Crises in the elderly

by Dr I Rudolph, MBBCh, MFGP (SA)

For most people ageing is not a disease, it is a natural and gradual process of the passing of time with an almost imperceptible slowing down of physical and mental capabilities, and the longer we live, further deterioration occurs and eventually total disablement and finally death.

The rate of retardation and deterioration varies in each individual and the causes are multifactorial, not the least of which is genetically determined. Whatever the cause, the interaction of biological, genetic and socio-psychological factors seem to be involved.

We all know the "old man" of 55 and we admire the "young" man of 80. So in dealing with the various stages and categories we realise that flexibility is the operative word.

It is impossible to deal adequately wtih such a vast subject in the space allotted. For this reason, I propose dealing with the white population only, but bear in mind that many of the crises apply equally to the other racial groups.

The primary group - This group is characterised by the progress of time, probably influenced by genetic factors and about which nothing can be done, and from which there is no turning back.

It is marked by the various organs functioning at reduced levels of effectiveness and diminished output of hormones.

The secondary group - This group is related to disease processes such as Diabetes, Atherosclerosis and Trauma which result in:

- Impairment of visual and hearing faculties. Memory and mentation, become blurred; energy is reduced.
- Disability is associated with some degree of organic brain damage. Usually the mental faculties do not deteriorate as rapidly as the physical changes.
- Handicap is characterised by actual physical frailty and loss of the power of locomotion, comprehension and speech.

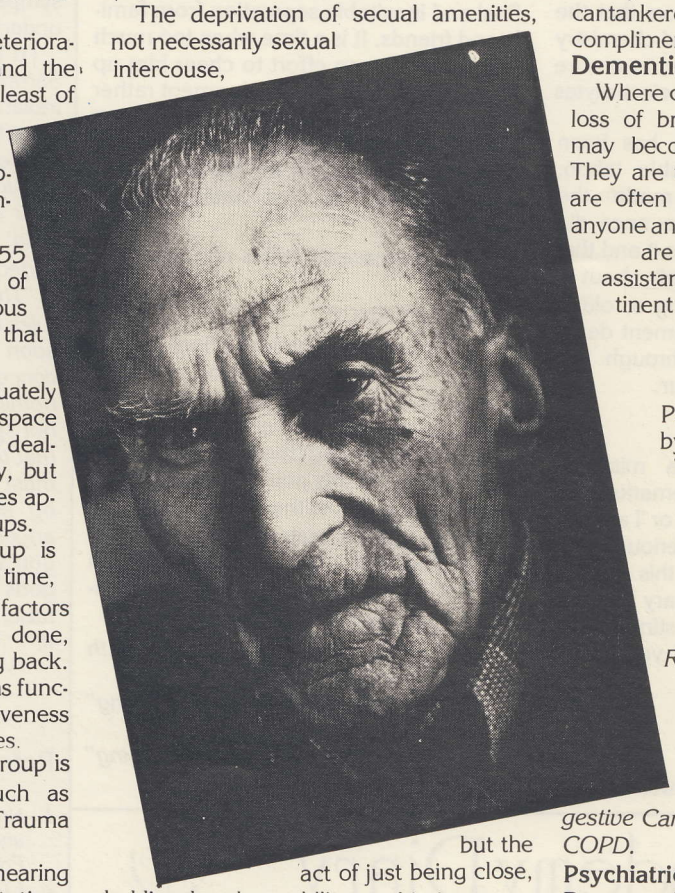
Phychological crises

Anxiety and/or Depression

Under this heading we know and have experienced the acute depressive states, and the acute anxiety that can occur, mostly brought about by reduction in energy, forced retirement from a lifetime of work and activity which is suddenly cut off and which results in reduced income, curtailed social interaction and loss of selfsesteem.

At this time too, in addition to being retrenched there may be loss of a spouse, relatives or friends leading to loneliness (or, as I call it, "aloneness").

The deprivation of secual amenities, not necessarily sexual intercouse,



but the act of just being close, holding hands, cuddling or kissing is an important factor in the development of depression.

One should remember this during prolonged illness, and where applicable the required privacy for a couple should be catered for. By tactful discussion one can gauge how significant this might or might not be to the individual.

It is well documented that early retirement for the average person is not necessarily in his best interest. Provided that mental and physical faculties are preserved the retirement date should not be at a fixed point in time. There should be a gradual modification of activities to suit each case.

In Western Society, parents CANNOT and DO NOT live with their children. There is a hackneyed saying that

"One Mother can provide a home for ten children, but ten children, cannot provide a home for one Mother."

Is it any wonder then, that so many elderly folk become depressed, agitated, cantankerous or given any other non complimentary label.

Dementia

Where cerebal degeneration with actual loss of brain tissue occurs, the person may become completely disorientated. They are uncontrollable emotionally and are often extremely aggressive towards anyone and everyone including those who are kind to them with feeding and assistance. They are frequently incontinent and require certification for institutional care.

There is another group which can be referrred to as the Psuedo-demented, characterized by confusion and other delirium. The causes are multifaceted and can be classified under the following headings:

Metabolic Diseases *eg Diabetes, Uraemia, Thyroid disease Hypo & Hyper.*

Infections *Urinary Tract or Respiratory tract.*

Tauma Fractures of the large bones. Subdural haematoma.

Oxygen deprivation *Sudden acute arrythmia Myocardial Infact. Congestive Cardiac Failure Sever anaemia & COPD.*

Psychiatric *Severe depression*

Perceptual *Visual & hearing loss or impairment.*

Miscellaneous *Retention urine, faecal impaction dehydration.*

Iatrogenic *Drug toxicity.*

To add to the trauma of growing old, we all know we have to die one day, but fortunately we are able to push the thought aside, or into the back ground until reality presents itself with such suddenness that we are unprepared.

Many elderly folk have witnessed a spouse or a friend during the last weeks of their lives, in abject misery with tubes stuck into every possible orifice, besides all the frightening machines bleeping incessantly, just waiting to set off the alarm signal which will herald the demise of the

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patient. They are terrified that they may have to endure a similar undignified fate.

A change has come about in recent years, in our attitude to death. We have come to accept institutionalized medicine as a persuit of CURE rather than CARE. We almost believe that if you pay enough and the Medical team works hard enough, death is somehow avoidable. Cure is still a rare event.

The act of practising medicine is the science of prolonging disease, and only if we are very lucky is it also the art of improving or maintaining the quality of life. We have become pretty good at treating disease but lack feeling and understanding in treating people. It may become a matter of pride to some doctors that the patients shall die with his blood chemistry as near normal as possible and to ensure that he will die with his serum electrolytes in balance.

Death, like Sex before it, has been made the great unmentionable taboo. Only recently have we made the discovery about death, as we once did about sex, that every one does it and that it is quite safe and helpful to talk about it.

Whether a person – young or old is faced with the reality of immiment death he or she usually passes through five phases or emotional behaviour.

1 DENIAL & ISOLATION

"Not me" . . . 'probably a mistaken diagnosis' It is manifest by remarks such as:- 'When I get back to work' or 'I am getting better' or 'It's nothing serious is it?' The GP should not challenge this reaction by the patient as it is a necessary adaptive respone to a highly traumatic stimulus. By saying "no, it is not serious" you isolate the patient still further.

2 ANGER

"Why me?' 'What have I done to deserve this?' The patient will castigate anyone and everyone, sometimes for trivial incidents.

It is important for the GP to recognise this phase, and when the patient castigates the doctor for not doing more for him, the doctor should not rush to his own defence by justifying his treatment, but rather could say 'you appear angry today, would you care to talk about it?'

3 BARGAINING

This often takes the form of silent bargaining with God: 'If I promise to be a better (or more religious) person will you give me more time?'

4 DEPRESSION

We often tend to forget the extreme grief that the terminally ill patient has to endure in order to prepare himself for his final and inevitable separation from family and friends. It is a time when too much interference in an effort to cheer him up hinder the emotional development rather than enchancing it. There is little or no need for words. Concern is often expressed by a touch of the hand or stroking the hair, or just sitting quietly together.

NB Antidepressants in this phase are not indicated.

5 ACCEPTANCE

This is the dying patient's final goal. It should not be mistaken for a happy stage, as it is almost as if the pain is gone, the struggle is over. Visitors are no longer desired and there is little communication. At this point the family may need more support than the patient.

There are recognised ways of communicating with a dying patient and if you are not au fait, there are several publications which will be helpful:

Sylvia Poss "Towards Death with Dignity" 1981.
Cecily Saunders "Care of the Dying" 1959.
E Kubler Ross "On Death & Dying" 1959.

Academy Diary

The 2nd Annual General Meeting of the Cape of Good Hope Region of the SA Academy of Family Practice/Primary care, will be held on Wednesday, 9th March, 1983, at the Amenties Building Conference room No 3, Medical School, University of Cape Town.

Hot and cold snacks will be served. The meeting which will take place at 20h15, will be sponsored by Hoechst Pharmaceuticals and Albert Pharmaceuticals, (Division of Hoechst).

Further meeting held under the auspices of the Cape of Good Hope Region of the SA Academy of Family Practice/Primary Care entitled 'Sexology for the GP' will be held on Wednesday, 16th February, 1983. The meeting will commence at 20h15 at the D3 Lecture Theatre, Red Cross Children's Hospital, Klipfontein Rd, Rondebosch.

The speakers will be Dr Herb Laube, and Dr Lydia Faith Lubbe, both Clinical Psychologists from Minneapolis USA, who have a special interest in Doctor/Patient communications. Snacks will be served. All are welcome to attend. The meeting will be sponsored by MPS Laboratories.

For further enquiries, please contact Rose Jonker, Secretary, SA Academy of Family Practice/Primary Care (Cape of Good Hope Region), telephone: (CT) 53-8205.

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knows how the other feels, so that needs and resentments continue simmering beneath the surface without being recognised.

In our consultative process with patients and the families (especially where possible crises may be involved) the way we communicate with them is of paramount importance. We should try and be non-judgemental, should not presume, we should put ourselves in their position. We should realise as much as possible, the mental state of the patient, enter into his feelings – gently scan his faults. The kindly word, the cheerful greeting, the sympathetic look – these the patient understands.

I'd like to end with a quotation from a Samhita or textbook written by Susruta an Indian Physician who lived in Benares sometime between 800 BC and 400 AD.

"Dedicate yourself entirely to helping the sick, even though this be at the cost of your own life. Never harm the sick, not even in thought. Endeavour always to perfect your knowledge . . ."

"The physician should observe all the rules of good dress and good conduct. As soon as he is with a patient, he should concern himself in word and thought with nothing but the sufferer's case. He must not speak outside the house of anything that takes place in the patient's house. He must not speak to a patient of his death if by so doing he hurts the patient or anyone else. In the sight of the gods ..... you are to pledge yourself to this. May the gods help you to follow this rule. Otherwise, may the gods be against you. So be it."

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