Geriatrics and Gerontology in Every-day Practice

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Geriatrics—a word that probably nine out of ten would be unable to define—is that branch of medicine which is concerned with elderly patients, just as pediatrics is the branch concerned with babies and children. Gerontology is the science of aging, in the broader sense, and includes sociology, economics, psychology, and any other science or branch of science related to aging or the aged. Geriatrics is therefore a part of gerontology. Nascher, who is considered the father of geriatrics, used the term "geriatrics" for the first time in 1909.

It is not accidental that geriatrics and gerontology are receiving increasing attention. The increasing proportion of elderly and old people in the population—a trend noted in the United States, Great Britain, and several other Western European countries, is responsible for the growing interest in geriatrics and gerontology.

According to the U. S. Bureau of the Census, nearly 8 per cent of our population is of age 65 and older; in 1900, the same age group accounted for only 4 per cent of the population. Between 1930 and 1940 the total population of the United States increased 7.2 per cent; in the same interval the number of those 65 and over increased 35 per cent. In 1945 the census showed 21,446,000 in the age group up to 9 years, and 15,193,000 in the age group over 60; it is expected that by 1980 the figures for these groups will be, respectively, 19,249,000 and 31,218,000 in a general population of 153,000,000—that is, 12.6 per cent children as against 20.4 per cent elderly or old individuals. If the estimates of the statisticians are correct, we may expect that in the not too remote future our society will contain twice as many old people as young ones.

The longevity of the population has increased rapidly during the last fifty years. In ancient Rome, about two thousand years ago, the average length of life was 22 years; during the Middle Ages, average length of life was about 35. In this country the life span has risen from 49.2 years in 1900-1902 to 65.8 in 1945.* According to the Federal Security Agency, the longevity figure for 1946 was 67 years.

It is therefore not surprising that every day brings new evidence that interest in geriatrics (there is less interest on the whole in gerontology) is

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increasing. Federal, State and City committees to study the problem have been created, funds for research have been appropriated, and books and journals have been published. American medicine and American psychology are leaders in this new and modern field of medicine and science. Only recently we have had the testimony of Sturdee[1], Howell[2], and Warren[3] as to the inspiration which the writings of American pioneers in geriatrics furnished for the development of new trends in the care of aged persons in Great Britain. In view of this it is surprising to note how little the modern ideas have penetrated among American physicians and the American public in general.

The feeling that aging and senescence are diseases which inevitably end in death is so strong that an elderly person is generally considered as a lost cause and worthy only of pity. A hundred years ago, Cannstadt[4] taught that in senescence, pathology and physiology are synonymous. But for long before Cannstadt and for many decades after, the civilized world subscribed to the belief *senectus ipsa morbus*. Even today, when new beliefs are stirring, one often receives the impression that even those who profess to be sympathetic to modern ideas of geriatrics in fact do not believe that any real change in the approach to the problems of elderly persons is possible. The old ideas are still deeply rooted in the every-day life of our society.

The following cases are illustrative of this attitude:

Case 1. The intelligent daughter of Mrs. E., an 84-year-old patient, was furious with her mother for coming for medical attention when she was not acutely ill. She argued that an elderly person must expect to suffer and that no doctor in the world could cure her senescence. Actually the patient had a severe Vitamin B deficiency and her desire to see a doctor was entirely justified.

Case 2. A 79-year-old patient, Mrs. F., was suffering from a senile pruritus. She felt that any treatment in her case would be futile and that her real disease was her age. This otherwise lively and alert patient, who took a daily walk of 20 to 30 blocks, lost her itching after treatment. She continued, however, to repeat that old age is a hopeless disease. A thorough check-up was desirable because of the presence of an unusually high sedimentation rate, yet her son, a physician, was opposed to this since in his opinion nothing could be done for elderly patients.

Case 3. Mr. L., a business executive, 67 years old, was suffering from myocardial damage following a coronary occlusion. The details of Mr. L's case are not significant for our purposes, but the attitude of his doctor is. In the doctor's opinion the patient's position with the firm that employed him was at stake. His three-year contract was about to expire. The chances of his obtaining another adequate position were almost nil. Life under such circumstances would become a torture for him. The doctor, who was other-

wise kindly disposed toward Mr. L., did not see any necessity, under the circumstances, of "artificially," as he called it, prolonging the life of the patient. The elderly man was classified, both psychologically and somatically, as a lost cause. Fortunately, the patient was referred to another doctor who started active therapy, and the patient has been improving since. His employment contract was twice renewed and it is almost certain that it will be renewed for a third time. The patient is in better condition now than he was six years ago.

Case 4. Several weeks ago I intervened for a patient, Mr. S., a 57-year-old white-collar worker, who was suffering from a mild coronary arteriosclerosis. The business executive with whom I was negotiating in his behalf was an old friend of mine, himself 55 years old, who, in spite of all my efforts, declined to employ the patient strictly on the basis of his age. When I was unkind enough to mention his own age, he replied that he was conscious of this and knew that if he should lose his job he would have no chance of obtaining another.

"Nobody wants you when you're old and grey," wrote a man of 72 recently to the New York Joint Legislative Committee on Problems of the Aging.

Similar experiences could be recounted ad infinitum.

I recently witnessed an expression of a similar attitude, on a mass scale, in a fraternal organization for mutual help, of which I have been a member for many years. The organization is a progressive one. It recently celebrated its fiftieth anniversary. In 1945 the Guardian and Mortuary Fund of this society had assets of $7,793,116.57, and the Disability Fund $463,427.71. The organization maintains a medical department and operates a sanatorium for tuberculous patients; it has an educational, social service, and other departments. In 1945 the organization had a regular membership of about 70,000. From the gerontological point of view the organization serves a selected group since the membership consists mainly of aging and aged members—48,223 (about 70 per cent) are over 50 years old; 5,558 (about 12 to 13 per cent) are over 65. The average age in 1945 was almost 53. In view of the composition of its membership it is natural that the society has been facing all forms of geriatric and gerontological problems. The only solution suggested, and which has been under serious consideration for many years, has been the establishment of a home for the aged. About twenty years ago an Old Age Home Fund was created and dues set at one dollar a year. Up to 1945, $978,580.50 had been collected. When, however, the Executive Committee and the majority of the active members realized that for many reasons a single home, or several homes, could not be built and maintained, collection of dues for the fund was discontinued and the suggestion was made that local homes for the aged be established if possible. No other measures were recommended.

The decision was approved by a convention of the members, but the disappointment among the elderly members was nevertheless strong.

Being aware of the conditions in the organization and the needs of the members, I felt that the society should adopt the principles of modern gerontology and geriatrics. During the years 1944-1947 I wrote a series of articles for the society's official bi-monthly organ, which has a circulation of approximately 50,000; spoke at several meetings; and had many private conversations with individual members. I proposed a concrete program. The suggestions for the reservation of special hours for geriatrics cases in the society's dispensary; the establishment of a psychological consultation service; the setting up of a joint committee of the society and other organizations such as influential labor unions to study the problem of working conditions of elderly persons, and many other suggestions, were considered impracticable. I did not even succeed in having a committee appointed to study the problems from the angle of modern gerontology. The suggestion that contact be made with other geriatrists was not accepted. One well-known geriatrist was easily accessible to the society since for many years he has been a consultant in heart diseases for the organization. The physician himself was ready to participate in any sound geriatrics project.

It is obvious that profound prejudice is involved in the general approach to the problems of senescence. The belief, which has endured for centuries, that senescence is decay, cannot be easily eradicated.

Up to now the aging and aged have been the physically weaker group in the struggle for existence. The stronger ones, the members of the younger age groups, are not conscious of psychological cruelty in their handling of their grandparents and great-grandparents, and the latter have accepted this unconscious ruthlessness on the part of their grandchildren as a natural attitude.

The commercialization and industrialization which occurred during the Nineteenth Century and the beginning of the Twentieth heightened the general feeling that an elderly person with no means of self-support is a burden—a burden to his family, to the community, and to himself. The indigent senile were committed to "workhouses," almshouses, overcrowded and unhygienic homes for the aged. They were condemned to poverty and inactivity.

There has been ample proof that environmental factors, forced inactivity, and the feeling of uselessness, rather than advanced age, have been responsible for decay and deterioration in many elderly individuals. The life story of Dr. Samuel Hahnemann[5] is a striking example.

Hahnemann, the founder of homeopathy, was, in his 70's, compelled to retire. He went to the small German town of Coethen. Feeling useless and having nothing to hope for, he began to deteriorate and to become

senile and bitter. A young French woman, Mlle. Melanie d'Harvilly, came to Coethen to visit the once famous doctor, who was then a man of 80. To make a long story short, they married and went to Paris. Poor as a beggar when he arrived there with his young wife, he had to begin to practice medicine again in the hope of making a living. In this he was most successful. He became famous, this time as the father of homeopathy but as the society doctor of Paris. He led a very active life, attended the theater and opera, collected pictures, and became a patron of the arts. He was wealthy when he died at the age of 88.

The fate of the bulk of the elderly individuals of Dr. Hahnemann's time, however, was entirely different—they deteriorated in an atmosphere of hopelessness and were often easily referred to by their fellow men of younger age as "datant's," "ga-ga's," or in similar insulting terms. These and other environmental conditions created the atmosphere in which the elderly people lived and suffered.

Every-day experience in geriatric practice provides convincing evidence that neither society nor we as individuals have basically overcome this ruthless attitude toward elderly persons. Public opinion and our general approach to the elderly is even today, to a substantial degree, under the influence of the past.

There would appear to be a difference between public reaction toward the aged in this country and in Great Britain. Here, doctors and social workers were the initiators of modern geriatrics and gerontology. The public at large has remained fundamentally uninvolved. This is not so in Great Britain. In the carefully prepared "Report of a Survey Committee of the Problems of Aging and the Care of Old People,"[6] we read: "In recent years there has been a considerable awakening of public interest in the problems of old age, an awakening that has manifested itself in a sympathetic attitude to old people and in a widespread desire to be generous to them."

The lay public in Great Britain has shown more interest in and accessibility to advanced views concerning the care of the aged than have British physicians.[7] Perhaps for this, and possibly for other reasons, Britain is going her own way in the field of care of the aged.

The British approach, for example, to the problem of housing of elderly people is a promising one and deserves the consideration of all who are interested in a genuine solution of gerontological problems. Under the National Assistance Bill every elderly person in Great Britain, irrespective of means, will be provided housing in hotel-like arrangements. The question under discussion is whether the arrangement should provide for one-room apartments with kitchen and bathroom, or whether there should be separate bedrooms and living rooms. Kitchens are planned to be simple, cupboards easily accessible, bathtubs comfortable to enter. A bell system

will assure communication with neighbors in case of need for help. An economical rent will be charged. Every person receiving aid under the bill will presumably be able to afford the rent. If, however, financial difficulties should arise in individual cases, the other residents will not know of these circumstances and assistance will be provided by appropriate agencies. Eviction is not possible. This proposed solution opens a new page in the history of old-age care.

Many attempts to improve the lot of the aged have been made in this country. Minor housing projects have been set up. None of these, however, goes as far as the British National Assistance Bill, which has been made possible, apparently, by the support of public opinion.

In this country an interesting effort was the creation, in 1943-1944, of an Old Men's Division in the Dodge Plant of the Chrysler Corporation, in Detroit, Michigan. The average age of the workers involved was 66 years; some were over 80. The results of the plan were reported as very satisfactory.[8] Many employers during the war were full of praise for their elderly workers, although some difficulties were noted. Employment of elderly people was, however, stimulated by the lack of manpower. In the postwar period conditions have changed and the elderly worker, despite the record he made for himself during the wartime manpower shortage, finds it difficult to get a job. Ewan Clague, Commissioner of the Bureau of Labor Statistics, has stated that the next depression, or even business recession, will hit the workers 45 years of age and older particularly hard.[9] A depression or recession may mean that fifteen million workers will slip into conditions of insecurity and hardship.

There are a number of clubs and organizations in existence which give help to their elderly members. There are even clubs comprising exclusively elderly persons whose main purpose is to get jobs for their members. The Forty-Plus Clubs, an association of unemployed older executives, assists its members in securing employment.[10] While the assistance offered by such clubs is of value, it does not change the atmosphere of uncertainty in which elderly persons now live.

Unless a basic change in public opinion occurs, we can hardly expect that there will be recognition of the value of the elderly person. Instead of useful occupation, hobbies, social gatherings, games, and sports have been recommended as substitutes for gainful employment, but for an elderly person who can be creative, such substitutes are rather a confirmation that there is no room for him in active life.

As Adler has shown, no person, regardless of his age, can be or become again a human being unless he has the feeling of being useful. In Adler's teaching, moreover, the idea of usefulness is combined with the idea of community.[11] [12] Social adjustment—the practical goal of psychotherapy[13] is possible if it is based upon the idea of usefulness within the community.

The deeper psychological value of a vocation lies in its providing a sense of usefulness not only for himself but for somebody else as well. Where recreation, however, enters in after a period of no creation, especially in an environment in which financial and other difficulties are an every-day problem, it takes on another and very specific meaning: it implies that while one feels he could participate in improving his own and his family's condition, he is not permitted or trusted to do so because of his age. Under such circumstances resentment must arise. The substitution of recreation for creation stresses once more the hopelessness of his condition and predestines an increase of a depressive state of mind.

A new Social Magna Charta[14], under which the rights of elderly people would be assured in accordance with the principles of modern geriatrics and gerontology, would have a decisive influence on both the psychology of the aged and public opinion. I fear, however, that the implementation of such an idea will take much more time than progressive geriatrists and gerontologists anticipate. A quicker solution lies in a change in attitude on the part of the lay public. To achieve such a change, all means at our disposal should be mobilized.

An essential place in this new and important field is left to modern psychology. The individual psychological approach opens a fruitful way both for the social adjustment of the elderly individual and the adaption of society to his requirements.

One factor of great value has not been made use of up to now—the elderly person himself. He has been a passive spectator in the struggle for his own rights. Many aged persons, it is true, are participating in political, social, and economic life. They are usually so absorbed in their professional problems that they try to suppress the fear that their positions may soon be lost because of their age. When separated from their activities, they usually slip into the old-age state of feeling doomed, into desperation, or into the uselessness of the every-day life of the aged. Among retired elderly persons there are to be found, however, persons of different classes and circles, different abilities and talents. I am sure there are to be found among them efficient writers, speakers, publicists, who, when united by the idea of defending themselves against injustice and fighting for their right to a creative and useful life, will be able to impress public opinion. Life itself may assume another meaning for this category of the aged and they will be able to draw other aged persons into their clubs and organizations and inspire them with interest in the fight for their own emancipation, the fight to create new conditions for elderly individuals and make each of them useful to himself and to others.

This kind of activity will at least counteract the depressive feeling of being useless that dominates the psyche of the great majority of our elderly patients. It will demonstrate both to them and to the world that aging and

aged persons are not helpless creatures who have nothing to give, nothing to say, and nothing to hope for. It will demonstrate that times have changed.

An increased and purposeful activity of elderly persons in a struggle for their own rights may help to bring nearer the turning point in public opinion without which modern gerontology cannot achieve its goal.

Summary

1. Despite the fact that geriatrics has made progress in this country, the general atmosphere and public opinion have remained basically unfavorable to a modern approach to the problems of elderly persons.

2. The difference in lay public opinion in Great Britain and the United States has made it possible for projects aimed at basic improvement of the psychological and social conditions of elderly persons to go much farther in Britain than in this country.

3. Modern geriatrics opens new opportunities for the Individual Psychology school of thought. The idea of usefulness for both the individual and the community, and the social adjustment of the individual on the basis of this principle, may be instrumental in attaining to a new approach to the elderly.

4. Since medical circles and social workers in the United States have developed initiative, interest, and activity in both geriatrics and gerontology, there is reason to hope that improvement of environmental factors may be expected. The support of the public, however, is needed.

5. The necessity of increased activity on the part of aging and aged persons in their own behalf is advocated for practical and psychological reasons.

References

[1]Sturdee, E. L., "Care of the Aged and of the Chronic Sick in Great Britain," *Geriatrics,* Vol. 2, No. 6, November-December, 1947, pp. 359-365.

[2]Howell, Trevor H., "The Medical Care of Old People," *Geriatrics,* Vol. 2, No. 6, November-December, 1947, pp. 370-372.

[3]Warren, Marjory W., "The Evolution of a Geriatric Unit," *Geriatrics,* Vol. 3, January-February, 1948, pp. 42-50.

[4]Cannstadt, Carl Friedrich, *Die Krankheiten des Hoeheren Alters und irhe Heilung,* Erlangen, 1839.

[5]Boyd, L. J., *A Study of Simile in Medicine,* Philadelphia, 1936, pp. 31 ff.

[6]*Old People,* a Report of a Survey Committee on the Problems of Aging and the Care of Old People, under the chairmanship of B. Seebohm Rowntree, C.H.LL.D., The Nuffield Foundation, Oxford University Press, London, 1947, p. 95.

[7]Howell, Trevor H., *ibid.*

[8]*Monthly Labor Review,* 57, No. 1, July, 1943, United States Department of Labor, Bureau of Statistics.

[9]Clague, Ewan, quoted by Hal Borland, *The New York Times Magazine,* March 8, 1948.

[10]Lawton, George, *Aging Successfully,* Columbia University Press, New York, 1946, p. 91.

[11]Adler, A., *Understanding Human Nature,* Greenberg Publ., New York, 1927; *Social Interest: A Challenge to Mankind,* Putnam Sons, New York, 1940.

[12]Birnbaum, F., "The Importance of Alfred Adler for the Present," *Individual Psychology Bulletin,* Vol. VI, Fourth Quarter, 1947.

[13]Adler, A., *The Science of Living,* Greenburg Publ., New York, 1929, Ch. IX: "Social Problems and Social Adjustment," pp. 199 ff.

[14]Cowdry, E. V., "The Broader Implications of Aging," *Journal of Gerontology,* Vol. 2, October, 1947, No. 4, pp. 277-282.