The Linacre Quarterly

Volume 33 | Number 1 Article 10

February 1966

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Recommended Citation

Lippert, Jerome H. (1966) "Medical Care of the Aged," *The Linacre Quarterly*: Vol. 33 : No. 1 , Article 10.
Available at: http://epublications.marquette.edu/lnq/vol33/iss1/10

Medical Care of the Aged

JEROME H. LIPPERT, M.D.

In view of the ever increasing life expectancy the population explosion is not limited to any particular age group. In 1900 there were approximately 3,000,000 people aged sixty-five and over. By 1970 this figure is expected to reach 20,000,000. We have all encountered comparatively young and alert individuals with the chronological age of eighty and conversely we are also seeing people whom we might class as old who are only aged fifty.

Since all people of sixty-five and over should not be considered aged or senile, let us divide this group into three general classifications. In the first group we have the comparatively adequate person who is able to live independently either with members of his family or in his own domicile. He may continue working full or part-time and is well able to care for his own needs. One in this group presents little problem. Financially he may have independent income, friends or relatives who may contribute to his support, assistance from welfare agencies, Social Security, or retirement funds.

In the second group we may include those individuals who need regular, but not constant, medical care, who may, with just a moderate amount of supervision, maintain themselves, and who may be able to continue with some degree of interest their hobbies, employment, or social activities.

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In group three we will include those chronically disabled individuals who for the most part need constant medical supervision because of either mental or physical disabilities. I will try to place emphasis on this group since they present the greatest problem. Although this group comprises only three to five percent of our over sixty-five population the facilities for caring for and maintaining them are woefully inadequate in both quantity and quality. The rapidly expanding, and to me dreaded, practice of forced retirement at age sixty or sixty-five is adding greatly to the number of people in this classification. Only a very small number in this group have prepared themselves for retirement by developing hobbies or interests. The key word in management of people in group three is motivation. We have all seen highly motivated people with multiple and chronic physical disabilities who still find a great deal of pleasure in life and are able to accomplish many successful and gratifying activities with very little notice of their disabilities. Conversely we have also seen the unmotivated with only minor disabilities become depressed and gradually vegetate and deteriorate both physically and mentally until they become entirely dependent. The number who are able financially to provide medical, nursing, and ancillary facilities within the confines of their homes is very small and in-

deed very tunate. For the rest this mean stitutional care.

Care of se individuals may be divided int three main categories. First consideration should be for the physical, in which an attempt is made to bring them up to their maximum functional capacity. This requires something akin to the general hospital. Constant medical and nursing supervision with consultation available in all major specialties other than obstetrics and pediatrics is essential. Diagnostic aids should include complete X-ray and laboratory facilities. Since the old, frequently heard axiom, "He's old, what can we do?" has been proven false we now know we can do a great deal to benefit these people. The institution should have complete physical therapy facilities, occupational therapy, sheltered workshops, and muscle exercising and coordinating gymnastic equipment. Dental care is an essential part of the program.

The second phase should be focused on the mentally or emotionally disturbed individual. To accomplish this, regular psychiatric attendance is indicated along with some of the treatment already mentioned.

The social phase again returns to that old key word of motivation in which any type group therapy or activity which stimulates the patient is very important.

To accomplish this type of care, a good working relationship with a top general hospital is almost essential. This hospital should preferably be a teaching institution and one that is research oriented. At this time on minimum amount of research ing carried on in the geriatric

Among th oblems in this area are the lac interested medical and para-m al personnel. This is somewha derstandable since the cost is h and the results are not as spect ar and gratifying as in the trea nt of the younger groups in w h recovery is often rapid and c plete. Improvement is often slow d chances of complete recover re limited. Remuneration is o inadequate for the time and effo involved, because of lack of fun available for this prolonged ca

Should w ttempt to provide separate facil s for the mentally and the chro ally physically disabled individ in this age group? This again p s a very controversial question r which there are many answe

At present re are only a minimal number institutions providing near ad ate care. For the most part t se are community sponsored b religious or local charitable gro s with some assistance from S l Security, federal and local wel re agencies. In a handful of inst nces the family may be financially able to pay for the individual car Who should pay the costs of this care? I cannot express a definite opinion on this question since regardless of which agency provides the funds it must still come from the pockets of the public. Whether government, private, church, or community financed, these people are entitled to care and it must be provided.