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Some Aspects of Aging

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increasing number of non-medical addicts, especially juvenile addicts, evoked concern. Finally, two years ago regulations were amended so that only rehabilitation clinics can prescribe heroin to addicts. The effort is to discontinue the drug; failing that, to maintain the patient on reduced amounts of heroin or methadone. Methadone maintenance as practised in the United States seems preferable to heroin maintenance: one dose a day is sufficient, and that can be given by mouth.

Sweden, and to a lesser degree, the other Scandinavian countries, have had difficulties with Preludin, an amphetamine-like compound. Introduced more than a dozen years ago as a safe weight reducing pill, it began being abused when large amounts were swallowed for its euphoriant effect. Later the material was crushed, dissolved and injected intravenously. Over 10,000 people in Sweden inject Preludin despite the fact that stimulants can now be prescribed only with the approval of a special committee. The substance is smuggled in or manufactured in illicit laboratories.

Japan succeeded in overcoming a serious methamphetamine problem after World War II by a combination of education, strict law enforcement and drying up of supplies. More recently, paint thinner inhalation, the return of "pep" pills and of sleeping medications among groups of young people are becoming popular.

Countries on both sides of the Iron Curtain are finding that hashish is "in" although each of the East German states controls manage to keep the prevalence down. So far as we know, Nepal is the only country with restrictive legislation for cannabis. This is interesting in view of the many countries of the Middle East and Near East that have traditionally sanctioned the use of cannabis.

There are nations which are depending upon severe penalties to deter drug traffic. Nigeria and Egypt have a death penalty for growing cannabis, and Iraq is cracking down on the growing of Cannabis sativa in their countries. The penalties were increased recently in Pakistan, where the drug is cultivated commercially. Whether these sanctions will be effective remains to be seen.

Ceremonial drug use remains in certain cultures — khat use in Arabia, kava in the Melanesian archipelago, betel nut in parts of the East Indies, peyote among the Indians of the Native American church, yage among a few Andean tribes, and the ordeal beet still occasionally used in the Congo. Unfortunately, alcohol, this expensive and easily produced beverage tends to displace these ancient ritual drugs.

As a commentary on the motivation for certain indulgences in drugs new to a culture, it is interesting to note a situation in some of India's large cities. Here the old folks drink bhang, a weak decoction of cannabis, while many of their sons and daughters drink Scotch.

Although this brief review is hardly a comprehensive picture of the global drug scene, at least certain highlights are presented which may be meaningful to the situation in this country.
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 and 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 power, the 25% fall in nerve fibres in nerve trunk, the slowing of nerve impulses by some 15%, the read decline in taste and sight and hearing, the grim toll of the degenerative diseases — these are familiar to all.

Similarly there is no need to dwell on the psychology of aging. Research psychologists, striving to be rigorously scientific in their tests and assessments and conscious of the complexities of their subject, do not make dramatic assertions or cause such statements to lend themselves to easy out-of-context quotation.

When one comes to consider the part that social and emotional factors play in this problem, a few lines from 'Macbeth' come to mind:

'And that which should accompany old age,
As honour, love, obedience, troops of friends
What is today is remote from what should be. Far from being honoured our elders find themselves devalued and rejected. In more primitive static communities the old were respected as the teachers and guardians of the native tradition and culture; but in our rapidly-changing society, obsessed as it is with technological progress, the past is ignored and the experiences of the old seem irrelevant to their young.

Love is not much in evidence either in the way in which society treats its old folk. Even in Britain the lot of the aged poor is unenviable 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 explore 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 benefiting patients who might once have been so labelled. The confusion 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 severely bedridden 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 pioneer 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 species! Certainly you do find Irish mental hospitals an extraordinary preponderance of the unmarried at all age levels, and our psychiatric bed-rate of 6.6 per thousand of the population is still singularly high (no pun intended). It is nearly twice as high as the corresponding rates for Britain and America. But this may be due to social factors, primary isolation and also unemployment, poverty and the shortage of hostel and half-way houses, and a willingness to keep patients longer in hospital for social rather than strictly psychiatric reasons. Certainly I would be unwilling to admit that the Irish are madder than anyone else!

As you see there is considerable overlap of psychiatry and geriatrics and this prompts me to question the reclassification of medicine that seems to be the vogue today. With more and more specialties with ever-lengthening courses of training and an almost trade-unionistic drawing of demarcation lines. Perhaps we should be more 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 institutional 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 accommodation 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, 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.