Knowing when to change course

I will begin with a story. After recounting it I will attempt to apply it to our subject. It is entitled, “The Lighthouse Story.”

Two battleships assigned to the training squadron had been at sea on manoeuvres in heavy weather for several days. I was serving on the lead battleship and was on watch on the bridge as night fell. The visibility was poor with patchy fog, so the captain remained on the bridge keeping an eye on all activities. Shortly after dark, the lookout on the wing of the bridge reported, “Light bearing starboard bow.” “Is it steady or moving astern?” the captain called out. The lookout replied, “Steady, Captain,” which meant we were on a dangerous collision course with that ship.

The captain then called to the signalman, “Signal that ship: We are on a collision course, advise you change course 20 degrees.” Back came a signal, “Advisable for you to change course 20 degrees.” The captain said, “Send, I’m a captain, change course 20 degrees.” “I’m a seaman second class,” came the reply. “You had better change course 20 degrees.” By that time the captain was furious. He spat out, “Send, I’m a battleship. Change course 20 degrees.” Back came the flashing light, “I’m a lighthouse.” We changed course.

What’s the point I want to make with this story? Simply that we are sometimes confused about who gets to stay in place and stay the same, and who has to change. Who is the lighthouse and who the battleship? Those of us not yet elderly and sick or in some other way and degree dependent, all too often think it is our elderly and dependent members who should change while our role is to help them to adapt, to adjust, to fit into their new role of being elderly.

Playing the elderly role

I want to argue that, on the contrary, it is the rest of us who need to change, both our attitudes and our practices. The elderly have
earned the right and have a pressing need for the rest of us to let
them live with as few destructive changes as possible, and to do that
in a variety of ways. They are all too often overwhelmed by more
change than they can or should have to absorb.

The responsibility I have in mind obviously includes doing every-
thing we can to ensure that they are provided with adequate health
care. But it also includes, I suggest, the less evident but no less impor-
tant duty to protect and promote their autonomy. Or, put more sim-
ply, the duty to let them remain themselves.

Aging is only partly biological. For too many elderly persons,
being aged is also a role they play. We expect it and they oblige.
We write and reinforce their script by our tendency to stereotype.
For instance, “the elderly are all confused and forgetful.” We also
tend to paternalize. For instance, “they aren’t competent, they need
protection from themselves, we know what’s best for them.” Refusal
to play the aged role is too often taken as further evidence of elder-
ly incapacitation. The assertive elderly patient is “demanding,” the
quiet elderly patient is “senile,” the resisting elderly patient is
“putting herself at risk.”

The prevailing assumption about the elderly is that of a pervasive
incapacity. Unintelligent, unemployable, crazy and asexual, as a
prominent gerontologist observed, is the way our society tends to
view the elderly. According to one physician, the “normal” condi-
tion of the aged person is to be “frail and unsteady, dozing by day
and wakeful at night, confused about people and places, forgetful
and untidy, repetitive and boring, selfish and petty perhaps, and
consumed by fear of death.”

To attempt to impose a life entirely without risk or danger on
the aged is a cruel expression of paternalism. It denies elderly per-
sons the opportunity to mold for themselves a challenging existence
in their remaining years. Responding to that challenge will in some
cases not be realistic or safe, but when it is achieved even in part it
is far more rewarding for the elderly than the often frustrating con-
text in which well-meaning persons, institutions and governments
seek to protect people from themselves.

Of course many elderly persons have trouble remembering, but
not because memory always fails in old age—it simply takes longer
to work. It is now well established that the much publicized mental
deterioration rarely happens in most older people before the eight-
ties. What is loosely called senility may in many cases be caused by
malnutrition, anemia, excessive medication, medication interactions
and other reversible factors.
Of course many elderly people will at some point be dependent and need hospitalization for a time, but not necessarily all the time. Of course some are no longer capable of making all their choices, but they remain able to make some of them—if we let them and encourage them. Of course some are depressed, but it may be due to loneliness, a loss of standing and purpose, and the overwhelming number of changes around them.

Of course they may not be able to cope with every challenge and risk. But a life with no challenges or risks at all is hardly worth living, whatever one’s age. The challenge for those who care for the elderly or do research on aging or make policies affecting aged persons is surely to find new and creative ways for the elderly to continue writing their own scripts.

Drug prescriptions for the elderly
In the health care field there are many ways in which the script we write for the elderly not only restricts their autonomy, but puts their health and lives at risk. Consider, first of all, the matter of drug prescriptions for the elderly, specifically the very worrisome evidence of over-prescription, questionable prescriptions, dangerous drug interactions and hospital admissions for adverse effects of medications.

A 1994 study by a McGill research team led by geriatricians came to some shocking conclusions. Between 5% and 25% of all admissions to acute care hospitals for persons of any age are due to adverse effects of medications, that is, approximately 40,000 admissions per year. Seniors receive 28% to 40% of all prescriptions though they make up only 12% of the Canadian population. Some 45% of elderly persons received a questionable high-risk prescription, in other words prescriptions in which there is insufficient evidence of effectiveness to justify the risk. This was especially frequent with tranquilizers and sedatives, psychotropic drugs such as Valium, Dalmane, Halcion, Ativan and Serax. Some 13% of the elderly received a questionable combination of tranquilizers, and 31% received sedatives for an excessive duration, that is, more than 30 consecutive days. Some 13% of the elderly received contra-indicated and long-lasting benzodiazepine sedatives (Dalmane and Valium).

The explanations offered for all these and other shocking numbers reveal to what extent elderly persons are being poorly served. One such explanation is that many elderly persons see a number of doctors, to some extent hardly surprising given the need many have for more than one specialist. Over a given year elderly persons will
on average see four doctors and receive prescriptions from 2.3 doctors. Many will get their prescriptions from several pharmacies. But surely we need to establish more coordination and communication between pharmacists and between pharmacists and a patient’s primary physician in order to coordinate care and guard against the dangers noted. Computerized access by pharmacists to a patient’s prescription history and patterns is in the process of becoming available but does not appear to be rigorously used. Both physicians and pharmacists acknowledge that too many physicians tend to obtain their knowledge about prescription drugs from visiting drug company representatives rather than from more objective and informed pharmacists, and from more accurate and detailed studies reported in the medical literature.5

A second explanation, one offered by the McGill study, is that too many physicians wrongly assume that drugs which are effective with younger adults are always equally appropriate for the elderly. In reality, in the aging body a drug may be distributed differently, eliminated more slowly and have a variable effect on the target organs. For example, diazepam (Valium) accumulates in the increased fat stores of the elderly, takes weeks rather than days to be eliminated and can cause lethargy and confusion in the aging brain. Elderly users of Valium and similar drugs also have an increased risk of falling and breaking a hip.

Surely then we as a society and those in the health care fields need to encourage and do more research specifically into the safety and effectiveness of these and other drugs for the elderly. In this regard like many others, they are a neglected population. Undoubtedly what contributes to this research neglect is the stereotypical view that medical problems in the aged are simply natural by-products of aging rather than, in some cases, the result of uninformed and dangerous prescribing.

A third explanation offered for the prescription drug problems of the elderly is that all too often they do not take their medications as prescribed. That tends to be stated as if it is entirely their fault, simply another indication of their helplessness, a fact of life about which the rest of us need do nothing. Consider, however, some of the challenges some older individuals face. They may have six different medications at four different times a day, declining vision, reduced manual dexterity and memory problems.

But precisely in view of those challenges much can be done by others. For example, more careful and complete explanations can be provided by physicians and pharmacists to elderly patients and family
caregivers about timing and risks. Secondly, more visible and legible dosage and other instructions should be printed on drug bottles and packages. Thirdly, better supervision of drug taking should be ensured in institutions. Fourth, providing a continuing review by primary care physicians and pharmacists about whether all the prescription drugs an elderly patient is taking are really necessary, effective and safe. Lastly, there is a need for more consultation with individual elderly patients in order to determine as precisely as possible the appropriate prescription drugs for that patient consistent with his or her own quality of life and discomfort level preferences. For example, elderly patients, like others, have varying preferences as to the degree of alertness and control they are or are not willing to sacrifice for the sake of controlling pain and discomfort by means of medication.

No one should pretend that our inadequately funded and serviced health care system will readily provide for all these and other improvements. But evidence abounds that in the increased competition for time and services, our elderly population is all too often the loser. Only if these special needs of the elderly are acknowledged, along with their past, present and future contributions to society, will we advocate effectively that they receive a fair share of the pie.

**Legalizing assisted suicide**

It is at least plausible that our on-going debate about whether or not assisted suicide should be legalized is one more way of making elderly persons feel vulnerable and unwanted. Those who argue for legalizing assisted suicide claim, among other things, that it would provide an option which elderly sick persons want. Undoubtedly some do, and undoubtedly many of those who might choose it would not allow themselves to be pressured to make that choice by others or by its mere availability. But a question in need of serious consideration is whether legalizing assisted suicide would help to make those already vulnerable to commit suicide due to treatable illnesses such as depression, still more vulnerable.

Surveys and studies indicate that suicide is a problem of enormous magnitude in our society.\(^6\) In the United States it once ranked 22nd on the list of causes of death. It now ranks 8th or 9th. There is an alarming rate of suicide among young people—adolescent suicide increased 300% between 1955 and 1975. But the highest number of suicides are found in those over 50. Suicides of those over 60 years of age account for 25% of all suicides.

How rational are suicides? Some undoubtedly are, for instance in the cases of some persons with painful terminal illness. Evidence
indicates, however, that only a small percentage of suicides or attempted suicides, perhaps only 2\% to 4\%, are actually terminally ill at the time of death or attempted suicide. Two thirds of those who die by suicide in their late sixties, seventies and eighties were in relatively good health.

Studies suggest that 90\% to 100\% of suicide victims die while they have a diagnosable psychiatric illness, particularly that of depression. Not only is it well established that depressed persons are usually unable to recognize the severity of their own symptoms. Even more worrisome is the equally well established fact that many primary care physicians are not able to detect largely treatable depression in their patients. Regarding the elderly, this would seem to be at least in part due to ageism, the erroneous and stereotyping view that what are in reality manifestations of depression are simply part of the aging process, and that suicide is more “rational” in the elderly than in those who are younger.

Few doubt that there is already an unspoken coercion towards suicide in the environment of the elderly, who can hardly fail to pick up signals of rejection, and all too often experience isolation, fear and uselessness. Against that background, it does not seem unreasonable to conclude that in a society which would sanction assisted suicide, and therefore suicide, these pressures would greatly increase. Would we as a society and as caregivers become more tolerant of inadequate care of the elderly to make suicide more attractive? Hopefully not.

But if assisted suicide were legalized, more elderly and other vulnerable members of society could be manipulated into choosing that option. The more worrisome sequence then is that if assisted suicide were legalized, suicide would be more likely characterized as “rational,” as the reasonable option, making it more likely that not to commit suicide when one feels unproductive and burdensome could be viewed by more elderly and their caregivers as unreasonable. Surely it would be preferable if, instead of debating policy reforms such as this which are more likely to cause the elderly to feel still more unwelcome and risk more depressed suicides, we expended that time and effort in persuading them that they are valued members of our families and deserving of whatever burdens on us their care requires.

**Protecting and promoting primary languages**

A third manner in which we threaten the autonomy of the elderly and introduce unsettling change into their lives, is by unduly restrict-
ing the use of their primary language, whether English or French.

Language restriction, whether in the form of signs or spoken language, especially in the context of health care, is of course an issue for those of all ages. But it is particularly burdensome and disturbing for the elderly, many of whom have increasing difficulty coping with the unfamiliar, and are more likely than younger people to be facing a degree of confusion and memory loss. All of this is of course compounded if they are also sick. It seems to me such an obvious problem, one so readily corrected where needed without any threat to the other language, that one is embarrassed to have to add it to the list of changes elderly people do not need or deserve.

In this regard, a recent announcement is worth noting, namely that the Brome-Missisquoi-Perkins Hospital has received government permission to post some bilingual signs, a revision of the February 1998 decree of the OLF to the effect that the hospital must remove English from all its signs. It is frankly difficult to characterize the concession allowing 12 bilingual signs as significant, but one can always hope it is the first glimmer of reason to be followed by something more substantial.

Economic and employment policies

The previous issues are significant ones for the elderly wherever they live, whether in rural areas or towns and cities. A last issue worthy of consideration is one particularly relevant to the rural setting. It goes beyond health care policies strictly speaking, but has a direct impact on the health and welfare of the elderly. The subject is that of economic and employment policies.

For the past few years the provincial government has been promoting home care and promising to make it more possible. That policy is an excellent one and long overdue. Clearly any policy which encourages and enables elderly persons to remain in their own homes or those of their family members deserves applause and support. Assuming they do not require institutional care, that is clearly the setting in which elderly persons will normally have the most latitude to run their own lives and make their own choices. An obvious problem and major flaw is, of course, that adequate funds and services to fully enable the policy have not yet been forthcoming.

What I want to identify is something more general and fundamental, yet directly related. It is simply this. Unless younger family members, the potential caregivers for their elderly members, actually have homes and jobs, the elderly won’t have those homes to live in or those family members to care for them. And as those who live
in rural communities are only too aware, an alarming number of younger members of those areas are moving away. There is, in other words, a pressing need to link and address together economic and employment policies and health policies when it comes to our elderly members, and to design approaches which simultaneously promote all of them.

The same government which rightly seeks to empower the home as the primary health care setting, and family caregivers as a major health resource, surely needs to do more than simply channel funds from acute care institutions to home care services. It needs to address at the same time, particularly for rural communities, the conditions which lead so many rural businesses and farms to fail, so many healthy young adults to leave and seek employment elsewhere, with the result that so many elderly members have to fend for themselves, be institutionalized or follow their younger family members to new and unfamiliar places.

Limitations of space in this paper make it impossible to examine here all the factors behind this exodus, one all too often experienced by elderly persons as a desertion. Among the factors are surely these: excessive taxation, on-going and seemingly permanent political uncertainty, transportation costs of goods from rural communities to larger markets, for anglophones the marginalization of one’s primary language and lack of access to provincial government jobs. In principle none of these factors are beyond amelioration given the political will to address them and the creativity and hard work of members of rural communities. At present the latter is considerably more evident than the former.

Conclusion

I have attempted to demonstrate by considering four seemingly unrelated examples, that health care and the autonomy of the elderly are closely related. Attitudes and practices regarding the former will invariably promote or restrict the latter. Some of these attitudes, practices and obstacles are particularly at issue in rural communities. An example is that of employment and economic policies. All are common to rural, town and city contexts. The goal of this paper has been to suggest that we need to adopt a fundamental change in attitude, one which rejects stereotypes about the elderly and acknowledges their needs, choices and capabilities. Like the captain of the battleship in the story at the start of this paper, we have a choice to make as to whether we wait for the lighthouse to change course or correct our own course.
Deux des principales responsabilités des aidants naturels, des professionnels de la santé, des institutions et des politiques sociales envers les personnes âgées sont de leur offrir des soins de santé adéquats et de veiller au maintien et à la promotion de leur autonomie. La méthode de prestation de ces soins et le contexte social dans lequel ils sont offerts peuvent favoriser ou limiter l’autonomie des personnes âgées, élargir ou restreindre les choix et les défis qui s’offrent à elles. Les personnes âgées ne sont pas toutes totalement dépendantes des autres. Quelques-unes le sont, mais la plupart n’ont besoin de soutien qu’à certains égards. D’autres mènent une vie plus ou moins active et indépendante ou le pourraient si on le leur permettrait et si on les aidait. Dans bien des cas et à des degrés divers, elles se confinent dans le « rôle de la personne âgée », rôle trop souvent caractérisé par la passivité, des tendances à la dépression voire des idées suicidaires. Si elles agissent ainsi, c’est davantage en raison des comportements et des attitudes des autres envers elles que parce qu’elles ont perdu la capacité de faire leurs propres choix, de contrôler leur vie et de demeurer partie prenante de la vie, de ses défis et de ses gratifications.

La présente communication aborde seulement quatre des nombreux facteurs qui incitent les personnes âgées à jouer un rôle. Il est d’abord question des pratiques qui ont cours en matière de prescriptions de médicaments d’ordonnance aux personnes âgées, pratiques qui favorisent la passivité et mettent leur vie en danger. La communication traite ensuite de l’actuel débat sur la législation du suicide assisté, un débat et une politique qui peuvent intensifier le sentiment de vulnérabilité vécu par certaines personnes âgées et leur donner l’impression qu’elles représentent un fardeau de plus en plus lourd pour les autres. On parle ensuite des restrictions imposées à l’utilisation et à la visibilité de leur langue maternelle. Ces restrictions, qui modifient considérablement l’environnement familial de certaines personnes âgées, ont sur elles un effet déstabilisant. En dernier lieu, il est question de la nécessité de politiques économiques et de politiques d’emploi susceptibles d’enrayer l’exode des plus jeunes membres des familles qui vivent en milieu rural. Cette réalité est un autre facteur qui limite les occasions données aux personnes âgées d’habiter leur propre maison ou de vivre avec leurs enfants.
NOTES

1 F. Koch, adapted from *Magazine of the Naval Institute*, found in Stephen Covey’s *The Seven Habits of Highly Effective People*.


