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Medical Care of the Aged

JEROME H. LIPPERT, M.D.

In view of the ever increasing life expectancy the population explosion is not limited to any particular age group. In 1900 there were approximately 5,000,000 people aged sixty-five and over. By 1970 this figure is expected to reach 20,000,000. We have all encountered comparatively young and alert individuals with the chronological age of eighty and conversely we are also seeing people whom we might class as old who are only aged fifty.

Since all people of sixty-five and over should not be considered aged or senile, let us divide this group into three general classifications. In the first group we have the comparatively adequate person who is able to live independently either with members of his family or in his own domicile. He may continue working full or part-time and is well able to care for his own needs.

In group three we will include those chronically disabled individuals who for the most part need constant medical supervision because of either mental or physical disabilities. I will try to place emphasis on this group since they present the greatest problem. Although this group comprises only three to five percent of our over sixty-five population the facilities for caring for and maintaining them are woefully inadequate in both quantity and quality. The rapidly expanding, and to me dreaded, practice of forced retirement at age sixty or sixty-five is adding greatly to the number of people in this classification. Only a very small number in this group have prepared themselves for retirement by developing hobbies or interests. The key word in management of people in group three is motivation. We have all seen highly motivated people with multiple and chronic physical disabilities who still find a great deal of pleasure in life and are able to accomplish many successful and gratifying activities with very little notice of their disabilities. Conversely we have also seen the unmotivated with only minor disabilities become depressed and gradually vegetate and deteriorate both physically and mentally until they become entirely dependent. The number who are able financially to provide medical, nursing, and auxiliary facilities within the confines of their homes is very small and in-

sitter; therefore I can take off for a week or two and never mind my youngsters. I put the baby sitter right alongside the television set as being one of the evils of this era.

I don't think kids have changed very much in the last years. We're trying to recognize, we're making up problems to solve for them but I can remember, I was born and brought up in New York City and I can remember the groups who hung around and were paid to swoon every time Frank Sinatra came to the theater in New York City. We had our groups; we had our families; but I can say this: On weekends or on Saturdays and Sundays the family went out as a unit. The family went to church as a unit; the family picnicked as a unit; and the family was together.

If I were to be asked the prime cause for juvenile delinquency the first and uppermost cause in my mind is the breakdown in family communication and relations and mutual respects—that's the first and uppermost cause in juvenile delinquency, the breakdown.

It was stated that children want to know that they are loved. This is the truest thing that has ever been said. They want to know that they are loved and they are secure. I do not feel that any child minds being punished when he knows that the one at the other end of the stick is someone who loves him. They hate for it to be someone that is not respect and love.

I have no placea nor penicillin shot for juvenile delinquents. The greatest thing that has come out of Washington was the few things in the last ten years, has been the development of the pre-school kindergartens in my opinion. The development of the pre-school kindergartens and I think this is going to help our youngsters when they start in the age of three and get the environment that they can't get from the homes normally. I feel that very strongly seeing as I do that 75% of my case load in court comes from families in the deprived area where there is a mother only and the mother being the only support. We are very backward in Florida in one respect—I am advising all our dependents to move to California because in Florida all you can get is $81 a month, AFDC. I'm telling them all to go to California because you can go up to $250 or $260 a month. Some of them are taking my advice. I think it would be cheaper for Florida to subsidize them and send them. My case for juvenile delinquency amongst this group that I see now, my case for juvenile delinquency is a very difficult one but I can see it as a cure, and that is the termination of parental rights at birth, colonization in one of our states under the direction of the government, and then starting all over again. If you can sell that, I'll vote for it.
Care of these individuals may be divided into three main categories. First consideration should be for the physical, in which an attempt is made to bring them up to their maximum functional capacity. This requires something akin to the general hospital. Constant medical and nursing supervision with consultation available in all major specialties other than obstetrics and pediatrics is essential. Diagnostic aids should include complete X-ray and laboratory facilities. Since the old, frequently heard axiom, “He’s old, what can we do?” has been proven false we now know we can do a great deal to benefit these people. The institution should have complete physical therapy facilities, occupational therapy, sheltered workshops, and muscle exercising and coordinating gymnastic equipment. Dental care is an essential part of the program.

The second phase should be focused on the mentally or emotionally disturbed individual. To accomplish this, regular psychiatric attendance is indicated along with some of the treatment already mentioned.

The social phase again returns to that old key word of motivation in which any type group therapy or activity which stimulates the patient is very important.

To accomplish this type of care, a good working relationship with a top general hospital is almost essential. This hospital should preferably be a teaching institution and one that is research oriented. At this time only the minimum amount of research being carried on is the geriatric field.

Among the problems in this area are the lack of interested medical and paramedical personnel. This is somewhat understandable since the cost is high and the results are not as spectacular and gratifying as in the treatment of the younger groups in which recovery is often rapid and complete. Improvement is often slow and chances of complete recovery are limited. Renunciation is often inadequate for the time and effort involved, because of lack of funds available for this prolonged care.

Should we attempt to provide separate facilities for the mentally and the chronically physically disabled individual in this age group? This again poses a very controversial question as to which there are many answers.

At present there are only a minimal number of institutions providing near adequate care. For the most part these are community sponsored by religious or other charitable groups with some assistance from Social Security, federal and local welfare agencies. In a handful of instances the family may be financially able to pay for the individual care. Who should pay the costs of this care? I cannot express a definite opinion on this question since regardless of which agency provides the funds it must still come from the pockets of the public. Whether government, private, church, or community financed, these people are entitled to care and it must be provided.

Social and Economic Problems of the Aged

VERY REV. MGR. WILBUR F. SUEDKAMP

In the United States today, there are more than 17 million persons 65 years of age and over. By 1970, the number will exceed 20 million. Approximately 1,000 persons celebrate their 65th birthday each day. The average age in our institutions today is 81.

One begins to grow old the moment he is born. However, heredity, environment, ability to resist disease, diet, way of life and attitudes have a lot to do with one’s becoming “old.” “Oldness” really is something relative. There is no scientific definition of age. The calendar is only one way to measure a person’s age. There are others! Although science has given added years to man’s life span, society has not accepted the old person.

A. Permit me to highlight housing the elderly as a social problem.

SOCIAL ASPECTS AFFECTING HOUSING

Earlier marriages, earlier completion of childbearing, and the free movement of adult children, have left parents alone while still in their prime. They are in homes of their own, often more rooms than they need, and they live on into later maturity as a separate generation. Today rare are the three-generation households. Family “belongingness” has been replaced by community “togetherness.” The older person today is less dependent on the family. Society has assumed the responsibility of his health and welfare needs.

ECONOMIC ASPECTS AFFECTING HOUSING

Yesterday the old folks took what housing was available. Today, because most of them have some income, they are more expressive of their desires.

TECHNOLOGICAL ASPECTS AFFECTING HOUSING

Actually, through technological advancement in the home, older people are living longer. Certainly it is safe to say that they can now maintain their independence into later maturity for a longer time.

Where are our older people living? 75% (65-74) live in their own homes. 56% (75-up) still live in their own homes. 19% (65-74) live in a family environment and only 6% are living in institutions, transient hotels, trailers, rooming houses, and others.

What factors motivate people to change living arrangements? There are three:

a. Less income because of retirement.
b. More economical to move after the death of a spouse, and most common.