References

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.
Psychiatry in geriatric practice

Geriatricians are aware of the high prevalence of psychiatric disorder in old age. They know how often the acutely confused are so because of an underlying physical disorder which they can detect and treat. They can distinguish between such delirious states and dementia and give the right prognosis and management. They can often identify depressive illness, which according to Kay, Beamish and Roth (1964), is present to some degree in a quarter of the elderly population, where it accompanies or even mimics physical disease. They have an awareness of social medicine. They are prepared to visit the patient at home to make a social as well as a medical diagnosis, recognize the hazards and assets in the home and deploy the full range of domiciliary services. They are well aware of the dangers of iatrogenic disorder in the elderly and thus avoid overtreatment as well as undertreatment. For example, they can estimate how likely a patient is to take any tablets prescribed and they are very clear about what the prescription is supposed to achieve.

The role of all doctors in treating the old

The geriatrician is energetic but patient, and reluctant to accept the chronicity of any disorder. He uses physiotherapy and occupational therapy to the full in rehabilitation, and gets keen pleasure from a small but significant change in his patient’s condition towards greater independence, as well as from dramatic cures. He is firm but humane, kind without sentimentality. It helps enormously if he has a sense of humour. This paragon, however, is in short supply and much abused. For too long he has been kept out of the teaching hospital and has had to practise in the oldest and least well equipped accommodation. He has too few staff, of indifferent calibre. His wards are dumping grounds for other doctors’ failures. The patient discharged with unthinking heartlessness from a medical or surgical bed is referred to him next day after a night of suffering. His advice is sought on ‘disposal’ which means ‘take over’, and he is blamed and resented if the patient is not swiftly moved. Even psychiatrists have been known to try to make him responsible for otherwise fit demented patients, arguing that brain disease (despite considerable behaviour disorder) is the concern of the geriatrician rather than of the psychiatrist.

The prevalent antipathy to aging and the aged means that patients are referred to the geriatrician late in the course of their illness, that there is considerable resistance to their discharge, despite successful treatment, and that the best doctors are not often attracted to the specialty. Small wonder that some geriatricians are lonely and embittered!

Geriatrics is not the answer to old age when it is used by other doctors to evade their responsibilities for their own elderly patients. By so doing they fail to develop or to impart any experience in dealing with the elderly themselves. Geriatrics is too important to be left to the geriatricians.

Reference

Kay, D W K, Beamish, P, and Roth, M (1964). Old age and mental disorders in Newcastle-upon-Tyne.
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III Attitudes

Youth versus age when money is scarce

A contingency plan drawn up by a major regional hospital to deal with a possible cutback in funding, or a staffing crisis resulted in a reluctant decision that the psycho-geriatric unit would have to be the first to be closed down. This decision will come as no surprise to those concerned with the elderly, or the field of mental health in a work-ethic society who have become well used to being last in line for resources, new buildings, or the benefits of technology associated with high-status medicine.

Another manifestation of the same syndrome is to be found in the current debate over unemployment, where there is general agreement that all new plans and programmes must be concentrated on meeting the needs of young school leavers at the thresholds of their careers; whereas those who are older are expected to make their contribution by sacrificing themselves on the altar of premature retirement. In this particular context, the fact that the older worker may actually be more productive, so that his output could accelerate the process of industrial recovery on which everyone’s future depends, is considered to be of less consequence than occupying the young. Their anger at a sense of irrelevance, boredom, or uselessness is more likely to erupt into frightening violence than that of older workers who have had a lifetime’s experience in containing their feelings.

The health service administrators concerned with the hospital contingency plan in the first illustration, or the politicians and their advisers seeking to stabilize the economy in the second, who both appeared to devalue the intrinsic quality of older life, were not in themselves heartless or unfeeling people (they probably treat their own grandparents with respect and affection). Nor were they acting in face of public opinion because these decisions reflect the general ethos of the society.