Caring for the Elderly

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...Early this year, the Washington news media reported that a 90-year-old woman was discharged from a hospital and taken by stretcher to her small apartment to be left there alone.

The rationale? There was no specific medical justification for continued hospital treatment and her eligibility for government support had run out. The fact that she was alone and helpless did not enter into the equation.

Once the public spotlight focused on this sad incident, the bureaucracy moved quickly to place the woman in institutional care. The explanation then came out: no one had direct responsibility, and therefore, the system—not individuals—had acted.

The point of this human "noninterest" story is that the one ingredient essential to all health care was lacking—a basic attitude of treating the individual as a person, not a "case." This woman was a victim of the ageism that is still all too common in our society, including its health and social-service communities. The woman was frail, poor and alone, but above all else she was old.

Although neither a technical nor scientific concept, the idea of caring is basic to any endeavor that seeks to improve the condition of people, including the elderly. Congress was grappling with monumental issues—the massive growth of health care costs and the burgeoning population of older people—when it enacted the Research on Aging Act of 1974 (P.L. 93-296). But it did not neglect the fundamental factors of caring as it established the research-oriented National Institute on Aging (NIA). The Institute was created, said Congress, "for the conduct and support of biomedical, social, and behavioral research and training related to the aging process and the diseases and other special problems and needs of the aged" (emphasis added).

That is a broad mandate and it was necessary to devise a clear set of objectives and priorities to make certain that the human concerns implicit in the law were preserved. Congress instructed the NIA to prepare a long-range research plan on aging, which was entitled "Our Future Selves." In the introduction, the fundamental goal of the Institute is underscored:

The quality, not the quantity, of life should be the quintessential goal of research as well as other human efforts—let our future selves be in jeopardy.

Research in itself is an objective and detached process. But, it is guided by the intent to apply its knowledge to the lives of individuals, then research is a very practical matter, in terms of both economics and compassion. Through the judicious application of new knowledge acquired through research, existing services and health care can be improved. In this sense, research is the ultimate service and the ultimate way to contain costs.

We can expect the 25 million Americans 65 and older today to be succeeded by some 55 million in just 50 years, a growth from the present 10% of the population to 17-23% by 2030. At the same time, the costs of health care and services are mounting rapidly, especially for the elderly. In 1975, older people made up 10% of the population, but accounted for 29% of the total health care expenditures ($30.4 billion). This explosion in numbers and dollars will have serious social, economic, and personal ramifications if plans to meet the consequences are not made today.

Within the NIA, we have established five general criteria for setting our priorities: (1) the target constitutes a major health problem; (2) there is a high potential for alleviating family and personal anguish; (3) high social and health costs are involved; (4) there is a "critical mass" of trained scientists in aging to do the work; and (5) the problem is reasonably susceptible to scientific solution.

These criteria offer us a wide range of possibilities for exploration—from familiar matters such as nutrition requirements to the highly complex and mysterious process of immunological decline with age. In studying
these and other aspects of aging, scientists must distinguish between the decline that is part of the normal process of aging and those ailments that are due to individual heritage, life style and condition of living.

In some areas, such as biochemistry and immunology, highly technical and sophisticated basic research will be conducted. In others, long-range prospective studies such as the Baltimore Longitudinal Study are necessary to differentiate normal aging from disease. This study has been underway for 20 years at the NIA's Gerontology Research Center in Baltimore, Maryland. Women have been added to the study for the first time this year.

Finally, there are areas in which we do not have to reinvent the wheel, but must organize, refine, and apply knowledge that is already available. For example, we know that both children and the elderly respond differently to drugs and that there are drug-food and drug-drug interactions that can have serious consequences. Yet currently, physicians have no guidelines for prescribing medications for their older patients. The Institute is sponsoring a study of age-related effects of drugs in the elderly that is expected to produce a compendium of information from which guidelines for physicians could be formulated. Meanwhile, many adverse reactions can be avoided by awareness of this special drug-age situation. Careful attention to individual responses can avert serious and even fatal results.

Another area in which thoughtful concern can help avert tragedy is in dealing with the mental health of the elderly. Widespread misuse of the label "senility" results in the consignment of thousands to institutions as hopeless cases when, in many instances, the condition could be reversed completely or improved. The truth is that "senility" is not one condition, but a group of symptoms with 100 or more possible causes—ranging from malnutrition to drug reactions. Irreversible brain diseases occur in less than 20% of all individuals 65 and older. How many of the 1.2 million older Americans in institutions are there needlessly?

These and many other problems and illnesses of the aged can be overcome through the application of the findings of scientific research. But before this potential can be realized fully, there must be a change within the health care community regarding geriatric medicine. Gerontology and geriatric medicine have by and large been seriously neglected by the scientific and medical worlds. One exception, however, is the specialty of gerontological nursing. Fewer than 2% of an estimated 25,000 faculty members of American medical schools have expert knowledge in geriatric medicine; there is but one endowed chair in geriatric medicine in the United States; and few schools teach the subject—less than half of the 120 American medical schools offer electives in the field.

The Institute intends to encourage and support the changes that are needed to create a trained cadre of scientists in this field and to make the health care professions more widely aware of the importance of geriatric medicine.

There could well be some important scientific breakthroughs in the years ahead as a result of intensive research, and findings along the way can help to improve the quality of life in old age and, possibly, increase life expectancy somewhat. But such accomplishments themselves could produce additional problems if they are not accompanied by corresponding advances in the way we deliver health care and in our attitude toward the aged. Long-term care must be improved and extended through increased emphasis on home health care and day care for the elderly. Medicare, a great boon to the old and to their families, in many respects looks on the old as if they were young. Modifications are necessary to provide basic needs such as hearing aids and eyeglasses. Retirement policies, now being relaxed, must be assessed still further so that those who have the ability and the desire to continue productive and active lives may do so.

As research in the laboratory and at the bedside proceeds, and as society comes to recognize the special economic and social problems of the aged and moves to correct them, the day-to-day work of providing health care for the aged continues. Vast improvements in the condition of the aged and their prospects for a decent and dignified old age can be achieved by those individuals who are in regular contact with the elderly. After all, it is in the hospital wards, the nursing home corridors, and in the home where the connection between scientific research and human well-being is made—where knowledge is actually applied. If that essential connection is made by people who understand and care about the elderly, we can indeed improve the quality of life for the aged measurably.