28 (7.7%) had inappropriate medications. Medications identified to be inappropriately used in this study included propoxyphene, dipyridamole, diazepam, metformin in presence of renal failure or heart failure, and diltiazem in presence of heart failure. Gout, COPD, CHD, CHF, and increasing number of medical diagnoses were found to be significant risk factors for polypharmacy. The use of inappropriate medication was significantly associated with polypharmacy.

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IN MEMORY OF PROFESSOR BERNARD ISSACS

Sadly, Professor Bernard Issacs, one of our international board of Honorary Editors, passed away in March 1995 in Jerusalem at the age of 70 after a short illness.

In the late 1950's, Professor Issacs was a senior registrar under Ferguson Anderson in Glasgow, who became the first ever Professor of Geriatric Medicine. He gained international repute for his research and promotion of the "Giants of Geriatrics", a term he himself coined to embrace the 4 I's of geriatrics (intellectual impairment, immobility, incontinence, instability), the "common final pathway" of the clusters of chronic diseases which frequently afflict very old people with diminished powers of recovery. He had been the Charles Hayward Chair of Geriatric Medicine at Birmingham University from 1974 to 1989. His teachings and reputations had attracted many geriatricians from around the world to spend time in his unit; among one of them was our former Society President.

He was invited to Hong Kong in 1988 as guest Honorary Professor for our annual Society Scientific Week. I can still recall vividly some of his teachings and sayings. In response to the remark of a medical student that a stroke patient was having poor

motivation, he asked, "Who is poorly motivated, the patient or the staff?" When a stroke patient yelled in reaction to a student's attempt to elicit plantar reflex, he commented, "What matters to a patient after a stroke is whether he can walk and not whether his big toe will go up when his sole is scratched, which only inflicts discomfort and pain." He emphasized the pitfall of focusing on diagnostic techniques but ignoring functional assessment to detect disability and handicap in a stroke patient. He expressed annoyance at the common sight of restraints in a psychogeriatric ward, "It is not a prison. Who has the right to restrain these old persons?" In a research meeting on fall, I was somewhat embarrassed when asked to define "imbalance", the meaning of which seemed to me obvious. He illustrated how the principles of physics (displacement, equilibrium, stability) could be applied to a medical subject (instability and fall). He was also a skillful actor, reflecting that he was a very observant clinician. In an evening seminar, he demonstrated how a stroke patient might struggle with the topological parts of a sweater during dressing and undressing when disabled by perceptual deficits. How many doctors will pay

attention to how a stroke patient dress and undress and correlate the disability with the neurological impairment? One junior colleague, perhaps not so sure whether he should continue to pursue geriatrics in his career, asked Professor Issacs whether there was any difference between geriatrics and general internal medicine. He responded quickly, "It depends on whether you are happy to stay on in geriatrics". That colleague has stayed on and is now a consultant geriatrician. A more thoughtful answer can later be found in his last book: "There has been much discussion on whether geriatrics is just general internal medicine and nursing, or whether it is a specialty in its own right. The question will become superfluous when all doctors and nurses are confident of managing the Giants of Geriatrics as they are of dealing with other diseases and disabilities which they encounter." He showed gratitude for our hospitality despite we had given him a busy task for the whole Scientific Week. But he did make one complaint afterwards, and that was the sharp contrast between the poor and the rich in Hong Kong. His sensitivity to poverty and compassion for poor elderly people was also evidenced in his earlier book in 1972 "*Survival of the Unfittest*", which pictured the terrible illnesses afflicting elderly people in Glasgow.

He had been an Honorary Editor and Advisor of our Journal since our inaugural issue in 1990. Besides contributing review articles and providing referee for submitted articles, he had written to our Journal critical yet constructive letters to help improve the standard of our Journal, and he was so kind as to ask the editor-in-chief not to publish these candid criticisms as letters to editors! He objected to the use of the expression "the elderly" in our publications: "The characteristic feature of

old people is diversity. There is no homogeneous biomass called 'the elderly'. When we talk of 'the elderly' we generalize. When we talk of 'elderly people' we particularize." He pointed out that blank space in a publication was a wastage and he suggested filling it up with meaningful short pieces; and he contributed the first filler - his aphorism on "poor historian". Unfortunately he could not live to see this contribution published in our Journal, nor the changes he advised.

His life-long observations, experience and wisdom in geriatrics has been crystallised into his last book "*The Challenge of Geriatric Medicine*", which was published in 1992. In it can be found the principles of relativity seldom taught in clinical medicine: expressions often used to describe elderly patients such as "poor historian", "poor motivation", "poor compliance" might just reflect poverty on the side of doctor himself, i.e. lack of knowledge and skills, and negative attitude to enrich the doctor-patient interaction. He emphasized the importance of shifting the frame of reference from doctor-centredness to patient-focus in the practice of geriatric medicine. After his retirement in 1989, he and his wife Dorothy has emigrated from United Kingdom to settle in his homeland Israel, there to contribute to the fields of geriatrics and gerontology. His is survived by his wife, four sons, and eleven grandchildren. He will be remembered as a giant of geriatrics and his teachings will continue to inspire many to take up the challenge of geriatric medicine.

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