THE CARE OF THE AGED

G. LANGE, M.D., M.R.C.P. (EDIN.)

Senior Physician, Edenvale Hospital, Johannesburg

No problems are isolated entities. Those centering around the aged are merely part of a great socio-economic problem, but the disconcerting selfishness of our small selves prevents us from appreciating this. Long life without health and security is more than a personal tragedy, it is a major social evil that may well threaten national economy.

It has recently been computed [1] that in the U.S.A. today there are 13 million people over 65 years of age. In England in 1891 45% of the population were under 20 years of age and 7% over 60 years; in 1947 27% of the population were under 20 years of age and 15% over 60. It has been calculated that in 1977 one-third of the population in Britain will be over 65 years of age. A comparable increase in South Africa over the past 50 years is shown by the rise of those over 60 from about 3·4% to about 9·4% of the population.

The frequency with which the increasing average age of the populations of various countries is emphasized in the literature indicates the urgent need of facing the problems surrounding old age. It is submitted that 90% of deaths are premature through infections, illness and neglect during youth or middle age, and that increasing age may be largely attributable to the innovation of modern drugs such as penicillin, aureomycin, etc. 'Bigger and better' antibiotics may further prolong lives and thus make the problem still greater. The Union Government and Provincial Administrations insist on compulsory retirement of all their employees at 60 years of age, although some may be at the peak of their productivity and some may desire to continue work. It is interesting to note that the Government seriously contemplates raising the retiring age of male public servants from 60 to 63. Dr. Wilfred Wright in a recent issue of *The Lantern* stated: 'There can be no denying that conservatism, inertia, and loose thinking all operate against the placement of unemployed older persons.'

Cause of Ageing. Two diagonally opposed theories still exist, viz. that ageing is due to (*a*) the result of wear and exhaustion, and (*b*) structural involution through disuse. One fact, however, is certain, viz. that abuse and disease accelerate ageing. Whatever the aetiology of atherosclerosis, it is reasonable to suggest that senility is largely the result of its effects on various structures of the human body.

In 1936, less than 1% of 3 million people studied in America were chronic invalids; the people studied were of both sexes and all ages, but it is not stated whether they were a random selection of the population.[2] While disease, in its chronic form is most prevalent between the ages of 35 and 40, actual invalidism and disablement reach their peak far beyond these years. Rheumatism (arthropathies) tops the list, together with heart disease, high blood pressure and arteriosclerosis. As a cause of disability, however, these conditions are surpassed by mental and nervous diseases. Statistics reveal that invalidism and disablement have increased in the past 15 years; and the human wastage is inestimable. Age is an important factor in chronic disabilities, and it is probably accurate to say that some form of chronic disease either patent or hidden, occurs in practically every aged patient.

In 1953 Sheldon, in a special survey of elderly folk in Wolverhampton, found that 66% suffered from some degree of disability, 22·5%were capable of only limited locomotion, 8·5% were confined to rooms, and 2·5% were bedridden. It is assumed that the analysis refers to those over 60 years of age.

Appropriate statistics in South Africa are unfortunately not available but an intimate association with a chronic-sick hospital in the Transvaal for several years has disclosed some interesting facts. During a 3-year survey there were 722 applicants for admission to the hospital. Of these 50% were regarded as sociological problems and therefore not admitted. Of the 370 applicants who were in the 'aged' group (i.e. 61 years and over) half qualified for admission. To quote further statistics at this stage might cloud the main issue of this article; suffice it to say that the facts and figures indicated the gravity of the problems concerning the aged. They certainly revealed tragically 'man's inhumanity to man' in the abundant examples of efforts to relegate invalid aged relatives to the mercy of strangers or to discard them as unwanted animate bodies that had outlived their utility. A suggestion is made that this may be due to the diminishing sense of family responsibility encouraged by Governmental pampering. Further, it appears to be insufficiently appreciated that elderly patients are often capable of rehabilitation. In this connection one was struck by the fact that in the symposium on Rehabilita-

tion at the Medical Congress held in Port Elizabeth last year, except for references by one or two speakers, little stress was laid on the importance of rehabilitating oldsters.

Let us, for purposes of discussion, group the aged in 4 main categories:

1. Those requiring care in acute general hospitals
2. Those requiring care in long-term hospitals
3. The homeless aged wholely or partially capable of looking after themselves
4. The homeless disabled aged incapable of looking after themselves but who can be satisfactorily looked after by an attendant, not necessarily of the skilled nursing type.

1. CARE OF THE AGED IN ACUTE GENERAL HOSPITALS

A common, though often fallacious, practice is to ascribe diseases in the aged to 'getting on in years'.

The characteristic differences between diseases of youth and of senescence may be summarized here:

	Youth	*Senescence*
Aetiology:	Exogenous	Endogenous
	Obvious	Occult
	Single	Multiple
	Specific	Superimposed
	Recent	Often over the past
Onset:	Sudden and florid	Insidious
Course:	Immunizing	Non-protective
	Acute, Self limited	Chronic and prolonged.

Whilst the main ailments of elderly patients are usually of a slowly progressive and degenerative type, there are very few diseases, including whooping cough and the so-called specific fevers of childhood, that may not occur during senescence. True, certain conditions occur more frequently in the aged, but it is doubtful whether any particular disease is caused by old age.

In our experience at Edenvale Hospital, the average period of hospitalization in acute wards was 11 days for those under 60 years of age, and 17 days for those over 60. In a previous publication, I referred to the frequency with which one finds young patients with subacute bacterial endocarditis, other heart ailments, and diseases of academic interest, and young cases in which the diagnosis has not been finalized, occupying acute beds for many months without application having been made for their transfer to a chronic sick hospital—a privilege seldom extended to the aged. Whilst accepting that the recovery period in the aged is usually longer than in younger patients, it is felt that a large percentage of the elderly patients for whom treatment is sought in long-term hospitals should be cared for in acute hospitals. A few examples may help to demonstrate this point:

Heart Disease. In the elderly this is not always the result of arteriosclerosis and is often as responsive to acute medication as in the younger age-group.

Bone and Joint Pains. These, ascribed to age, have often after investigation revealed themselves as the result of faulty posture, gout, myelomatosis, or secondary metastases.

Hemiplegia. As a disablement, this rates amongst the greatest wastages of man power. National figures are not available, but the importance of this disability may be gauged from the following:

In a recent survey W. J. Davison stated that in Western Australia 2.1 beds per thousand population were required for the care of hemiplegia and that 9% of all his chronic cases were hemiplegics. Our own figures showed that 173 of a total of 722 applications to a chronic sick hospital were for hemiplegics.

Recovery of movement in most hemiplegics is at best incomplete, and one feels that the only period during which treatment is of real rehabilitative value is shortly after the onset of the paralysis. On our experience, those admitted to non-acute hospitals never regained any useful or permanent activity. It is therefore submitted, in spite of overwhelming views to the contrary, that this group should receive treatment in an acute hospital. Incidentally we remain unimpressed with the results of anticoagulant therapy, so enthusiastically advocated by some.

Diabetes. While common at all ages—and it is known that barely 50% manifest symptoms of the disease—all the 57 applicants for admission to a long-term hospital in the Transvaal were over 65 years of age.

Gall-Bladder Disease. Common from 40 years upwards, not one of the 63 applicants, as chronics, was below the age of 68 years. It must be assumed that the younger sufferers of the 2 last-mentioned diseases had received medical attention in some acute hospital.

2. CARE OF THE AGED SICK IN LONG-TERM GENERAL HOSPITALS

Non-acute hospitals are specifically intended for those requiring prolonged and constant skilled nursing and/or medical attention, and *not* for incapacitated individuals who can be satisfactorily cared for by an unskilled attendant.

An analysis of 7,941 old chronic cases at the Peter Bent Brigham Hospital showed hypertensive disease (including 15% with cerebral arteriosclerosis) in 80%, neuropsychiatric disease in 59%, heart disease in 55%, gall-bladder disease in 25%, neoplastic disease in 14%, respiratory disease in 13%, diabetic disease in 10%, and malnutrition in 54%. Whilst practically every one over 50 years of age had osteo-arthritic disease, barely 10% complained of symptoms. Only a small percentage of these required prolonged hospitalization.

Data in a recent publication of mine [3] showed that the needs of the so-called chronics in the Transvaal are being satisfactorily served by the long-term section of Edenvale Hospital. Hitherto, however, inadequate facilities for rehabilitation have influenced the period of stay in this hospital and have precluded the admission of some.

A large section of the public and medical profession insist that it is the unqualified duty of the Provincial Administration to care for the chronic sick in long-term institutions. Provided cases are carefully assessed, I am partly in agreement. If, however, Professor Delore's definition of chronics [4] is accepted, it must remain an open question. He regards 'chronics as long-term sick,

with a potentially long span of life'. At the long-term section of Edenvale Hospital, out of 223 deaths, 180 died within 3 months of admission. One is therefore influenced to agree with Dr. Hugo's suggestion that the general hospitals should—after careful screening—make provision for most of their own chronics. As for others there would appear to be no serious obstacle to the introduction in this country of a scheme based on the Philadelphia plan for the home-care of chronically-ill old folk.[5] The plan, in essence, is one employing part-time medical practitioners, nurses and visiting domestics to serve the long-term sick in their own homes, or in provided homes where they are domiciled.

3. THE HOMELESS AGED

Whilst old-age homes fill a great need in a community, one feels that their provision is, in principle, no more commendable than the charitable provision of shelter for any other homeless being. It is noteworthy for serious criticism that the Transvaal boasts of several small private institutions supposed to be for the aged, but which exclude those who are unable to look after their own toilet requirements. Some even make a condition that inmates should be able to do their own cooking; practically all require that applicants should not be bedridden.

Basically, it should be the unquestioned responsibility of the State to look after the needy aged; but this should not be permitted to influence private individuals to shelve their duties towards their families. Efforts should be made to enlighten the public on their bounden duty to accept more personal responsibility and to depend less on Governments and charitable bodies. Churches, as one of the most powerful influences, should awaken this sense in their communities.

Old folk, like trees, do not like to be uprooted and are as a rule happier in their accustomed surroundings. It has often been remarked that the welfare of the aged depends more on home surroundings than on the disability from which they may suffer. It may be for this very reason that many are better off in institutions. Some oldsters, for example, have entirely grown away from their families and are happier in the company of other old people.

Management. The general principles of the management of the aged are common to all the 4 groups mentioned. They will however, for convenience, be embodied in this category.

The aged in general are more deeply and warmly grateful than younger folk for assistance, kindness, and patience. V. H. Matthews states, 'If I were to give a civil post to persons who were to have the care of old people, I should first find out whether they liked old people'. The supreme tragedy of old age is awareness of uselessness and unwantedness. In a book entitled *You Are Younger than you Think* Martin Gumpert states that he believes many old people die of boredom. Institutionalized oldsters should therefore be given fixed duties in the form of light work within prescribed limits according to their capabilities. They should be made to feel important and to believe that their duties are essential to the institution and the community. Recreation and diversional and occupational amenities should be provided in the form of arts and crafts, games, concerts and religious facilities. An inflexible rule with us is that elderly people are not permitted to be kept too long in bed or even too long at rest.

Diet. There is normally a decreased need for calories in oldsters, because of restricted activity and decrease in weight and a normal reduction in their interest in food. This may be contributed to by the loss of sense of smell and taste, missing teeth etc., and by psychological or sociological factors. Not uncommonly, however, elderly people have enormous appetites, if permitted to eat all they can. At a recent London Congress of the International Association of Gerontology it was reported that an octogenarian ate without any ill effects, in one meal, a large loaf of bread, 3 oz. of margarine, 3 oz. of cheese and 3½ oz. of sugar.

Food requirements are said to diminish after the age of 50 at the rate of 3% to 5% per decade. An ample diet for an oldster is provided by 1,500 to 2,000 calories per day, to include one g. of protein per kg. body-weight. Fats should be used sparingly. Obesity is merely the result of over-eating, irrespective of whether the appetite is stimulated by physiological or pathological factors. In humans, as in experimental rats, obesity is not conducive to 'ripe old age'. Detrimental at all ages, it is particularly undesirable in old age, not alone because of its tendency to promote atherosclerosis, but also as an aggravating factor in diseases such as bronchitis and asthma and in hernias.

Sub-clinical, or even frank, avitaminosis—especially deficiencies of vatimin C, thiamin, riboflavin, etc.—are not uncommon in the aged. Deficiency of vitamin A is to a large extent regarded as the cause for the harsh dry skin with hard keratotic plugs projecting from the hair follicles in the arms and thighs. Professor G. H. Percival of Edinburgh University reminds us that 'at a great age the skin may exhibit an almost juvenile smoothness and pliability of texture', so it would appear that the characteristic tissue-paper-like appearance of the skin of elderly people may not be entirely due to ageing of the tissues. Enlargement of the heart, with swelling of the feet, tender calves, and disorientated mental states are often improved by giving vitamin B, and the common manifestation of haemorrhages under the skin and liver deficiencies may be due to lack of vitamins C and K.

It is interesting to speculate that the reason for old people not responding readily to stress situations is a lack of vitamin C, as the integrity of the adrenal glands depends largely on this vitamin.

In summary, the diet should be balanced and light with regular meals and regular intake of fluid.

Contrary to popular belief, the average oldster does not suffer from constipation, but a weekly mild laxative may be preferred.

4. THE DISABLED AGED

From the criteria laid down in group 2, it is obvious that there are a large number of disabled aged who do not qualify for admission to any recognized institution in the Transvaal. It is specifically for the care of these that I desire to make my most earnest plea. They consist

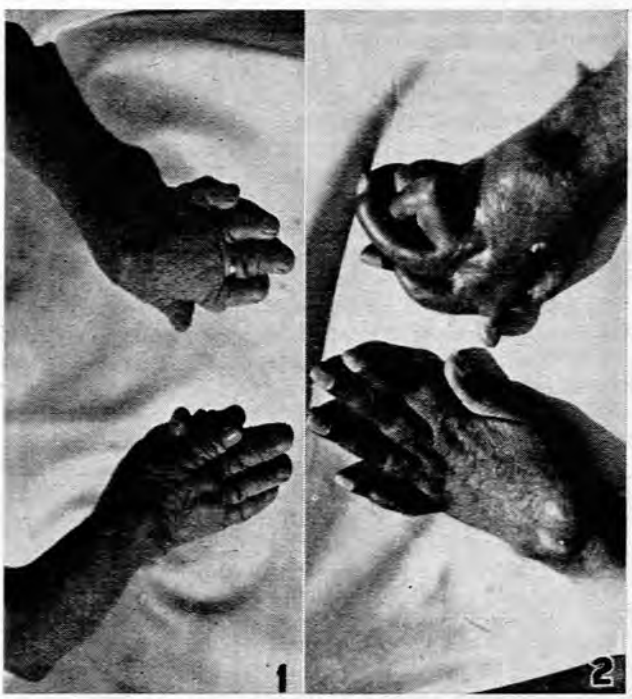
mainly of the crippled arthritics, sufferers from Parkinson's disease and limb deficiencies, hemiplegics and other paralytics, and senile incontinents. In spite of contrary views held by many, I submit that it should no more be the function of a technically or college trained individual to attend to the toilet requirements of an uncomplicated incontinent than that such specialized staff should be specifically engaged to wash, feed and dress non-sick cripples. I would add here, that a person should be regarded as bed-borne only if it is in the interests of his health that he should be confined to bed, and not because facilities are unavailable for getting him out of bed. It is an extraordinary thing that while legislation exists—even if only partially—to meet the needs of the sick, the aged, the healthy pensioner, and others, no provision is made to meet the needs of the disabled oldster who, had he but a home and the financial resources, could be satisfactorily looked after by a servant. Not only is there no legislative provision for this group, but even voluntary or charitable bodies appear to have forgotten them.

The accompanying photographs are but a few examples typifying incapacitated individuals who are generally regarded as chronic sick but could, it is submitted, be satisfactorily looked after by good domestic servants.

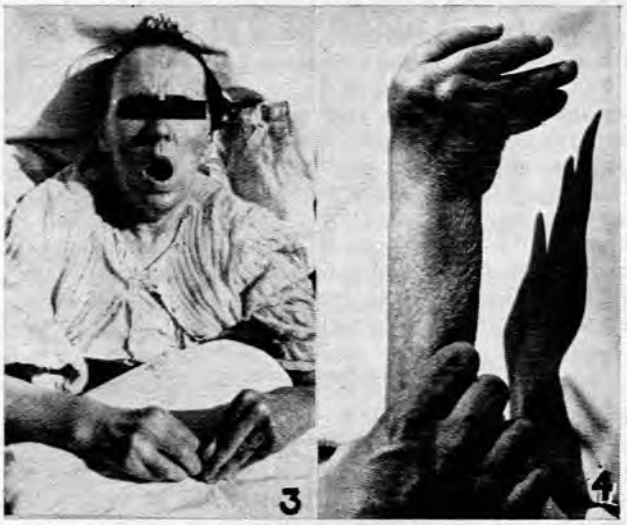
Fig. 1 shows the hands of a chair-borne old lady whose useless hands and feet—the result of a mutilating type of rheumatoid arthritis—prevent her from walking, feeding herself, or attending to her own toilet.

Fig. 2 shows the hands of a legless old gentleman suffering from a similar disease.

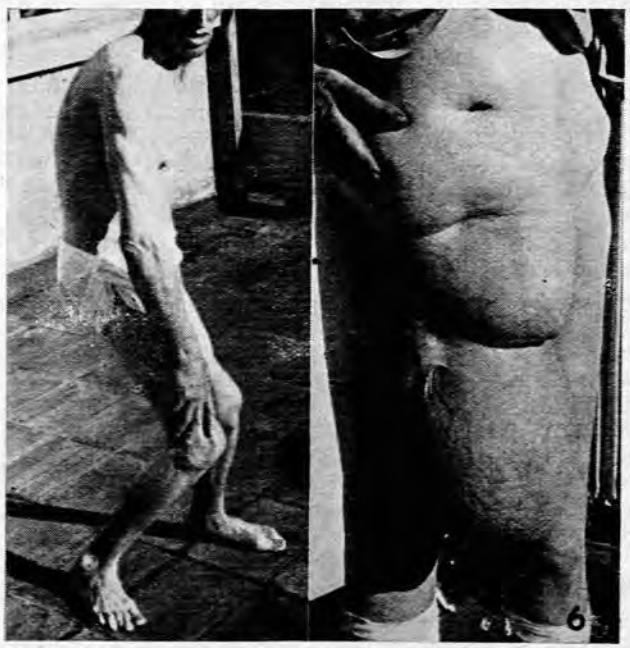
Fig. 3. This elderly lady, suffering from Parkinson's disease, is unable to walk unaided, dress or feed herself.



Figs. 1 *and* 2.



Figs. 3 *and* 4.



Figs. 5 *and* 6.

Fig. 4 shows the arm of a one-armed, leftsided hemiplegic old lady with rheumatoid arthritis, who is quite happy when placed in her chair.

Fig. 5. A youthful-looking 62-year-old congenital spastic, who had spent half a century in various institutions. He was not acceptable in a so-called old-age institution because of his facile mentally-arrested state.

Fig. 6. This 67-year-old subject with massive herniations and chronic heart disease had to leave a self-styled old-age home because he determinedly refused operation.

Dr. H. J. Hugo, Director of Hospital Services in the Transvaal, quoting extracts from the sixth Annual

Report of the National Corporation for the Care of Old People, says 'The Governors have for some years urged the provision of Homes for the Infirm or Rest Homes'. One wonders whether such homes are intended to provide for the disabled aged of this group or whether they are intended, once more, merely to act as old-age homes to assist children to 'park' their aged parents and relations.

CONCLUSION

To epitomize, the care of groups 1 and 2 (the aged sick in acute and long-term general hospitals) should remain the full responsibility of the Provincial Administrations, and that of groups 3 and 4 (the homeless aged and the disabled aged) shared between those members of the public on whom the responsibility falls, the State department of social welfare, and charitable bodies.

The care of group 4 (the disabled aged) should receive attention in priority to group 3 (the homeless aged not disabled). Both groups (3 and 4), however, might well be cared for in one institution, and I would suggest that consideration be given to the provision of such an institution, preferably with a trained qualified nurse constantly available. It would constitute a worthy effort for State-aided charitable bodies.

My thanks for the photographs are due to Mr. I. Norwich of the staff of Edenvale Hospital.

REFERENCES

1. Stieglitz, E. J. (1949): *Geriatric Medicine*, 2nd ed., page 12.
2. National Health Survey. Sickness and Medical Care. Series 1936. Bulletin No. 6. Washington: U.S. Government Printing Office.
3. Lange, G. (1954): S. Afr. Med. J., **28,** 72.
4. Hugo, H. J. (1953): *Ibid.*, **27,** 641.
5. Udell, L. (1953): J. Amer. Med. Assoc., **152,** 990.
6. Hugo, H. J. (1954): S. Afr. Med. J., **28,** 892.