# *Editorial*

## GREEN OLD AGE

In a small, but quite delightful volume, written by the now almost forgotten Dr. James Mackenzie of Worcester, is a short essay on Old Age[1]. Old age he says may be divided into three periods: vigorous or green old age which, in good constitutions, lasts from 60 to 70; declining, or stooping old age which reaches from 70 to 80; and, third, decrepit, or helpless, old age which creeps on from four score to the conclusion of life.

This eighteenth century classification compares favourably with that of Roger Bacon who 300 years before divided the old into two groups only, those between 35 and 60, and those over 60. This difference in outlook no doubt reflects the increased expectation of life that occurred during the centuries which separated these two writers. Life in the middle ages was rated cheap and was indeed brittle. When we compare Mackenzie's scale with that of today, there is a striking similarity, and his groupings of the aged still holds good. Though we have greatly prolonged the expectation of life at birth, we have made little impression on the expectation of life of those who are entering their sixties; while the baby born fifty years ago could expect to live to 40, the baby of today can look forward to 70 or 75 years of life; those who were 60 fifty years ago could expect fifteen years of living, and there is promise of no longer time for those who are 60 today. The truth is that nothing that medical science has achieved has had any effect on the life-span of the human cell.

If we look at the problem of ageing from the point of view of the usefulness of the individual in the community, we find that, whereas amongst those aged 30 we may expect something less than 5 per thousand invalids, at 60 nearly 25 per thousand may be classed as such, and of those 70 years old 60 in every thousand are invalids. Obviously, to arrest this trend we will have to concentrate not so much on those who are truly old as upon those who are entering the period of green old age, and those aged between 50 and 60 will most reward us for our care. But this is a duty which can be performed only by the general practitioner and the general physician. The speciality of geriatrics by definition concerns itself with the diseases of old age, and scarcely at all with the prevention of old

age or in maintaining the old in health. Most geriatricians would endorse the words of Horace and see in them a challenge:—

> Old men are only walking hospitals,
> Where all defects and all diseases crowd
> With restless pain, and more tormenting fear,
> Lazy, morose, full of delays and hopes,
> Oppress'd with riches which they dare not use;
> Ill-natur'd censors of the present age,
> And fond of all the follies of the past:
> Thus all the treasures of our flowing years
> Our ebb of life for ever takes away.[2]

We do not know how to postpone our inevitable dissolution beyond our allotted span, but, by prolonging our flowing years, we may perhaps shorten our ebb of life. There is too much talked today of rehabilitation, too little attention paid to habilitation; by which we mean enabling people still to continue in their daily lives without faltering by the wayside. This problem has been scarcely looked at. We have under review a volume of *Modern Trends in Geriatrics*[3] and neither in the table of contents nor in the index can we find any mention of the word ' prevention '. DR ANNIS GILLIE[4] in a thought-provoking paper (1956) stressed the commonly met and so often ignored disabilities which occur during the passage from middle to old age. DR GIBSON in his Butterworth Prize Essay published in this issue (p. 99) is concerned with the passage of the vigorous oldster into Mackenzie's second stage of stooping old age; he tells us that he keeps a register in which he places all who qualify for the special care which he as the family doctor and the state as the dispenser of social welfare are expected to give. The geriatricians, though they may have rescued many an old person from a paradise of bedfastness, and placed them in a state of uncertain mobility, are not interested in the acuter illnesses of those on the verge of old age, and we are concerned that the very existence of this specialty should have created an artificial division between those in middle life and those who are past their prime. There is much to be said for the system which admits all sick to one general hospital and will not allow the admission of old people directly to geriatric units. In old age, hospital beds are difficult to procure. Acute infections, these days, are as rapidly cured in the old as in the young, though recovery may be slower; there is, however, no reason why on that account the elderly should be denied their rightful place in a general hospital when they go down with acute illness.

When it comes to the problem of retirement we would like to see changes made in the provision for old age pensioners so that those who become old before the official time are enabled to retire, and having a pension allotted to them would be able, perhaps, to supplement it by doing small jobs and part-time work, thus becoming less of a burden upon the community than they so often are, drawing as

they do sick pay for perhaps five years while waiting until the day when they will become 'official' old age pensioners. There are too many vigorous men of 65 doing nothing and too many frail old men of 64 struggling to continue work which they are incapable of performing efficiently.

But this is wishful thinking. What can the family doctor do, and what are his duties ? Dr Gibson's register only comes into operation when his old person has become ill or has found need to consult him about something. Would not a register of declining middle age reveal many interesting facts ? Perhaps, once a patient had been registered in such a way, he would become one of those to whom we felt special care and attention ought to be given. The signs of chronic illness in the elderly are slow in appearing, and are so often accepted by the patient as just one more nail in the coffin, and full of delays they are reluctant to complain, fearing to be told either that they are indeed ageing or, alternatively, that they have a mortal disease.

The work by old peoples' clubs, hostels, homes and other social units, useful as they are, all have this one disadvantage—that the accent is on the word ' old '. Are we perhaps pandering to old age without taking care of its dignity ? Should we not try to keep them in their green old age, useful and active members of the community ? A man's pride should be in his achievement and not in the years he has attained.

REFERENCES

1. (Mackenzie, James) Essays and Meditations on Various Subjects, by a Physician. Edin. 1762. p. 25.
2. The Poetical Works of Went. Dillon, Earl of Roscommon. Edin. 1780. p. 117.
3. Hobson, Willis (Ed.) Modern Trends in Geriatrics. Lond. 1956.
4. Gillie, Annis, Research Newsletter (1956) **3**, 95.

## THE COLLEGE IN AUSTRALIA

**Annals of General Practice.** Vol. 1, Part 2. Published by the College of General Practitioners in Australia. December, 1956.

This attractive quarterly periodical consists of 28 pages of instructive writing with an appropriate bias towards general practitioner affairs as they are in Australia. A forward-looking editorial stresses the need for study of the scope of general practice with a view to full realization of its potentialities. A lecture on Disorders of the Thyroid Gland by Sir Hugh Poate is reproduced, in which much practical advice on latest methods of treatment is given.

A short but lucid research report on the presentations of Neurosis in General Practice gives food for thought. Figures from this are worth quoting for comparison with experience here. Of 500 consecutive patients, 85 were diagnosed as psychological disorders (excluding psychosomatics) and 22 had no appreciable disease.