Dysmobility in Geriatrics

Conceptualisation, Clinical Approach, and Aging Theory

José Luis Dinamarca-Montecinos

With contributions by

Emma L. Sutton
Carmelinda Ruggiero
Cecilia Bonta Arias
Soraya León Araya
Viviana García Ubillo

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José Luis Dinamarca-Montecinos
Orthogeriatric Program
Hospital Dr. Gustavo Fricke
Viña del Mar, Chile

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Dedicated
to Perfect Movement,
to Infinity Love.
The Author

Foreword

This book is fruit of a professional persistence and commitment for advancing in our understanding of the essential keys of life and aging: that is the Movement-Time Theory, life and aging as the eternal product of movement and time. Individual and humankind life as a continuum of biological and physical movement over time, from the very initial developmental phase to advanced ages, from the Earth's birth to everyday individual births and deaths—both, milestones in the journey from the initial to the last breath of mobility, and examples of the transformative phases of the universal legacy.

Focusing on mobility changes, the Dysmobility approach represents a captivating and provocative framework for understanding the complexities of health and disease, to better define the medical answers and social services, needed for aging-related personal needs affecting the individual's ability to maintain independence and quality of life.

One could imagine human life, from the body's development phase up to the extremely advanced ages, as the combination of motions across environment and time to get resources for a quality survival and living. And the body's machinery sustaining homeostasis and leading to continuous internal movements, then interactions with the environment generating the main determinants of life, health, and quality of life.

Mobility, as the sum of individual movements experienced over time, will summarize intrinsic vitality, leading to different degrees of expression according to biological strata and interconnection levels of functioning, from micro to macro, in the body's structural and functional dynamics.

The body's ultimate strive of the dynamic movement is maintaining homeostasis through continuous interactions with the

environment, which are pivotal for health and quality of life. Indeed, throughout life, humans adapt their movements to changing environmental conditions. For instance, adapting to seasonal changes by altering physical activity patterns or modifying living spaces to accommodate aging-related mobility issues.

Dysmobility abruptly or slowly can significantly affect individuals' homeostasis and health outcomes, promoting the acceleration of the entropy related forces at the individual and ecosystem levels.

Then, understanding the concept of Dysmobility not only proposes strategies to enhance care and mitigate human suffering while aging. It also provides significant insights when considering the aging process within the broader context of human evolution and ecosystem adaptation throughout the life course.

Integrating Dysmobility syndrome into healthcare systems underscores the importance of movement at every stage of life as a means to maintain health, quality of life, and resilience against disease, and to promote healthy aging.

By promoting healthy mobility, we can ultimately enhance individual well-being and societal health, and contribute to the sustainability of human life in our planet. It is likely the secret for counteracting or delaying the system's entropy at the individual, societal, and species levels.

This perspective aligns with the continuous dance of elements within our bodies, environments, and the broader ecosystem, emphasizing the interconnectedness of health and mobility in the entire universe.

Carmelinda Ruggiero

Gerontology and Geriatric Section
Department of Medicine and Surgery
University of Perugia
Perugia, Italy

Orthogeriatric and Geriatric Acute Care Units
Perugia University Hospital
Perugia, Italy

The Fragility Fracture Network - Italia
Rome, Italy

Prologue

The world is experiencing a significant demographic shift with falling birth rates and increasing life expectancy, placing age and aging at the centre stage of social, economic, political, health and academic debate.

José Luis Dinamarca, in this massive immersive experience—*Dysmobility in Geriatrics*—challenges the traditional view of the birth, life and death of individuals and how mobility and 'Dysmobility' is viewed by society. Here, we are presented with the idea that living beings begin to age 'before' existing and continue to age 'after' dying. *Dysmobility in Geriatrics* also encourages the reader to challenge assumptions about the connection between movement and time (Dysmobility Theory) and that chronological years lived does not explain *when* we age or *how* we age. In fact, aging generates, in parallel, two effects: deterioration and maturation—and one does not occur without the other. As we all move through time, we also develop skills, create links, complete achievements, generate knowledge and acquire wisdom, and these are not signs of deterioration.

This is a refreshing and optimistic view of aging in comparison to the perhaps too commonly held negative stereotypes which tend to be associated with deterioration, ill health, and decline.

This book presents age and aging within the context of the whole person *and* the universe in which they live. It will present you with big ideas, it will challenge assumptions and, most importantly, it will give you a practical toolkit to support your everyday

clinical practice and assessment of the older person. I beckon you to dive straight into Chap. 1.

This is exactly what I did, and I was delighted, that as a Physiotherapist I was immediately challenged within the first few pages to re-frame my own perception of mobility and immobility. Instead, I now channel my thoughts within the context of Dysmobility.

One of the most important concepts presented in this book is that everything is moving continuously, movement does not pause. *'Even when sleeping, we can say that we execute a set of movements that allow us to rest'*. This seems obvious to me now that I have experienced the journey through *Dysmobility in Geriatrics*, but previously I had been trained to treat the person with immobility—and the physical and emotional consequences resulting from this.

José Luis Dinamarca guides readers like me gently through key stages, from considering human movement at a molecular level, the genetic level, and the system level (and the interdependent continuum "NEMOH": Neuro Endocrine Muscle Osseum Hematological) and then allowing them to place this in the context of Dysmobility as a geriatric syndrome.

Dysmobility, as a geriatric syndrome, consists of discomfort, difficulty and/or an inability to move part of the body, and this occurs secondary to various pathological situations which can be of *any* origin (biological, psychological, social, spiritual, functional, etc.). Dysmobility affects quality of life and/or can have a risk of progression. Throughout Chap. 4 the method of triaxial diagnosis of Dysmobility—the geriatric syndrome—is presented. We learn to define the presentation as slow or abrupt and then we can apply D-STAGING, a dynamic system consisting of 10 substages. We move deeper throughout Chap. 5 learning to integrate time and understand the concept of progression, which can move Dysmobility towards deeper stages, and stabilization and regression which can move Dysmobility towards earlier stages. The reader then moves towards the end of the book gaining practical assessment and diagnostic prompt cards (Chap. 6), the luxury of a full history of the evidence base of Dysmobility (Chap. 7), and example clinical cases (Chap. 8).

I therefore leave you now, with another delight and revelation to me—the paraphrase from Descartes '*I move therefore I am*' (Chap. 9). Dysmobility as a diagnosis and a concept allows us to place the person within their whole spiritual, societal, physical, and emotional context; movement is constantly present at all levels, and everything can be mediated through movement—which never stops—I move therefore I am.

Let us all go into the world, equipped with the knowledge presented in these pages, to make a difference to those we support and care for, and to make a difference to ourselves.

University of Birmingham Emma L. Sutton
Birmingham, UK

University Hospitals Birmingham NHS Foundation Trust
Birmingham, UK

Preface

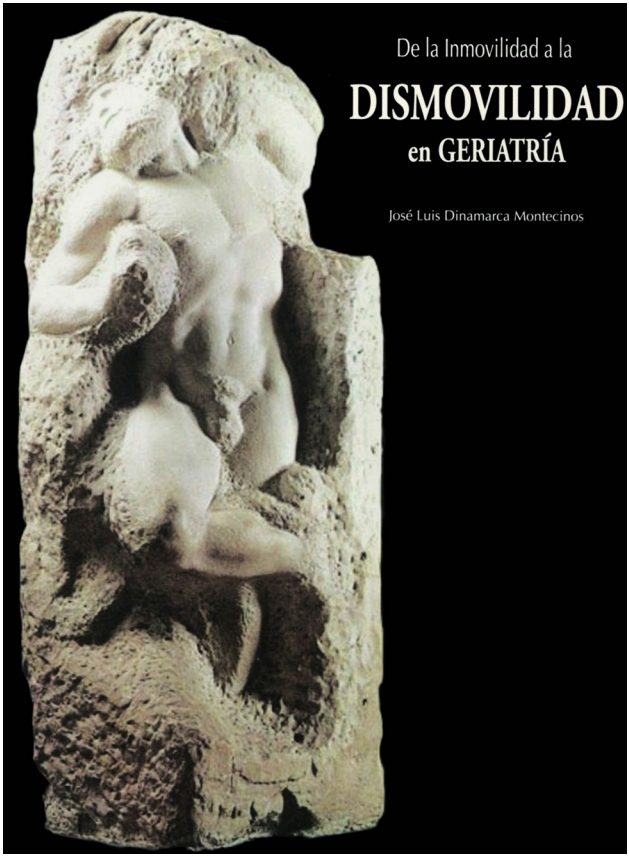

Fig. 1 Original frontcover of the first Spanish edition of the book "From Immobility to Dysmobility in Geriatrics" (SOCHIPSI Editions, Santiago de Chile 2004)

The year was 2001 and I was responsible for taking charge of the then-called 'Prostrate Program' of the Santo Tomás Hospital, in the city of Limache, in the region of Valparaíso, in Chile. The patients were mainly elderly people who couldn't get out of bed, but I also fondly remember a little girl and her mother who took care of her.

With a small group of professionals and technicians, we toured the city every Tuesday between 8 a.m. and 2 p.m. in a van, visiting the program's patients in their homes. Our resources were limited, so I had to limit our actions and responsibilities. As a result of several meetings, in the middle of the year we generated a regulation, which operated a set of guidance notes to improve management of this patient population.

Within the guidance, we divided the city into nine parts, conducting visits every 3 months, so that we could visit all our patients four times a year on a scheduled basis. I remember that we tried to define 'prostrate patient' without much success, even though we were reviewing the literature for several months.

In the end, we changed the name of the program, from 'prostrate program' to 'Home Care Program'. The eligibility criteria were summarized in the phrase 'any patient who, with the means available to him, cannot go to the nearest health centre when needed, due to permanent medical conditions'. There were other administrative and organizational criteria (for example, the city in which patients live) that helped us decide eligibility and who would be accepted on the program, mainly because we only had time and capacity for 63 people in that condition.

In December of the same year, I started working at the city's Geriatric specialty hospital, the La Paz de la Tarde Geriatric Hospital. In my enthusiasm for the work we had done throughout the year, I made it a condition to be able to allocate part of my hours to continue working in the Home Care Program. Dr. Ernesto Rojo Flores, Director of the Geriatric Hospital, a doctor with a lot of vision, must have been a little surprised by this request, but he backed my request and, in turn setting a condition, he asked me to send a summary of our work to the National Congress of the Society of Geriatrics and Gerontology of Chile, during October 2002. Without thinking about it (or perhaps, thinking about it) I had