

OLD AGE, ILLNESS and DISABILITY

in a

SCOTTISH COUNTY

by

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1959

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## INTRODUCTION

It is the purpose of this Thesis to describe and to analyse the medical and social conditions of the elderly sick in Fife, both in urban and rural areas; to examine in the light of the evidence adduced, some of the major problems and prevailing assumptions regarding the care of the elderly; and finally, against this background, to discuss the implications for the future development of our services for old people. The origins, scope and limitations of the investigation on which the thesis is based are briefly described in the following paragraphs.

In January 1957 the writer was appointed by the South-Eastern Regional Hospital Board "to develop and take charge of a Hospital geriatric service in the County of Fife". At that time no such service existed; there were in the whole County, with a population of over 300,000, a total of sixty-three hospital beds allocated to the "chronic sick" of all ages. During the next six months however a further 70 beds were made available, and it then became possible to organise the beginnings of a service for the elderly sick who needed, but could not otherwise gain admission to hospital.

So precious however were beds that only those patients whose needs were most urgent could be admitted; and in order to ensure that the available beds were allocated in the fairest way, and used to the best advantage, the system was instituted, in the autumn of 1957, of visiting in his or her own home, every patient on whose behalf the family doctor sought admission to hospital, or advice from the hospital physician as to the patient's future care. This system was rapidly accepted by the great majority of practitioners; it soon became established practice, and during the first two years following its inception the geriatric physician has been approached on behalf of elderly patients by about 80% of the general practitioners in Fife.

Initially /

Initially, the system of domiciliary visiting was instituted (as in other regions in Great Britain during recent years) with a view to assessing the urgency of each case relative to others awaiting admission, and at the same time to provide the hospital physician with first-hand knowledge of the patient's domestic background and living conditions, since these must necessarily be taken into account in determining the patient's fitness or otherwise for discharge from hospital.

It early became apparent however that here was an opportunity to study at first hand the diseases and disabilities of old age under social conditions very different from those with which the writer was formerly familiar in Glasgow, and from those described in surveys among old people elsewhere. Previous surveys of old people in their own homes, whether of special groups, or unselected, have almost all been carried out in older urban areas; but here in Fife was a population already enjoying to a large extent the benefits of a vigorous post-war housing programme. What effect, then, has the re-housing of the working man and his family had on the care of the older generation, particularly when incapacitated by illness ?

Again, the County of Fife, though mainly industrial, has a widely scattered agricultural population, with a number of small Burghs, little larger than extended villages, and definitely rural in outlook. Here also was an opportunity to enquire whether the diseases of old age, particularly the degenerative diseases, affect both industrial and rural communities in equal degree; whether in old age each faces the same social difficulties - or whether it is true (as has been alleged) that old people in rural areas are better cared for than those in city and town. Finally, it seemed that evidence might be accumulated to throw light on some of the controversial questions of the day; is it true, for example, that there is a decline in the family sense of responsibility ? And /

And how far does the employment of younger women in industry and business affect the home care of old people who are no longer independent ?

These were some of the questions which presented themselves as experience grew. It therefore became the writer's practice, when a new patient was seen for the first time in his own home, first to carry out, as far as circumstances permitted, a detailed clinical examination of the patient; then to take note of the type of house he occupied, whom he lived with, what relatives were available, how far neighbours assisted, and whether any social services were being provided, together with any other details relevant to the case. No pro-forma was used, it being the writer's firm belief that none can be devised adequately to cover all the complexities of pathology, still less of human relationships, to be found among the aged; but all observations, clinical and social, were recorded in detail while still fresh in the memory, and in an orderly sequence. No hospital almoner or social worker was available to the geriatric service, and all observations therefore were of necessity those of the writer himself.

This Thesis is based on the records of 400 patients, all of whom were visited by the writer between late 1957 and the beginning of January 1959. Since the survey is concerned with the elderly, patients under the age of 60 were excluded from the series (an arbitrary but necessary dividing line); also excluded were the records of patients seen on a second or subsequent occasion, patients referred from other hospitals and patients seen in nursing homes, private or Local Authority Old Persons' Homes. In short, the series covers 400 persons over the age of 60 seen for the first time in their own homes, and to that extent is consecutive and unselected. It includes old people from all parts of Fife, urban and rural, and representative of all social classes; common to all was illness or disability of such a nature and in such circumstances that the family doctor felt compelled to call on the hospital physician for advice or assistance regarding the future treatment or care of the patient.

There is now a considerable body of literature, medical and otherwise, on the subject of old age; published series of cases however vary widely in the basis of selection, in the standpoint of the writer, and in methods of classifying and presenting results; it is therefore extremely difficult to make comparisons and to draw conclusions which are valid on any one aspect of the subject. Reference is made in the text where appropriate, however, to other published work on the subject under discussion, and a list of references is given at the end of each Chapter.

Where individual cases from this series are quoted in the text, only sufficient detail is given, extracted or summarised from the original record, as is necessary to illustrate the point at issue. In order, however, to demonstrate the form and method of recording the observations and findings following each domiciliary visit, there are included as Appendix A, at the end of this work, exact copies of the original records of six representative cases, only the name and address of the patient being omitted. Appendix B consists of two maps, referred to in Chapter I.

## CHAPTER I

THE COUNTY OF FIFE AND ITS OLD PEOPLE

The County of Fife, a peninsula some forty miles long by twenty miles wide, bounded on north and south by the Firths of Tay and Forth, and on the east by the North Sea, and separated from the west by the barrier of the Ochil Hills, forms a natural entity, geographically isolated and historically independent. Its very isolation, at a time when land communications were in any case negligible, and an abundance of natural harbours and anchorages on its southern shores, gave an early impetus to trade by sea with the Baltic States and the Low Countries, so that in mediæval times Fife achieved an importance in Scotland out of all proportion to its size; an importance acknowledged by the establishment of the royal residence in Dunfermline in 1060, by the ecclesiastical supremacy of St. Andrews, and by the founding, also in St. Andrews, of the first University in Scotland in 1411; and the vigour of its trade and the influence of its merchants was recognised in the proliferation of Royal Burghs in the County, eventually reaching eighteen in number, no less than thirteen of them strung along the northern shore of the Firth of Forth, from Culross to Crail.

Modern times have seen the decline of Fife from its position of supremacy to that of a backwater, and its later resurgence in the late nineteenth and present centuries. The removal of the Court to Edinburgh, and later to London; the effect of the Reformation on the Church, and of the Dutch Wars and the Navigation Acts on the trade of the coastal Burghs; the development of trade with the New World from western ports, and the growth of heavy industry based on the coal of Lanarkshire - all these



combined to destroy the early importance of Fife. But revival came eventually, partly through the revolution in agriculture which enormously increased the productivity of its naturally rich soils, partly through the application of power-driven machinery to weaving, which established linen manufacture as an industry (notably in Dunfermline), but most of all through the expansion of coal-mining, which, from employing a mere 6,000 workers in 1880, employed 27,000 by 1910<sup>(1)</sup>. The expansion of coal-mining, with its ancillary industries, transport, and port facilities, has more than any other factor been responsible for the steady growth of the population of Fife during the past century, a growth which remains so far unabated. During the period 1931-1951 the population rose from 276,000 to 306,000, an increase of 11%<sup>(2)</sup>.

By the accidents of geography and history the main lines of communication through Fife, by rail from Edinburgh to Dundee, and by road from the West to St. Andrews, bypass the major industrial areas; while Cupar, the County town, lies in the heart of rural Fife. The visitor is therefore apt to think of the County as predominantly rural. Yet today 74% of the population is concentrated in the comparatively small area covered by only fourteen of its 60 parishes, and of its 306,000 people, no less than one-third live within the two large Burghs of Dunfermline/Rosyth and Kirkcaldy/Dysart. Apart from these, the major concentrations lie in the East Fife coalfield, north and east of Kirkcaldy, including Buckhaven, Methil, Leven and Kennoway, and in the Central Fife coalfield, including Cowdenbeath and Lochgelly. By far the largest employer of labour is the National Coal Board, followed by national and local Government Departments, distributive trades, textiles, linoleum (centred on Kirkcaldy) and ship-building and repairing (based on the Royal Naval Dockyard at Rosyth, and on Burntisland). Agriculture and fishing together employ only 7.6% of the working population, and outside of the urban areas the largest town in the County, St. Andrews, has a population of under 10,000.

The most striking feature of the towns - and even of the villages - of Fife today is the number and diversity of new housing estates, and the evidence of the replacement or reconstruction of old, congested areas. Most striking of all perhaps is the New Town of Glenrothes. Initially based on the new Rothes Colliery, Glenrothes already has a population of (3) close on 10,000, will ultimately reach 32,000 (including 7,000 from Glasgow), and is in process of attracting a number of new industries. While present uncertainty with regard to the future of coal-mining, particularly in the central area, may lead to some re-distribution of population, continued expansion for Fife as a whole is forecast for the foreseeable future, with the emphasis on increasing diversification of industry.

#### The Distribution of Old People in Fife

In common with Great Britain as a whole, the proportion of old people in the County is steadily rising, though less rapidly than in other areas of more stable population. In Fife, the number of persons of pensionable age (males 65 years and over, females 60 years and over) rose from 26,080 in 1931 to 37,050 in 1951; these figures, expressed as a percentage of total population, are compared in Table I with those for Great Britain as a whole and with those for the four Border Counties (Berwick, Selkirk, Roxburgh and Peebles), in which the population remained almost static throughout the period :-

Table I

	<u>Percentage of Persons of Pensionable Age</u> <u>County of Fife</u>		
	<u>County of Fife</u>	<u>Border Counties</u> (4)	<u>Great Britain</u> (5)
1931	9.5	12.4	9.5
1951	12.1	16.5	13.1

The fact that the rate of increase in Fife is less than in Great Britain as a whole is of course accounted for by the rapid increase in the working population, due to industrial development.

In Fife, the distribution of old people in the population shows wide local variations. The proportion of persons over the age of 65 for example is lowest in the industrial areas - lowest of all (7.8%) in Buckhaven and Methil - and below 10% in all the major urban areas. In the rural areas however it is much higher, particularly in the small Burghs east of Largo Bay (the "East Neuk" of Fife) where it reaches 17.8% in Crail and 20.4% in Elie and Earlsferry. The small Burghs, apart from the high proportion of old people, are also notable for the excess of females over males (155 to 100 in Elie) and, among elderly females, the high proportion of widowed and single women. In Elie, 72% of women over 60 are widowed or single as against 52% in the large Burghs (Dunfermline and Kirkcaldy). Nevertheless, although these minor concentrations of old people present local problems, their numbers are small compared with the great majority living in urban areas.

#### The Elderly Sick : Distribution ; Sex, Age Groups and Marital Status

Of the 400 elderly patients with whom this survey is concerned, 310, or 77.5%, lived in industrial or urban areas and 90, or 22.5%, in rural areas - as against 74% and 26% respectively of the general population. The classification of each patient as "urban" or "rural" was based on domicile, the urban areas being the large Burghs and the associated areas engaged in mining and industry as previously described. In a few cases "domicile" may be misleading : an old person may move from a rural area to live with younger relatives in a town, or on retirement may move from town to country ; but as a general rule the classification is valid.

The great majority of patients seen in rural Fife, including the small Burghs, had lived there for the greater part of their lives, and, conversely, those living in the mining areas belonged to families long associated with the pits.

Map II (Appendix B) shows the distribution of these 400 patients in relation to the urban areas of Fife, and, superimposed on Map I, the distribution in relation to the Burghs and other towns.

The sex distribution of the 400 patients in this survey was as follows :-

Table II

Sex Distribution of 400 Patients

	<u>Males</u>	<u>Females</u>	<u>Total</u>
Urban	126	184	310
Rural	40	50	90
	166	234	400
	41.5%	58.5%	100%
(Fife County, persons over 60 years)	(45%)	(55%)	

As might be expected, females substantially outnumbered males, the difference being rather wider in urban than in rural areas, but generally corresponding to the preponderance of females over 60 in the general population. Experience in Fife closely corresponds with that of similar series elsewhere ; Exton-Smith found that of 215 consecutive requests for the admission to hospital of old people from a London borough, 61% were females and 39% males<sup>(6)</sup>.

The age distribution of all patients in the series was as follows :-

Table III

Age Distribution of 400 Patients

	Age : <u>60-69</u>	<u>70-79</u>	<u>80-89</u>	<u>90+</u>
Males, No. of cases	33	74	57	2
Males, Percentage	20%	44.5%	34.3%	1.2%
Females, No. of cases	32	102	90	10
Females, Percentage	13.7%	43.6%	38.4%	4.3%

Again, this distribution does not differ significantly from Exton-Smith's series, but, as expressed above, masks the interesting observation that in rural areas the age distribution, particularly in respect of females, is appreciably higher. The corresponding percentages for rural patients only are shown in the next Table :-

Table IV

Age Distribution of 90 Rural Patients

	Age: <u>60-69</u>	<u>70-79</u>	<u>80-89</u>	<u>90+</u>
Rural Males	7.5%	40%	47.5%	5%
Rural Females	-	40%	50%	10%

It will be noted that there were no rural females below the age of 70 years, whereas in urban areas 32 females (17.4% of all urban females) were in the 60-69 age-group ; and in rural areas, 60% of females were over the age of 80, compared with 38% of those in urban areas. The age-distribution of rural as compared with urban males is equally significant, if less striking.

No similar survey in a rural area elsewhere is available (so far as the writer is aware) for comparison, and the reasons for this apparent maintenance of health to a later age, particularly among women, in rural life, are not clear ; some tentative pointers emerge later.

The marital status of all patients in the series is shown below ; corresponding percentages of those over 60 years in the County as a whole are also given for purposes of comparison :-

Table V

Marital Status of 400 Patients

	Married	Widowed	Single
Males : No. of patients	72	74	20
Males : Percentage	43.3%	44.7%	12%
Males over 60 in County : Percentage	66%	25%	9%
Females : No. of patients	63	131	40
Females : Percentage	27%	56%	17%
Females over 60 in County : Percentage	42%	40%	18%

It will be noted that the proportion of married patients, of both sexes, is much lower than that of married elderly persons in the general population, while the proportion of widowed patients is much higher; on the other hand, the proportion of single patients differs little from that in the general elderly population. Exton-Smith noted the same trends, both in males and females. In rural areas, the distribution of male patients by marital status is similar to that for the series as a whole, but female patients show a lower percentage of married women (10%) and a correspondingly higher percentage of widows (62%) and single women (28%). Separate figures for those over 60 in all rural areas of the County are not available for comparison, but these percentages obviously reflect the high proportion of widowed and single women living in rural life, particularly in the small Burghs, as already noted.

In brief, the analysis thus far demonstrates that among the elderly sick females outnumber males; that those in rural areas apparently maintain health to a later age than those in urban areas; and that in terms of illness or disability requiring outside aid, the widowed far outnumber, both relatively and absolutely, either the married or the single.

It is now proposed to consider, in the Chapters which follow, the results of the clinical examination of these 400 elderly patients.

References

1. Smith, A. : The County of Fife (Third Statistical Account of Scotland). Edinburgh and London, 1952, p. 50.
2. Census, 1951 : County of Fife (from which all population statistics in this Chapter have been extracted, except as otherwise stated).
3. "Glasgow Herald", January 21, 1959 ; Supplement, p. vii.
4. Census, 1951 : Counties of Berwick, Peebles, Roxburgh and Selkirk.
5. Report of Committee on Economic and Financial Problems of Provision for Old Age (Phillips Committee) ; H.M.S.O. London, 1954. Table IV, p. 16.
6. Exton-Smith, A.N. : "An Investigation of the Aged Sick in their Homes". Brit. med. J., 1952, 2, 182.

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## CHAPTER II

THE CAUSES OF ILLNESS AND DISABILITY IN THE ELDERLY - IIntroduction

In the aged, no less than in other age groups, accurate diagnosis and clinical assessment depend on careful history-taking and detailed physical examination of the patient : a principle which was practised in respect of the 400 patients under review, as far as circumstances permitted. Circumstances naturally varied widely (as a comparison between Case 3 and Case 4, Appendix A, will show) but in general, home conditions allowed of a reasonably satisfactory clinical examination of the patient ; his medical history was a compound of information obtained from the patient, his family doctor, relatives and neighbours. The findings were then recorded in detail, together with the diagnosis arrived at in each case.

In recording diagnoses however, and still more in classifying them in such a way as to give an intelligible picture of the relative incidence and importance of the numerous conditions met with in the aged, two particular difficulties have to be resolved. In the first place, it is now well recognised that the illness or disability of the aged patient can rarely be compassed by a single diagnostic label ; this difficulty has perhaps been best expressed by Thomson and his colleagues in Birmingham :-

We were confronted with so many individuals who showed evidence of numerous distinct and serious pathological processes in one body at one time that we found it impossible to classify them even by "systems". This was true in at least half the cases, and in the remainder a single diagnosis was often not more than approximately accurate. (1)

The writer's experience in no way differs from that of Thomson and in the great majority of cases "multiple diagnoses" were necessarily made. Unfortunately however, if enthusiasm for completeness is carried to extremes, the end result is a catalogue of diseases and abnormalities which gives no

clue as to their relative importance and has no meaning in terms of prognosis or treatment. Therefore it has been the writer's practice to limit diagnosis to those conditions which have practical significance : that is, conditions which materially contribute to the patient's illness or disability; which affect the prognosis ; or which would require to be taken into account in drawing up any therapeutic programme. Even so, the list of significant or material conditions found in these 400 patients is considerable, totalling 827 ; this may be compared with Trevor Howell's series, in which 850 "medical reasons for admission to hospital" were found in 507 patients. (2)

Apart from the foregoing limitation, an attempt was made, in reviewing the whole series, to designate in each case one condition as the principle or leading cause of the patient's breakdown or disability. It was found that in the great majority (94% of all cases) one condition could fairly be so designated. This further definition is of considerable assistance, not only in providing a more intelligible orientation in the individual case, but also in determining the relative importance of each condition as a primary cause of ill-health in the group under review.

The second difficulty which confronts the investigator of disease in the aged is that of classification, particularly in connection with degenerative disease of the cardiovascular and nervous systems. No classification can be entirely logical ; the aim of the writer has been to avoid as far as possible all terms which, however accurate from the point of view of aetiology or pathology, convey no clear clinical picture and are of no practical value from the point of view of function, prognosis or treatment. Terms such as "hypertension", "hypertensive heart disease", and "arteriosclerosis" (whether further qualified or not) all describe conditions not incompatible with normal activity in old age, and are in fact frequently unrecognised until they result in a cerebro-vascular accident, congestive heart failure, or mental confusion. It is with these latter that the physician is confronted and which determine the fate of the patient.

Classification has therefore been based on these common manifestations of cardiovascular disease rather than on the underlying and often obscure pathological process.

On this basis, then, all conditions diagnosed, leading and contributory, were grouped and classified, and are presented in a comprehensive list (Table VI, pp. 13 and 14). For convenience of presentation, the list is in two parts: Table VIA, which contains all those conditions which occurred both as leading and as contributory causes of disability; and Table VIB, which contains all other conditions diagnosed, none of which however occurred, or could clearly be designated, as the leading condition.

It may be noted, before proceeding to further discussion, that a distinction has been made between "mental deterioration" and "psychiatric conditions" - again from practical considerations. The former term has been applied to all cases in which the patient's condition could fairly be ascribed to involutional or degenerative changes associated with ageing, and which do not normally require that the patient should, or ought, to be admitted to a mental hospital. The latter has been reserved for those cases with a previous history of mental illness distinct from the deterioration of old age, together with a small number of cases showing dementia so advanced as to require reference to a psychiatrist, usually with a view to direct admission to a mental hospital.

Finally, "incontinence", which was recorded in all cases in which it was present, is included in the diagnostic list because, although only a symptom, it is so often by itself of over-riding importance in determining the future care and management of the patient. It is further referred to later in this Chapter and again in Chapter VII.

In the paragraphs which follow, the major causes of illness and disability, as set forth in Table VI, are considered in further detail, together with some points of special interest which emerged from the records of these 400 patients.

TABLE VIA.CLASSIFIED LIST OF CONDITIONS DIAGNOSED IN 400 PATIENTS

DIAGNOSIS	MALES			FEMALES			TOTAL ALL CASES
	Leading Condition	Contributory Condition	Total Males	Leading Condition	Contributory Condition	Total Females	
Cerebro-vascular accidents and effects	48	10	58	58	8	66	124
Congestive Heart Failure	14	17	31	29	22	51	82
Other Cardiovascular disease	-	4	4	4	4	8	12
Mental Deterioration	33	23	56	64	23	87	143
Chronic Bronchitis	12	3	15	3	1	4	19
Other Respiratory Conditions	7	9	16	4	10	14	30
Parkinsonism	7	-	7	7	-	7	14
Other C.N.S. Disease	2	-	2	1	1	2	4
Psychiatric Conditions	3	1	4	9	7	16	20
Rheumatoid Arthritis	4	1	5	6	1	7	12
Osteoarthritis	5	5	10	14	26	40	50
Other Bone and Joint Conditions	3	1	4	-	5	5	9
Accidents, Effects of	4	7	11	5	10	15	26
Malignant Neoplasms	5	-	5	9	2	11	16
Anaemia	2	3	5	5	10	15	20
Gastro-intestinal and Metabolic Conditions	3	7	10	7	11	18	28
	152	91	243	225	141	366	609

TABLE VII.ADDITIONAL LIST OF MISCELLANEOUS CONTRIBUTORY CONDITIONS

	MALES	FEMALES	TOTAL ALL CASES
Incontinence	42	57	99
Neglect	5	3	8
Blindness	5	8	13
Deafness	11	11	22
Blindness & Deafness	2	1	3
Skin Conditions (Ulcers, Bed-sores, drug eruptions, etc.)	4	7	11
Acute Urinary Infections	-	4	4
Prostatism (incl. suprapubic cystostomy)	10	-	10
"Gross Obesity"	-	11	11
"Weakness"	3	11	14
Myxoedema	-	2	2
Alcoholism	3	1	4
Chronic renal disease	-	3	3
Conditions due to trauma	4	2	6
Contractures of legs	-	4	4
Undiagnosed conditions	1	3	4
	90	128	218

SUMMARY

Total Diagnoses, leading and contributory : 827

One leading condition diagnosed in 152 males  
225 females

= 377 cases

= 94% of all cases

Cerebro-vascular accidents, Mental Deterioration and  
Congestive Heart Failure (Table VIA)

Of all conditions responsible for disability in these 400 old people, pre-eminent were cerebro-vascular accidents, mental deterioration and congestive heart failure, in that order. The condition most commonly diagnosed was mental deterioration (143 cases), but a "stroke" was the most common leading condition, occurring in this situation 106 times, or in 26.5% of all cases ; mental deterioration was the leading condition in 97 cases (24%) and congestive heart failure in 43 cases (11%).

It is difficult to extract strictly comparable information from other series elsewhere. Of published series referring to patients awaiting admission to hospital, only Howell records the incidence of the most frequent diagnoses (expressed as percentages of his total diagnoses). His findings correspond with those of the present survey in so far as the three conditions most commonly found were cerebral thrombosis, "senility" and congestive heart failure, in that order<sup>(2)</sup>. Thomson and his colleagues<sup>(1)</sup>, who investigated patients already in hospital, record similar findings. Ferguson<sup>(3)</sup>, who enquired into the medical and social conditions of 300 old people who were being attended regularly by District Nurses in Glasgow, found diabetes to be the commonest single condition among women, closely followed by "senility" but with cerebral thrombosis comparatively common in both sexes. Other investigations dealing with the elderly sick or disabled (e.g. Thomson and Curran<sup>(4)</sup> in Glasgow, Chalke and Benjamin<sup>(5)</sup> in London) stress the importance of degenerative cardio-vascular disease. In general terms, the findings in the present survey differ only in degree from what is already well-known : that cardiovascular disease and mental deterioration are the commonest causes of disability in old age. What is so striking in these 400 patients is the very high incidence of these conditions.

One or other of these three conditions was the major cause of disability in 246 cases, or 61.5% of the whole series ; and one or other of them appeared as a "contributory" condition in a further 103 cases.

How far these conditions dwarf all others as causes of incapacity in old age is emphasised by the fact that, of these 400 patients, in only 37 males and 52 females, or 22% of each sex, did the final diagnosis not include one or more of them.

In Fife, the incidence of cerebro-vascular accidents and of mental deterioration showed some interesting variations in distribution :-

Table VII

Incidence of Cerebro-vascular Accidents and  
Mental Deterioration

	<u>Males</u>		<u>Females</u>	
	<u>Rural</u>	<u>Urban</u>	<u>Rural</u>	<u>Urban</u>
<u>Cerebro-vascular Accidents</u>				
No. of cases	13	45	9	57
Percentage of group	32%	35%	18%	31%
<u>Mental Deterioration</u>				
No. of cases	16	40	20	67
Percentage of group	40%	32%	40%	36%

It will be noted that the incidence of cerebro-vascular accidents is much lower among females in rural areas as opposed to urban areas, a finding which does not apply to males.

A further, and perhaps allied observation, not apparent from Table VII, is that although mental deterioration shows a high incidence in all groups, only four (or one-fifth) of the 20 rural females with this condition were under 80 years of age, whereas no less than thirty-nine (or more than half) of the 67 urban females were under this age. It would seem therefore, from the evidence adduced in this series, that women in rural areas are less susceptible to cerebro-vascular accidents than those in urban areas and that they maintain independence to a later age,

at which stage degenerative disease is more likely to manifest itself as mental deterioration.

Based on such small numbers, these findings cannot be regarded as other than tentative, but they point at least to one direction in which further enquiry might usefully be made ; for, if true, they have some practical bearing on the planning and distribution of hospital and local authority accommodation for the elderly sick and mentally confused in rural as opposed to urban areas.

The third most common condition, congestive heart failure, was clinically demonstrable in 82 cases, and was the leading condition in approximately half of these. It showed little variation in distribution, being lowest in urban males (19%) and highest in urban females (25%). It occurred in conjunction with a variety of conditions, most of them associated, directly or indirectly, with cardiovascular disease : cerebro-vascular accidents or mental deterioration (28); known or suspected myocardial infarction (8); obesity and diabetes (9); anaemia (5); chronic respiratory disease (3, all males); chronic renal disease (2); Paget's disease (1); but in all other cases the condition could only be ascribed to hypertensive, arteriosclerotic or ischaemic heart disease.

It has been the writer's experience, abundantly confirmed in this series of cases, that congestive heart failure is the condition by far most commonly overlooked in the elderly patient, and that the restlessness and mental confusion, particularly at night, which so often accompanies heart failure in old people, is too frequently ascribed to "senile deterioration". In this series, heart failure had not previously been mentioned in any form in 55% of the cases in which it was found; yet it was never diagnosed at the domiciliary examination unless the two cardinal signs, peripheral oedema and moist sounds at the lung bases, were clearly demonstrable.



### Other Cardiovascular Conditions

The small group classified as "Other Cardiovascular Conditions" is a miscellaneous one, consisting of four cases in which a presumptive diagnosis of coronary artery thrombosis was made ; three seen during or immediately after an attack of acute left ventricular failure; one with severe peripheral vascular insufficiency and gangrene; and three with valvular heart disease - one with aortic stenosis, one with mitral stenosis and one with both mitral and aortic lesions.

These last two provide a reminder that rheumatic heart disease is not incompatible with long life, under certain conditions. The first, a woman aged 69 when seen, had a well-authenticated history of rheumatic fever in youth; at about the same age she had developed a severe limp due to hip-joint disease (thought to be Perthe's disease) which had limited her activities throughout adult life; but she had enjoyed good health until two cerebro-vascular accidents, probably embolic in origin, finally crippled her in her 70th year. The second, a woman aged 74, also had a well-authenticated rheumatic history, and her valvular lesions had long been known to her family doctor. While still a young woman however she had contracted encephalitis lethargica, followed by the development of typical Parkinsonian features which considerably reduced her mobility. She was referred to the hospital physician at age 74 on account of increasing rigidity with mental deterioration and incontinence, and not on account of the cardiac lesions. In both of these cases a coincidental condition had, by reducing the patient's mobility over a long period of years, presumably protected a damaged heart.

Cardiac arrhythmias were very common, auricular fibrillation being present in 28 cases (7%) of all patients at the time of examination. In ten of these it was found in conjunction with a cerebro-vascular accident, and in a further ten with congestive heart failure or other heart disease; in the remainder it had no apparent cardiovascular associations.

Although "hypertension" was excluded as a diagnosis, for reasons already stated at the beginning of this Chapter, blood-pressure was always recorded where circumstances permitted of a reasonably accurate reading : that is, where the patient was in bed, at rest, and not unco-operative. It was recorded in 249 cases (109 males, 140 females).

If the criteria accepted by Master<sup>(6)</sup> are to be followed, then 92 of these patients (37%) were "hypertensive"; that is, they had a resting diastolic blood-pressure of 110 mm.Hg. or higher. This percentage, as might be expected in a series consisting so largely of individuals suffering from cardiovascular disease, is much higher than that of Anderson's and Cowan's series (16%), in which the patients were unselected, ambulant old people<sup>(7)</sup>. The following table shows the incidence of cerebro-vascular accidents in relation to diastolic blood pressure in these 249 cases :

Table VIII

Diastolic Blood Pressure and Cerebro-vascular Accidents (C.V.A.)

	110 mm.Hg. and over			Under 110 mm.Hg.		
	<u>Males</u>	<u>Females</u>	<u>Total</u>	<u>Males</u>	<u>Females</u>	<u>Total</u>
Total cases	35	57	92	74	83	157
No. with C.V.A.	18	28	46	14	20	34
% with C.V.A.	50.5%	49.5%	50%	19%	24%	21.6%

The correlation between diastolic blood-pressure and "strokes" is very striking, and appears to apply equally to both sexes. A similar correlation was noted between obesity and cerebro-vascular accidents.

Ninety patients (22 males and 68 females) were described as "obese", "overweight", or in some similar term, and of these 36, or 40%, had sustained one or more strokes at the time of examination. At the other end of the scale, one hundred and fifteen patients (48 males and 67 females) were described as "thin" (excluding emaciation associated with wasting disease) and of these only 22, or 19%, showed evidence of a cerebro-vascular accident.

It is relevant, in concluding this review of cardio-vascular and allied conditions in these 400 patients, to refer to incontinence (Table VIB). This symptom was present in 99 cases, or almost 25% of all patients; it was frequently the main reason for referring the patient to the hospital service; it was common in all groups, male and female, urban and rural - lowest in rural males (20%) and highest in urban females (29.3%); it was rarely encountered in the absence of mental deterioration or a stroke; in five cases it was associated with congestive heart failure, and occasionally, and incidentally, in association with an acute infection.

So far as valid comparisons can be drawn, the incidence of incontinence in this series appears to be higher than that found by others who have investigated similar groups. Greenwood<sup>(8)</sup> reported incontinence in 18% of 677 patients requesting admission to hospital in Manchester; 68, or 13%, of 509 patients were "admitted on account of incontinence" in Howell's series<sup>(2)</sup>; and Ferguson<sup>(3)</sup> noted that 17% of 300 old people receiving regular visits from District Nurses in Glasgow were incontinent. The high incidence in this series parallels the high incidence of strokes and mental deterioration already noted in this Chapter; its importance however lies in the severe strain which it imposes on the nursing resources of those who are caring for the patient at home, and it is further discussed in this context in a later Chapter.

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## CHAPTER III.

THE CAUSES OF ILLNESS AND DISABILITY IN THE ELDERLY - II.

It is proposed in this Chapter to discuss briefly the remaining conditions, or groups of conditions, as set forth in Table VI. Against the overwhelming preponderance of cardiovascular conditions and mental deterioration however, most of these are relatively unimportant.

Respiratory diseases constitute a small group in this series.

"Chronic bronchitis" as a leading condition was found in only 15 patients - less than 4% of all cases. It was not found at all in rural females, and in only three rural males, in none of whom could it be regarded as typical: one, a retired accountant, aged 75, had spent most of his working life in the English midlands; one was a retired stonemason, 81 years of age, in whose case silicosis might have been a more accurate diagnosis (but could not be proved); the third, a retired ploughman, had reached the age of 84 before being invalided with chronic cor pulmonale. The remaining twelve cases occurred in urban areas, mainly in ex-miners.

The thirty cases classified as "Other Respiratory Conditions" were mainly acute respiratory infections, occurring either as the leading condition (11 cases) or as a complication of a stroke or some other cause of immobilisation in bed. Three cases were suspected of being tuberculous but only one was so confirmed on admission to hospital.

As a leading condition, respiratory disease, chronic and acute, occurred in 26 cases, or 6.5% of all cases; and chronic respiratory disease, as a major cause of disability, is certainly uncommon in Fife, relative to cardiovascular disease, among the older age groups.

Apart from mental deterioration, diseases of the central nervous system form another very small group. Parkinsonism however provided a distinctive, if small, sub-group, since in the fourteen cases in which it was diagnosed it was the leading cause of disability. The diagnosis was confined to cases of classical Parkinsonism, of which mental deterioration is not a feature; all cases showing certain Parkinsonian features, e.g. rigidity, in association with evidence of mental deterioration, were excluded. This distinction is worth making, since classical Parkinsonism may respond well to active treatment and carries a much better prognosis than those cases in which the Parkinsonian signs are part of a more widespread degenerative process.

"Psychiatric conditions" included anxiety states, neuroses and three cases of long-standing mental illness not properly the province of the geriatric physician; seven patients, all females, were grossly demented and were referred to a psychiatrist with a view to certification and admission to a mental hospital.

Arthritic conditions formed a much larger group. Rheumatoid arthritis was found to be a significant cause of incapacity in only twelve patients. In ten of these, however, it was the leading condition and carried an importance out of proportion to its frequency, since in these cases the disease was far advanced, and home circumstances were such that the stage had been reached where long-term hospital care offered the only solution to the patients' difficulties.

Osteoarthritis was much more commonly diagnosed, being a significant cause of disability in 50 cases, or 12.5% of all cases. Only one case was seen in rural males, and 8 (6.3%) in urban males; in urban and rural females the incidence was much higher - 17.4% and 14% respectively. It was commonly associated with obesity.

A variety of other "bone and joint" conditions were found, some of very long standing, such as ankylosing spondylitis in a man aged 63, in whom the disease could be traced back for over 30 years; osteomalacia in a woman aged 71, with associated fractures of femoral neck and of clavicle, and with typical "trifoliate" appearance of the pelvis as seen radiologically; and more recent causes of disability such as so-called sub-acute infectious polyarthritis.

"Accidents" formed another small group, important on account of serious injuries or complications not suspected at the time. Of the nine cases in which the effects of an accident constituted the leading condition, five had sustained a fracture of the femoral neck, two had suffered burns which had become grossly infected and resulted in the patients becoming bedridden, and one was thought to have had a stroke followed by a fall, whereas the patient had fallen and fractured his skull, with resulting hemiparesis and amnesia. (He subsequently made a complete recovery).

Fracture of the femur may escape diagnosis in old age owing to the absence of typical or expected symptoms :-

Mrs. K., age 90 : "Took to her bed" because she had lost confidence following a fall; could not walk; no pain. On examination (ten days after the injury) : fracture of left femoral neck, with shortening of the affected limb.

This old lady was admitted to an orthopaedic unit next day, but no operative treatment was undertaken owing to her extreme age and the complete disorganization of the hip joint. She was therefore transferred a few days later to a geriatric ward, where, because she felt no pain, it was possible to mobilise her in spite of the fracture. She ultimately walked out of hospital unaided. If the absence of pain masks diagnosis, it has its advantages during the process of rehabilitation!

"Malignant neoplasms" need little comment; the majority of cases were advanced and required hospital care in the terminal stages; five however were seen on account of some other condition, but were suspected of having malignant disease which was subsequently confirmed in hospital.

Anaemia is a finding which, in the elderly, no less than in the younger patient, demands search for an adequate explanation. In the present series, 20 patients (5%) were found at the time of examination to have a haemoglobin under 75% (excluding cases where there was an obvious cause, for example, malignant disease); in only two of these could it fairly be ascribed to malnutrition, and further investigation in hospital was mandatory. Where the cause is sought, the results may be very rewarding :-

Mrs. R., age 82 : Widow, living alone; active until 5 weeks previously when she "fainted" ; had since been confined to bed. History of swelling of feet and breathlessness for some time.

On examination : Gross congestive heart failure.

Haemoglobin : 65%.

This patient was admitted as an emergency to a general medical unit, where she was found to have pernicious anaemia. The response to treatment was excellent, and she was discharged well.

The twenty-eight cases classified under "gastro-intestinal and metabolic conditions" included 11 known diabetics, only five of whom however (4 males and 1 female) required regular insulin; the remainder included a variety of conditions, including reactivation of a gastric or duodenal ulcer, exacerbation of chronic gall-bladder /



disease, and one case of recurring haematemesis, subsequently proved to be due to hiatus hernia with associated ulceration. One case, a man aged 69, with a recent history of vomiting following an acute attack of substernal pain, was thought to have sustained myocardial infarction; subsequent investigation in hospital proved that he was suffering from suprarenal failure, probably thrombotic in origin. His recovery on cortisone therapy was dramatic and sustained and he was enjoying good health when seen three months after discharge.

Of the contributory conditions listed in Table VIB (p. 14) incontinence has already been mentioned. "Neglect", as a factor by itself contributing to disability or illness, could be so described in only eight cases; six of these patients lived alone, three in an advanced state of mental deterioration; one old lady lived with a useless and idle son, and one old man with an equally useless wife. A much greater number of patients lived in homes which were "neglected", but this is a social, not a clinical, definition and is discussed in the appropriate Chapter.

Defects of vision and hearing are important causes of disability in old age, and were common contributory conditions in this series. Of the twenty-two patients suffering from a significant degree of deafness, only three were found to be making intelligent use of a hearing-aid.

Little need be said of the remaining miscellaneous conditions in Table VIB, except perhaps in a negative sense. To include deformities of the feet, hernia, hydrocele, superficial bed sores, and urine rashes would have so swollen the list as to render it meaningless, and in any case,

these conditions, common as they were, were rarely of significance beside the major disabilities on account of which the patients were referred to the hospital physician. Eleven cases of "gross obesity" (all females) were included, as in these the accumulation of body fat was of itself a significant cause of disability, even of immobility ; osteoarthritis of knees or hips co-existed in all of these patients. "Weakness" was a diagnosis made in a few patients, usually of extreme age, in default of any more definite clinical description.

Finally, having completed the analysis of the major causes of illness and disability in these 400 patients, to which the last two Chapters have been devoted, it is appropriate at this point to comment on the general picture in terms of incapacity and need. Only two comments need be made.

In the first place, one of the most depressing aspects of the examination of these elderly patients was the high proportion who were suffering from long-standing and irreversible invalidism. This applied chiefly to those who had sustained - often many years previously - a cerebro-vascular accident ; many had never been treated ; others, having been treated initially in hospital, had been sent home only to revert to a state of helplessness because no system of after-care existed and relatives knew not what to do.

Secondly, the clinical survey not only confirms the great variety of pathological conditions found in old age - covering in fact all the major disciplines of medicine, - and several of them often existing, as Thomson noted, "in one body at one time", but it also confirms the necessity for careful and detailed examination of the patient, in order that conditions amenable to treatment may not escape diagnosis.

For the presence of one condition of long standing often obscures the development, and may even be held to explain the symptoms, of a new condition. Heart failure, as already noted, was commonly overlooked because the mental confusion with which it presented was not thought remarkable in a patient long regarded as "senile", or because oedema was not observed in the old lady whose arthritic knees had long been swollen and deformed; and what was true of heart failure was also true, in lesser degree, of anaemia, of respiratory and urinary infections, and even of fractures of the femur.

The implications of these remarks are considered in the final Chapter of this thesis.

## CHAPTER IV

HOUSES AND HOMES

The overcrowding census of 1935 revealed that in the central Fife coalfield area overcrowding was twice the national average ; only three Burghs in Scotland had at that time a higher proportion of overcrowding than Cowdenbeath, and by the end of the Second World War the situation was even worse. However, the gloom of this picture has already been largely, if not wholly, dispelled.

Soon after the War, a vigorous re-housing programme was embarked on by the County and Burgh Councils in Fife, and has been carried through in two stages ; the first phase, completed about 1954, was the provision of houses for the homeless ; the second phase, not yet complete, but already far advanced, was the replacement of the old by the new. The aged, no less than other sections of the community, are now enjoying the benefits of this programme ; and of the 400 old people in this survey - all of whom were visited in late 1957 or in 1958 - the great majority were found to be well housed.

As will be seen from Table IX (p.30), 66% of those in urban areas and 50% of those in rural areas were living in a modern Council house or its equivalent, or better, and a further 19% and 31% respectively in old property which had been modernised, by which is meant that essentials such as inside toilet, water supply and, almost always, electric light were available, but not necessarily a fixed bath. The remainder lived in old property which, though not modernised, was not always lacking in indoor sanitation or good lighting.

Table IXHousing Conditions of 400 Elderly Patients

	URBAN					RURAL			
	MCH	MH	OPM	OP	LH	MCH	MH	OPM	OP
Males	65	17	24	15	5	6	14	15	5
Females	95	29	35	24	1	9	16	13	12
Total	160	46	59	39	6	15	30	28	17
	51%	15%	19%	13%	2%	17%	33%	31%	19%
	(66%)					(50%)			

MCH : Modern Council House or equivalent (e.g. S.S.H.A.)

MH : Modern house, all conveniences.

OPM : Old property, modernised.

OP : Old property.

LH : Lodging house.

As might be expected, a much higher proportion of those in urban areas lived in Council and similar type houses than did those in rural areas (51% as against 17%); on the other hand, a higher proportion of those in rural areas lived in modern stone-built houses, bungalows or cottages, or in old property which had been modernised. In brief, it can safely be stated that in both rural and urban areas over 80% of the old people in this survey enjoyed reasonably satisfactory housing conditions; and of the remainder, only a few lived in property which lacked most of the essential amenities - and much of this property had already been condemned and was due for replacement in the near future.

Six patients lived in "lodging houses", a term which in Fife does not always carry the same connotation as in larger industrial areas. Three of these old people were living in modern lodging-house accommodation provided by Kirkcaldy Corporation, in which each resident has a bed-sittingroom, toilet, and kitchenette ; two had the assistance of a home help, also provided by the Burgh.

It is difficult, and in fact serves little purpose at a time when housing conditions are rapidly improving in all parts of the country, to compare the present housing conditions of old people in Fife with those described in previous surveys elsewhere. The difficulties of living on the upper floors of old multi-storey tenements, such as Exton-Smith describes in St. Pancras<sup>(1)</sup> or Ferguson in Glasgow<sup>(2)</sup>, are rarely experienced in Fife ; nor would it be possible to find in Fife today any tenement area where conditions are so adverse as those selected for study by Mair, Weir and Wilson in Dundee<sup>(3)</sup>.

Thirty-six patients in this series (9%) however were found to be occupying houses which had no inside toilet, the proportion in rural areas being twice as high (14%) as it was in urban areas (7%). Lack of indoor toilet facilities may have little to do with the development of illness, but it can be a major inconvenience to the partially disabled ; thus Mrs. H., aged 77, who lived in a small East Fife rural village, and suffered from osteoarthritis of the spine (and was visited on a cold January day ) :-

Lives alone ; small single-storey cottage ; spotlessly clean ; toilet in garden at back of house, and cannot be reached in bad weather. At present using a chamber-pot indoors - but this too is difficult owing to her arthritis.

On this subject however it must be remarked that a toilet outside the back door may be no greater disadvantage than a ground-floor bathroom and toilet if all the bedrooms are upstairs. This arrangement may not be

inconvenient when all members of the household are active, but if illness occurs, and particularly if the invalid is old and helpless, the difficulties of nursing can rapidly become overwhelming :-

Mr. McQ., age 72 : Slow mental deterioration for some time but able to get about and to manage stairs until 10 days ago when he developed diarrhoea and has since been confined to bed. Lives with married niece; modern Council house; toilet downstairs; patient's bedroom upstairs; cannot manage to toilet now.

No home help; district nurse attending.

In such a case it is not only the impossibility of getting the patient to the toilet; it is the constant carrying of water and utensils upstairs and down again every time the patient is washed or given a bed-pan, which more than anything else wears down the nurse.

The alternative is to nurse the patient in the living-room downstairs, which raises its own problems :-

Mrs. F., age 74 : "Stroke" 3 years ago; left hemiplegia; aphasia; incontinent unless frequently attended to; can manage to toilet with considerable help.

Has lived for past 4 months with daughter, son-in-law and their two children, aged 18 and 8; modern Council house; bath and toilet on ground floor; bedrooms upstairs - so old lady sleeps in living-room, with daughter beside her to attend her at night.

Daughter now tense and emotional; feels her family life is being broken up; children cannot bring in their friends because the old lady occupies the living-room ...

It will be noted that in both of these cases, the home was a "modern Council house". It is not known how many houses of this type, with toilet and bedrooms on different floors, have been built altogether in Fife in recent years, but of some 12,000 houses built by the County Council in the landward areas (i.e. excluding the Burghs), one-third have been of the 4-apartment cottage type which includes this arrangement. Having up to three bedrooms, it enables a married couple with no more than one child to accommodate an active elderly parent in comfort; but the bathroom and toilet arrangements are a potent source of breakdown in family care, if the aged relative becomes disabled or bedridden.

Although housing conditions were on the whole good, overcrowding was found in a few homes. The writer did not possess any technical yardstick of measurement, but in 14 homes (3.5%) gross or obvious overcrowding was noted. In thirteen of these, the elderly patient was living with younger relatives, and of these families, no less than ten were occupying a modern Council house, or its equivalent; one occupied a modern cottage-bungalow, and only three lived in old, unsatisfactory property.

In a much larger number of cases however the presence of the elderly patient entailed, if not actual overcrowding, at least some disruption of normal family life: the patient occupied the living-room either because (as noted above) the toilet was downstairs, or because no bedroom was available; alternatively, and more frequently, the patient was given a bedroom at the expense of younger members of the family, who had therefore to sleep in the living-room. These are discomforts unavoidable and commonly accepted in modern homes, but they add, especially if illness is prolonged, to the tension which arises in so many families caring for disabled old people.

Forty-seven patients (almost 12%) were found to be living in homes described as "neglected" or "dirty", or in some similar term. This has no reference to the type of house; it reflects the type of



family who occupied it, or the patient's incapacity to maintain it. Twenty-four of these patients were living alone; these form a separate and important group, and are further considered in a later Chapter. Suffice it to say here that the condition referred to by Amulree "which can be called 'primitive', 'filthy' or 'squalid', but is equally recognisable under any of these names", and which he found in 50% of 137 old people living alone<sup>(4)</sup>, was seldom seen in Fife; the term "squalid" could be applied only to some half-dozen homes, four of them occupied by old people living alone, and in an advanced state of mental deterioration. The remaining 23 patients were living in six cases with the spouse only, or in lodgings (two cases), or with other relatives - nine of them in a modern Council house with families who would have been dirty in any circumstances.

A home described as "neglected" however does not necessarily imply a patient "suffering from neglect" - of whom only eight were so described in the preceding Chapter. The old people referred to above who were living with relatives in dirty or neglected homes were in general well cared for - as well as the family knew how - and were often, and obviously, regarded with affection. It was in fact in these homes that most of the few cases of overcrowding were seen, and in which the families faced the greatest difficulties.

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## CHAPTER V

RELATIONSHIPS - I.Introductory

Having described the homes in which these 400 old people lived, it is now proposed to discuss what are by far the most important considerations with reference to the problems of the aged sick : their relationships with their families and their neighbours ; how far additional help was required in their disability or illness ; and by whom, and to what extent, that help was provided.

Table X. groups the 400 patients in this series according to their domestic relationships: -

Table X.Domestic Relationships of 400 Elderly Patients

	URBAN				RURAL				Total all Cases	% all Cases
	M.	F.	Total	%	M.	F.	Total	%		
Living alone	19	45	64	21%	9	23	32	36%	96	24%
Living with spouse only	32	36	68	22%	10	6	16	18%	84	21%
Living with relatives, same generation	10	12	22	7%	2	1	3	3%	25	6.25%
Living with younger relatives	58	87	145	47%	18	17	35	39%	180	45.0%
Living with others	7	4	11	3%	1	3	4	4%	15	3.75%
	<u>126</u>	<u>184</u>	<u>310</u>	<u>100%</u>	<u>40</u>	<u>50</u>	<u>90</u>	<u>100%</u>	<u>400</u>	<u>100%</u>

It will be noted that the proportion of patients who lived alone is much higher in rural than in urban areas - highest of all in rural females (23 out of 50 cases, or 46%) ; conversely a higher proportion of patients in urban areas lived with relatives. These variations reflect the high proportion of single and widowed women living in the small rural Burghs of East Fife, as previously noted in Chapter I.

The proportion of patients living alone (less than 1 in 4 over the whole series) is however surprisingly low in a series so highly selective - in that it consists entirely of ill or disabled old people. In Exton-Smith's<sup>(1)</sup> and in Amulree's<sup>(2)</sup> similarly selective series in London Boroughs, the proportions were respectively 45% and 38% ; even in a series not so selected, Curran and his colleagues<sup>(3)</sup> found 28% of 1001 old people living alone in Glasgow in 1946 ; while Mair and his colleagues<sup>(4)</sup> found no less than 47% living alone in a Dundee tenement area.

Townsend has calculated that in 1951, in Great Britain as a whole, about 12½% of all persons over the age of 60 were living alone ; that 58% lived with people other than husband or wife, and at least 40% of them with children<sup>(5)</sup>. It is apparent however that wide local variations occur, and that this factor rather than "selectivity", determines the proportions living alone or with relatives in any given series. Unfortunately, it is not possible to extract comparable statistics for the population over the age of 60 in any particular area from the 1951 Census data.

The groups referred to in Table X. are now considered in further detail in this and the two succeeding Chapters.

### Those Living Alone

That the term "living alone" requires considerable qualification has already been noted by Sheldon<sup>(6)</sup>, Townsend<sup>(7)</sup> and other writers. Many old people who live alone, in the sense that no-one else sleeps under the same roof, are nevertheless in close contact with nearby relatives, or are helped by neighbours or friends; and this applied to the majority of the ninety-six patients found, in this survey, to be "living alone". The sources of help available to them have been classified as follows :-

Table XI.

#### Sources of Help available to those Living Alone

Source of help :-	URBAN			RURAL		
	M.	F.	Total	M.	F.	Total
Relatives only	11	13	24 <sup>x</sup>	2	10	12 <sup>x</sup>
Neighbours only	2	17	19 <sup>x</sup>	5	9	14 <sup>x</sup>
Relatives and neighbours	1	6	7 <sup>x</sup>	-	1	1 <sup>x</sup>
Home Help only	3	3	6	1	1	2
Home Help and District Nurse only	1	2	3	-	-	-
No help at all	1	4	5	1	2	3
<b>Totals</b>	<b>19</b>	<b>45</b>	<b>64</b>	<b>9</b>	<b>23</b>	<b>32</b>

<sup>x</sup> Approximately half of the patients in these groups also had the assistance of a Home Help, or District Nurse, or both.

It will be seen that of these 96 patients, over one-third were being assisted by relatives, and a further one-third by neighbours, while only one in twelve had no help of any kind (2% of the whole series).

At this point, however, statistics break down. It is not possible to convey, in statistical form, the amount of help given nor, what is more important, its quality; whether it was given willingly, or of necessity and grudgingly; nor whether the help available bore any relation to the needs of the patient. Consider for example the difference in quality of help given by "relatives only" in the two following cases, which in other respects are very similar :-

Mr. R., age 71 : Chronic bronchitis; reduced more or less to bed by recent exacerbation. Lives alone in upstairs room of old row of cottages; toilet downstairs, which he cannot reach at present; uses pail in his room. Says he is "looked after" by married niece who lives nearby in same row; but room dirty, patient obviously neglected and miserable ...

Mr. K., age 75 : Chronic bronchitis; has worked little for past 30 years; completely bedridden for past month. Lives alone in ground-floor flat, 2 rooms. House clean, patient well cared for. Has son and daughter-in-law nearby. Son sleeps in patient's house at present and daughter-in-law calls twice daily ....

Or consider the help given by a kindly neighbour, which may exceed that of the most attentive relatives :-

Miss M., age 74 : Old carcinoma of breast; now has abdominal metastases; thin, weak and completely bedridden. No relatives; lives alone in old cottage; her next-door neighbour, Mrs. M., does everything for her; house and patient spotlessly clean - but nursing problem now getting beyond her neighbour's capacity ....

It would be erroneous to assume that the eight patients shown in Table XI as having "no help at all" were necessarily the most neglected. Four of them were independent old folk who had managed very well alone until struck down by sudden and severe illness - thus precipitating a crisis requiring the urgent aid of the hospital service. All four had younger relatives - in three cases, living a considerable distance away - who had in fact turned up to give temporary aid by the time the patients were visited. A fifth was an old lady whose doctor wanted advice about her future care; she was not in need of hospital treatment and subsequently entered a Church of Scotland Home, at her own request, rather than go to stay with a son in a distant part of the country. The remaining three belonged to that group of 24 patients who, it will be recalled from the previous Chapter, were found to be living alone in "neglected" or "dirty" homes, and which now fall to be described.

In measuring the extent to which those who live alone lack adequate help for their needs, the state of their homes and persons provides a more immediate and reliable guide than the number or proximity of relatives. In this survey, 24 old people - one quarter of those living alone - were found in conditions of dirt or neglect which left no doubt, not only of their incapacity to look after themselves, but of the inadequacy of such help as was available to them. Of these patients, thirteen lived in urban and eleven in rural areas; economics had nothing to do with their plight.

Eight of them (including the four previously referred to who lived in "squalor") suffered from mental illness or deterioration so advanced as to render them incapable of appreciating their surroundings; one of these, a man aged 64, had £700 in banknotes in his possession; another, an old lady, lived in a large house overlooking a village which she had dominated for half-a-century or more, and was, in her ninetieth

year, consuming a bottle of sherry a day (according to her relatives) and was still driving her car on the public highway, to the mortal peril of all; she brooked neither advice from well-meaning neighbours nor interference from anxious relatives, and had, while yet maintaining independence, reached an advanced stage of senile dementia.

The remaining sixteen had however become incapable through illness of looking after themselves or their homes, to a greater or lesser degree. Only three of them, as previously noted, had no help of any kind; two had the help of nearby relatives, eight were aided (five to a considerable degree) by willing neighbours, and two had a daily home help; in only one case could it be said that the patient had been neglected by relatives who were in a position to help. Why then had these sixteen old people become so neglected?

Townsend draws a distinction between the "isolates" and the "desolates", the former being those secluded from family and society, the latter those who have been deprived, usually by death, of someone they loved<sup>(8)</sup>. All the patients in this group of sixteen, with two possible exceptions, belonged to the first group; they represent the "isolates" of Fife. Their disabilities ranged from the weakness of extreme age to gross congestive heart failure; they were representative of all five recognised social classes; they had in common one unmistakable characteristic: a stubborn determination to maintain independence to the last. Their neglected state was due to their refusal to accept advice, to be "beholden" to anyone, or to change their way of life if it involved giving up their homes.

The writer will not readily forget a visit, on a late summer afternoon, to a large house in a popular holiday resort in the East Neuk of Fife. A knock at the door, which was unlocked, brought no response; on the hall table, on a layer of dust and sand, was a pile of unopened letters; a parlour and the dining-room were empty, the polished mahogany covered with dust; upstairs, the bedrooms, five in all, were fully furnished, dressing-tables dust-covered, silk bedspreads undisturbed;



in the bathroom, guest-towels were on the rail, unfolded and unused; dust covered all the Victoriana of the drawing-room. Downstairs again, the kitchen premises were empty, bare, stone-flagged and cold; and finally, in a little room hitherto unnoticed, opening off the parlour - "the maid's room" - lying on a single iron bed, uneasily asleep, grossly oedematous, was found an old lady. Awakened and reassured, she told her muddled story - first apologising for being asleep; a story of the gradual passing of her generation; of the increasing difficulty of keeping - and finally of getting - servants ("They won't stay nowadays, doctor - they get better wages in the hotels"); and implied in her story - but not admitted - the arrogance, perhaps, of "the mistress", now no longer tolerated; and, finally the lonely battle against increasing disability, ending in the little bed in "the maid's room", the only bed in the house to which her swollen legs and failing heart would carry her.

At the other end of the social scale, the aged isolates, however independent, seem to fare better :-

Mr. A., age 90 : Bachelor; has developed a suspicious tumour in the neck; family doctor hesitates to send him to a Surgeon ...

Frail, deaf old man; has lived alone for 40 years; small cottage 1 mile from nearest village; house dirty and neglected, but warm; says he gets all the help he needs from a kindly neighbour; sitting in front of fire, frying fish for tea when visited. Refuses to enter hospital (or anywhere else) "except to get the lump taken away".

(He was subsequently admitted to hospital with a view to surgery but left after three days because, in his own words, "I couldna' stand the crowd").

It will be noted that almost half of the patients in this group lived in rural Fife - an unduly high proportion, but to be expected from what has already been said regarding the high percentage of elderly widows /

and single women in these areas. The case of the old lady described above is no uncommon one; there are many, like her, still occupying houses too large for their needs, living alone in increasing isolation, unable to comprehend, or refusing to acknowledge, the social changes which have taken place during the last decades of their lives. If their determined self-sufficiency compels admiration, their loneliness is exposed, and all the more pathetic, when illness and disability finally reduce them to helplessness.

In reviewing the circumstances of these ninety-six old people who lived alone, it can be seen that they are far from being a homogenous group. At one end of the scale were those who, closely supported by relatives and neighbours day by day, were in fact no less secure than those who lived with their families; at the other extreme were the "isolates"; and in between were all grades of need and of attempts to meet it. But many, apart from the isolates, clung to independence and insisted that they "could manage" (in spite of all evidence to the contrary), not realising how far they were dependent on outside help and goodwill.

In terms of need for further help in illness or incapacity, however, the demands made by this group on the hospital service far outweighed, in proportion to their numbers, those of any other. Applying the stringent criteria which the shortage of hospital beds dictated, no less than thirty-eight (or 40%) of the 96 patients who lived alone were in "urgent" need of admission to hospital, as against only 20% of those living with younger relatives; and the urgency was determined, in the great majority of these cases, not by the nature of the illness but by the inadequacy of the resources which could be mobilised at home to meet even the elementary requirements of full-time nursing.

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## CHAPTER VI.

RELATIONSHIPS - II.Those Living with Spouse Only

The group now to be considered is a substantial one both in numbers and in the fact that, next to those who live alone, it makes the greatest demands on the hospital service in proportion to its size.

Of the 400 patients in this series, 84, or 21% were living with the spouse only : they were evenly distributed between the sexes and, in proportion, between urban and rural areas :

Table XII.Patients Living with Spouse Only : Distribution

	Urban	Rural	Total	%
Male patient, living with wife only	32	10	42	25%
Female patient, living with husband only	36	6	42	17%
	68	16	84	21%

As with those who lived alone, help was available to these elderly couples from other sources in varying, but often considerable degree. Of the 42 male patients (who are first discussed), no less than twenty-four had additional help from other relatives ; a further three had help from neighbours ; ten were being attended by the district nurse, and seven had a home help. But twelve patients in urban areas (or almost 40%) were being cared for by their wives alone ; this applied to only one of the rural males.

How the patient fared in these cases then, depended not only on his degree of incapacity but also - in fact much more so - on his wife's

state of health and on how far additional help was available to her. By far the commonest reason for reference to the hospital service was not the husband's incapacity but the wife's inability to stand the strain any longer, with or without help.

Of the 42 male patients in this group, only seven merited admission to hospital on account of illness requiring investigation or treatment, irrespective of home conditions; but in no less than nineteen cases the major reason for requesting hospital admission was the continuous strain, often severe, sometimes of long standing, which the patient's wife had been called upon to bear. Many, as noted above, had the assistance by day of relatives, neighbours, home help or nurse; but by definition, in the cases under consideration in this group, no-one other than the patient's wife lived in the house, and therefore by night the wife had to manage the patient alone. Hence those patients who were confused or restless at night imposed the severest strain, most likely to lead to the wife's breakdown: -

Mr. T., age 82 : Increasingly "muddled" and forgetful over past four years; gets lost; can't put on his clothes properly. Modern ground-floor Council flat; wife elderly but active and alert; managed him very well until recently, when he began to insist on getting up during the night; won't go to bed at proper time. Wife anxious to keep him at home as long as possible but now obviously under strain due to lack of sleep ...

Long-standing hemiplegia, especially if associated with mental deterioration, imposes severe strain :-

Mr. R.S., age 74 : Two strokes, the last 18 months ago, with residual R. hemiplegia; able to be up and to go to toilet with help; slowly deteriorating; increasingly difficult to manage; unco-operative, emotional, bad-tempered. Good home; modern stone-built terrace house; wife willing,

but frail and cannot manage patient alone; has to call in a neighbour to help by day; now obviously in a state of exhaustion ....

On the other hand, if the patient remained co-operative, even though severely handicapped, a sensible wife could develop a routine and carry on indefinitely, given a respite from time to time :

Mr. P., age 60 : Severe stroke four years ago, with later recurrence; severe L. hemiplegia; emotional but not incontinent; mentally alert; has been practically bedridden for 2 years.

Modern ground-floor Council flat; well cared for by wife, who has a part-time morning job. She would like patient accommodated in hospital for two weeks so that she can visit her only child, a married daughter, in West of Scotland.

Or, if she realised that the end was not far off, the wife would often prefer to carry on alone rather than be parted from her husband. This must be true of many cases of whom the hospital physician never hears :

Mr. G.Y., age 82 : Long history of congestive heart failure associated with myocardial infarction; now able to be up in a chair for short time only; memory failing; very confused recently.

Lives with wife in modern Council house; sister-in-law lives 10 miles away but visits regularly. Wife rather frail but realises ultimate outcome and prefers to carry on alone; she has developed a routine of nursing and manages well; will ask for home help or district nurse if necessary ....

There were, in this group, two cases in which the admission of an invalid husband was sought because the wife had herself fallen ill; two

in which both partners were so incapacitated that both had to be removed to hospital ; one in which relatives undertook the care of a sick wife while her husband, also ill, was admitted; and one, a similar case, in which the Local Authority undertook the care of a partially disabled wife while her husband, aged 90, who had hitherto looked after her, was admitted for treatment of a septic foot and incipient congestive heart failure. These cases serve to illustrate how very slender becomes the hold on independence of many elderly couples, as age and frailty advance upon them.

Turning now to the remaining half of this group, in which the wife was the patient : it is perhaps a natural assumption that a sick husband is more likely to be well cared for by a still-active wife than is a sick wife by an active husband; in other words, where the wife falls ill, a crisis is more likely to arise and more help is likely to be required. The assumption is not borne out by the evidence in this series.

Of the 42 couples in this group in which the wife was the patient, in only eighteen cases was the additional help of relatives available; four had substantial help from neighbours, fifteen had a home help, and twenty were being attended by the district nurse. Five husbands however had no help at all, and four more had the aid of the district nurse only.

As in the case of the male patients already considered, the major cause of reference to the hospital service was that the husband, with or without the help available to him, was unable any longer to bear the strain imposed upon him; this applied to eighteen cases; in only ten cases could it be said that the patient was in need of hospital treatment irrespective of home conditions.

In all these respects then, these two sub-groups were similar, and one of the most surprising (and admirable) features was the number of

husbands who long continued to care, with quite inadequate help, for an invalid wife; not only was the task carried on for a long period, but many showed a considerable aptitude for nursing. In this sub-group of 42 cases, no less than twenty husbands were compelled to act not only as housekeeper but to carry out all the routine duties of nurse as well.

Most remarkable (and humbling) perhaps was an 81 year old man, who lived with his wife in a modern Old Persons' cottage. His wife, aged 78, had been deteriorating mentally and physically for five years; for the past two years she had been completely bedridden, apart from an occasional excursion to a chair; she could feed herself but was otherwise quite helpless, completely disorientated, and incontinent at all times. There was one daughter, married, who did not live in Fife; apart from the district nurse, who called twice daily, the old man looked after his wife unaided; he did all the housework, cooking, washing (for which purpose he had installed a washing-machine), ironing and nursing himself. The house was clean, the patient well-nourished, clean and without a sore other than a superficial urine-rash.

When visited, the husband said he did not wish to be parted from his wife; his complaint was that his back was sore and "he felt he needed a rest". His wife was therefore admitted to hospital for four weeks, while he disappeared to visit his married daughter. It was confidently expected that once released he would not be prepared to resume his burden - nor could anyone have blamed him; but on the twenty-eighth day he arrived at the hospital to take his wife home "according to his bargain".

Equally humbling was the endurance of the spouse in the following case :

Mrs. H., age 83 : Unable to walk for over 12 years; bedridden over one year; gross defect of memory; incontinent (doubly) at times; feeds herself, otherwise helpless. Skin intact, well cared for.

Lives with husband, age 82, in modern Council house - ground floor flat; no family; husband has home help by day but looks after patient himself. Main complaint /



is that he has to get up every night to attend to his wife; does not get adequate sleep. Could she be admitted to hospital for a period to give him a rest ?

(This patient has twice been admitted on a temporary basis in the past 18 months and on each occasion has been discharged home, where her husband continues to care for her).

These two cases are outstanding examples of what was true of half the cases in this group, though in the majority more help from relatives or others was forthcoming. In four cases the husband was himself incapacitated or ill; three of these have already been referred to, and in the fourth case the wife, completely incapacitated by a severe hemiplegia, was being cared for, without any additional help, by a husband who was slowly dying of malignant disease. In seven cases the husband was himself frail and unequal to the task of looking after a sick wife; in only two cases of these 42 could it be said that he was shirking his responsibilities.

In reviewing this group as a whole, there was little evidence that elderly couples were neglected by younger relatives who might have helped; those who lacked such help were either childless or their children no longer lived in the area. In six cases a younger relative had come from a distance to help temporarily at the onset of sudden illness in one of the parents, until such time as admission to hospital could be effected or other arrangements made. One daughter travelled every day from her own home, ten miles away, to "do the washing" for her elderly mother, who otherwise had to care unaided for her invalid and incontinent father.

It is clear, from this study of the records of these 84 patients, and from the writer's vivid recollection of many of the households, that elderly married couples prefer to remain together, even when one of them is seriously disabled, and that the active member of the partnership /

will endeavour to carry on until the strain reaches breaking-point, before asking for relief; and even then, a temporary respite may be preferred to permanent separation. It is notable too, that in these cases the strain is the physical one of heavy or long-continued nursing; the situation of stress or tension which so often builds up in the household where an elderly invalid is being looked after by younger relatives (and to which reference will later be made), is seldom seen where an aged husband or wife is caring for a disabled partner. It follows then that when relief is ultimately asked for, the need may already have become a clamant one. In 29% of the 84 cases in this group, again applying the most stringent criteria (as is necessary in Fife), the sick member of the partnership required admission to hospital as a matter of urgency - and mainly, as has already been shown, to relieve a domestic situation which was rapidly progressing beyond human endurance.

#### Those Living with Other Relatives of the Same Generation

This comparatively small group (Table X, p.36) consisted of 25 patients, twelve men and thirteen women, all but three living in urban areas.

The majority of this group were old people who had remained unmarried: seven of the men were bachelors and of the women nine were spinsters; a further three of each sex were widowed; the remaining three lived with their spouses and other elderly relatives. The commonest domestic situations were those in which the patient lived with an unmarried or widowed sister (11 cases) or with a married brother or sister (9 cases); the remainder consisted of such odd arrangements as where an elderly childless widow, who had a long history of mental instability, lived with a bachelor cousin aged 91; or where a crippled old lady (the patient) and her husband (both of them in their mid-eighties) lived with two spinster nieces (one bedridden), both of whom were over 70 years of age - and therefore, for all practical purposes, of the "same generation".

A notable feature of this group was that few of the patients, or those with whom they lived, had younger relatives on whom they could call for assistance. The households consisted almost entirely of the unmarried, or the childless widowed, or elderly married couples with no families or whose children did not live in the area. In only three cases were younger relatives available to help; in two of these, nieces living nearby were giving assistance to an elderly aunt caring for her disabled brother, and in the third the patient, a spinster, lived with a widowed sister who had married daughters in the vicinity. In all other cases those caring for the patient were themselves elderly, often frail, and without additional help, apart from a home help (3 cases) or the district nurse.

It followed therefore that sudden, incapacitating illness could not be dealt with in the home :

Mr. T., age 77 : Artificial R. leg (result of an old accident), but active until two days ago when he suddenly lost power of L. side. Not incontinent or confused, but a heavy, helpless patient.

Widower; no children; lives with brother and sister-in-law, the latter a semi-invalid. District Nurse calling; Home Help one day per week; otherwise brother trying to do all nursing, which is beyond him.

Four other cases were similar and in all of these admission to hospital at the earliest opportunity was mandatory.

A further feature of this group however was that family ties were less strong than those which bind the elderly husband and wife; relatives were therefore less willing to undertake the care of the brother or sister who had become a burden to them, and who had, in the first place, come to live with them perhaps because he had "nowhere else to go". Three cases were referred to the hospital service only because

the family doctor was being pressed by relatives who felt they had more than fulfilled their responsibilities to an unwanted member of the family; in a fourth, a brother and sister had become exasperated by a lazy, cantankerous, but by no means disabled elder brother whom they had "taken in" some time previously; in yet a fifth, an old man was so constantly nagged by the sister with whom he lived that he took to his bed in self-protection, whereupon his sister announced her inability to nurse him and proceeded to pester the family doctor to have him removed!

In few cases in this group were the relatives capable of nursing long-continued illness, or willing to undertake it. In only four cases was there seen the strain to the point of exhaustion, so commonly found in the spouse caring for a disabled wife or husband. These were cases in which the ties of kinship were strongest: two in which elderly spinster sisters had lived together for many years, and did not wish to be parted; one in which a widow who lived with a sister and brother-in-law had become bedridden mainly because her sister, who did not wish to part with her, had a sick husband to care for as well, and could not manage both; a fourth, in which an old bachelor lived with a widowed sister, who asked for relief only when he became confused and incontinent after a long period of deterioration.

In summary, five patients in this group (20%) were in urgent need of admission to hospital; two of them for treatment urgently required, but all five also because their elderly relatives could not nurse them; seven however, almost one-third of the whole group, were not suffering from any illness or disability which could justify admission; in the remainder, the need was admitted on a delayed or temporary basis, the degree of urgency being determined by the disability of the patient and the incapacity or unwillingness of his relatives to care for him

It is evident, from this brief analysis, that the elderly unmarried person or widowed person who has no children, who makes his home with others of the same generation, is in a more precarious situation than

those (as will be seen) who live with their married children, or than husband and wife living together, or even than many of those who live alone with younger relatives nearby. Those with whom this group lived were themselves old; few had the help of a younger generation, and most were either unable or unwilling to undertake the care of the relative who had become an added burden to them.

### Those Living with Others

It is convenient, before turning to the largest and most important group of all, those who lived with younger relatives, to close this Chapter with a brief reference to that small group of fifteen patients who lived with, or had living with them, people who were not their relatives.

The group consisted of eight men, five of whom were single, and seven women, four of whom were single, the remainder being widowed. Again characteristic of the group was the lack of younger relatives; none of the widows had children, and only one of the widowed men; he had five, with one of whom he had lived for a time after his wife's death, but ultimately he had quarrelled with and parted from all of them.

Seven of these fifteen patients lived in lodgings, on the whole in good conditions; one old man had been well looked after by his widowed landlady for 20 years, and another had lived with the same family for 7 years. Five lived in their own homes: three were women who kept boarders, and two of these had looked after, and were in turn being cared for by male lodgers who had been with them for over twenty years; one old lady was looked after by a housekeeper, and the fifth, an old man, had a young married couple sharing his house and helping to look after him.

An old lady, a childless widow, had sold her house after her husband's death and gone to live in a boarding-house "because she was so lonely"; and one elderly man was living in a Y.M.C.A. Hostel.

These patients were, in general, living in conditions in which illness or invalidism could not long be tolerated, yet all but two were being cared for as well and as kindly as circumstances allowed; seven of those living in lodgings had become seriously ill, disabled, or mentally impaired, before their removal to hospital was sought. Nonetheless, ten of these fifteen patients had to be regarded as more or less "urgent" cases in terms of need for hospital admission, and this largely on account of adverse domestic circumstances. This high proportion once more illustrates the precariousness of those old people who have no younger relatives at hand.

## CHAPTER VII.

RELATIONSHIPS - III.

The point has now been reached at which the last, and by far the largest single group in this series must be considered : those who had made their homes with, or who had still living with them, younger members of their families - in the great majority of cases their own children. It is also the most important group; and the difficulties which faced those who looked after these patients, and the causes of breakdown in family care, merit careful examination; for, in the care of the aged (in Fife no less than elsewhere), as Sheldon has so well said, "the participation of the family so completely dwarfs other sources of help that any serious overspill would have immediate consequences".<sup>(1)</sup>

Therefore it is proposed first to analyse briefly the households of which these patients were members and to indicate, from the assessment made at the time each was visited, how far domestic or social, as opposed to purely medical reasons, had compelled the family or the family doctor, to call on the help of the hospital service. Thereafter, in the remainder of this Chapter, it is proposed to discuss in greater detail the most important aspect of the care of old people at home which emerges from a study of this group : the strain which the care of the elderly invalid imposes on the younger generation, and the causes of that strain, with particular reference to incontinence.

Those Living with Younger Relatives

There were in this group 180 patients, or 45% of all cases (Table X, p. 36); in 42 cases the patient and spouse shared a home with relatives of a younger generation, but the great majority of

patients in this group were widowed ; only seven were single. Details are given in the following Table :-

Table XIII

Marital Status of Those Living with Younger Relatives

	<u>Married</u>	<u>Widowed</u>	<u>Single</u>	<u>Total</u>	
Urban Males	19	38	1	58	46% of urban males
" Females	18	66	3	87	47% of urban females
Rural Males	5	13	-	18	45% of rural males
" Females	-	14	3	17	34% of rural females
	42	131	7	180	

Of the 400 patients in the series, it will be recalled that 205 were widowed; of these, no less than 131, or 64%, as shown above, lived with younger members of their families, this high proportion applying both to males and females, and demonstrating in striking fashion how far the bereaved rely on their children. The other noteworthy feature of the above Table is the low percentage of rural females who lived with younger relatives - the corollary of the fact noted on p. 37 that a much higher proportion of rural females lived alone.

The phrase "living with younger relatives" however, like the term "living alone", requires considerable qualification; it covers a wide range of relationships and of itself conveys little in terms of the help available to or the care bestowed on the individual patient. A more detailed analysis of the family relationships of these 180 patients shows that they fall into two large groups : those who lived with married children (95), and those who lived with an unmarried son or daughter (67);



with the remainder, a very small group (18) consisting of those who lived with other more distant younger relatives. Further details of these groups are set out in Table XIV :-

Table XIV.

Detailed Relationships of those Living with Younger Relatives

	Urban Males	Rural Males	Urban Females	Rural Females	Totals	
<b>1. <u>Living with married children :-</u></b>						
with married son(s)	8	4	13	3	28	
with married daughter(s)	21	7	34	5	67	
	29	11	47	8	95	95
<b>2. <u>Living with unmarried children :-</u></b>						
with unmarried son(s) alone	12	1	16	1	30	
" " daughter(s) alone	10	5	14	3	32	
" " son and daughter	2	-	3	-	5	
	24	6	33	4	67	162
<b>3. <u>Living with other younger relatives :-</u></b>						
with nephews or nieces	2	1	6	4	13	
" grandchildren only	2	-	1	1	4	
" step-daughter	1	-	-	-	1	
	5	1	7	5	18	180

Of the 95 households in the first group, no less than 65 contained grandchildren, some of them old enough to be working, but the majority of school age or younger; in all, there were 73 households of three generations; two households of four generations were recorded and one or

two defied complete elucidation.

More precariously placed were those patients in the second group, living with unmarried sons or daughters, most of whom were normally at work. But in many of these cases additional help was available; of the thirty patients living with an unmarried son, for example, ten had assistance from other nearby relatives, and in eight cases the patient's spouse was still living. In all, 45 households had help available to them from other relatives, twenty-four of them in the second group.

Four patients in the third group, it will be noted, lived with grandchildren. Two were old men, each living with an unmarried granddaughter who was at work; one old lady lived with a married granddaughter (separated from her husband), and three great-grandchildren; the fourth was an old lady who had living with her a fifteen-year-old grandson whom she had brought up; but living nearby were two married daughters who looked after her and the boy.

It will be seen then that these patients lived in households which varied widely in terms of available help, from those containing up to four generations and all age groups to those in which the only relative was a son or daughter who might be at work all day - the patients in the latter circumstances being no better off than those who lived alone, except that someone else was in the house at night.

The assessment of these patients - as of all others in this series - was primarily in terms of need for admission to hospital, and the decision was influenced to a considerable degree by the shortage of hospital beds. However, since all assessments were made by the same observer, who controlled all the available beds, this limitation applied equally to all patients.

The 180 patients in this group were classified as follows :

<u>Need for admission</u>	<u>No.</u>	<u>Percentage of Group</u>
Urgent	41	23%
Delayed	46	25%
Temporary	24	14%
Remain at home	57	31%
Referred Local Authority or elsewhere	12	7%
	<u>180</u>	<u>100%</u>

In general, notwithstanding the high proportion (31%) who were refused admission, there was little evidence in this group of any attempt to abuse the hospital service. Only about 15 cases in all could be described as "non-hospital", in the sense that they needed neither hospital treatment nor nursing care and should not, in the writer's opinion, have been referred to the hospital service. Many of these 57 patients, who, it was decided, should remain at home, were in fact chronic invalids who would have been better cared for in hospital, but whose relatives, once assured that hospital treatment was not indicated, were prepared to continue caring for them.

Of the 41 cases assessed as "urgent", in only thirteen could it be said that this decision was dictated entirely by the nature of the illness, irrespective of home conditions; these were cases of unexplained anaemia, suspected neoplasm, congestive heart failure (one with diabetes), suspected myocardial infarction, and two cases of fracture.

In a further 21 cases the admission of the patient was a matter of urgency because the resources of the family were insufficient to deal with a sudden crisis, such as a severe stroke, or with the nursing problem created by prolonged illness. Twelve of these patients were living with an unmarried son or daughter only; in five, the only available female relative had to stay off work to nurse him; in two the only female relative

was herself "getting on in years" and unequal to the nursing burden, and one lived with a married daughter whose husband was dying of cancer. In each of these 21 cases the whole burden of nursing fell almost entirely on one younger female relative.

In the remaining seven cases classed as "urgent" the deciding factor was severe and obvious strain in the household; six of these patients were incontinent and all of them mentally confused; five lived with married sons or daughters, three with young children in the house. In all but one case the nursing burden fell on one younger female relative, and in all it had been long-continued.

The 46 cases classed as "delayed" differed little from the previous group, but, as the term implies, the patient could continue to be cared for at home until a hospital bed could be found. Most of those in this group required hospital treatment, mainly rehabilitative, but home circumstances were better. The majority were suffering from the effects of a cerebro-vascular accident, or from degenerative cardiovascular or arthritic conditions.

The existence of the group classed as "temporary" was dictated largely by the shortage of hospital accommodation. In none of these cases was hospital treatment likely to be of benefit, but all were either completely bedridden or required constant attention in the home. Temporary admission was therefore offered in order to tide the family over a crisis (for example, the approaching confinement of the married daughter who looked after the patient), or to allow those nursing a chronic invalid to have a rest or a holiday. In nine cases in this group, early admission of the patient on this basis was offered in order to relieve severe strain which was rapidly becoming intolerable; in these, insistence on the discharge home of the patient was a harsh decision.

In sum, then, of 180 ill or disabled old people living with their younger relatives, over 120 were in need of admission to hospital, but only a fraction of them - thirteen in all - on account of the patient's

illness alone. In all other cases, the surrounding social circumstances played some part in determining the necessity for admission and the degree of urgency.

Discussion of two important and general questions, which have already been raised by implication - the effect of the employment in industry of younger female relatives, and whether younger relatives who might have helped were neglectful - is reserved for the next Chapter. It is proposed now, as stated at the beginning of this Chapter, to direct attention to that aspect of the family care of the elderly sick which appears to the writer, from a study of this group, to be of more consequence than any other, and one which has hitherto received insufficient consideration: the strain which is imposed on the younger female relative, who all too often bears the burden alone.

### Strain on Younger Female Relatives

In the now voluminous post-war literature on the subject of old age, it is notable that the two writers who have made the most detailed studies of the family care of old people, are alone those who have called attention to the severity of the strain which the burden of illness and disability in old age places on younger relatives. Sheldon, in his now classical study of old people in Wolverhampton, found that 7.7% were "causing great strain on the younger generation, using these words to imply a mode of existence which deprived the individual of a normal life and turned her into a drudge" (2). Townsend, in his more recent researches into the family life of old people in Bethnal Green, and applying rather wider criteria, found that 13% were imposing strain on their relatives, severe in 3½% and moderate or slight in 9½% (3).

These investigations were carried out however among unselected samples of old people living at home. The present series is highly selected in that every patient was suffering from infirmity, mental or physical, to a greater or lesser degree, and the incidence of strain was therefore much higher. In the whole series of 400 cases, it was considered that in 130 of them, or 32.5%, the patient was imposing strain on those who cared for him; and of these 130, no less than 87, or 67%, were living with younger relatives. Expressed in other words, 87, or close on half, of the 180 patients living with younger relatives, were causing appreciable strain; in at least 14 cases the strain had reached an extreme degree, and in nine was the sole reason for assessing the case as "urgent" in terms of hospital admission.

The assessment of strain, and particularly of its degree, must to some extent be subjective, depending on how far the observer sympathises with the patient, on his estimate of the nursing load, and most of all on how far he appreciates the effect of that load on the nurse's freedom to lead a normal life. Nevertheless, the type of strain so clearly described by Sheldon can scarcely be overlooked, and as Sheldon says, any scheme for the care of the elderly which failed to take account of it "would be lacking in equity".

Reference has already been made (p. 50) to the strain imposed on an elderly spouse caring for an invalid husband or wife. In these cases however the strain is the purely physical one of nursing, and the burden is carried for so long as the spouse is physically able to bear it; it is rarely psychological. Many younger female relatives undoubtedly bear a similar physical burden; but the strain now under consideration is of a different order: it is the strain which develops where the younger woman, anxious to fulfil her obligations to her parent, sees at the same time the life of her own family being disrupted; this is the strain of conflicting loyalties, of which the case described on p. 32 (Mrs. F.) provides a good example. It is also the strain of a task which,

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perhaps undertaken temporarily at a time of crisis, has dragged on and become seemingly interminable ; it is the strain imposed by deprivation of leisure, of time to go out, of holidays with the children; and which eventually leads to that state in the household, so aptly described by Sheldon as "emotional sensitisation". The qualitative difference between these two forms of strain is evident and unmistakable in the phrases used by those who experience it. The elderly housewife, worn out by her husband's long illness, uses a flat expression of weariness : "Doctor, I'm just not able for it now"; whereas the cry of the daughter, tied for weeks or months by the demands of a hemiplegic, bedridden and incontinent parent, and striving to look after home, husband and children as well, is "Doctor, I cannot stand it any longer".

Many factors contribute to the development of this form of emotional stress, and of these duration is perhaps deserving of most sympathy :

Mrs. D., age 68 : Long history of gradual deterioration; unable to walk for over 3 years; bedridden for many months; frequency of micturition; often incontinent; emotional, difficult to deal with; both legs now almost fully contracted; no bedsores.

Good home - modern Council house. Has lived for 4 years with married daughter; two children, aged 4 years and 16 months. Daughter now in state of extreme tension; last holiday a brief one two years ago.

Mental deterioration or confusion in the patient is an additional and potent cause of strain ultimately leading to breakdown :

Miss W., age 78 : Mental deterioration for three or four years; gross loss of memory for some time - unable to recognise her own relatives; now confined to bed, mainly because relatives fear for her safety when up.

Good home; modern house. Lives with married niece, niece's

husband, and 19 year old son, both of whom are working.  
 Niece bears whole burden; now emotional and weepy;  
 "has reached the end of her tether" ...

The fourteen cases referred to, in which strain had become extreme, and of which these two are examples, differ from one another only in detail. In eight, a married daughter bore the strain unaided; in two a daughter-in-law; two patients were cared for by nieces, and the remaining two by a single and by a widowed daughter.

In the cases quoted above, the burden of responsibility for the elderly patient had fallen unremittingly on one younger relative for a protracted period. But a new burden suddenly and unexpectedly imposed may rapidly become intolerable:

Mr. S., age 81 : Widower; lived in lodgings until three months ago when he developed congestive heart failure. Treated temporarily in a Nursing Home, then removed (because funds ran out) to present address. Not now in heart failure; but a heavy man, unable to get up unaided; typical Parkinsonian tremor and rigidity; depressed; sorry for himself; prefers to lie in bed.

Now living with widowed daughter; good home, modern bungalow. Daughter's husband died a year ago after a long incapacitating illness during which she nursed him herself. A tense, overwrought woman; has no children of her own; cannot face prospect of nursing another invalid indefinitely.

This form of strain, ending in acute tension rather than in physical exhaustion, depends however not only on the nature and duration of the patient's illness; it depends - and very largely so - on the attitude and aptitude of the daughter or other younger relative who has to deal with



the patient :

Mrs. L., age 92 : Long history of gradual deterioration, mental and physical. Now doubly incontinent; bedridden, helpless; but has become very demanding and upset if left alone. Has lived for past 8 months with son, daughter-in-law and their grown-up daughter who is at work. Good home; modern Council house; patient well cared for; but daughter-in-law has become a slave to the old lady; ("she makes such a fuss if I am out of her sight"); claims she has not been out of the house for 8 months ....

In this case, the daughter-in-law's life had become completely dominated by the aged patient, but unnecessarily so. There was no reason why she should not have arranged for help by day to let her get out; nor why she should not have gone out in the evenings when her daughter was at home. But she was afraid to go out : Mother "always wanted something" or "something might happen" - these were the phrases she used to express her fears, when in fact the old lady was quite incapable of getting out of bed or of doing herself any injury even if left alone.

This case has been described in some detail as it illustrates a very common situation : the increasing domination exercised by an elderly invalid over a younger relative to the extent that she becomes "a drudge". It is a situation which developes because the younger woman, having no experience of degenerative disease, and in her efforts to please, does not realise that the more she is at hand, the more will the patient, like a child, expect and demand of her ; nor is there anyone to advise her at the outset, or to tell her where she is going wrong; and so she struggles on, under continuing strain and growing tension, until the point of breakdown is reached.

At this stage, permanent removal of the patient may be the only

solution; but much may be achieved to relieve the strain - if it is not too far advanced - by temporary admission of the patient to hospital for retraining, and to give the younger relative a respite :

Mr. N., age 77 : Prostatectomy a year ago. Did not regain bladder control; suprapubic cystostomy performed; sent home with permanent suprapubic catheter. Since then has been a bedridden invalid with bladder draining into bottle by bedside. Deaf, but mentally alert; no paralysis; has become very demanding.

Lives with married daughter, son-in-law and their two children. Good home; modern Council house. Patient well cared for, but daughter now feeling strain; afraid to go out because the old man becomes so upset if she is not at hand.

This patient was admitted to hospital; the tube was clamped off and he was taught to empty the bladder at regular intervals; he was mobilised and was soon able to go to the toilet for this purpose himself - aided and disciplined by a little "therapeutic neglect". He was discharged home fully independent, arrangements being made for the bladder to be washed out and the tube changed at regular intervals.

In the cases just described, the strain had arisen largely because of the relatives' inability to adjust themselves to, or to deal with, a situation beyond their training or understanding. But there were other cases in which younger relatives were bearing an equal or even a greater burden, and in which no strain or tension in the household had developed. These are worth some study.

By a curious paradox, the households in which the greatest strain might have been expected, and in which least, or none, was found, were those

in which the patient was being cared for under the most difficult conditions; they were in fact the overcrowded households, to which reference has already been made (Chapter IV, p. 33).

It will be recalled that there were 14 patients living in overcrowded conditions, thirteen of them with younger relatives, and that ten of these families occupied modern Council houses. Twelve of the patients were widowed and had lived with married children for a long time - in one case for 15 years, and in another for 10 years; some had joined their children in old homes, and had moved with them into new homes in new housing estates in recent years; and when sudden illness overtook them, or their strength failed, their continuing care was accepted as a matter of course.

In these cases, the question of relief from strain did not arise; all that these families asked for was temporary aid during a crisis, or they were concerned to obtain the best treatment for a parent's illness.

Mrs. M., age 75 : Two years history of mental deterioration; bedridden for past 8 months; doubly incontinent, contractures of legs; no bedsores.

Lives with daughter, son-in-law and five children (ages 16 to 4 years); small modern Council house; overcrowded; but patient has small room of her own; daughter manages very well - not complaining; main concern is her mother's deterioration and whether she needs treatment.

Assured that her mother is now beyond any rehabilitative measures, she is prepared to carry on.

Perhaps the most remarkable case of long-continued self-sacrifice on the part of a daughter-in-law was the following :-

Mr. M., age 66 : "Stroke" 8 years ago with left hemiplegia; able to get about until 2 years ago, when he deteriorated; bedridden, incontinent, feeds himself with difficulty, resents

interference; now has complete L. hemiplegia with typical contractures but no bedsores.

Has lived for 5 years with son and daughter-in-law and their 5 children in 4-apartment modern Council house; overcrowded. Daughter-in-law expecting sixth baby in three months time; going into hospital for confinement and wants her father-in-law accommodated while she is away ...

Not often does one find a relative willing to admit that the needs of others might be greater than her own :-

Mrs. H., age 64 : Mental deterioration for 5 years; now incontinent; lying curled up in bed, resists any attempt to straighten her legs; left hemiparesis; no bedsores. Patient and husband live with daughter and son-in-law and four young children in modern Council house. Patient's bedroom upstairs; toilet downstairs. House overcrowded. Daughter wants her mother in hospital "for a month" so that she may have a rest herself and to let her father have a holiday.

(Some weeks later a bed was offered on these terms; but the daughter stated that her mother had been temporarily accommodated by another relative, so "she would not now need to take up a hospital bed").

Finally, to illustrate the problems, and the fortitude, of this small group, there was the daughter who, living in a two-roomed house with a leaking roof in a condemned miners' row, looked after her husband and four children and both of her own parents as well. Her mother, a severe diabetic with long-standing ischaemic heart disease, was in the last stages of congestive heart failure. The daughter, an able and intelligent woman, asked that her mother be admitted to hospital only because "she didn't want her to die in sight of the children".

These overcrowded households have been dwelt on at some length because of the striking contrast which they afford with all those previously described. In them, as in others, the burden fell no less on one younger relative, who in all cases had a home and a large family to look after as well. Yet in none of these homes was there any sense of strain or tension, and it was in these that the strongest ties of affection and the most shining examples of endurance and self-sacrifice were found.

It is clear, from this brief review, and as Sheldon so well recognised, that where disabled old people are being cared for by their own families, the burden of nursing almost always falls on one younger female relative, usually a daughter or a daughter-in-law. It is also evident that whether the younger relative will or will not be able to sustain the burden depends on many factors, not least of which - in fact, as the writer interprets the evidence, more important than any other - is her own character and her attitude towards her responsibilities.

This is not a simple question of affection or of "willingness" on the part of the younger woman; the great majority in this whole group were anxious to do their best, and neglect of the patient was rare; all the patients referred to in this section were well cared for; none, it will have been noted, had bedsores, and in fact, as has been shown, in these households where strain was most apparent, there was the patient receiving the most slavish attention.

It is here perhaps that the crux of the matter lies. For these households in which tension was so acute and so obvious were those in which, or so it seemed to the writer, the younger woman was a perfectionist, unable to reconcile herself to a compromise in her responsibilities. Anxious to fulfil her obligations to the helpless parent, she could not at the same time see her children denied their rightful share in the home ;

or, proud of her house, she could ill tolerate the presence of constantly soiled clothes and bed-linen, the stale smell, or stains on the carpet.

It is another paradox, perhaps, that in the very process of rehousing the population, in giving the working man a decent home to return to, in providing his wife, perhaps for the first time in her life, with a house in which she can take some pride, and their children with bedrooms of their own and fields in which to play, there have been accentuated these very difficulties in the care of the elderly sick which would have been accepted with little embarrassment in other surroundings. For the modern home was built for two generations, not for three; and the younger woman who sees it as a home for herself, her husband and her children may find it hard to see it also as a home for a confused and incontinent parent.

### Incontinence

A high proportion - almost one in four - of the cases in this series were incontinent, as would be expected from the high incidence of mental deterioration and of cerebro-vascular disease; it was common in all groups, as shown in Chapter II. How far incontinence influenced demands for hospital admission it is not possible to say, but just as strain developed in one household and not in another under similar conditions, so also incontinence would in one be a major embarrassment while in another it would be accepted and dealt with as a matter of routine. There is no doubt that it played a large part in the development of strain.

Incontinence was present, it will have been noted, in many of the cases described in the preceding pages, and it is not intended here to

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multiply the number except to illustrate two common situations. The first is that in which young children are in daily contact with an incontinent grandparent who shares their home :

Mr. F., age 75 : Fractured femur 7 months ago ; poor recovery ; has since been confused, incontinent of urine and sometimes of faeces. Up every day but has little control over bladder and no insight into his condition. In bed when seen - soaking in urine.

Lives with daughter, son-in-law and their four children in modern Council flat. Children all young.

Daughter says the old man's habits "especially with the children in the house" are getting beyond her endurance.

A further, but minor, complaint in this case was the constant washing of soiled clothing and linen; in the case which follows - which illustrates the second situation - it was the major cause of reference to the hospital service.

This patient was visited on a wet October afternoon; he lived in a modern two-bedroomed Council flat with his daughter, son-in-law and their 14 year old son. His bed was in the living-room, which was festooned with pyjamas, underclothing and bed-sheets, reluctantly drying in the already humid atmosphere; a glance through the open kitchenette door gave a brief view of a similar scene. Over all hung the typical ammoniacal smell, and sitting by the fireside, the cause of it :

Mr. B., age 84 : Mental deterioration with congestive heart failure and incontinence for 18 months. Oedema of feet and ankles; just able to walk unassisted. On treatment with digoxin and mersalyl.

Daughter very willing but has no help; constantly washing clothes and bedclothes, especially on "mersalyl" days; says she had to change bedding seven times yesterday ....

Incontinence was much less commonly complained of by the elderly caring for their own generation - particularly by the spouse nursing a husband or wife - than by younger women caring for their parents. By the old, incontinence is perhaps accepted because the difficulty of control is better understood, but to the young it is an added irritation, a cause of embarrassment, and a further source of strain. Nevertheless, the two situations illustrated above were not exceptional; they were extremely common, and what was surprising was not that younger relatives asked for relief, but that they had so often endured for so long. These families were not insensitive: but what opportunity had either of them to inculcate habits of decency in their children or to maintain decent standards in the home when grandfather daily soiled the bedroom floor, or when the living-room was constantly in use as a wash-house or drying-room? It was difficult to escape the conclusion, in cases such as these, that in a more sophisticated locality, more voices would have been raised long since in protest, and in higher places.



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## CHAPTER VIII

### The Employment of Younger Women ; Neglectful Relatives ; Local Authority Services.

It is now proposed to complete this survey, first by considering two important (and as yet controversial) questions concerning the care of the aged sick and infirm in their homes, in the light of such evidence as can be obtained from the 400 cases in this series; and finally by referring briefly to the part played, in the care of these patients, by the domiciliary services provided by the Local Authorities in Fife.

#### The Effect of the Employment of Younger Women

It is perhaps generally assumed that the widespread employment of women in professions, business, and industry must result in increased demands for the institutional care of old people, particularly of those who are sick, infirm or otherwise incapable of maintaining their own independence. Sheldon has referred to this question, but is content "to stress the fact that in my view there is a problem" <sup>(1)</sup>; and Shenfield, discussing the family care of the elderly, goes no further than to state that "the more women, and especially married women, are drawn into employment, the more likely it is that alternative care may have to be found for elderly relatives needing a good deal of attention" <sup>(2)</sup>. There is, at least in the medical literature, a striking absence of any factual information as to how far the elderly sick require admission to hospital because younger female relatives, on whom they mainly depend, are at work.

In the present series, there were 33 cases (8.25%) in which the younger female relative normally responsible for the care of the patient,

or on whom the patient mainly depended, was, or had been, employed. Twenty-five of these younger women were still working at the time the patient was visited; five were temporarily off work on account of the patient's illness, and three had given up work to care for the elderly relative.

These last three were all unmarried daughters living with an aged and invalid mother. One patient was a diabetic with chronic congestive heart failure; the second was also in heart failure and blind; and the third was still active physically but so mentally confused as to require full-time observation. This last patient was ultimately admitted on a permanent basis to a mental hospital, as her condition was beyond the resources of any normal home; the first two would almost certainly have required permanent institutional care had their daughters not been prepared to give up work to look after them.

Of the five who had temporarily stopped work, three were single daughters looking after an elderly father; one was an unmarried niece caring for a spinster aunt; the fifth was a married woman (whose husband was also at work) and who looked after her father-in-law. In four of these cases the aid of the hospital service was invoked on account of sudden illness in a previously active old person, and the question of permanent hospital care did not arise; three were in fact treated in hospital and discharged home sufficiently active to enable the younger relative to continue in her employment; the fourth died shortly after admission to hospital.

The fifth case was more complex but it poses a nice problem and is therefore worth description. The patient, a widower, was an old man who had undergone suprapubic cystostomy and who had been discharged home from hospital with an indwelling catheter which he could not manage himself; he was mentally confused. He lived in a modern cottage-bungalow (his own property) with an unmarried daughter who was at work and whose earnings /

were necessary in order to maintain the home, her father's small pension being alone insufficient. When her father came home, following his operation, he was so confused that she had to stay off work to look after him; and since no improvement occurred, admission to hospital was sought so that she could resume work.

The daughter could afford help by day, but not a full-time housekeeper or nurse; but she could not continue at work (with day help for her father) and look after him alone at night, because he required so much attention that she could not get adequate sleep. If she sold the house in order to obtain sufficient funds to keep her father in a nursing home, she deprived herself of what she regarded as her own home and which would become her property on her father's death.

The old man was admitted to hospital, where he remains - eighteen months later, pleasant, not bedridden, but so mentally confused that he could not be discharged unless full-time care were available. The daughter remains at work and still has her home.

Twenty-five cases remain in which the younger relatives were still at work at the time the patients were seen. Fifteen of these patients lived with, or had living with them, one younger female relative only on whom they were dependent: an unmarried daughter, a widowed daughter, a grand-daughter or a stepdaughter - all of whom were working. The remaining ten households were more complex; in five, the patient lived with a married son or daughter, both husband and wife being employed; in two cases there was an unmarried son and daughter in the house - both working; one old lady lived with a niece, her niece's husband and two grown-up sons, all of whom were working; one lived with a married daughter and grand-daughter, both working; and finally one male patient lived with his wife, much younger than himself, who worked part-time, together with an unmarried son and daughter, both of whom were at work.

It might readily be assumed that the burden on the Hospital or Local Authority Services would have been considerably reduced if some of /

these numerous younger people had given up work to care for the invalid relative ; but a closer examination of these cases demonstrates that this is not in fact so - unless the hospital service is to fail in its own obligations.

Of the fifteen cases in which the patient relied on one younger relative alone, five were in urgent need of hospital treatment; one had a fractured femur, and one a suspected (and subsequently confirmed) fracture of the skull; both recovered in hospital and were discharged home; two had sustained recent and severe strokes, one dying soon afterwards and the other from a later recurrence while still undergoing rehabilitative treatment. The fifth was in an advanced state of senile dementia and was removed to a mental hospital after a period of preliminary observation. In a further seven cases, admission to hospital was considered advisable, though less urgent; five of the seven were in fact treated and discharged home, the younger relative in each case being able to continue at work, but one required eventual admission to a mental hospital. The seventh made a slow recovery in hospital, and when eventually fit for discharge, begged not to be sent home as she and her daughter, who looked after her, did not get on well; this had no connection with her daughter's employment. Her admission to an Old Persons' Home had been arranged when she fell, fractured her femur and died soon afterwards of pulmonary embolism. The three remaining cases of these fifteen were not considered to require hospital treatment or care and admission was refused.

Of the remaining ten cases, in which more than one younger relative was available in the household, one patient was in urgent need of hospital treatment but died shortly after admission; four were admitted temporarily in order to improve the patient's condition or to give the family a rest or a holiday, and all were duly discharged home, the female relatives continuing at work. In the remaining five cases, admission was considered unnecessary and was refused - a decision which, in four cases at least, the relatives willingly accepted.

Thus, of 33 cases in which the younger relative or relatives normally responsible for the care of these patients, were at work, only four patients came to require long-term accommodation in hospital. Three of these were certified and admitted to a mental hospital and none could have longer been cared for at home, whatever the family circumstances. In the case of the fourth patient - the confused old man previously described - the writer himself would not care to say where responsibility rightly lies. At the same time, he would readily concede that several of these patients would undoubtedly have become a permanent hospital liability were it not that each had first been visited in his own home, where his condition and prospects, and the family resources, were fully explored, assessed and discussed in advance with those responsible for him.

Finally, in how many of these cases were the earnings of younger women necessary in order to maintain the home ?

In all these cases in which the patient depended on one younger female relative, it will be recalled that in only three had a daughter given up work permanently in order to care for an invalid parent. All had good homes and presumably economics did not have to be considered. (One was a schoolteacher who had already reached the age of retirement; her mother, the patient, was ninety years of age). In the remainder, nineteen cases in all, it seemed to the writer (without knowing the full financial circumstances) that the daughter, grand-daughter or other younger relative could not forego her earnings without hardship to those who depended on her, or without lowering the standard of living of the household. How far it is justifiable to expect a younger relative to give up her employment, and to accept a lower standard of living, in order to care for an aged parent is a matter best left to the individual conscience; but it should also be remembered that the younger woman,

if unmarried, may be in process of building a career in pensionable employment which will cover her own old age, and which, once broken, she may not be able to resume.

Suffice it to say here that so far as the evidence of this small series will allow, the employment of younger women need not throw any appreciable extra burden on the hospital services. The evidence suggests that if the hospital is prepared to play its part - as it surely ought - in dealing with sudden and unexpected illness, in rehabilitating, as far as possible, the disabled patient, and in affording temporary relief in times of difficulty or crisis, and if full use is made of the domiciliary services of the Local Authorities, then the majority of cases can continue to be cared for at home; and where they can not, it is unlikely that the employment of younger female relatives has any bearing on the outcome.

The findings in this brief analysis came as something of a surprise to the writer, who would not claim for them, based as they are on so small a series, and confined to one area, any general validity. None the less, an assumption, so plausible as hitherto to have been accepted without question, has been sufficiently challenged as to demand further and wider enquiry.

#### Neglectful and Unwilling Relatives

In seeking to explain the enormous increase in the financial and other claims made on the State by the aged in recent years - in particular the apparent greatly increased demand for hospital and local authority accommodation - it is commonly alleged that there is today a decline in the family sense of responsibility, or a new reluctance on the part of young people to undertake the care of their parents. Sheldon, though unwilling to commit himself, in the absence of positive evidence, has voiced the general disquiet: "among those with first-hand experience there is an ominous concord of agreement ... they speak of an increasing /

tendency for children to regard the care of an aged relative whose management at home has become tedious or difficult as the proper concern of the State"<sup>(3)</sup>.

The younger generation, as a scapegoat for the social evils of the times, is however both popular and traditional, and it is as well that the argument, as stated by Sheldon, should be reduced at the outset to a proper perspective. It is in fact a very old argument, and it has been voiced at intervals in much the same terms over the past hundred years or more. The Report of the Royal Commission which enquired into the Poor Laws in Scotland in 1909, records that "many witnesses have stated that the children of the working classes are less conscious of moral obligation towards their parents than was formerly the case"<sup>(4)</sup>. One witness said he found "an increasing neglect of families to assist their parents", and another that "there is a great difference shown by the working classes to their parents, and I am sorry to see it". The Commissioners however, perhaps wiser than their witnesses, were careful to point out that these statements were made by those administering the Poor Law, and "who see the very cases in which children have been undutiful, but who do not see those cases (still constituting the vast majority) in which indigent parents are kept from pauperism by the kindly offices of sons and daughters, often at great sacrifice"<sup>(5)</sup>.

But even earlier, Sheriff Fraser of Renfrew, giving evidence before a Select Committee on the Poor Law in 1869, said he believed that "pauperism had increased mainly through decay of family responsibility"<sup>(6)</sup>; and twenty years before that, in Fife itself, the parish minister of Burntisland had called attention to "extreme unwillingness to contribute towards the maintenance of infirm or aged relatives"<sup>(7)</sup>, whilst his colleague in the parish of Leslie deplored "a growing disposition to take every advantage of the poor's funds and children willing to free themselves from every burden when their parents advance in years"<sup>(8)</sup>.



This brief historical digression demonstrates at least that the "ominous concord of agreement", of which Sheldon speaks, must be treated with considerable reserve; and in fact the reservation made by the Commissioners in 1909, quoted above, is of singularly topical relevance.

In attempting to assess the extent to which families neglected their old folks in the present series, it was seldom easy to make a fair judgment. There were, on the evidence available, eighteen patients, twelve in urban and six in rural areas, who had relatives who might have given assistance but who refused, or had made no offer, to do so. This represents 4.5% of the whole series. Since however it was not usually possible to seek out the "neglectful" children or to enquire into their circumstances, the information available, which was obtained from the patient or from the relatives in whose care he was, was apt to be one-sided.

Five of these patients were living alone. One old lady, who lived in a small flat in a new housing estate, had a son and daughter, both married, in the West of Scotland; she had had little contact with them for many years but whose fault this was, no-one could say. Two old men who lived alone were married, but had been separated from their wives and families for years; another old lady, found in a state of neglect, had lived with a married daughter but had quarrelled with her and had elected to live alone. The fifth, an old lady whose married daughter lived next door and looked after her, had two married sons living a few miles away who might have helped but did not.

Eight patients lived with married sons or daughters, all of whom complained that other members of the family did not give any assistance; in two of these cases, however, it was found that the patient

had in fact previously lived with other children but had parted from them by mutual consent; one old man had a long history of alcoholism which had driven his daughters from him; when seen, he was living with a married son, whose wife, having become acquainted with his habits, said "she could not blame the daughters".

Two patients were living with their spouses only; one had a daughter who apparently neglected her parents; the other, an old man, had been married twice; his second wife did not get on with his two daughters by his first wife, so they did not visit him or help when he became ill. One old man lived in lodgings: he had five children, none of whom was willing to look after him when he became ill; he had previously lived with one of them, a married son, but had left because his habits were unacceptable to his daughter-in-law.

Of the remaining two patients, one, an old lady, lived with an unmarried daughter who was a nurse; another married daughter apparently would not help. The other, a confused, incontinent old woman, lived with her husband and an unmarried son; she relied mainly on one married daughter who lived nearby and who bitterly attacked two of her sisters, who lived in the vicinity but "would not lift a hand to help her".

From this short recital it would seem that the number of younger relatives who neglect their parents is not large, and that where there is apparent neglect, there may well be faults on both sides. On the whole, experience in this series corresponds closely with that of other investigators. Curran<sup>(9)</sup> and his colleagues, who enquired into the circumstances of the aged poor in Glasgow in 1946, found that of 1001 old people only 27 had a family "at hand but not interested"; Anderson and Cowan<sup>(10)</sup>, who studied the influence of work and retirement on the health of older men in Rutherglen, found that a significant number

of retired men were receiving financial assistance from their children, and that where children existed but were not assisting, "only a few of these children were apparently callous and indifferent ... most of them had insufficient income to cover their own family needs and that of their parents". Chalke and Benjamin<sup>(11)</sup>, who investigated the circumstances of old people receiving assistance through the Home Help Service in the Lewisham and Camberwell districts of London, enquired into those instances where relatives existed but gave no help. They found that of 1082 households surveyed, only a dozen relatives could but would not help. The conclusion reached by these authors was that "there is not a great deal of extra help which could be sought from relatives nowadays and the alleged 'negligent spirit of the age' is in reality a factor of minor importance".

This is an important conclusion, based on a large survey. It has not been disputed, so far as the writer is aware, and it is, on the evidence of this series, equally applicable to Fife.

The impression appears to be current that old people in rural areas are better cared for by their families than are those in urban areas. Adams and Cheesman, who carried out a survey among old people both in hospitals and in their homes in Northern Ireland, reported that "discussion with the medical and nursing staffs in the hospital survey suggested that this sense of filial obligation may be stronger in rural than in urban districts"<sup>(12)</sup> and again that "most practitioners in rural areas confirm the view that families there are more prepared than their counterparts in town to look after their elderly dependents at home"<sup>(13)</sup>.

But views and impressions are not evidence, and on this point the writer is not aware of any survey in a rural area which could validly be compared with those in urban areas so far published - for /

example that of Chalke and Benjamin. In the present series, a higher proportion of old people in urban areas were cared for by younger relatives than in rural areas (Table X, p. 36), but "neglect", as has already been shown, played no significant part on either side. It would seem that differing local conditions (such as have already been described in Fife) are of far greater importance in determining the proportion of old people who lack help from younger relatives than any variations in the sense of moral responsibility - a most hazardous postulate.

It may well be that in large cities, particularly seaports such as Belfast, Liverpool or Glasgow, there is a greater floating population which in old age has fewer family associations to support it, and which gives rise to the impressions recorded by Adams and Cheesman. But where the urban population is relatively stable and well-housed, as in Fife, old people are more likely to have relatives at hand who can look after them, than are those in rural areas.

Still more difficult to assess, however, is how far relatives are "unwilling" or are keeping their old people "on sufferance". Here one enters on dangerous ground. At one end of the scale are those who clearly feel that they have been saddled with an older relative whom they do not want, and at the other are those who, having cared for an aged parent through a long and incapacitating illness, reach the stage where they feel that removal of the invalid offers the only hope of relief; numerous cases in this latter category have been described. In the former category, there were perhaps a dozen cases in the whole series, the following being a typical example:

Mr. F., age 75 : Recent cerebral thrombosis with R. hemiparesis; making good recovery; continent; but likes to remain in bed. Formerly lived in lodgings,

but was "taken in" two years ago by daughter and son-in-law. Good home; patient has bedroom (and bathroom) to himself on second floor, but now can't manage stairs. Has been well cared for.

Son-in-law very bitter; says the old man was selfish all his days and is now trading on his daughter's soft-heartedness; wants him removed as he now needs nursing, and asserts that he will not take him back.

A further four cases were of the same sort; but in the remainder there was a greater or lesser degree of understandable strain due to the patient's illness. The circumstances in which families definitely asked for the removal of an aged relative varied widely. One woman complained bitterly that she could no longer nurse her father (who had been ill for two weeks) and look after her husband and family as well - the family consisting of a grown-up son and daughter, both of whom were working; she demanded her father's "immediate removal". But another daughter asked "if her mother could be accommodated somewhere soon", as she had looked after her for ten years and the old lady, a heavy woman, was now bedridden and was losing her memory. There were seven members of the family occupying a three-apartment Council house; the patient's bed was in the livingroom downstairs, and the bathroom and toilet were upstairs; it took three members of the family to move her. The daughter's request seemed not unreasonable.

There is little point in attempting a further breakdown of these cases; it is easy to recognise those which lie at the extremes, but in the great variety of situations which lie between it is less easy to reach a fair conclusion. For, in the last analysis, when one considers the stresses and strains of family life, the infinite variety of human character and personality, the inconvenience of many homes, the constant irritations, the difficulties of nursing the bedridden, the incontinent or the confused, and how little really is known of the patients themselves :/

what sort of parents they made, and what sort of example they set for their children to follow - when all these have to be taken into account, who is competent to pass judgment ?

### The Domiciliary Services of the Local Authorities

This survey of the elderly sick and disabled in Fife would be incomplete and unbalanced without some reference to the part played by the District Nursing and Home Help Services which each of the three Local Authorities (the County and the two large Burghs) has developed in recent years, and which are increasingly occupied with the needs of old people. In the Burgh of Kirkcaldy, in the year 1958, one-half of the patients visited by home nurses were 65 years of age or over, and they received two-thirds of the total visits paid; similarly, of 331 persons supplied with domestic help, no less than 258 were of the same age-group <sup>(14)</sup>. In Dunfermline, in 1957, half of the total visits paid by the home nursing service were to old people, and of 254 cases provided with domestic help, 184 were described as elderly and infirm or chronic sick <sup>(15)</sup>.

Of the 400 patients in this series, 115 (29%) were being attended by the district nurse at the time the patient was visited; and 73 (18%), almost all of whom were living alone or with the spouse only, had the assistance of a home help. The distribution was as follows :-

Table XV. /

Table XV.Patients Assisted by Local Authority Domiciliary Services

	<u>District Nurse</u>	<u>Home Help</u>
Urban Males	24 (19%)	20 (17%)
" Females	60 (33%)	33 (18%)
Rural Males	15 (37.5%)	4 (10%)
" Females	16 (32%)	16 (32%)
	<hr/> 115 (29%) <hr/>	<hr/> 73 (18%) <hr/>

These figures reflect the facts, already referred to earlier, that a smaller proportion of men live alone, and that in rural areas a much higher proportion of women live alone. The high proportion of rural women who were provided with home help, as compared with other groups, is the more striking when it is recalled that in the holiday resorts - notably St. Andrews - it is extremely difficult, and at times impossible, to obtain domestic help in the home during the summer months.

There was however some evidence that these services were not fully appreciated, or made use of as fully as they might have been. There were 32 cases in the series (8%) in which it was felt, when the circumstances were assessed at the domiciliary visit, that the patient could carry on at home, at least temporarily, if domiciliary services were made available; or in which it was considered that these services should already have been provided. In some, the failure to obtain help was the fault of the patient or relative :-

Mr. G.G., age 65 : Two minor cerebro-vascular accidents; not incontinent but emotional, demanding, and has great difficulty in getting about. Lives in modern Council flat with his wife who now finds nursing a burden. Previously offered home help but refused. Now /

agrees to talk over her difficulties with local Health Visitor and to accept help.

Many elderly women, as is well known to all who work among the aged and infirm, resent the presence of "a stranger in the house" even when they so obviously need help.

In other cases - the majority of this group - it had not occurred to anyone that a disabled old person living alone might need help, nursing or domestic, or both, until admission to hospital could be arranged :

Mrs. L., age 64 : Said to have been suffering from "arthritis"; previously attending orthopaedic O.P. department for treatment but now unable to travel on account of pain; now confined to bed. Widow; living alone in tenement flat; looked after by a neighbour, a young woman with a baby. No domiciliary services. To be admitted for investigation; meantime needs home help and district nurse ...

In general, however, the patients in this series were either clearly in need of admission to hospital or could remain at home under the existing circumstances, and extension of the domiciliary services, except as a temporary measure as described above, could make little difference to the eventual outcome. There were in fact seventeen cases in the series in which the approach to the hospital service was made in the first place, not by the family doctor, but by the Local Authority, on the grounds that the needs of the patient had progressed beyond the resources or scope of its services.

Night attendant service for old people ill and alone, of the sort described by Elliott in Kent <sup>(16)</sup>, is provided only as a temporary measure in Fife in certain localities, notably in Dunfermline, through the Dunfermline Nursing Association Committee (using funds privately administered)



and elsewhere through the good offices of certain Old People's Welfare Committees, at the request of the family doctor. Assistance of this sort, however, valuable as it is in the emergency of the moment, cannot relieve the hospital service of its obligations.

Finally, it must be recorded that in all these cases in which the writer approached the appropriate Local Authority for domiciliary assistance, - as in the two cases described above - the help requested was readily and promptly forthcoming, as far as circumstances permitted. It is also worth noting that the practice, commonly adopted in Fife, of employing as a home help someone who knows the patient, perhaps a neighbour who has already been giving purely voluntary help, goes far towards removing fear of the stranger, and at the same time often ensures that the patient will be given that little extra help, at odd times, or in the evening, which may make all the difference between mere existence and reasonable comfort.

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## CHAPTER IX

RETROSPECT AND PROSPECT

In this final Chapter it is proposed to consider, against the background of the evidence adduced and discussed in the preceding Chapters, the implications for the future development of services for the elderly sick and disabled, with particular reference to the place of the hospital service.

While the social changes of the past half-century have benefitted mainly younger age-groups, the needs of the aged have during the past fifteen years received increasing attention, from statutory authorities as well as from voluntary agencies. In Fife, apart from improved housing conditions which have benefitted all sections of the community, all three Local Authorities now maintain well-appointed, comfortable Old Persons' Homes, together with domiciliary services which, as previously noted, are already devoted largely to the assistance of the elderly. Meals-on-wheels are provided, and chiropody services are being developed either by the local authority or, with its support, by Old People's Welfare Committees. The Church of Scotland maintains two Eventide Homes in the County, and the Red Cross Society meets a wide range of individual needs. Old People's Welfare Committees, of which there are twenty-one in the County already affiliated to the national body, now carry out regular visiting among old people, provide various services in time of need or emergency, and support many organised activities for the older members of the community.

But all these services, and this growing volume of voluntary effort, are in general directed towards helping those who are still capable of living independent lives. It is when the stage is reached where increasing disability calls for full-time nursing care, or when the effects of a sudden and disastrous stroke demand prompt and vigorous reablement measures, or when those who care for the aged invalid can no longer face the difficulties and

strain imposed by incontinence and mental confusion, that the limits of local authority services and of voluntary aid are reached, and the inadequacy of the available services for the treatment or care of the aged becomes apparent. It is in respect of the aged sick that social change has failed (in the words of Titmuss in a similar context ) "to be accompanied and eased by social justice".<sup>(1)</sup> What follows therefore in this Chapter constitutes an attempt to show how justice may best be done.

The first and fundamental requirement must be a hospital service adequately equipped in terms of beds and staff to fulfil its obligations; for it must be conceded, in principle at least, that the benefits of a state hospital service should be equally available to all - from which it follows that no individual in need of hospital treatment or nursing care should be denied that treatment or care because he is old.

It will be recalled that one of the most depressing aspects of the clinical examination of these 400 patients was the high proportion who were suffering from long-standing and irreversible invalidism, and that many, particularly those suffering from the effects of a cerebro-vascular accident, had never been treated. "There are today", says Homburger, "more than a million and a half hemiplegics in the United States. Some of them are getting proper treatment; many are still victims of indifference, ignorance and neglect. They are confined to a useless existence and are a burden on their families and their communities. This is the result of medical apathy and reactionary thinking on the part of practitioners who ought to know better, combined with old-fashioned notions ingrained in the minds of laymen, that a stroke is the end and that the poor patient has suffered enough and should be left alone".<sup>(2)</sup>

Homburger's indictment might well be applied to Fife; but before condemning the practitioner "who ought to know better", it is relevant to enquire what support or assistance has been available to him from the hospitals. For, as Anderson has said, "the general practitioner may be

fully aware of the dangers of inactivity. In view however of the home circumstances, the general feeling among the relatives, and the lack of skilled supervision, he is unable to put into practice what he feels to be the correct treatment. There is no doubt that rehabilitation is much easier in hospital ..... "(3)". The high proportion of irreversible, untreated, invalidism seen in these patients therefore is a measure of the inadequacy of the hospitals in Fife to provide the correct treatment : so inadequate in fact that a stroke, however severe the resulting disability, has not hitherto been regarded as a sufficient reason for admission to hospital, unless the social circumstances of the patient demanded that "a bed be found somewhere". The effects of this attitude, in terms of invalidism, incontinence and misery for the patient, and of stress and strain on those who look after him, have been sufficiently illustrated in the preceding Chapters.

It is not relevant to discuss here the reasons for the shortage of hospital beds for the elderly and long-term sick in Fife, nor what steps should be taken to remedy the deficiency; these are matters for the hospital authorities concerned. Suffice it to say that there are at present in the County approximately 150 beds for the aged and long-term sick, including the younger chronic sick, serving a population of 306,000, and representing 4.3 beds per thousand persons aged 65 and over. By comparison, in England and Wales as a whole, in 1954-55, there were 11.2 beds per thousand persons aged 65 and over, a number which (as the official Report considered) is "about sufficient in total if they are properly used and better distributed".<sup>(4)</sup> The need to provide Fife with a comparable number of beds is now admitted.

The pattern on which hospital services for the elderly are now organised, based on acute (or admission) units, and long-stay units, on the lines suggested by the Committee appointed by the British Medical Association in 1946 <sup>(5)</sup>, is now well established, and needs no discussion here, except in one respect. This concerns that large proportion of the elderly sick /

who suffer from mental deterioration or frank dementia (constituting, it will be recalled, one quarter of all cases in the present series), whose treatment or continuing care presents one of the most pressing problems of the day, both for Hospital and for Local Authorities.

When these patients can no longer look after themselves, or be cared for by relatives, and where neither local authority nor hospital geriatric accommodation can be found for them, they are frequently certified and admitted to mental hospitals, because no alternative exists. It has however long been recognised that for the great majority of these cases certification is unnecessary : a recognition acknowledged in the recommendations of the recent Royal Commission on Mental Illness in England and Wales,<sup>(6)</sup> and already embodied in proposed new legislation, which will, as appears likely, be applied in due course to Scotland in similar form.

While it is difficult as yet to predict the effect of this change, it is clear that it will demand an appropriate assessment of these patients in terms of responsibility, where necessary, for their ultimate care, and that this in turn must involve very much closer co-operation between mental hospitals, geriatric services and local authorities than has hitherto existed. One essential step in this direction, so far as the writer can foresee, must be the establishment of psychiatric observation units in close contact with geriatric admission units, working together and with the local authority, and permitting a free interchange of patients.

Assuming however that an adequate number of hospital beds will in due course be made available in Fife, it remains now to consider briefly the functions of the hospital service in relation to the general care of the elderly sick.

First of these is of course to provide treatment for those capable of being restored to health or to some measure of active life. But /

successful treatment implies complete and accurate diagnosis; and here the second comment at the close of Chapter III may be recalled, that many causes of illness and disability in these patients remained untreated because they had never been diagnosed. It is not sufficiently realised, and it cannot be too strongly emphasised, that old people become ill, not because they are old, but because they are victims of pathological processes which require at least to be identified before the patient is pronounced "incurable". Since however the pathologies of old age cover so wide a field, the first qualification for the doctor who would make the care of the aged his province, is not highly-specialised knowledge, but a sound knowledge of general medicine in its broadest sense; to which must be added not only a particular knowledge of degenerative disease but an awareness of the unusual modes of presentation of acute illness and disease in old age - much of which can be acquired only by observation and experience. And the diagnostic skill so acquired must be tempered with judgment, for multiple pathology being the rule rather than the exception, it is as important to determine what can and should be treated, as it is to know how to treat. To all these must be added patience and determination, for, as Adams and McComb have shown, the seemingly hopeless hemiplegic may begin to respond, and may ultimately regain activity, only after many weeks of apparently fruitless endeavour<sup>(7)</sup>.

But to regard the hospital as a diagnostic and treatment centre is too narrow a concept, and the physician who conceives his duties as being "limited to the daily treatment of patients" will, as has been recognised elsewhere, achieve little<sup>(8)</sup>. In the care of the aged, the hospital cannot properly play its part in isolation; it must work in collaboration with and in support of others who may be responsible for the future care of the patient. This concerns particularly the younger /

relatives of those patients who have families of their own, and where there are no younger relatives, it concerns the local authority.

It will be recalled that 45% of all patients in this series were living with their younger relatives; and the burden which many of these families carried, the stresses and strains to which they were often subjected, and the necessity, often urgent, of giving relief to the daughter or daughter-in-law who bore the burden unaided, have been discussed at some length. It has also been shown that although the majority of families now enjoy good housing conditions, the small modern home by no means solves the difficulties of nursing the elderly sick, and may in fact even aggravate the strain imposed by long-continued invalidism. The evidence, in short, clearly demonstrates that where the aged sick are being cared for at home, the patient's illness can seldom be dealt with in isolation; the impact on the family, and the reactions of the family to it, are of no less importance than they would be if the patient were, for example, a defective child.

Here it must be stated that the writer would not himself support any policy for old age which encouraged the belief, or which sought to imply, that children should expect as of right to be relieved of responsibility for their parents when they become ill or disabled, or even permanently bedridden. On the contrary, experience in Fife suggests that not only could a great deal of misery be alleviated, but hospital beds could be used to much better advantage, if the hospital service endeavoured to support and encourage the family in its continuing care of incapacitated parents.

It is however one of the defects of the modern hospital system that the physician has himself little contact with the patient as a member of his family and community; yet if the hospital is to function in support of the family, it is essential that the physician should have as much knowledge of the family, of its attitude towards the patient, of the home in which he lives, and of its resources, as he has of the patient himself. This is one of the strongest arguments in favour of domiciliary



visiting by the physician prior to the admission of the patient to hospital, for, armed with first-hand knowledge of all the relevant facts, the physician is then in a position to discuss their difficulties with the relatives, and to explain to them what the hospital service will undertake, and what it will not undertake, in terms of the future care of the patient. It must be made clear at the outset that the hospital does not exist to relieve them of a burden, and that their responsibility does not end with the patient's admission to hospital. At the same time, help must be offered - and the obligation must be honoured - as circumstances require : it may be the admission of the patient for treatment - if possible at an early stage of his illness, when treatment is most likely to be of benefit; or it may be the temporary admission of an incurable invalid in order to tide the relatives over a domestic crisis, such as illness in some other member of the family, or in order to let them have a holiday, or to relieve intolerable strain, or perhaps in an attempt to render the patient more manageable. In only a small proportion of cases, where skilled nursing is required and the family resources are meagre, should admission on a long-term basis be considered.

Furthermore, knowing the resources of the family, the physician is also in a position to determine how soon the patient who has been treated can safely be sent home, and to what extent further guidance or help will be required. For, as has also been demonstrated, many younger relatives lack experience and confidence, and have little conception of how to deal with the disabled elderly patient; much anxiety can, however, be relieved by explanation and demonstration in the hospital ward before the patient is discharged, and by attention to such simple details as the provision of a bedside commode in a home where the patient's bedroom and the toilet are on different floors. It is also in the after-care of those patients who have been discharged home that a geriatric out-patient clinic perhaps has its most useful function, for not only can deterioration in the patient be sought for and checked by further treatment

but the difficulties of management at home, which inevitably arise, can be discussed and resolved between the physician and the relatives.

Thus, based on the physician's personal knowledge of all the circumstances, a partnership is formed between hospital and family, in which the latter has a continuing responsibility for the patient, but is not abandoned to bear the burden unaided; and it is the writer's belief that by these positive methods many patients who would otherwise become permanent occupants of hospital beds can continue to be cared for at home. This is a policy in which the family doctor will willingly co-operate, for he has hitherto in Fife received so little support from the hospital services that he himself has become discouraged in the attempt to treat his aged patients, or to relieve the distress of the relatives, with the result that by the time the patient is eventually removed to hospital, neither his family nor his doctor are willing that he should return.

There remains now to be considered that large proportion of the aged sick who have no relatives, or whose only relatives are themselves old and unable any longer to look after them. The proportion is substantial, for approximately 25% of all persons over the age of 65 in this country are without children<sup>(9)</sup> - and this does not include those whose children have emigrated, or who live in distant parts of the country, or are otherwise unable to assist their parents. It is mainly in relation to the care of these patients that the hospital service must support, and be supported by the local authority, for these are the patients who so often, when independence is lost, require permanent care.

It seems to the writer an elementary proposition that if the needs of the aged who have no families of their own are to be appropriately met, the two statutory services most intimately concerned, and whose duty it is to meet those needs, should work in harmony and close

collaboration. There can be little excuse today for the situation, described in the Report on the services available in England and Wales in 1954-55, in which "the hospital and the local health authority appeared to ignore each other's existence", or in which the services "existed in isolation" <sup>(10)</sup>. The respective responsibilities of the hospital and of the local authority in the care of the aged have been clearly defined, and the definition has been often quoted <sup>(11)</sup>; but no definition, however carefully expressed, can cover every case and circumstance, and, especially where the aged are concerned, the definition which applies today may be inapplicable tomorrow. Those who need help quickly, as old folks often do, will derive little comfort from him who would stand by the letter of the law, or excuse himself by pleading someone else's responsibility. The gap between hospital and local authority services cannot be bridged by a definition, necessary as that may be as a general guide. If help is to be given when it is needed, it should be given by whoever first learns of the need, so far as his resources permit, and the question of responsibility determined thereafter.

Reference has already been made in Chapter VIII to the part played in Fife by the domiciliary services in the care of the aged in their own homes, and to the co-operation of the local authorities in providing temporary assistance, at the request of the hospital physician, for those awaiting admission to hospital. Similar arrangements are made, it may be added, as a matter of course, when domiciliary assistance is required for a patient on discharge from hospital. Where however the patient is unable to return home, and the question of permanent care has to be considered, the decision as to where he should best be accommodated is arrived at by mutual agreement between the hospital and the local authority concerned. Such a decision is never regarded as final, but is subject to review as the patient's condition may demand; and, in order that the patient's doubts and fears may be allayed, the medical officer of health, or the appropriate member of his staff, is as welcome to visit him in the hospital wards before any move is made, as is the hospital physician to /

visit a resident in an Old Persons' Home.

Co-operation of this order however demands two things : first, that each service must be fully aware of the resources and limitations of the other; and second, it demands a clear understanding between those who control each service - an understanding which can be based only on personal relations of friendship and trust. These relations exist in Fife, and given the resources, the needs would be met.

To the aged at all times, but more so in sickness and infirmity than in health, the worst that can befall them is to know that they are unwanted, that they have become a burden, and that such help as is given them is given only as a duty or of necessity. Whoever therefore has a duty to give help, whether as son or daughter, or as hospital physician or as welfare officer, must give it willingly and ungrudgingly. None can disclaim responsibility, for all are members of the same community, which is responsible for its aged and infirm no less than for its children. At the present time, the increasing proportion of old people, with their attendant illnesses and infirmities, presents many problems; but if the community is made aware of, and accepts, its obligation, the problems are not insuperable. The obligation was stated in its simplest terms, four hundred and fifty years ago, by the only English writer to attempt, after the manner of Plato, to create the perfect state; the intervening centuries have not diminished its validity :-

"For they (the Utopians) judge it a great point of cruelty, that anybody in their most need of help and comfort should be cast off and forsaken, and that old age, which both bringeth sickness with it, and is a sickness itself, should unkindly and unfaithfully be dealt withal"<sup>(12)</sup>.

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11. See, for example, "Not by Beds Alone", (the Minister's Advice on the Care of the Elderly); Lancet, 1957, 2, 790.
12. More, Sir Thomas : "Utopia - the Second Book", Louvain, 1516.

APPENDIX A.

SIX ILLUSTRATIVE CASE RECORDS

Mr. D.S.

Age : 76.

Unit No. G.34/58.

Dr. S.

Visited: 28.1.58.

Clinical Notes

Enjoyed good health during working life. No disabilities except old injury to R. ankle. Retired age 66.

For some time has suffered from cramps in legs while walking and increasing stiffness of limbs, especially legs. Became unable to walk about one month ago and has since been in bed; no history of any sudden loss of power.

Appetite fair; bowels regular; sometimes has some "difficulty" with micturition.

Fresh looking old man; superficial sores on buttocks. No lymphadenopathy. No cyanosis. A little sacral oedema.

Pulse 76/min., regular. B.P. 190/110.

Heart - apex beat not localised; rhythm regular. No venous overfilling in neck.

Chest - dull both bases with poor air entry; no crepitations heard.

Tongue - clean, moist.

Abdomen - soft, no tenderness, no masses.

C.N.S.

Alert but expressionless; speech slow.

Coarse tremor of hands.

Pupils react briskly; no nystagmus. Fundi : no papilloedema.

"Nipping" of veins; not much else made out.

Upper limbs : tone increased. Good range of movement and fair degree of power but R. hand weaker than L. Fingers extended at distal joints; cannot be abducted.

Lower limbs : tone increased both limbs. Both stiff but can flex R. hip and knee through good range. Cannot flex L. knee and can just raise L. leg off bed. Knee can be passively flexed with difficulty. Tendon reflexes present but diminished. L. plantar response extensor.

Haemoglobin : 80%<sup>+</sup>.

Impression :

- (1) Parkinsonism.
- (2) Cerebral thrombosis with L. hemiparesis.

Social /





Mrs. D.

Age: 69.

Unit No. G.437/57.

Dr. S.

Visited: 21.10.57.

Clinical Notes

Patient has suffered from arthritic pains in knees and upper limbs for some years and has been slowly deteriorating. Her daughter says she had a 'slight shock' some years ago and another a few weeks ago (patient is unaware of this). She was, however, able to get about and to manage stairs until July, 1957, when she was admitted to West Fife I.D. Hospital with ? pneumonia. While there, some fluid was removed from left side of chest. She was discharged 2 weeks ago but is now unable to walk, complains of pains in legs when got out of bed and is very weak.

Fairly well nourished; conjunctivae well injected. No oedema, no clubbing, no lymphadenopathy. Breasts: nil. Rheumatoid deformities of hands; left wrist almost fixed; limitation of movement left elbow; fair range of movement at knees and hips but left knee especially is swollen and painful on flexion. Skin intact. Pulse 90/min., regular. Heart regular, no bruits. B.P. 130/65. No venous overfilling in neck.  
R.S. :

P.N. impaired both bases. Air entry impaired left base; a few rhonchi left lower zone; no crepitations.

G.I.S.

Tongue moist, furred. Abdomen: nil.

C.N.S.

Alert. Iridectomy L. eye, cataract R. eye. Vision poor in R. eye. A little weakness left hand as compared with right - more so than can be accounted for by rheumatoid deformity. Weakness both lower limbs, especially left. Tendon reflexes brisk. Plantars equivocal.

Impression :

Rheumatoid arthritis.  
Cerebral thrombosis, left hemiparesis.  
Recent ? pneumonia with effusion.

Social Circumstances

Lives with daughter, Mrs. S., in new Council house - 2 floors. Other occupants are - daughter's husband (pithead worker), her brother (dockyard worker) and daughter, who works in Silk Factory in Dunfermline. Her daughter, Mrs. S., has recently had mastectomy for carcinoma of breast, followed by radiotherapy and although able to carry out housework, finds nursing her mother too much for her. She has no Home Help. Working

Working members of family are on shifts and two weeks from now will all be on back-shift together, so that Mrs. S. will have no help with the patient from 2-11 p.m.

Disposal

Patient might be rehabilitated with treatment for arthritis, plus reablement therapy.

Admit when possible. Home Help to be arranged meantime.

Waiting List.

Letter : Dr. S.  
County Medical Officer.

Mrs. C.

Age : 79.

Unit No. G.470/57.

Dr. J.

Visited : 26.11.57.

Clinical Notes

Gall-bladder removed 21 years ago (no recurrence of gallstones since then).

Diabetes discovered 2 years ago; mild, controlled with Insulin - 13 units (now 8 units Lente per day) and diet.

Well and active until almost 2 years ago when she was struck by some boys playing in the street. A few days later, she developed pain in left leg and was laid up for three or more weeks. She recovered but some months later developed pain and weakness in right foot. This disabled her to such an extent that she had to give up living alone and went to stay with her daughter at present address. At that time (15 months ago) she could still walk but condition has progressively become worse. Now has gross weakness of right leg but also considerable pain and tenderness in right foot, leg and lower back. Pain comes and goes - not related to exercise; cannot bear weight; able to be up in wheel-chair only.

No trouble with bladder. Tendency to constipation but appetite fair; no vomiting; no swelling of feet; no dyspepsia or cough.

Well nourished woman; moves in bed with difficulty. No cyanosis, oedema, clubbing or lymphadenopathy.

Breasts : nil.

Pulse 76/min., regular. B.P. 190/95.

Heart regular, no bruits.

No venous overfilling in neck.

Chest : clear but marked scoliosis to left. (Daughter thinks this deformity became noticeable after her gall-bladder operation).

G.I.S.

Tongue clean, moist. Abdomen : operation scarring; no masses.

Liver and spleen not palpable.

C.N.S.

Alert. Pupils react normally; cataract but can read with glasses. No facial weakness. No loss of power or movement and no sensory loss in upper limbs. Wasting and gross weakness with foot drop, right leg. Tenderness in all muscle groups - right leg. Tendon reflexes diminished. R. plantar not elicited; L. plantar flexor. Diminution of all forms of sensation in right leg below mid-calf - areas difficult to determine but touch, pin prick, position sense all affected. Some osteoarthritic changes of right knee. Spinal deformity as noted. Tenderness on pressure over lumbar spine at point of maximum deformity.

Fundi : no papilloedema, no exudates or haemorrhages seen (but examination not satisfactory).

Haemoglobin /

Haemoglobin : 80%.

Impression : ? Peripheral nerve injury due to collapse of vertebral bodies.  
Diabetes mellitus. ? Diabetic neuropathy.

Social Circumstances

Lives with daughter and son-in-law in modern bungalow and is well cared for : no social problem.

Disposal

Should be admitted for investigation and treatment; if possible. May be considerable degree of osteoporosis which may play a part in pain production.

Admit early - not long-stay case.

Waiting List.

Letter : Dr. J.

Mr. A.W.W.

Age: 88.

Unit No : G.532/57.

Dr. S.

Visited : 27.12.57.

Clinical Notes

Frail, thin old man; sitting in a chair by the fireside, fully clothed; dyspnoeic on slight exertion but not distressed; had some sort of acute episode recently when he was unable to get up and his doctor thought he was going to die : has however recovered.

No oedema; pulse 76/min., regular. A little cyanosis of lips. Mentally alert. Has full use of limbs but unsteady on his legs.  
Very dirty : full examination not possible.

Impression :

? Chronic bronchitis.  
Frail; neglected.

Social Circumstances

Living in single room in a modern lodging-house. Has Home Help every morning - but he says she is not much use to him : he is probably right, judging by the state of filth of the bed and the room. No attempt has recently been made to clean the place up.

He has a brother living in Balsusney Road (a recent geriatric patient), who could not possibly look after him.

Disposal

Have spoken to Dr. S. Patient's name will remain on my Waiting List - he will need hospital care sooner or later - and I will admit him when I can. Meantime, if he becomes acutely ill, we might arrange admission to General Medical Wards.

Waiting List.

No letter.

Mrs. McG.

Age : 69.

Unit No. G.217/58.

Dr. W.

Visited : 26.6.58.

Clinical Notes

"Rheumatic fever" in childhood; developed limp at same age due to shortening L. leg (? hip joint disease).

Had operation for hernia 3 months ago in K.G.H. - made good recovery.

Health good until 5 weeks ago when she sustained cerebral vascular accident with loss of power L. side and incontinence.

Has been completely bedridden ever since; wets bed at night, dry by day.

Appetite fair; bowels regular.

Small, alert old lady. Skin intact. A little sacral oedema. No lymphadenopathy. Gross deformities of feet with bunions, hallux valgus and hammer toes. L. leg. about  $1\frac{1}{2}$ " shorter than R.

Pulse 90/min. Heart grossly irregular - auricular fibrillation. Soft apical VS murmur. B.P. 135/90.

Chest : a few scattered basal creps.

Tongue: moist, clean.

Abdomen: nil. Well healed L. inguinal scar.

Weakness L. side of face. Flaccid paralysis L. arm and leg; can extend L. leg to some extent but practically no power in arm. L. plantar extensor. Mentally quite alert.

- Impression :
- 1) Cerebral thrombosis or embolism; L. hemiplegia.
  - 2) Rheumatic heart disease - auric. fibrillation.
  - 3) Old L. hip joint disease with shortening L. leg.
  - 4) Deformities of feet.
  - 5) Incontinence of urine.

Social Circumstances

Lives in old 2-storey house, 4 rooms, inside toilet.

House clean; patient well cared for.

Lives with husband, who is active.

At present, daughter-in-law (with two young children) living with her to assist. Her husband works in -- and she is shortly moving to a new house in -- . She is a capable woman.

A married daughter lives in St. Monance - at present in Craigtoun Maternity Hospital.

District Nurse calls daily.

No Home Help.

Disposal /

Disposal

Hospital when possible. Family can manage meantime. Problem will arise when daughter-in-law leaves in near future. Patient should be encouraged to be up. She can be up in chair daily - how this should be done was demonstrated to family.

Waiting List<sup>+</sup>

Letter : Dr. W.

\* Proved on admission to hospital to have mitral stenosis. This case is referred to on p. 18.

Notes

... in old 8-story house, ...  
... patient well ...  
... husband, who is ...  
... daughter-in-law ...  
... husband ...  
... woman ...  
... lives in ...

Mrs. P.

Age : 73.

Unit No. G.274/58

Dr. McC.

Visited: 22.7.58.

Clinical Notes

Patient had a 'stroke' 6 years ago from which she made a good recovery and was able to get about very well.

A year ago, she was admitted to the Medical Unit, Victoria Hospital, following an attack of severe retrosternal chest pain, followed by swelling of the feet and ankles. She remained in hospital for 6 months but since discharge (8.8.57) she has been able to get about the house only with difficulty. During the past 3 weeks she has become unable to walk at all, except to drag herself to the toilet; she has complained of pain in L. leg or hip; she has become very emotional and appetite has been poor. Her daughter says she seems to have lost confidence altogether, she has lost interest in everything and she wants into hospital to die !

A thin, anxious old lady; very tense, apprehensive of every movement. Very slight oedema of feet and a small pad of sacral oedema. Small, dirty ulcer over R. external malleolus, otherwise skin intact. No clubbing. Cyanosis of lips. Breasts: nil, no lymphadenopathy.

Pulse 90/min.; heart regular apart from occasional extra-systoles. A.B.  $4\frac{1}{2}$ " from m.s.l. No venous overfilling in neck. B.P. 160/80.

Chest : scattered rhonchi, bases clear.

Tongue : furred.

Abdomen : nil.

C.N.S.

Apprehensiveness the main feature. Mentally clear. Pupils react normally. Moves all limbs through good range - but power generally diminished; no paralysis. Plantars flexor. No evidence of injury to L. hip. Can in fact bear her weight and make an attempt to walk but is afraid to do so. Very sorry for herself.

Haemoglobin : 85%<sup>+</sup>.

Impression : Anxiety and mental depression.  
Old coronary thrombosis with infarction.  
Incipient congestive cardiac failure.

Social Circumstances

Lives with daughter, son-in-law and their children (12 and 7 years) in modern flat, 1 stair up.

Accommodation good; house clean; patient obviously well cared for.

Patient /



Patient has lived here since her husband's death, a year ago - which precipitated her own breakdown.

Daughter is intelligent and anxious to look after her mother but is now afraid to leave her alone; she has not been out of the house lately. No domiciliary services.

Disposal

Leave at home meantime. I have advised that the old lady should be got up in the morning and be left in a chair for an hour or two; that her daughter should start going out and leaving her alone for a little while to begin with. Old lady should be encouraged - or forced - to use her legs again and to take more interest : no reason, e.g. why she should not knit.

Also suggest all drugs should be withdrawn except Saluric, 1G. b.d. twice or thrice weekly.

Eusol soaks to ulcer on foot until clean - then Brulidene or Zn. Cream.

Not for Waiting List meantime. Have promised to help if the old lady fails to improve.

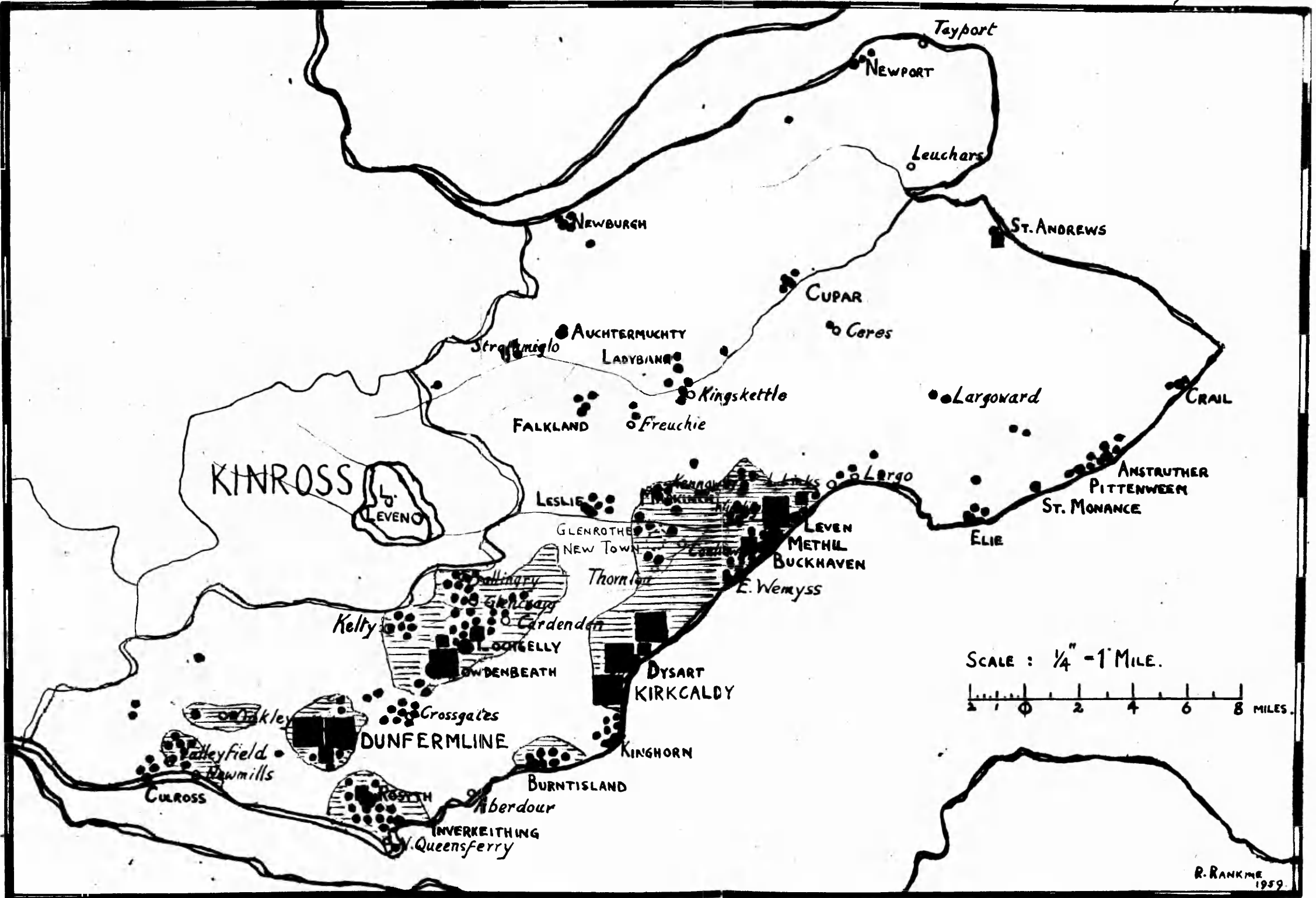
Letter : Dr. McC.

APPENDIX B.

MAP I - COUNTY OF FIFE

MAP II - DISTRIBUTION OF 400  
PATIENTS VISITED

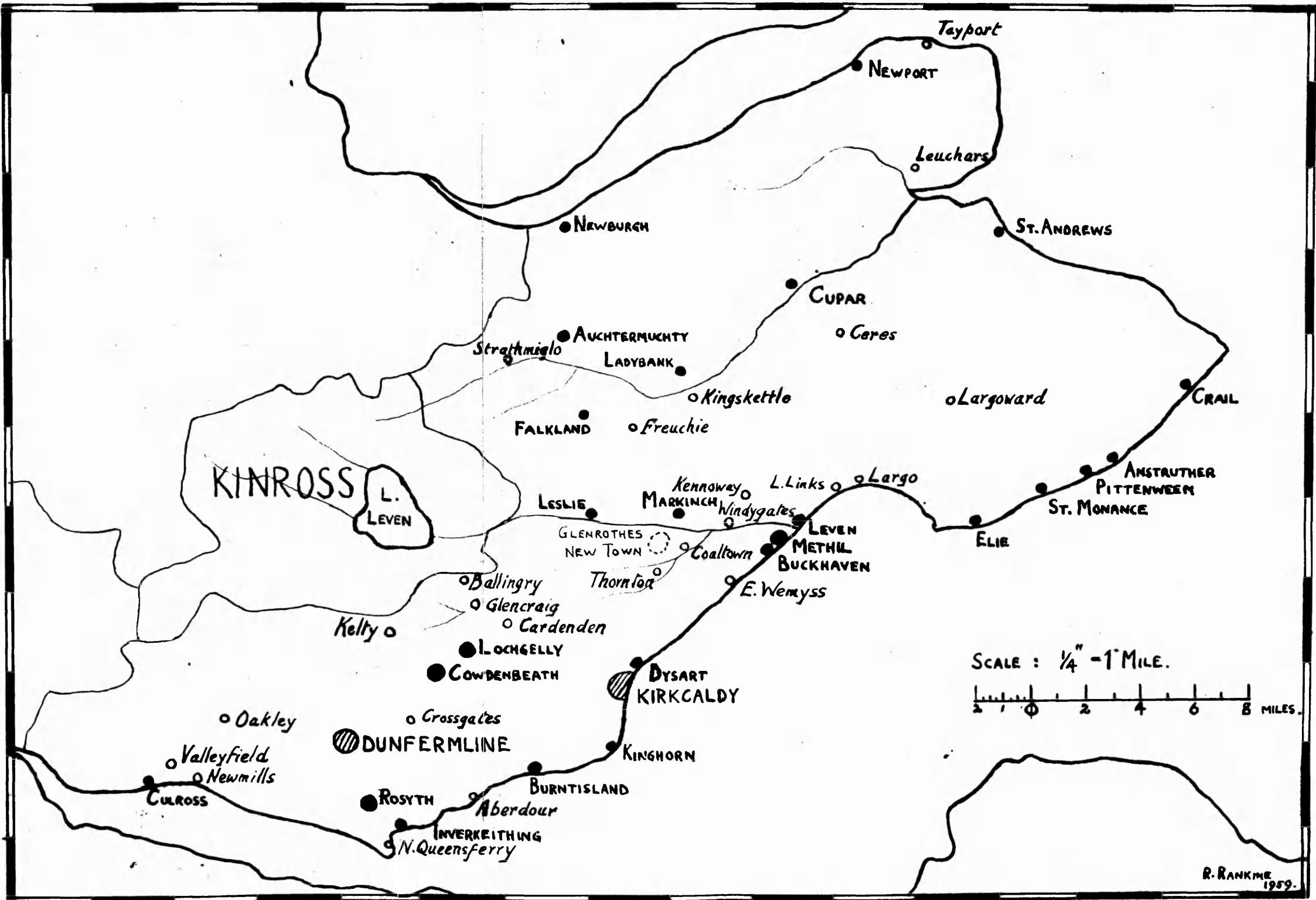
MAP II. (TO BE SUPERIMPOSED ON MAP I.)



DISTRIBUTION OF 400 PATIENTS VISITED.

- Represents 20 patients.
- ▨ Mining and Commercial Areas.
- LARGE BURGHS :- 10 patients
- SMALL " :- 1 patient
- OTHER TOWNS :- Newmills

# MAP I



## COUNTY OF FIFE.

- |                 |   |             |
|-----------------|---|-------------|
| LARGE BURGHS :- | ● | DUNFERMLINE |
| SMALL " :-      | ● | LEVEN       |
| OTHER TOWNS :-  | ○ | Newmills    |