Letter from Australia

Coming of age

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In Australia, as in many Western countries, the population is ageing. In coming decades we can anticipate that the medical care of the elderly will claim an increasing proportion of medical and economic resources. It will also confront us with an expanding challenge in the ethical issues affecting the aged.

One can easily define the ingredients in the Antipodean problem but the solutions are not so obvious. The population of Australia is ageing: in 1901 4 per cent of the population was over 65 years and in 1976 the figure was 8.7 per cent; in 1901 8.3 per cent of the population had celebrated their 50th birthday while in 1976 22 per cent reached their half century. Further, for the elderly of today, survival following illness is more common. Previously an acute illness in an old person often led to death. Now sickness frequently results in a residual disability for which care must be offered. In earlier days there were the 'quick and the dead', but today there are the 'quick and the elderly who are not quite so quick'. Another factor that will increase the number of people pushed towards the geriatric group is the early retirement schemes being adopted to help offset unemployment in the young.

The first problem is clear: an increase in the number who will require geriatric services. The second problem – which serves to frustrate and subvert attempts to effect this care – is the containment and reduction of medical resources and spending, and the increasing cost of medical care.

There are many other unfortunate seams in the geology of geriatric care. One is the inevitability of ageing and its associated medical problems. Apart from the correction of sociogenic factors and attitudes towards the elderly – which are difficult to reverse quickly – little can be done to prevent the effects of ageing. Another is the breakdown of the family unit and the decreasing responsibility of offspring for the care of parents, together with a style of life leading to greater individual mobility and geographic separation, both of which undermine essential community supports for the elderly.

If one adds to these some unfeeling policy decisions being made by health insurance companies and governments in relation to the infirm and chronically ill,

we are left with a sense of discomfort about the probability of adequate future care for the elderly.

What are the ethical issues which will arise as a result of a progressive increase in the age of the population? I believe these issues will involve government, society, the family, the profession and individual practitioners – and for convenience they can be considered under these headings.

Government

Governments will need to decide the order of medical spending and the place which geriatric care will have in that hierarchy. Of course, in part, this will depend on political philosophy but it will also involve ethical decisions on the priorities of spending on research, hospital services or community services. More specifically, Governments will be involved in decisions relating to provision of housing for the elderly. They will need to have guidelines on the accommodation needs of the aged and may need to consider mortgage adjustment and borrowing schemes designed to bring about effective housing. Decisions can be anticipated on the appropriateness of supplementary schemes for both housing and sickness benefits. Special concessions could be offered to families prepared to accept the responsibility for the care of their elderly relative. Recently in Australia there has been grave concern expressed about the standard of care in private, profit-making, special accommodation for the elderly. State Government officials have promised an investigation and a review of the legislation in this area.

Predictions have been made that in the future elderly patients will need to be an effective organised political lobby.

The community

It is not a cynical observation that society is only interested in 'successful' agers who do not stress the community or make demands on its resources. From old age is regarded as failed old age – a state of dependency. An important ethical area involves the attitude of a society to its elderly. A society usually has an unspoken philosophy in relation to the usefulness of its dependants, and also in its sociogenic attitudes towards age. Society does impose a role on people as they reach a certain chronological age. Insofar as this is unjustified we have sociogenic forces which undermine the elderly. Frequently, a transition to senior years or into

retirement exposes an individual to social attitudes which make a capable person feel unintelligent, unemployable, asexual and socially inadequate. Modern research indicates that many of the mental and human changes seen in senior people are not biological effects of ageing but are due to their fateful acceptance of a part imposed on them by an unfeeling society. It has been said that society's prejudices against the elderly indoctrinate us while we are young but affect us when we are old. The trouble with the part the community assigns to the elderly is that it is a destructive part which reduces self-esteem and self-sufficiency. In turn, this leads to dependency and to a further strain on community resources. In youth we sharpen knives which cut our own wrinkled throats in years to come. By ignoring the needs of a vulnerable minority which we are inevitably going to join, we are burying ourselves.

Social attitudes towards the elderly are destructive and one possible prophylaxis against them is a modification of our view of our life purpose. At the moment our education is vocation and work orientated. It is certainly not life orientated. As Alex Comfort has said 'we are educated to act as a one way projectile which at the end of our trajectory is designed to explode'. By educating for general abilities and interests related to the non-vocational aspects of our lives, we can avoid a sense of demeaning idleness and uselessness as each of us moves to a situation where we do not work but still have time to be creative individuals.

More specifically, each member of society is involved with decisions concerning self and selflessness. Most geriatric patients can benefit from volunteer groups, particularly those assisting stimulation programmes. Music, group singing, craftwork and even simple company all can have beneficial effects.

Certain groups within society which accommodate only members of their own group in non-profit hostel accommodation may need to give a justification for that policy when the needs of non-members are greater than some of their 'own kind'. Community services offered for preventive geriatric care can assist with information about resources, and pre-treatment counselling can be of benefit to counteract destructive socio-genic pressures. Such services will be determined by the availability of community funds and resources.

The community as a whole will need to define its attitude towards health insurance companies, particularly those loading premiums for the chronically ill. A related but independent issue is the responsibility of all members of society to make provision for the management of their assets in preparation for old age. The offer of superannuation and retirement schemes, and of the availability of schemes which stimulate young members of society to allocate their resources to provide for their aged years, are basic to this issue. This could involve employing organisations and employees in ethical decisions about the desirability of *compulsory* participation in such schemes. It would also involve governments in policies which recommend compulsory superannuation.

The family

All families which have elderly dependants are involved in decisions on the degree of their commitment to the care of their relatives. Together with the doctor, the family may be involved in ethical decisions in relation to offers of home support, decisions on whether to treat the patient, and for taking the responsibility for decisions for a patient who may be incapacitated.

The profession

Among the ethical issues which concern the profession are, first, our basic attitude towards care of the elderly. In the past, when care has been indicated on medical or social grounds, the patient has been admitted to the hospital. In recent times, it has been recognised that social frailty without associated specific medical problems is best cared for in the home. Even when specific medical problems are present, their correction can be followed by a rapid return to the community and its supporting resources. This is the desired objective of enlightened geriatric care.

The majority of patients who come to geriatric hospitals arrive from the community. Modern geriatric thought is directed towards increasing the number who are able to return to their home or community rather than to special accommodation, long term care homes or geriatric public hospital beds. A proportion of geriatric patients die during the course of their admission. For those who improve it has been shown that an active policy in relation to home discharge can reduce very considerably the number of patients who continue to use valuable geriatric hospital resources. At Mount Royal Hospital for the aged in Melbourne, the active pursuit of this policy has resulted in only 22 per cent of patients admitted being accommodated in long-term hospital care. This is a considerable reduction from the number in past years, but it is dependent on the efficiency of social workers, the sense of responsibility in the family, and the availability of community resources. Another approach being practised is to review all patients who have been long-term patients and to see if some can be discharged. At Mount Royal Hospital, over one quarter of such patients were happily housed away from the major hospitals.

Aside from questions of philosophy, the medical profession, the universities and the research grant organisations will have to decide on their priorities for research spending and the allocation for hospital resources. And it takes no imagination to realise that the euthanasia debate may become very active.

Doctors and associated professionals

Among the many ethical issues which will concern individual members of the medical professions will be: the decision to treat elderly incurable patients; the decision to operate on elderly patients; the dilemma of soliciting the views of a confused or eccentric or

demented patient; the handling of a patient who refuses treatment against medical advice; the conflicts which could arise with selfish or over involved relatives; the unfortunate necessity of occasionally splitting dependent elderly couples – and many others.

Doctors will have additional responsibilities for the accurate documentation of the incidence of diseases in the elderly. It is virtually impossible to predict or estimate morbidity in the elderly. Over the age of 75, it is thought that nearly 65 per cent of patients have some disability; however, there is a hidden incidence of morbidity. Unreported illnesses such as defects in vision, senility, musculoskeletal deficiency, feet prob-

lems and urinary problems are very common but often unrecorded. In part this is an effect of the attitude of patients who regard such symptoms as normal for their age rather than evidence of an active disease process. The professionals and the doctors will have the responsibility adequate documentation and reporting of statistics on disease incidence in the elderly.

Someone has said that one can judge the morality of a society by the way it treats its young, its infirm and its elderly. Adequate planning and forethought – with humanity as a large factor in the decision making – in the care of the elderly could lead to a situation where our societies can feel a sense of self respect.

Medical groups

Further information on Medical Groups

For fuller details, complete lecture lists are available from the secretaries of the medical groups listed below. Please enclose a stamped addressed A4 envelope.

ABERDEEN MEDICAL GROUP

Dr James Hendry and Dr David Hood,
Medical buildings, Foresterhill,
Aberdeen AB9 22D

BIRMINGHAM MEDICAL GROUP

Dr Anthony Parsons, Department
of Obstetrics, Birmingham
Maternity Hospital, Edgbaston.
Birmingham B15

BRISTOL MEDICAL GROUP

Dr Martin London, 11 Somerset Street,
Kingsdown, Bristol BS2 8NB

CAMBRIDGE MEDICAL GROUP

Mr Patrick Doyle, Department of
Urology, Addenbrooke's Hospital,
Hill's Road, Cambridge

CARDIFF MEDICAL GROUP

Dr Jonathan Richards, Flat 2,
1 Howard Gardens, Routh, Cardiff

DUNDEE MEDICAL GROUP

Dr Douglas Shaw, Department of
Pharmacology and Therapeutics,
University of Dundee, Nine Wells
Hospital, Dundee

EDINBURGH MEDICAL GROUP

Dr Brian Potter, EMG Project Office,
24 Buccleuch Place, Edinburgh EH 8
9LN

GLASGOW MEDICAL GROUP

Dr Valerie Kyle, 8 Crown Road North,
Glasgow G12 9DH

LIVERPOOL MEDICAL GROUP

Dr Colin Powell, Dept of Medicine,
Royal Liverpool Hospital,
Liverpool L7 8XP

LONDON MEDICAL GROUP

Director of Studies, 68 Tavistock
House North, Tavistock Square,
London WC1H 9LG

MANCHESTER MEDICAL GROUP

Dr Mary Lobjoit, Teaching Unit 4,
University Hospital of South
Manchester, Nell Lane, West
Didsbury, Manchester M20 8LR

NEWCASTLE MEDICAL GROUP

Dr Christopher Drinkwater, 14 Belle
Grove Terrace, Newcastle-upon-Tyne
NE 2 4LL

OXFORD MEDICAL FORUM

Dr James Falconer Smith, 20 Park
Close, Bladon, Oxon OX7 1RN

SHEFFIELD MEDICAL GROUP

Dr Martin Hayes-Allen, 183 Whitham
Road, Broomhill, Sheffield S10 2SB

SOUTHAMPTON MEDICAL GROUP

Dr T R M Billington, 56 Glen Eyre
Road, Southampton SO2 3NJ