Is geriatrics the answer to the problems of old age? ¹

Two doctors attempt to answer this question, one a specialist in geriatric medicine, the other a psychiatrist interested in the psychiatric problems of the elderly and the old. Both, however, come to the same general conclusion: attitudes of the doctors themselves and of society must be changed. These attitudes can determine not only whether an old person lives or dies but how he lives. Old people should not have to survive in mentally suspended animation with all objectives gone but should be helped to achieve the goal of an independent life until death in their own homes.

The third paper in this miniature symposium is provided by David Hobman, of Age Concern, who amplifies the specialist views of the first two writers in his discussion of attitudes to the elderly in modern society. He hints, however, that these may shortly change as the elderly become a sophisticated and powerful lobby which governments are forced to heed.

I Thoughts of a geriatrician

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I should like to reconsider the objectives of a modern geriatric service by looking briefly at factors that influence attitudes. Examples from the fields of hypnotism, athletics, medicine and education have been chosen to illustrate the point that people behave in the way that they are expected to behave.

Prophecy its own fulfilment

Moll in 1898 stated that prophecy causes its own fulfilment, and took examples from hypnosis to demonstrate that subjects behaved as they were expected to behave. At about the same time, Jastrow (1900), writing about athletics, said that 'the entertainment of the notion of a possible failure to reach the mark lessens the intensity of one's efforts and prevents the accomplishment of one's best'. He did not say whose expectations were involved.

¹Based on a lecture given under the auspices of the London Medical Group in January 1976.

In the medical field we have evidence for a placebo effect. It has been shown that, at the very least, doctors' prophecies can affect their prescription that the patient will improve and, very likely, their prophecies can also bring about the patient's actual improvement (Loranger, Prout, and White, 1961).

In education, it is well known that a larger proportion of disadvantaged children rather than middle-class children are failing at school. Disadvantaged children, by definition, come from the lower socio-economic groups where low income is associated with values that are different from the culture of the predominantly middle-class school. Rosenthal and Jacobson (1968), in an American school in a predominantly lower-class community, reported to their teachers that 20 per cent of the children were showing unusual potential for intellectual growth, as assessed by a new test. Eight months later these unusual, or 'magic', children showed significantly greater gains in IQ measurements than did the remaining children. The test used had been a standard IQ test, and the 'magic' children had been chosen by random numbers. It was solely a change in the teachers' expectations that had led to an actual change in intellectual performance of these randomly selected children. This would seem to support the concept that the lower-class child is punished for what he is.

Rose (1956) wrote that if both whites and negroes expected the negro to fail at school then could this not stop the negro from trying? If, in addition, the state spends less than one-fifth as much on the education of its negro youth as compared to its white youth, then inferiority of scholastic achievement may well have become a reality.

There may be similarities found with our medical provision for the elderly. If the medical and remedial professions expect the elderly to fail, could this not stop them from trying? If in addition the elderly are provided with inadequate facilities and often ignored then the poverty of their achievement will have become a reality. We can justify our failure in the same way as the failure of the disadvantaged child can be justified. We can talk about, and quantify, their advanced years, their poor housing, their bad eyesight, their incontinence, their deafness and their dementia. We can then extrapolate from these valuations to artificial scores of their mental state, social isolation, social contacts, mo-

bility, and continence, and from these we can then measure their failure.

As the rehabilitation of the sick patient is an exercise in setting targets, there is a lot that we can learn from the field of education. If it is true that people behave in the way that they are expected to behave then we too should be looking at the teachers and not at the taught. By that I mean that we should be examining ourselves as doctors and nurses and members of the remedial profession and our own attitudes instead of measuring our patients' inadequacies. The person looking from the outside at a group of patients can prophesy that they will not do well, that their incontinence is irremediable, that their minds will be muddled and that their age is against them. They, however, are only passers by whilst we remain. We cannot be allowed the casual prophecies of the passer by, for our prophecies will be fulfilled. A pessimistic prognosis, if supported by the staff, relatives and patient, carries a formidable force which, if it is a prediction of death, is usually accurate, especially if nothing is done to prevent it. Similarly, the prophecy that a patient is irremediable and needs a long-term hospital bed will be accurate, especially if it is unopposed. It is interesting to reflect that research has shown that subjects who perform poorly but expect to do so seem to be more satisfied than those who perform well but had not expected to.

What would happen if we all decided that we should always start to discuss the elderly with an optimistic prophecy? You will all by now have said to yourselves that this is impossible, and will have thought of an individual case to prove your point of view. You may say that it is no longer defensible to make generalizations about old people as if they were all the same, and that old people are individuals with individual diseases and that some of them are poor and some of them are dirty and some of them are not wanted by anybody. I agree, but my generalization was not about the elderly but was about ourselves.

Are the 'problems' of old age inevitable?

It is often thought that the problems of old age are an inevitable accompaniment to our present type of society, but this is not true, for living has its problems in all types of societies. The elderly in Great Britain cannot accurately be described as usually disabled from illness, economically destitute or psychologically alienated. On the contrary, most old people in urban industrial societies have been found to be reasonably competent in meeting their needs socially as well as personally (Brantl and Brown, 1973). Not all elderly people have the same needs, nor do they require the same services, and it is no longer profitable, nor indeed defensible, to make generalizations about the aged as if they constituted a single category. This fact, however, has been

totally ignored in the reorganization of the National Health Service, where the officials concerned have placed their faith in health care planning teams for the elderly at least 10 years after it has become known that you cannot plan for the elderly but must plan for the total care of individuals in a health district regardless of age.

The achievements of geriatric medicine

The development of geriatrics services in Britain has been the major advance in total patient care in this century but mainly it has occurred in hospitals isolated from the main stream of medicine and the achievements have been ignored. The major achievement of geriatrics has been to show that the dependent patient, if managed optimistically and treated energetically in the right environment, with the right furniture, dressed properly and treated with respect, can gain the necessary independence either to leave the hospital to resume life at home or can, within the hospital, achieve a potential far beyond the expectations of the referring doctors who, in some cases, describe them as irremediable 'bed-blockers'.

The tragedy is that the lessons learned about managing patients have not been taken up. That today one can still find non-adjustable high beds, cot sided chairs that are too low or too high for the individual or chairs with restraining tables in most of our hospitals, and an attitude of mind towards the elderly that is, to say the least, pessimistic, is a reflection of our failure as doctors to provide the right type of medical service for patients in Great Britain, whatever their age.

Geriatrics, then, is not, and never will be, the solution to the problems of old age because living has its problems at any age. It is, however, an attempted solution to the inadequate coordination, organization and delivery of medical services in Britain. It grew out of neglect, and at this time I find little to encourage me that this neglect is not continuing. It is only by an attack upon that neglect that we will provide some of the answers to cope with the problem of ill health and dependency in our society. That solution will not be found by looking at our present geriatric services in their isolated, poorly staffed and unwanted hospitals to deal with the burden alone. The solution to the problems of old age will only come by examining ourselves and our own attitudes, and planning to provide a medical service geared to the patient's needs which identifies each patient as an individual with individual aspirations, dreams, and hopes, and which, for each patient, makes both an accurate medical and social diagnosis and works with that patient to enable each one to achieve the goal that we all want ourselves—an independent life until death in our own homes.

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II A psychiatrist's view

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Is geriatrics the answer to old age is clearly a provocative question. Is paediatrics, it might as reasonably be asked, the answer to childhood? But childhood is not often seen as a problem, whereas old age frequently is. The problem is essentially that the proportion of old to younger people in our population is increasing and that the elderly are more liable to illness.

Since the turn of the century the percentage of those over the age of 65 in the United Kingdom has increased by two and a half times to 13, while the actual number of the elderly has increased fourfold. While the length of life remaining to those past retirement age has increased little, far more people survive to retire. The provision of 10 general hospital beds for bodily illness in those over the age of 65 is approximately four times that for the general population. Whereas patients over 65 formed barely a quarter of those in psychiatric hospitals 30 years ago, they now comprise more than half.

The answer to old age—respect

If old age needs an answer, then, perhaps it should be respect—based at the least upon enlightened self interest—as the great majority of the young are going to survive to be old themselves. Respect for the elderly is implied in the term 'senior citizen' but in practise seniority often seems equated with senility, and the rights of the elderly as citizens are not infrequently infringed. They are not always given a proper say in whether they are admitted to hospital, transferred to another ward or discharged. Their right to self determination may be overlooked by denying them, in institutions, a choice about what to eat, wear or do. Commonly they are not given their proper names and titles but addressed as 'Pop', 'Gran' or 'Dear'. Staff may think that they

are merely being friendly by using such terms, but the effect is to deprive the personality of the elderly patient of an important attribute. Even at home the expectations society has of the elderly and the resources given them seriously limit their choice. Too often, once they have ceased to make a material contribution, their individuality and potential are ignored and they are regarded as 'passengers' to be lightly patronised, or as a scarcely tolerable burden.

Education for retirement

An alternative answer to old age may be education for retirement as part of education for living. To this end research is required into the range of behaviour in old age, and the factors associated with a fuller life. What makes a Charles De Gaulle, a Bertrand Russell, an Emmanuel Shinwell or an Edith Evans? Is it intellect, or was Cicero right in asserting that 'old men preserve their intellects so long as they preserve their interests'? How do personality, education, health, occupation and opportunities contribute? On the other hand we need to know how much the inertia and apathy of some old people is 'normal for their age' and how much the consequence of illness (such as depression) or lack of stimulation.

The final 'answer' to old age is of course death. This being so, perhaps we should learn about the attitudes of the elderly to death—their own and of those around them. How many old people face death equably, how many in fear and how many practise denial? My own experience of group discussions with elderly psychiatric patients is that very few indeed can face up to their own mortality. Bereavement is the most critical of the many losses suffered in old age and a major factor in morbidity, particularly depressive illness. Means of giving support and comfort need to be explored and applied.

Geriatrics, which is a branch of medicine, cannot of course provide an answer to the condition of old age, but it can do much to enhance the health of the elderly. To my mind the special contribution of the geriatrician is his informed optimism. He does not assume that disability, however severe, is irreversible or the inevitable consequence of aging. He has the commonsense (not, alas, all that common outside his field) to recognize that seeming dementia may be a consequence of deafness, that dysarthria may be due to lack of dentures, that falling may result from ill-fitting or inappropriate footwear or that some old people bump into things because they are wearing the wrong glasses. When geriatricians took over from their defeatist predecessors 30 years or so ago they would not accept that any patient should be bedridden, and thousands who had lain in former poor law institutions were enabled to get up and even to go home.