Reflections on ageing

These tales of ageing in a book by a geriatric psychiatrist reminded Desmond O’Neill why he became a gerontologist.

As a child I was fortunate to experience a wide range of older people. That all four grandparents had dementia mattered not a whit to us as children. One grandfather made tea using tobacco; the other reverting to moistening his cheroots by inserting them completely into his mouth as he had learnt in the trenches at the Somme. With or without dementia, their independence of spirit was notable and intriguing. Our unquestioning acceptance of them, and of some highly individual great aunts, was tempered and transmitted through the lens of care, interest, and engagement shown by my parents and their family.

I have no doubt that these experiences influenced my choice of career, and the vast majority of geriatricians share this abiding sense of enjoyment and fascination of working with older people, the most complex, enriched, and challenging of patient groups. To us it is not unsurprising that several studies have shown that care satisfaction in our specialty is higher than for almost all other specialties.

And yet it is still clear that many healthcare workers have a troubling moral and professional blindness to the humanity and complexities of older people, the most complex, enriched, and beyond our current state of care. That all four grandparents mattered not a whit to us as children.

A deeper problem lies in appreciating the value of existence of life at advanced age, or with cognitive impairment. The rhetoric of “a good innings” is all too pervasive, as is the unhelpful depiction of dementia as a marker of dehumanisation rather than a series of impairments wherein our challenge is to engage with the person in radically altered circumstances.

Those who teach geriatric medicine and gerontological nursing are faced with a pressing need to articulate more clearly the remarkable nature of later life, the possibilities of change and growth in the face of loss, and the definition of the very real bonus of wisdom in a way that is not eroded by mawkish sentimentality.

A medical humanities approach can tease out not only these complexities but also our own fears and aversion as practitioners. The mature output of great artists is a potent metaphor for what we gain with ageing, and enlightened ethicists, such as Stephen Post in his Moral Challenge of Alzheimer Disease, are beacons of lucidity and inspiration for recognising the fullness of life with dementia.

Yet the more pragmatic students and practitioners may be resistant to these high concept approaches, and there is a crying need for an articulate physician to provide a road map to the meaning of old age, framed in a clinical context that will resonate in a realistic way with healthcare workers.

Marc Agronin makes an impressive start in How We Age: A Doctor’s Journey into the Heart of Growing Old. An articulate and imaginative geriatric psychiatrist in Florida, his book resembles Sherwin Nuland’s ground-breaking How We Die or Atul Gawande’s Complications in its adroit and successful marriage of gritty clinical practice and big ideas. Each chapter focuses on one or more patients and draws on philosophy, developmental psychology, Judaism, gerontology, geriatric medicine, and psychiatry to make sense of ageing, advanced dementia, and the possibilities of growth and reconciliation.

The delivery is crisp and the narrative turns often surprising. The description of a seminar with the ageing Erik Erikson looks as if it is shaping up to be a cringe making Tuesdays with Morrie fest of adoration at the feet of the sage, until he starts factoring in Erikson’s evolving dementia. What is most impressive in this is Agronin’s ability to make us see a context and sense to these changes, not so much sugaring a pill as drawing some of the poison of popular stigma from conditions to which older people and their families often make surprisingly good adaptation.

Counterpointing some of the older people’s stories with the traumas of their earlier years—many are war veterans or Holocaust survivors—reminds us not only of the relevance of old age as a time when we make sense of life, but also the real possibility that life can indeed be better in some ways. It also leads to a wonderful defence of “unreasonable” and “exasperating” behaviour. We also get insights into the importance of gerontological expertise, hope, and, most crucially, a true sense of how stimulating care of older people can be with the right attitudes, skills, and approaches.

This anthology of reflections does much to restore old age as an epoch of equivalent (if not superior) value as the other stages of life, and is well written and entertaining. If the unexamined life is not worth living, we are fortunate that Agronin’s examination of later life allows us to appreciate its surprisingly rich vitality.

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The rhetoric of “a good innings” is all too pervasive, as is the unhelpful depiction of dementia as a marker of dehumanisation.
A healthy island

The first tourist guidebook to the island of Sark, as far as I know, was written by a doctor, G W James, in 1845. The guidebook is understandably short, the island being so small; but the author, being a doctor, devotes an eighth of it (14 pages) to medical matters.

Sark, on the face of it, was not an exciting place to visit: “To those whose minds are only kept in motion by the aid of others, or by the attractions of the billiard-table and news room, Sark might, after a cursory view, prove a source of ennui.”

But Dr James offered some reassurance to nervous visitors to such a remote destination: “It may here be observed as important to visitors in the event of sickness or accident, that a surgeon now resides on the island, which was not the case until the year 1840.”

Till then, islanders and visitors had to send to Guernsey for medical assistance. As one might imagine, for whom “fatalism very nearly usurped the place of reason.”

The value of medicine as a profession was established beyond reasonable doubt for Dr James by a section on death rates on the island, which was so small; but the author, being a doctor, devotes an eighth of it (14 pages) to medical matters.

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Sark Guide, omits to say so in so many words, but the doctor who arrived on the island in 1840 was Dr James, the author of The Sark Guide.

Sark was just the place for those worried about their health. There were no epidemics: “During the prevalence of epidemics, this island has escaped miraculously. In the year 1832, when Indian cholera prevailed so fatally, there were in Jersey 341 deaths out of 787 cases, and in Guernsey 100 persons were carried off, but not a case occurred on Sark.”

Dr James thought this might be because of the disinfecting iodine and chlorine released into the air by the seaweed, used both for fuel and fertiliser, as well as the constant sea breeze that diluted the infective miasma.

So healthy indeed was Sark that some bad habits might be indulged in with relative impunity: “Irritation of mind and body is known to be a dread destroyer of the human race, but with the prophylactics of simple diet, exercise and tranquillity, even the consequences of excess are kept at bay; in proof of which some of the natives, who are habitual spirit drinkers, have attained a very advanced age. Indeed, if they survive childhood, their most common age of death is between 70 and 90, with as many dying between 80 and 90 as between 70 and 80.”

Above all, Sark was an excellent place for cognitive behaviour therapy and graded exercise for the hypochondriacal: “Brace up the nerves and muscles of a timid valetudinarian by a gentle and systematic course of exertion on the hills, and he will gradually become more bold and energetic.”

Theodore Dalrymple is a writer and retired doctor.
Bad medicine: digital rectal examination

For many years I taught medical students rectal examination using plastic dummies. I explained that largely it was a useless examination, but this met with hostility: “They wouldn’t teach us this if it was pointless, Dr Spence!” It was futile to challenge the orthodoxy, so I approached the clinical exams like a drama teacher might approach an end of term school musical. The clinical examiners always said it was “great,” but we all knew it was amateurish nonsense. All clinical examinations are in fact clinical “tests,” like radiography and blood analysis. They should be subject to the reflective rigour of the positive predictive values, error rates, and the rest.

So does rectal examination have purpose? Inspection has value, to examine for warts, fissures, dermatitis, and piles. But what of the role of digital rectal examination? Logically it has perhaps two purposes: to detect rectal tumours and to palpate the prostate. It has no obvious logical diagnostic value in appendicitis or acute abdominal pain, which were once traditional indications.

Consider the rationale for detecting rectal tumours. The patient presents to the doctor with rectal symptoms. If the patient is young then the possibility of malignant disease is extremely low, so digital rectal examination as screening test has no value. But if symptoms are persistent or in older patients with bleeding, change in bowel habit, or tenesmus this would warrant urgent definitive endoscopy.

So how would a digital rectal examination change management? A negative result might offer false reassurance and positive result might be false, generating unnecessary anxiety. Either way this would not change the need for urgent inspection of the bowel.

What about examining the prostate? The “annual” is common practice in the United States but has not been shown to reduce mortality (Cochrane Data Syst Rev 2006;3:CD004720, doi:10.1002/14651858.CD004720.pub2, and BMJ 2011;342:d1539), and it is associated with a possible rate of overdiagnosis of prostate cancer of 50% (Br J Cancer 2006;95:401-5), resulting in unnecessary treatment, destructive surgery, and psychological sequelae. Rectal examination of the prostate may cause more harm than good.

Rectal examination is unpleasant, invasive, and as an investigation has unknown sensitivity and specificity. In a young population digital rectal examination has almost no value, and in older patients may have very occasional and limited indication. It is time to question the once standard practice of routine digital rectal examination because it represents flimsy thinking and bad medicine.

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No news is good news

When the latest report on maternal mortality in the United Kingdom was published three months ago, there was a small flurry of press interest, focused on a rise in deaths from sepsis (BJOG 2011;118:s1, doi:10.1111/j.1471-0528.2010.02847.x). The press reaction to shrill headlines. About instant guidance produced in obstetrics to the Confidential Enquiries into Maternal Deaths from 1994 to 2011.

Competing interests: JOD was a national assessor in obstetrics to the Confidential Enquiries into Maternal Deaths from 1994 to 2011.

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Saving the lives of 20 women is not a big story when nobody, least of all the women themselves, knows who they are. If the media had noticed, they would have asked why it took so long. The answer, unattractive to politicians and bureaucrats alike, is that you need time to get things right. This is why clinicians are so sceptical about instant guidance produced in reaction to shrill headlines.

My long involvement with the confidential inquiries gained me no academic brownie points. Today the inquiry’s future is under review. I hope it survives. It convinced me that guidelines are a good thing, and if it can do that, it can do anything.