complicated by asthma. His ability to continue to find joy and meaning in life became an inspiration for others, and he was profiled by newspapers and featured on radio and television interview programs. In *Letting Go* he offers a guide to living with disability, pain, and the prospect of death. Schwartz shares some of the experiences that influenced his life from childhood onward, but not much in the way of clinical detail about his illness. It is a direct, unmannered presentation: an extended version of the storytelling recommended by Slater.

Perhaps his philosophy can best be summarized in one of the aphorisms sprinkled liberally throughout the book:

> Seek the answers to eternal and ultimate questions about life and death but be prepared not to find them.

Schwartz models a tolerant, exploring, open-minded approach to experiencing the last phase of life. He encountered physical ordeals and psychological challenges of high magnitude, yet did not take refuge in any extremity of response. The goodheartedness and sense of humor remain intact; there is little evidence of a driven or apocalyptic mindset. In his later years he practiced meditation and arrived at a personal integration of themes from several world views. There is more of the East than the West in one of his final aphorisms:

> Entertain the thought and feeling that the distance between life and death may not be as great as you think.

He also remained true to his career as participant-observer:

> Be a witness to yourself. Act as an observer to your own physical, emotional, social, and spiritual states.

Schwartz died peacefully at home at the age of 78 in 1995.

What is the position of death in Schwartz's world view? It may be easier to infer what it is not. Death is not personal failure. Death is not punishment. Death is not compensation and fulfillment. Death is not a tool of political or cosmic agendas. What death *is* in the grand scheme of things depends on there being a grand scheme of things: and that may be a little too much for the limits of human understanding. So — what then? So, we die as we have lived, knowing a lot of things, guessing about some others, and having not much of a clue about the ultimata.

Schwartz's philosophy seems to have something important in common with Johnson and Barer's oldest old: We can always learn more about life through living, and we can often find a way not only to keep going but to create and share meaning. The prospect of making an early exit seems tempting at times; however, life remains more tempting. Conflicting social forces may try to whip one into line, but after many years of experience and achievement, one trusts one's own judgment about the most suitable terms of engagement with life. Schwartz did not live quite long enough to be exposed to the now-in-progress social construction of the second millennium. No doubt he would have found this to be a phenomenon worth reflecting upon, although his sense of perspective (and humor) would probably have dominated.

As we approach 2001 (or it, us) there may be subtle and unpredictable alterations in our views of tradition, futurity, the social contract among generations, and the meaning of life in general. Perhaps our innermost terrors, worthy of our medieval ancestors, will rise to the occasion, luxuriating in the prospect of apocalypse. Perhaps religious faith will again approach high tide. Or perhaps we will recognize in the happenstance of calendar numerology our own impulse for renewal. And perhaps we will also recognize that this impulse does not have to depend on auspicious days for its fulfillment. As Morris Schwartz might well have said: What's wrong with today?

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Reference

Tornstam, L. (1989). Gero-transcendance: A reformulation of the disengagement theory. *Aging, 1*, 55–63.

THE MARRIAGE OF MULTIDIMENSIONAL ASSESSMENT AND GERIATRIC PRACTICE: SOMETHING OLD, SOMETHING NEW, SOMETHING BORROWED ...

Geriatric Assessment Technology: The State of the Art, edited by Laurence Z. Rubenstein, Darryl Wieland, and Roberto Bernabei. Editrice Kurtis, Milan, Italy, 1995, 304 pp., no price listed (cloth).

In-Home Assessment of Older Adults: An Interdisciplinary Approach, edited by Charles A. Emlet, Jeffrey L. Crabtree, Victoria Ann Condon, and Linda A. Treml. Aspen Publishers, Gaithersburg, MD, 1996, 280 pp., no price listed (paper).

Multidimensional assessments of older adults are designed to obtain a holistic picture of the individual by assessing strengths and weaknesses across the spectrum of physical, mental, and social dimensions. The consequences of these assessments for the patient or client are enormous. The results often require clients to come to terms with a loss of or decline in functioning in one or more areas where previously they had been more functional. At the same time, undergoing assessment is a requirement to receive many financial, health, and social services. Assessment is used to establish eligibility to begin or continue services, to justify the amount of care and the need for other important tests, treatments, or interventions, and to determine the amount of reimbursement for care providers.

Yet, in spite of their obvious and crucial importance in any system of long-term health care, multidimensional assessments of older adults are easily damned with faint praise. Because of their scope and their length, these assessments inherently involve compromises, but rarely the kind that lead all users to be satisfied. More than any other type of assessment, multidimensional assessments involve hard choices between depth vs breadth, measurement precision vs respondent fatigue, comprehensiveness vs feasibility, and research objectives vs practice requirements. At the same time, the art of conducting clinical asssessments is often lost. Here, I will explore current issues in multidimensional geriatric assessments in the course of reviewing two recent books that address different aspects of such measures.

Multidimensional assessments of older adults should serve clinical functions, which in the broadest sense means helping geriatricians, nurses, social workers, and case managers and other health professionals develop an adequate information base for understanding the client's problems, needs, resources, and strengths, and assisting these workers and the client in making decisions about care. However, these assessments typically serve additional functions, many of which impose competing requirements on the design, content, and length of the instrument. These functions can include: (1) establishing eligibility for programs; (2) providing a useful tool for training and supervising assessors; (3) creating a uniform framework for discussing cases; (4) providing a basis for decision making about the allocation of services based on need for and benefit of service; (5) generating information for state officials, legislators, and the general public about the type, extent, and distribution of needs in the community; and (6) serving as the foundation for provision of timely and relevant feedback to practitioners and programs about the effectiveness of services in meeting needs.

There are some classic treatments of the subject, including Rosalie and Robert Kane's *Assessing the Elderly: A Practical Guide to Measurement* (1981) and, more recently, M. Powell Lawton and Jeanne A. Teresi's (1994) "Focus on Assessment Techniques." These texts and similar comprehensive reviews provide useful benchmarks for state-of-the-art measurement in multidimensional geriatric assessment, and track growth and progress of assessment techniques, emerging issues, and future trends.

New Developments

In the past decade, there has been a startling growth in the number and type of assessment instruments, in the number of health professionals conducting comprehensive assessments, and in the use of these assessments in long-term care (Geron, 1997). In areas of assessment that are already well established, researchers have made significant progress in increasing the precision of established tools without increasing the cost of administration or the burden to clients. There also have been substantial efforts to develop new standardized measures; for example, for caregiver burden and stress; dementia; values and preferences; and social functioning and quality of life. Somewhat paradoxically, considering the profusion of assessments, there has been less progress in establishing the utility of assessment to practitioners or in confirming the benefits of assessments to consumers. Another important area that has not received sufficient attention is the cultural appropriateness of standardized measures and multidimensional assessments with minority populations.

One of the significant advances in the field has been in the development of specialized geriatric assessment programs. These programs, which can be organized on either an inpatient or outpatient basis, combine full health assessment including physical examinations and laboratory tests by a geriatrician who, acting alone or as part of a team, provides therapy and follow-up care. Acute hospital patients whose conditions are stabilized, but who are not able to be discharged to the community, are often candidates for further assessment in inpatient geriatric assessment programs. Such programs incorporate protocols for multidimensional assessments, which are used both to aid diagnosis and to plan aftercare. Unfortunately, the supply of geriatricians has limited the development of these programs. Geriatrics is still a small specialty — only about 11,400 United States doctors are currently certified in geriatrics, and about 20 percent of those are geriatric psychiatrists who do not deliver general care. By comparison, there are about 19,000 cardiologists and more than 111,000 general internists in the United States (Knox, 1997).

For frail older adults residing in the community, the design and conduct of assessment have been established as core elements of long-term care programs. The emergence of community-based long-term care demonstration projects under Medicaid waivers in the 1970s and 1980s stimulated the growth of formalized comprehensive assessment to determine the needs of clients for services and to provide a uniform basis to make decisions about the appropriate type and intensity of services. Case or care management by "generalist" practitioners, typically social workers, nurses, and case managers, has become one of the fastest growing occupations, and a dizzying array of comprehensive assessment tools have been developed and are in use. More recently, the efforts to reduce federal and state spending in general, and the growth of managed care in health and long-term care, have transformed the rationale and methods of assessment. Formalized and mandated client assessment are now conducted in part because health care insurers are demanding it for reimbursement. Agencies and programs use assessments to help justify what they do as they compete with insurance companies and managed care corporations for scarce public and private dollars.

At the same time, the technology of assessment is changing. Advancing computer technology has transformed assessment, allowing assessment — at home and at a distance — of clinical changes that once required a hospital laboratory (Kane, 1997). We now have the technology that makes it feasible to track client assessments over time and to compare characteristics and outcomes of clients who are using different services, who are sequenced from one service to another, or who enter and reenter the formal health and long-term care service system. The most significant development in the computerization of assessment information is the creation of the federally mandated Minimum Data Set for Nursing Home Resident Assessment and Care Screening (MDS). The MDS, which is administered to all nursing home residents nationally, is linked to care-planning guidelines and is designed to facilitate the collection of clinically useful assessment information.

Geriatric Assessment Technology: The State of the Art, edited by Laurence Z. Rubenstein, Darryl Wieland, and Roberto Bernabei, provides a comprehensive treatment of trends in multidimensional geriatric assessment. A by-product of a 1994 international conference in Italy, the book contains 23 concise chapters that are brimming with useful information about geriatric assessment and contain current and comprehensive bibliographies. Like most multi-authored books, the presentation is sometimes uneven, but, on the whole, the textbook is a valuable addition to the literature.

Among the authors, a high proportion of them are researchers and geriatricians who are known as experts in their areas. Also impressive is the range of entries included, which are by and large well written and thorough. The book includes chapters on what are now standard components of geriatric assessment such as the medical evaluation; assessment of functional status; gait, balance and mobility; social functioning, cognitive impairment and depression; urinary function; and nutrition assessment. In addition, the book includes chapters on a number of specific topics that are often not included, such as home environment; application of patient criteria to determine the appropriateness of a geriatric assessment; quality improvement; and database requirements. Still

other chapters cover geriatric assessment as practiced in various settings, contexts, and countries; hospital geriatric assessment units; consultation teams; special hospital geriatric units; home preventive visits; assessment in nursing homes; and geriatric assessment in general practice in the United Kingdom.

I particularly liked the chapters summarizing research on the effectiveness of geriatric assessment, the discussion of targeting criteria to determine the appropriateness of a client to receive a geriatric assessment, and the discussion of equality improvement, though topic preferences will no doubt differ with each reader and depend upon that reader's area of expertise.

The limitations of the book are minor. The intended audience of the book is not described: Is it the practicing geriatrician who needs review of recent evidence, other health professionals involved in multidimensional assessment of older adults, or the general lay audience? Because of the scope of the book, the reader would benefit from having separate divisions or sections for the chapters that summarize research findings; review particular dimensions of assessment; and describe the practice of geriatric assessment in different settings. The editing is spotty in places, e.g., various definitions of geriatric assessment are given. The third chapter, "Comprehensive Geriatric Assessment: Assessment Techniques," seems to be mistitled, as the chapter primarily focuses on reviewing health and functional status measures.

The second book addresses the type of geriatric assessments conducted in the home. As in *Geriatric Assessment Technology: The State of the Art*, there is much to like about *In-Home Assessment of Older Adults: An Interdisciplinary Approach*, edited by Charles A. Emlet, Jeffrey L. Crabtree, Victoria A. Condon, and Linda A. Treml. The authors come from a variety of health profession backgrounds. Together, they have extensive clinical practice experience in such areas as social work, occupational therapy, nursing, and physical therapy. The intended audience is clearly indicated; the book is "designed to provide persons from a variety of disciplines and levels of education with practical and useful information" to conduct in-home assessments. Fourteen chapters address topics relevant to in-home assessments: determination of accessibility and safety, physical function, mobility, physical systems, medication management, nutrition, social functioning, cognition and depression, referrals, caregiver assessments, and community resources.

The chapters are generally well written and well organized. I particularly like the inclusion of tips and suggestions for practitioners to use when conducting assessments, such as specific probing questions. The review of basic assessment domains and measures is buttressed with specific case studies, practical suggestions, sample informational postings from NIA's Age Page, photographs, and lists of resources. Actual examples of assessment forms are included, among them instruments for physical examination and cognitive functioning. The Appendix lists the addresses and phone numbers of state units on aging, regional offices of the Administration on Aging, and state offices responsible for adult protective services.

Again, some minor complaints. The authors claim that the book is specifically designed for interdisciplinary assessment, defined as a "blend of different professionals working interdependently in the same setting and interacting formally and informally" as opposed to multidisciplinary assessment, in which "professional practitioners ... work independently, often in the same setting, and interact informally." Although interdisciplinary assessment is a laudable goal, this is difficult to accomplish in practice, and even harder to describe in writing. A random review of references in the chapters shows some gaps. For example, in the chapter on assessing physical functioning, a more recent review of the literature that should have been included is the excellent chapter by Kovar and Lawton in Lawton's and Teresi's review (1994). As another example, the otherwise strong chapter on ethics would be strengthened by including a treatment like Rosalie Kane's and Howard Degenholtz's (1997) recent instrument on values and preferences assessment.

Conclusion

Anyone interested in geriatric assessment will find much new and useful information in each of these books. At the same time, the books cover familiar territory. The technology and the techniques of assessment are rapidly evolving, and neither book successfully incorporates these developments. Future textbooks on assessment will hopefully do so. As research progresses, future works also will need to address the issue of determining the cultural appropriateness of geriatric assessments. We are living in an age when the diversity of the United States is increasing but the design of culturally equivalent assessment tools has lagged behind. This issue was not mentioned in *Geriatric Assessment Technology: The State of the Art*, and only addressed cursorily in *In-Home Assessment of Older Adults: An Interdisciplinary Approach*. The best assessment protocols acknowledge cultural diversity and consider the implications for the instruments used with non-English speakers and minority clients. Finally, while much has changed in the world of assessment, the art of conducting assessments has not. Both books are testimonies to the knowledge and skills of geriatricians and skilled assessors, yet illustrating how practitioners actually develop and use analytic skills in the assessment process is a subject that is hardest to convey in textbooks. It may be that traditional textbooks are not the best format for doing so, and that future works will need to employ multimedia formats to fully illuminate the judgment, analytic skills, and therapeutic techniques used in conducting muiltidimensional assessments.

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References

Geron, S. M. (Ed.). (1997). *Using assessment to improve practice: New measures and developments. Generations, 21*(1).

Kane, R. A., & Degenholtz, H. (1997). Assessing values and preferences: Should we, can we? *Generations, 21*(1), 19–24.

Kane, R. A., & Kane, R. L. (1981). *Assessing the elderly: A practical guide to measurement.* Lexington, MA: Lexington Books.

Kane, R. L. (1997). Using technology to enhance assessment. *Generations, 21*(1), 55–58.

Knox, R A. (1997, Monday, July 21). Geriatric practice offers more than medical care. *Boston Globe,* pp. C1, C4.

Lawton, M. P., & Teresi, J. A. (Vol. Eds.). (1994). Focus on assessment techniques. In *Annual review of gerontology and geriatrics: Vol. 14* (pp. 353–375). New York: Springer Publishing.