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SOME ASPECTS OF AGING

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"Every man would live long, but no one would be old." The great Irish satirist, Jonathan Swift, who himself suffered the horors of aging, struck to the heart of the matter in this pithy phrase. From time immemorial men have dreamed of a much longer life than their allotted span and a life that would retain the fullness and vigour of youth — the land of youth, Tir na n-Og, is an Irish tradition as ancient as the Tales of the Fianna. Determined attempts have been made and are being made to turn this dream into a reality. In the western world the number of scientists studying the aging process has greatly increased in the last three decades. In the U.S. alone, more than one thousand scientific teams are engaged in this work. More than twenty speculative theories of aging are being tested in scientific laboratories around the world. Now and again some gerontologist hits the headlines with an optimistic forecast of a major breakthrough which the popular press is only too happy to sensationalise. But the hard fact remains that to date the quest for longevity has largely failed. It is true that in the western world we have an increasing elderly population. In the U.S., France, Sweden and Britain some 10% of the population are over the age of 65. Today there are more than 20 million Americans over the age of 65 and some 12,000 centenarians. Since 1900 the number of individuals aged 60 and over in the United Kingdom has trebled and the proportion of the population

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that they constitute has increased by over 50%. In 1850 those aged 65 or over constituted only 2.5% of the population of the U.S. Today, 10%. But the actual increase in the life-span has been small indeed. In 1900 men who had reached the age of 65 could expect to live 10 years and 10 months longer. Today they can expect to survive 11 years and 9 months. The reduction in infant mortality due to the great advances in Public Health and Medical Therapeutics and the decline in the birth rate since the turn of the century are the prime causes for our increasing elderly population — not any triumph of gerontology.

And so, instead of a dream coming true, we are faced with a nightmare. We are confronted with the prospect of an ever-increasing proportion of our population being over the age of 65 and — this is the point — being subject to the disabilities and inadequacies which to a greatly varying extent, it must be emphasized, afflict the aged.,

Aging, of course, is a gradual cumulative process (or set of processes) whose effects begin at different times in different people and progress at different rates, so that one finds among older people a very wide range of individual differences. But the biological, psychological, medical and social problems of human aging cannot be evaded.

It is unnecessary here to detail the physiological changes which occur between the ages of 30 and 90 — the drop in brain weight as cells fail and are not replaced, the 30% loss in muscle weight and corresponding loss of po er, the 25% fall in nerve fibres i nerve trunk, the slowing of n ve impulses by some 15%, the ad decline in taste and sight a hearing, the grim toll of the d enerative diseases — these are miliar to all.

Similarly there is no ed to dwell on the psychology aging. Research psychologists, triving to be rigorously scientific their tests and assessments a con-scious of the complexities f their subject, do not make d gmatic assertions or unqualifie state-ments that lend themselve o easy out-of-context quotation.

When one comes to nsider the part that social and en tional factors play in this proble a few lines from 'Macbeth' c ne to mind:

'And that which should ccom-pany old age,
As honour, love, ob ience,
troops of friends . . ."

What *is* today is remote fr what *should* be. Far from being honoured our elders fin them-selves devalued and reje d. In more primitive static comm nities the old were respected s the teachers and guardians of he na-tive tradition and culture, but in our rapidly-changing soci y, ob-sessed as it is with techn ogical progress, the past is ignor d and the experiences of the ol seem irrelevant to their young.

Love is not much in ev dence either in the way in which society treats its old folk. Even in Britain the lot of the aged poor is unenvi-able indeed despite the great merits and achievements of the Welfare State. Only this Spring the then Secretary of State for Social Services speaking on the National Superannuation and Social Services Bill said that it dealt 'with the greatest social problem of domestic policy: how to abolish poverty in old age.' One may deplore the traces of the British Imperialist idea still to be found, but their enlightened social outlook and progressive legislation compel respect.

Great work has been done in the medical field. Geriatrics has become an important branch of medicine since the pioneers in this work demonstrated what could be done and banished the atmosphere of apathy and therapeutic nihilism. They have shown that the diseases of the aged are worthy of special study, that the disease incidence and disease pattern in the elderly is different. We are all aware now that illnesses such as coronary thrombosis, diabetes, peritonitis, etc., can present differently in the elderly from the young adult. Higher standards of diagnosis and disease classification can bring positive results. The diagnosis of senile dementia, we now realize, was made too readily in the past and the newer anti-depressant drugs and tranquillizers are now benefitting patients who might once have been so labelled. The confusional states now are better understood and their underlying causes more often appropriately dealt with. Specially designed geriatric units with highly-qualified consultants, aided by well-trained and motivated nursing and para-medical staff, have shown how the old 'chronic sick' image can be dispelled and patients previously thought hopeless rehabilitated.

In Britain too, the importance of early diagnostic services for the elderly in the community has been proved. From the experience of the workers in this survey it appears that the offer of a routine medical examination to 'high risk' groups brings real benefits.

But the achievements of these physicians have only emphasized the pressing need for a comprehensive geriatric service. Far too many old people suffering from physical and mental infirmities receive inadequate medical care. At present only 5% of old people are in institutions. It is believed that at least as many are seriously ill in their homes, maintained there by hard-pressed relatives, usually unmarried daughters. Townsend estimates that but for the exertions of these relatives the burden on the Health and Welfare Services would be three to five times greater. And at present these services can barely cope.

A striking rise in the admission rates of old people to Mental Hospitals in Western countries has led many to suspect that patients are being dumped into these hospitals because of the lack of proper geriatric services. This is not to deny an increase in the incidence of mental illness in the senescence. Some workers maintain that psychiatric illness is probably the largest single cause of infirmity in senescence. But the overcrowded understaffed psychiatric hospitals can hardly be considered the ideal answer. To raise the facilities of the geriatric wards of psychiatric hospitals to the standard of the pioneering geriatric units I mentioned earlier would require more money than any government is willing, apparently, to pay. Statements by mini-

sters that resources are not unlimited and priorities must be worked out do not sound too promising.

Mention of the psychiatric illnesses of the aged prompts me to strike a personal note. I am not a gerontologist or geriatrician and indeed I am keenly aware that many of you could speak much more knowledgeably and authoritatively on this subject. If I have dared to speak on this subject it is because the size and urgency of the problem have forced themselves upon me in my everyday work. The small rural Irish county in which I work has a population of 60,000, 7,229 of whom are aged 65 or over. Of these 450 are in institutional care, 122 of them in the County Psychiatric Hospital to which I am attached and 206 more in an institution for the sick poor to which I am visiting psychiatrist. These figures are in accordance with our national statistics. In the Republic of Ireland 11.2% of our population is aged 65 or over. This you will note is somewhat higher than the corresponding figures in other countries and is at least party due to the emigration of our young adults to Britain and America. The figure of 5.26% of 'over 65's' in institutional care may also be marginally higher. That 31% of our mental population and a similar number of our admissions are over 65 may be due to social isolation because of our remarkably low marriage rate and tendency to late marriages. In some hospitals 91% of the patients are single. A wit has commented that the Irish have just enough sex to perpetuate their own cantankerous pecies! Certainly you do find Irish mental hospitals an tra-ordinary preponderance of he unmarried at all age levels. nd our psychiatric bed-rate of 6 per thousand of the populatio is still singularly high (no pun in nded). It is nearly twice as hig as the corresponding rates for Britain and America. But this ma be due to social factors, primari isolation and also unemploym t, poverty and the shortage o hostels and half-way houses, an willingness to keep patients l ger in hospital for social rath than strictly psychiatric reaso . Certainly I would be unwillin to admit that the Irish are mad r than anyone else!

As you see there is cons erable overlap of psychiatry an geriatrics and this prompts ne to question the over-compart ientalisation of medicine that s ms to be the vogue today, wit more and more specialties wit ever-lengthening courses of aining and an almost trade-un onistic drawing of demarcation lines. Perhaps we should be mor aware that we are doctors first and have special skills in a particular area secondarily.

If the elderly are to retain their distinctive human qualities, they must be treated as individuals, as human persons. We are not treating them as people when we herd them together in over-crowded understaffed geriatric wards in dreary psychiatric and 'chronic sick' institutions and there subject them to a dull deadening impersonal routine, or leave them in bed all day to vegetate. Fortunately we do not find this so frequently nowadays. Staff now encourage patients to do as much for themselves as possible, defects of vision and hearing are not simply accepted as being due to old age, but spectacles and hearing aids are provided, and an active programme of rehabilitation including physiotherapy, occupational therapy and recreational therapy is carried out. Increasing use nowadays is made of the medical social worker, psychiatric social worker and district nurse to maintain old people in the community.

Unfortunately financial provision for these services is limited and will never, I believe, be really adequate.

No wonder then that I see the growth of voluntary services as one of the brightest and most hopeful features in the entire scene.

Long before the pioneers of geriatric medicine set about their new approach to the diseases of the aged, private individuals had been stirred by the plight of the old and impoverished and had organised themselves into various associations to help them. Now there are societies which organise outings for patients in hospital, including the transportation, visit patients institutions and in their homes, bring them hot meals (meals-on-wheels service) — very relevant this when one considers the malnutrition found so frequently in old people living alone. Other organisations, through judicious publicity, spread awareness of the troubles of the old and lonely poor, run clubs for old people in which the old folks themselves are encouraged to participate as actively as possible, provide laundry services and voluntary home-help services and advise the old as to what state benefits they are entitled. In addition business firms such as cinemas, dry cleaners and hairdressers offer cheaper rates to the over 65's. Special accomodation in single-story dwellings, adjacent to churches and shops, is provided in some areas.

To sum up, the facts to which I have adverted lead in my opinion to certain inescapable conclusions. First, that we have here one of the great problems of our time, a problem which is growing ever larger and more formidable. Second, that despite the great advances made by the biologists, physiologists, psychologists and others, scientific progress alone will not solve this problem. Third, that insofar as this is an economic problem it will never be met adequately by government action solely. As long as nations are guided by political and economic considerations rather than human values, no authority will ever divert enough of its resources to this sector. Fourth, that what has proved invaluable and is indeed essential in this area is the maximum voluntary effort. Fifth, that the medical profession should shed its traditional conservatism and disinclination to share its work and responsibilities and set itself to cooperate as fully as possible with the para-medical and volunteer workers in this field. Finally that, we as Catholic doctors, who claim to have regard for spiritual values and ethical standards, that we are the people who can play a special part in this vital work.