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THE CARE OF THE ELDERLY IN GENERAL PRACTICE I

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" Youth is joyous; Age is melancholy.
Youth and Age together is but folly. "

It is notable that the title of this essay includes the words Care and Elderly, and, since there can be no development of the subject without a precise understanding of the meaning of these two operative words, it would be as well to lead off with a definition.

Care, according to the dictionary, is protection, concern, affection, respect and " giving serious attention to ". To take care of, therefore, implies a far wider responsibility than merely to treat, when (we are told) we are just handling or dealing with our patients.

The definition of elderly is also quite clear. An elderly person is one of greater age, one whose age entitles him to respect, who is senior in position, and who, significantly, is bordering on old age. There is a definite and obvious differentiation between the elderly and the old, for the latter are described as advanced in years, worn, matured, and decayed by the process of time.

We must, therefore, be prepared to acknowledge the existence of a zone between middle age and old age, in which our patients can be described as elderly. A vague and ill-defined age group, for it has no obvious beginning and no clearly defined ending.

The State regards the male as old at 65 and the female at 60. The medical profession knows better than this. Entry into the elderly age group varies from individual to individual. It is strongly influenced by medical, social and environmental factors, and it depends to a large extent on the protective measures we are about to discuss.

I have said enough by now to be able to declare the intention of this essay. I am not about to describe how, as a doctor, one should handle old people. My subject begins, as has been shown, at an earlier phase than this. I am concerned with the care and protection of those who have left the middle age-group and have reached the borders of old age. By caring for them, organizing them, rehabilitating them (if this is not too strong a word) at this stage I am hoping to prepare them for old age, so that I can thereby increase its comforts and its contentment, and add to its years. This is, of course, a quibble—or deliberate subterfuge, for it is obvious that by caring for the elderly one is automatically protecting the

aged. But by introducing my intention in this way, I hope to stress from the very beginning that the role of the general practitioner is to catch his patients in the ' elderly ' phase, for, by so doing, he renders the care of old age so much more effective.

If I were pinned down to an absolute definition of these people, I would quote Sheldon (1950) who describes them as having reached the stage when " the physical independence of adult life becomes so compromised that there is a definite limitation of activity ". But Lord Beveridge's description might be preferred: he says that " the essence of ageing is a decline in faculties, unpredictable in age and severity but inevitable in time. "

What, in general, is involved in the care of the elderly in general practice? An arrangement of the routine of their lives, their habits and, if necessary, their environment so that physical and mental activity may be maintained—at any rate in some degree—for as long as possible, and so that the strain on relatives, friends and the social services may be reduced to a minimum. In particular, care aims at the prevention of disease, or, better still, the deferment of the onset of conditions which could mentally or physically incapacitate, so that the elderly may continue to live as an integral and useful part of the domestic community.

Certain factors are essential if care is to be effective. First, it is obviously dependent on the medical and social condition of the patient; it requires, also, the creation and maintenance of a high degree of confidence on the part of the patient, together with a willingness and ability to co-operate; it entails the collaboration of relatives, neighbours and friends, for ' care ' is essentially a family problem; and it must rely on the integration and efficient working of all the allied social services. All these being accepted, then, except in special cases where medical or surgical conditions are involved, admission to hospital must be regarded as an indication of failure on the part of the family doctor service.

The Social and Environmental Conditions of the Elderly

Before enumerating the measures which together make up the care of the elderly in general practice, one must separate these people into groups, for, as we have said, particular care will depend fundamentally upon social and environmental conditions.

I divide them into two main groups: the solitary, and those in a family or other community.

The solitary group can be sub-divided into four:

1. Those of independent disposition whose daily routine is so ordered that no immediate interruption is required.
2. The independent in need of help, who may accept it readily, or—more likely—will require a gradual breaking-down process before they will accept any degree of protection (I well remember the elderly, solitary lady whose

" meal-on-wheels " I had to share before she could be convinced that she was not accepting (a) inferior food, and (b) charity!).

3. The solitary and apparently independent who are actually dependent on relatives and/or friends, and an increasing burden to both.

4. The solitary and utterly dependent on outside help; surely the most pathetic of all, clinging desperately to their lonely kingdom because of the fear of removal to a State institution which, to them, would be a living death.

The first division of the ' communal ' group comprises those who are satisfactorily housed with relatives or friends. They are an integral part of the household, capable of looking after themselves and able to do little jobs to help in the daily routine. They constitute the luckiest and the ideal sub-group and, regrettably enough, are undoubtedly the fewest in number.

The next are those living with relatives or friends who are prepared to give them house room so long as they can maintain their independence, but with the onset of the slightest disability are reluctant to keep them. This is a significant subdivision and the practitioner must recognize it and annotate it, for these elderly patients may require a change of environment to a State home or chronic-sick hospital at a moment's notice. The only thing, in fact, that saves them from being too suddenly unwanted is the ability, in certain cases, to add a pound or two to the family income each week, which would be missed if they were removed; but this should not be allowed to influence the practitioner in the environmental assessment.

Finally, this group will contain a certain number of elderly patients whose home care has broken down with the onset of some disability or illness, but whose relatives or friends are prepared to look after them if, with expert advice, the household can be reorganized and the helpers supplemented by the methods which are about to be described.

The Part Played by the Local Health Authority

Now I must examine the part to be played by the local health authority in the care of the elderly by the general practitioner. I divide these activities into three: supplementation, education and accommodation.

The first, which I shall enlarge upon later, includes the help given to practitioners by the provision of district nurses, health visitors and home helps. Convalescent homes are also available at the request of the patient's doctor, and are most useful.

It may be surprising that the education of patients in the elderly age group should be suggested. Propaganda might truly be a better word to use here, but it has horrible associations, is particularly disliked by doctors, and contains all the ingredients necessary to terrify the elderly. I must explain, therefore, what I mean when I talk of education. As has already been said, the care of the elderly

may involve radical changes in the daily living routine, and, possibly, in the environment of the patient. In fact, a change from independence to dependence on relatives, friends, or the social services. Such a change-over would not be taken lightly at any age, but in the elderly, particularly if it has to be undertaken against the patient's wishes, it is more than ever necessary that it should be gradually, quietly and skilfully induced, with a minimum of disturbance and confusion to the patient. In other words, the patient is gently educated to his or her new status in the community. Since the activities of the general practitioner in this direction are inevitably limited, he must be able to rely on the help of the ancillary services. Mental trauma, above all, must be avoided in all dealings with these patients; there must be a minimum of official visits, of discipline, dictation and direction. All activities should have a definite and obvious social atmosphere. Patience is vital, and its employment is always well rewarded.

A final word in this connection. There are clinics for children and young people. Is it not of equal importance that there should be a similar service for the elderly—though may it be forbidden that they should ever be called clinics? This service could well be run by general practitioners under the protective umbrella of the local authority, and with the approval of the Minister of Health. It is obviously unfair that elderly patients should be at the mercy of a haphazard organization depending on the enthusiasm and ability of a few general practitioners. The service for them should be as efficiently organized, and as much a part of the National Health Service as that provided for babies and expectant mothers.

The third service which is expected of the local authority is the provision of accommodation for those elderly persons who, for one reason or another, can no longer be left in their own homes, excluding, of course, the chronic sick and those who are able to pay to be housed in a privately owned Home. I must emphatically say here that the most drastic decision a general practitioner has to make is when he realises that his patient can no longer be left in the environment to which he or she has been accustomed for many years, if not for life.

I have already said that the main objective in the family-doctor care of the patient is that a life of serenity should be achieved and maintained, with its resulting increased longevity. It is unfortunate, therefore, if the stage is reached at which he is forced to take the step most calculated to cause unhappiness and to shorten life. With the help of the local health authority, means must, therefore, be obtained of softening this blow, or of transplanting these old roots in the most delicate fashion. The change, as has been shown, is preceded by a period of gentle and tactful suggestion, so that when

it becomes inevitable, it is expected and, maybe, even anticipated without disquiet. But this in itself is not enough. To what sort of an environment is the patient to be transplanted? To a county home for the aged? Hygienic, spacious, sumptuous, with three or four floors, rolling lawns, television, shared bedrooms, excellent cuisine and hot and cold *ad lib.*—expense to the tax-payer being no object, though this may be irrelevant from the point of view of this essay! Or to a small, modern bungalow in a nest of similar bungalows, surrounding a pleasant garden with sheltered seats, and an opportunity to sow a few seeds in the spring in one's own little plot; with one's own furniture, one's own uninterrupted memories and one's own separate existence. A matron in charge to pay regular visits, a home help if necessary, a sick-room if required, but otherwise an independent castle. The illusion of home shaken, perhaps, but not irretrievably shattered, and at how much *less* cost to the tax-payer. Obviously the latter is to be preferred, indeed must be regarded as the only alternative to the patient's own home. It involves far less trauma, and, above all, causes no interruption to the general-practitioner care, with all the comforts and advantages this embraces.

It is a pity that some county councils have gone ahead with grandiose schemes for supplying " hotels " for the elderly. They are disposal centres provided by well-meaning lay authorities, and are intended as the answer to the problem of how to relieve unwilling and unhelpful relatives of their elderly dependents, or else they remove old people from a solitary existence into that of a disciplined community at an age when they are least able to adapt themselves to such a change. They are certainly not calculated to bring comfort and peace of mind, except to a minority; nor, as I have said, are they economical.

The General Practitioner's Contribution

In succeeding paragraphs I am therefore assuming that the general practitioner has at his disposal the co-operation of the local health authority, from the points of view of nursing and home care; of education and rehabilitation; and in the provision of alternative accommodation, when required, as like as possible to the patient's own home. By these means will the illusion of independence, the atmosphere of peace and contentment, and an uninterrupted general-practitioner service be preserved. With this background I have attempted to set the scene for a detailed description of the care of the elderly by the general practitioner, and I shall now, therefore, concentrate on his own particular contribution, leaving until later the part he plays in co-ordinating the other services and in building up his team.

The first essential is that every practitioner should compile a register of the elderly patients for whom he is responsible, carefully

and gradually built up, with no specification as to the exact age of entry; it is much more likely that a patient will, in the doctor's view, suddenly qualify for membership. This entry into the register " presses the switch " and brings into being a number of routine activities all of which together surround and protect the patient in the progress to and through old age.

Two warnings I would give here; the first, that patients should not necessarily be told that they have been registered as " elderly ", for, whereas some might delight in it, others would most certainly be dismayed, and even disgruntled. The second, that all the activities which follow registration should be carried out informally and without any fuss; it is so easy to put the patient on to a moving band, and to let the wheels revolve unmercifully, without any regard to the mental trauma this might cause.

Registered elderly patients are encouraged to visit the doctor, or are visited at regular intervals. I use the word visited deliberately, instead of examined. The social, cup-of-tea atmosphere must take precedence over the rather official professional one. A complete examination, *per se*, can be very disturbing to the elderly; the same thing wrapped up in a friendly visit can pass almost unnoticed. The length of time between consultations will depend on whether the patient is found to be maintaining an adequate mental and physical standard or not; whether any chronic disease such as bronchitis, bronchiectasis, or hypertension is present; or whether the patient is " post-operative " or " post-traumatic ".

Routine visits must obviously be productive, and the examination of the patient, which has, as its primary function, the prevention or anticipation of any disease or disability to which the elderly are known to be at risk, is, therefore, as thorough and complete as it would be of any other age group; but it has its own agenda, the particular items of which must be noted at each succeeding consultation, so that any deterioration or alteration is at once recognized. It also differs from routine examinations of patients in other age groups—at any rate, as far as I am concerned—in that it has no set formula. In order to please the patient, for example, it may be necessary to proceed from an examination of the teeth to a discussion on the feet. Such a diversion from the normal may, at first, prove disquieting to the young doctor who has been impressed as a student with the correct method of carrying out an examination. But it pays dividends and, in a very short time, results in the adoption of a routine procedure which, although elastic, can be just as methodical and efficient as the more generally accepted one.

The consultation starts with a conversation on general lines. This will include a chat about the daily domestic routine, the relationship with the rest of the household or surrounding community: Is it

satisfactory? Has it deteriorated? Is there any change since the last talk? A brief survey of the financial situation, and a short discussion on current events as appearing in the daily papers or on the wireless is not a time-waster, and is deliberately included in order to test the memory and general mental awareness of the patient.

Next, a check on the vision and the hearing: the need for new lenses will almost certainly be acknowledged, but it is not always easy to get an admission of increasing deafness; yet this is an all-important factor in retaining the patient satisfactorily within the family circle.

An enquiry follows into the sleep habit, which may be altered, in that there is now too much sleep during the day, with disturbances, and only short bouts of sleep at night. Whilst on this subject, one can easily slip in a question on vertigo and headaches, and an unobtrusive examination in order to exclude any progressive nervous disease.

The weight must be watched: any increase, if maintained, must be checked and eliminated; any continuing decrease investigated.

Are the feet painful? Is there any aching in the calf muscles with prolonged activity, or any cramp at night? How are the knee-joints? Is there any limitation of joint movement, with or without accompanying pain? Can the hair still be done up in the morning, and the bath entered without difficulty?

How are the bowels acting? Are they regular? Are they overpurged? Is there any change in the bowel-habit since the last check-up? How is the appetite and the digestion? This is a particularly important question in the female, and in the elderly patient living alone, for they so often under-feed themselves, and their diet is woefully short of calories and vitamins. It is not easy to check on diet without putting the patient on guard—they will so often unwittingly deceive. It is better, if possible, to depend for the truth on the evidence provided by a relative or friend, but a glance at teeth, or ill-fitting dentures, may bring a rich reward, particularly if the patient is systematically removing the latter before each meal. An examination of the skin and mucous membranes follows naturally here, and may supply much useful information. Similarly, the presence of urinary or faecal incontinence is often concealed, yet either or both are more likely to disturb family unity and an otherwise affectionate household, than any other weakness or idiosyncrasy of the elderly.

An examination of the blood pressure, and a careful check to exclude early congestive heart failure must next be included. The search for oedema of the ankles, moist sounds at the bases, or a palpable liver, may disturb the patient; nevertheless, it must not be overlooked. What a curse combinations can prove in this connection! These Victorian under-garments can so easily be made the excuse

for postponing the complete examination. It is so much easier to arrange to call before the patient gets up in the mornings, unless, of course, the combinations are taken to bed too! Whilst searching for ankle oedema, the varicose veins can be glanced at, and the shape, colour and temperature of the toes.

Particular care must be taken with patients who, for one reason or another, or, unfortunately, for no reason at all other than the patient's inclination or the relative's perverted sense of kindness, have been confined to bed for a prolonged period. Contractures, stiffness of soft tissues and rarefaction of bone are but three of the accompaniments or sequelae of this regrettable over-indulgence. They are not easy to treat. Patients suffering from a chronic disease will require a check-up in this particular respect, as will also those being followed up after an injury or surgical treatment.

Whilst the patient is dressing there may be an opportunity for a few words with a relative or other companion. This is usually very helpful, not only to confirm some of the doubtful points in the patient's story—for, alas, many elderly people have a well-developed faculty for prevarication; in this, as in some other respects, they resemble the young, but their years prevent the adoption of those punitive measures usually calculated to cure the latter of this unfortunate disability—but also to keep a watchful eye on important factors in the environment, of which I shall be writing later.

A routine examination of the urine should always be included, and, if the practitioner has the facilities and the time at his disposal, an occasional haemoglobin estimation helps to complete the history sheet.

At the end of the visit arrangements are made for the continuation of the treatment of any chronic disease present, and for the institution of treatment of any condition discovered for the first time. It is important that all medical conditions should be treated, no matter how trivial, in order to avoid a general deterioration from one disability to the next. A typical example of this is the common cold, which a patient in any other age group usually throws off without difficulty, but which in the elderly, if ignored or improperly treated, can so easily result in bronchitis or pneumonia, and a fatal termination.

Finally—without comment, if possible—a scrutiny of the clothing to assess its suitability and adequacy; and, if necessary, a pep talk on the necessity for perseverance in treatment; a few words on diet and the daily regime, and the visit is over. Any new findings at these routine examinations should be underlined, so that they can be followed up at the next examination, and, if necessary, reported to the district nurse and health visitor.

All this does not allow for the acute illness or emergency. The

cardio-vascular accident, for example, or the sudden and unexpected injury to soft or bony tissues, the acute bronchitis or pneumonia, the acute or sub-acute intestinal obstruction, or the progressive senile dementia. These are treated within the general protective-organization surrounding the patient. As with other age groups, no amount of careful examination and supervision can prevent or anticipate them, but good team-work can successfully deal with most of them without recourse to the hospital services, and, if the proper care of the elderly is being implemented, the good team-work should already be in operation *well before* the emergency arises. Exceptions to this are the mental diseases: I comment on these later.

So much for the detailed examination of the patient by the doctor. The foundation upon which his care is built. Now, if he has not already done so, he must consider the general environment in which the patient is living. We have already discussed the groups into which these elderly patients fall, so that the practitioner's notes will include two items under the heading of environment: group, and its stability—Is it a temporary or a permanent environment? Will a sudden change be necessary in the event of a decline in the patient's mental or physical well-being?—and degree of disablement, if any. This may be static or likely to deteriorate. It may be slight or severely incapacitating, so that in these respects also a change may have to be anticipated at an early or later date.

Ancillary Help

Entry into the doctor's register qualifies the patient for visits from the health visitor. Her regular—yet unobtrusive—calls serve many purposes. We have already seen how useful she can be from the educational point of view, particularly in emphasizing the advice and instructions the doctor has given. But, as well as strengthening the protective screen surrounding the patient by these means, she will also watch over the diet, the bowel habit and the hygiene; she will keep a check on any disability reported to her by the doctor, and will at once contact him if there is any change in environmental, or other circumstances, of which he is unaware. These two will together assess the time at which a home help may be required, or regular calls by the Red Cross or W.V.S. " Meals on Wheels " service. The district nurse may be needed for one or more visits each week, to ensure adequate personal hygiene, and so on.

Depending, of course, on the approval of the patient, there may be an additional member of the team: the parish priest or his Nonconformist colleague. Their co-operation can be invaluable, not only for the comfort they bring to the patient, and as a valuable addition to the education process, but, also, because they bring with them a team of helpers who, by visiting the elderly parishioner, can

considerably relieve the burden on relatives and friends, and the loneliness of the solitary one. They can also help the Daily Living department. I know of one parish priest whose Youth Club is prepared to " take over " a household at a moment's notice and transform it into any shape at the bidding of the parson or the specialist in physical medicine.

Night care is a major difficulty with the elderly person living alone. Short of a friend, a companion, or a home help living in—and this may require money—it is bound to be a hazardous affair, and may well prove to be the reason for the breakdown of the general-practitioner service, and consequent admission of the patient to a State home or a chronic sick hospital. In a British Medical Association Report on the subject, it was envisaged that there could be night callers on these elderly patients. People who would go round from house to house during the night hours. I believe that this may even have been tried in some areas. On paper it is a good scheme; in practice one wonders whether it might not have a disturbing effect on the patient, and even on the neighbours.

So much for the general organization for the care of the elderly by the general practitioner supported by the services operated by the health authorities. By now, as can be seen, the elderly patient on the doctor's register is hedged around with security, and with all the devices necessary to obtain and maintain a comfortable existence. By now the family doctor has an up-to-date knowledge of the physical and mental condition of the patient, a general picture of the environment in which he lives, and of any change that may become necessary in the event of an acute emergency or a gradual deterioration in the medico-social scene, and he has a team of workers with him, each one of which is making his own particular contribution to the common design.

The immediate environment of the patient should now be as satisfactory as can be obtained: housing and sanitation are adequate, and house-cleaning is under control: flooring and lighting are suitable, and someone is laid on to do the shopping: diet is supervised, and the daily routine is agreeable for this particular patient—insistence on the same routine for every patient would be quite wrong. As a general rule the elderly should be encouraged to stay in bed for breakfast, to rest after lunch, to take a moderate degree of exercise (in short bouts rather than long lengths) and to go to bed reasonably early. But some find bed, and particularly having a meal in bed, most irksome; they may well have their own routine which suits them and, so long as there is no vital disturbance of the general family regime, there is no point in altering it. One must admit that a certain amount of discipline is necessary, and, indeed, may be beneficial, but it must be individual rather than collective discipline,

and the past and present habits of the patient must be taken into account.

I must emphasize again here that all the above has been arranged at an *early* stage in the patient's journey through the elderly phase of life, immediately after the practitioner has made the first entry in his register; the patient is still independent and still in reasonable health. If care is initiated at this stage, and the patient gets to know all the members of the team, so that they are his friends and welcome visitors, there will be no disturbance of routine, and no disquiet of mind, when more active protection becomes necessary.

The Part Played by the Hospital Service

Before I detailed the activities of the general practitioner in caring for the elderly, I spoke at some length on the help he required from the local health authority. The point has now been reached at which we must consider the part to be played by the hospital services. So far their resources have been untapped, yet there is a great deal they can do to help in looking after the elderly in general practice, and I find it an exciting thought that these elderly people provide an opportunity for the three main sections of the medical profession to work together, a phenomenon so seldom seen in these days. Neither one, nor two, of the three could offer a completely efficient service without the help of the third.

It may be thought that the capabilities of the hospital service should have been discussed at the same time as those of the local health authority. I have deliberately separated them, and intentionally given them a sort of alpha and omega relationship to the general practitioner, for whilst he will call upon the one as soon as his patient reaches the elderly stage, his demands upon the other will almost certainly come later.

I propose to ignore the ' escape ' provided by the hospital service in the allotment of beds for the elderly chronic sick. I am going to say little about the particular specialist allocated by this service for the treatment and disposal of the elderly and the aged—he is given the title of Geriatrician and I have yet to find any professional need for him at all. Elderly patients have their family doctors, and these, in turn, have numerous specialists at their disposal who are as capable of diagnosing and treating their particular specialty in the elderly as in any other age group. The need for this other specialist in general practice is, therefore, eliminated, except as an administrator who may—or may not—be able to find a hospital bed for the patient " somewhere in the county ". A similar service can be—and, indeed, always used to be—obtained from an efficient bed-service staffed by lay personnel, with less charge to the State and less frustration to the family doctor. These are strong words. I have

not used them without much thought and conviction. I have no doubt at all that the geriatrician must be a useful addition to the staff of a hospital, but, to the general practitioner, his existence as a doctor is of little value, and as an office-boy is a mere irritant.

With this comment behind me I shall now concentrate on the other aspects of the help available from the hospital services. The stage at which this help will be required is when independence is lessening, or the patient is rendered partially or wholly immobile.

The specialist in physical medicine will survey the scene with the general practitioner. There are an infinite number of ways in which his department can ease the lot of the elderly—too many for me to detail them all here. It is sufficient to say that he will provide adequate equipment for every need. Eliminating steps; adjusting bed levels so that nursing and movement to and from bed can most easily be effected; adapting the height of the commode so that it corresponds with that of the bed—even fixing it to the bed if necessary, and treating the lavatory seat in like manner; fixing railings to passages, stairs, beds, lavatories and commodes; providing bed-head pulleys and overhead rails, bath steps, bed-rests and bed-tables, so that meals can more easily be taken and reading and writing are possible in bed; arm chairs, wheel chairs, and self-propelling chairs; in fact, as I have said, producing countless gadgets intended to increase mobility and encourage independence, in spite of disability. These are all his responsibility, through his Daily Living department.

Physiotherapy may be going on concurrently with all these other activities—either the physiotherapist calling on the patients or the latter paying regular visits to the department, for massage and exercises and general encouragement. Speech-therapy may be necessary, and again is the responsibility of the hospital service.

With all the helpers I have enumerated, there is still a danger of the elderly patient's life becoming infinitely boring and monotonous. Though friends may arrange car rides, small shopping expeditions, visits to church, library or cinema, the conversation included in the doctor's regular visits, may reveal a lack of interest and enjoyment in life. It is as well to keep this in mind, for the hospital service, through its occupational health department, can be a tremendous help in this respect. Waking hours can seem very long to the elderly, lonely person, and the provision of a pleasant, if sedentary, occupation should never be over-looked. Even at this age, it is possible for them to take an interest in, and to wax enthusiastic over, an entirely new occupation. In my view, television has been very valuable to the elderly as one form of occupational therapy—they either like it or they loathe it! So many of them, by watching, can leave the close confines of their rooms, and join in sport, theatre and

other activities which they remember only too well from their younger days, but never hoped to see or hear again.

This brings me to the end of my detailed description of a model design for the care of the elderly in general practice. I may have been guilty of depicting an Utopian ideal. For this I cannot apologize; there is no harm in striving for perfection.

Several thoughts occur to me as I read through what I have written so far. The first is that the family doctor alone could not advance far in caring for these patients without the help of the local health authorities and the hospital services, yet, on the other hand, there could be little organized care without him. Providing he gives the initial word, the whole machine is set in motion, but he must be constantly at hand to make certain that it is running smoothly, quietly and efficiently. The onus is, therefore, on the general practitioner from first to last.

As I have said in the beginning, the time may come when the load will prove too heavy for the machine. Then it is the family doctor who must call it to a halt. Then, and only then, need the State be required to find room for the patient in one of its institutions for the chronic, elderly sick. A particular example of this, unfortunately, is the mental case, the senile dementia. The burden to the household here is tremendous, and no additional help can be sufficient to make it bearable. Loving relations may try to cling to these patients for as long as possible, and it falls to the family doctor to persuade them that this can only have an adverse effect on their own lives, without benefiting the patient's in the slightest.

My next thought is that the whole process, set out as it is in this essay, seems cumbersome and complicated. Yet, in fact, it is all so simple and easy. I will take an example from my own practice, although I cannot pretend that all cases would fit so ideally into the pattern.

A Case History

She was an elderly lady, who admitted to 84 years of age. She had been on my elderly register for two years because of occasional bouts of vertigo which I attributed to her hypertension, but, even so, I had not seen her for some weeks because she had been symptom-free for a long time and I had, therefore, lengthened the time between visits.

My notes gave details of her environment. A brother-in-law, aged 82, who was also on my register because of angina of effort, and a sister whose exact age I did not know, since she had never reported sick and was not registered, lived with her. So far as I could see she was a very healthy and active person of about 80 years of age. They lived in a bungalow which had only the disadvantage

of three steps up to the front and back doors. There was no apparent shortage of money, the brother-in-law was a retired postmaster. They were Methodists and well supplied with friends. I had no doubts as to the spirit of independence prevailing in this household: each had particular jobs to do and did them well.

So long as all three were in good health, the days went happily by. It was, perhaps, only the family doctor who saw how heavily each of the three was dependent on the other two, and how the whole machinery of living, for all three would break down with the failure of one. I was not, therefore, wholly unprepared for the crisis which faced me when my elderly patient had her hemiplegia, and was found lying helplessly in bed, not even able to speak her thoughts coherently to her two relatives. The male with angina dropped everything and sat down. The elderly, unregistered sister found that she could not manage alone. What was to happen to their independence? To my shame, and in my initial panic, I asked the geriatrician for a bed. To my later gratification he had no bed for her. I say this because I ought to have known that the grouping of this patient, and the circumstances of the environment, were not those which required a transfer to dependence on the hospital service.

Within forty-eight hours the household, which had suddenly stopped working, was set in motion again. The district nurse called twice daily; the home help service coped with the cooking, and took over all the tasks previously performed by the patient; the Methodist community and the Red Cross did shift work so that the sister could take time off from looking after the patient to go out shopping without fear of what was happening in her absence; the Daily Living department reorganized the bedroom, the bathroom and the lavatory, and converted the steps into a wooden slope; the physiotherapist got my patient up, and started her on massage and exercises; the patient herself refused absolutely to accept the disability, was prepared to co-operate in overcoming it, and maintained her morale at the highest level.

After a fortnight, the ambulance started calling each day to take her to the physical medicine department, where she continued her physiotherapy, practised her walking, had her midday meal and helped to wash up. She even tried rug-making which she found most stimulating. Within a month I was no longer required to call even twice weekly, and was able to return to my normal routine monthly visits, supplemented by calls from the health visitor. And as I write this, my 85 year old patient who has already survived to be one year older, has taken herself off by Red Cross car to a month's convalescence in a friend's house over 100 miles away. She could, of course, have gone to one of the convalescent homes

provided by the county council. They are excellent; but she preferred to be " independent ".

So effective. Yet all I did was to set the machine in motion and then sit back to watch it work.

The Immensity of the Problem

The final thought I have, is of the immensity of the problem. I am no statistician, but I have calculated that at least one-sixth of my daily round is taken up by my elderly patients, which means that they absorb far more than one-sixth of my time. Sheldon considers that, whereas there are now some 2½ million elderly persons in this country, by 1975 this figure may well have reached 8½ million.

I am writing this in a little fishing village on the east coast of Scotland. The majority of the population of 700 seem to fall within my definition of elderly, but most of them are gainfully employed. Within twenty-four hours, however, I have talked to one elderly subject with his left arm in a sling and dragging his left leg. He " walks " backwards and forwards along the quay twice a day, taking about half an hour to do two hundred yards. He tells me that he had a stroke just over a year ago. Another man, well past middle age, stops every few yards to lean against a wall because of a pain in the calf muscles of his right leg—pain which is worse in bed at night, he says. A female patient has had a fractured neck of femur; her right leg is over an inch shorter than her left. She is still working; I dread to think what must be happening to her vertebral column. Two others were pretty deaf. All this is leading up to the point that, unless there is a general awareness amongst general practitioners of the elderly patients' need for care and protection at an early stage, the strain on the hospital as well as on the local health authority services is bound to increase from year to year, until a general breakdown becomes inevitable.

This awareness should not be left to chance, to trial and error, or even to sudden necessity. It should be constantly instilled into the student in hospital, and into the doctor in his surgery.

The aim is that an effective family doctor service should be so organized and built up for the care of the elderly, that a standard pattern be achieved throughout the country, guaranteeing adequate protection for the patients under the best possible conditions, thereby reducing to a minimum the strain on the ancillary services and on hospital beds.

The lines I have used as my motto were quoted by Jeffery Farnol in one of his novels. He found them written on a sundial, and he thought them appropriate for his elderly hero to read just before his marriage to an attractive young lady. Besides being elderly, this gallant gentleman was disabled—at Ramilles, I believe—so that he

walked with a limp and, occasionally, with a stick. The author was at pains to expand on the delights of the environment, and the last paragraphs of the novel left the reader in no doubt as to the efficiency of the care which this particular disabled, elderly gentleman was to receive at the hands of his loving wife—supplemented by those of his faithful batman.

One cannot help but draw a parallel. As general practitioners we must be the affectionate partners of our elderly patients—indeed our definition requires that we should be—and we must so arrange their care and protection that there is joyousness to be found in age as well as in youth, and consolation in the union of youth and age together.

PUBLIC WELFARE FOUNDATION

Undergraduate Prize 1957, for Senior Medical Students

The College of General Practitioners will award 6 prizes of £40 each to the 6 most successful candidates in a competition which is open to senior students of all the medical schools in the United Kingdom and Eire. The closing date for entries is 1 August, 1957. The competition is open to students who have completed one year of clinical studies and have not yet passed the final examination.*

In this year's competition, candidates are asked to give a case history, with a suitable commentary, of one or more patients who have been seen in general practice. The patient may, but need not, have been admitted to hospital. The student is required to have seen the patient on three or more occasions in the patient's own home, or in the general practitioner's consulting room, and to have been introduced to the patient by the family doctor concerned. The student's account should include the clinical and social case history of the patient, and, where appropriate, that of the family concerned, a discussion of the diagnosis and treatment, and a summary.

The material, (approximately 1,500 words), should be written or typed on one side only of quarto paper. Application forms may be obtained from the dean's office of the student's medical school. The application form must be countersigned by the dean of the medical school or his deputy, and by the general practitioner concerned.

*—Entries will be accepted from individuals who may have passed the final examination before the closing date of the competition, provided that:—
(a) the entry is submitted before the candidate takes up his first hospital appointment,
(b) the required minimum of clinical work and observation has been completed by the candidate before sitting the Final Examination.