

Women entitled to a right to choose also have a right to expect that sympathetic and adequate services will exist to meet their needs. In 1990 fewer than half the abortions for women living in England and Wales were provided from NHS beds or paid for by the NHS through agency arrangements.⁴ Abortion is the only acute health need that is not met without question by the NHS, and parallels may be drawn between unwanted pregnancies and other combinations of behavioural difficulties and social circumstances—such as motor cycle accidents in young men. For these the NHS provides immediate, free, and sympathetic treatment; women who have reluctantly decided on termination of their pregnancy should not be obliged to pay for what is an essential service.

Does the current law on abortion give the right to choose? At present a woman can exercise the right only if two doctors agree with her decision. Abortion is legal if performed to protect the mental health of the woman. Health is defined by the World Health Organisation as a state of physical, mental, and social wellbeing; doctors must agree that the stresses of a continuous pregnancy would threaten the woman's mental wellbeing. Most women who request abortion are convinced of this, and most doctors accept that the woman is the person best placed to make this decision. The doctors' role is to check that she has considered all aspects of her situation and that she has accurate knowledge of the risks of both abortion and continuing the pregnancy. If a woman has made a firm and

well informed decision that an abortion is necessary the doctors can support her choice, but she is dependent on their interpretation of the law and personal attitude to abortion.

A national survey of consultant gynaecologists in 1989 found that 73% believed that a woman should have the right to choose abortion.⁶ Nevertheless two doctors still have to sanction the abortion, and this means that the right to choose is qualified and uncertain. Many European countries, such as Denmark, France, Italy, Norway, and Sweden, give the woman the right to choose in the first trimester. This minimises delay and enables abortions to be done earlier, when the methods are straightforward and uncomplicated. British abortion law should be amended to make this possible.

DAVID PAINTIN

Reader Emeritus in Obstetrics and Gynaecology,
Imperial College of Science, Technology, and Medicine
(St Mary's Hospital Medical School),
London W2 1PG

- 1 Harris Research Centre. Harris poll, April 1991. Richmond, Surrey: Harris Research Centre, 1991.
- 2 Royal College of Obstetricians and Gynaecologists Working Party on Unplanned Pregnancy. *Report*. London: RCOG, 1991.
- 3 Office of Population Censuses and Surveys. *Birth statistics 1988*. London: HMSO, 1990. (Series FMI No 17.)
- 4 Office of Population Censuses and Surveys. *Abortion statistics 1990*. London: HMSO, 1991. (Series AB No 17.)
- 5 Schaffer HR. *Making decisions about children*. Oxford: Basil Blackwell, 1990.
- 6 Savage W, Francome C. Gynaecologists' attitudes to abortion. *Lancet* 1989;ii:1323-4.

Abusing old people

Elder abuse needs to be looked for, quantified, and treated

Alex Baker, the first director of the Hospital (now Health) Advisory Service, called it granny battering.¹ The meaning of this robust, if patronising, phrase is plain, but the concept has since been widened. The current term, "elder abuse," includes psychological (verbal), financial, and even sexual as well as violent abuse causing distress to a person past retirement age.² The abuse may be active or by neglect, and it may take place in a domestic or an institutional setting. Indeed, if uncaring, disrespectful, or disparaging behaviour in hospitals and homes is to be included agism might seem as appropriate a term as abuse.

The issue should not, however, be blurred by more general concern for elderly people. Regrettable as it may be when an old person admitted to hospital is addressed breezily at first acquaintance as Joan or Gran or placed on a commode in view of other patients and passers by in the ward, this hardly compares with direct beatings causing bruises, welts, wounds, cuts, punctures, bone fractures, abrasions, lacerations, sprains, burns, and scaldings.^{3,4} At present many doctors and others feel righteous indignation about the whole range of slights and injustices to old people (which could even extend to those health trusts and authorities that have abandoned long stay beds and expect elderly patients and their families to make their own arrangements for continuing care, or send them a distance to where homes are cheap enough for the costs to be met by social security subsidies). Anger about these mean minded moves may possibly overshadow the smaller but important problem of elder abuse.

The term needs precise definition if the concept is not to be distorted and exaggerated. Prevalence ranges from 5% to 65% according to different criteria used by agencies likely to have had contact with abused elderly people.⁵ A figure of 4% for the "battered elder syndrome" in the United States was deemed authoritative enough to result in hearings by Congress, which

concluded that less than one sixth of cases ever came to official attention.⁶ Reporting of suspected abuse is now mandatory in many states.⁷

Here in Britain Homer and Gilleard interviewed patients referred to geriatric wards for respite care over six months and their carers.⁸ While the patients were guarded, 45% of the carers admitted to some form of abuse and 14% to physical abuse—pushing, grabbing, slapping, or hitting with a weapon. Nor was this all one way: according to their carers, 18% of the patients had been physically abusive, suggesting a cat and dog variation on the helpless victim scenario. Abusive carers were characterised by alcohol consumption, abuse by the dependant, "caseness" on the general health questionnaire and its depression subscale, having stopped work to care for the dependant, and greater social disturbance and communication difficulties in their dependants. Other characteristics of abusers may be a history of mental illness and recent decline and relying on the dependant for a home and money.⁹

This was, like most, a study of those at risk. On p 998 Ogg and Bennett report results of structured interviews (through the nationwide Office of Population Censuses and Surveys omnibus survey) with almost 600 people aged 65 or over and 1366 adult members of households in regular contact with a person of pensionable age.¹⁰ One in 20 old people reported some kind of abuse, but only one in 50 reported physical abuse (being pushed, slapped, shoved, or otherwise roughly treated). Though 10% of adults admitted to verbal abuse, only 1% acknowledged physical abuse.

This study probably indicates the lowest likely level of abuse—but one that is quite high enough to warrant concern. The statutory measures designed to curb child abuse do not apply to elderly people. The Social Services Inspectorate's report *Confronting Elder Abuse* found no pattern in the first response to abuse by social workers, a fairly rapid reduction in

priority after initial alarm, inadequate assessment and care plans, avoidance of confrontation, little cooperation between agencies, ineffective interventions, and a lack of policies despite general agreement that they were needed and that elder abuse was important.¹¹

Fisk has suggested that physicians and psychiatrists for elderly people (as well as social workers, primary health care teams, and the police) are especially well placed to detect elder abuse. A lower threshold for suspicion, despite the abused person's denials, may be required than has prevailed up till now. Once abuse has been confirmed the priorities for action are, firstly, the safety of the victim; secondly, the physical and psychological health of the victim; thirdly, the physical and psychological health of the abuser; and, fourthly, a plan to prevent recurrence of the abuse. Preventive measures might include information packs on caring for elderly people; support groups—self help or supervised; financial support for carers; physical, psychological, and financial support for elderly people; and specialist teams (from health authorities and social services) to detect, intervene in, and prevent elder abuse. Legislation may be needed to provide for mandatory reporting of abuse and protection for vulnerable elderly people.

Some may be sanguine about the effects of the implementa-

tion of the white paper *Caring for People* next April.¹² More are deeply concerned that there will be a period of chaotic struggling to assess priorities for scant resources—when the needs of many old people and their carers will not be met. An audit of elder abuse, using the baseline now offered by Ogg and Bennett, should be required by potential purchasers. It may help to give some political ammunition to those who insist that worthy intentions must be seen to work.

BRICE PITT

Professor of the Psychiatry of Old Age,
St Mary's and the Royal Postgraduate Medical Schools,
London W10 6DZ

- 1 Baker AA. Granny battering. *Modern Geriatrics* 1975;5(August):20-4.
- 2 Eastman M. *Old age abuse*. Mitcham: Age Concern, 1984.
- 3 Lau EE, Kosberg JI. Abuse of the elderly by informal care providers. *Aging* 1979 Sept/Oct:10-5.
- 4 Block MR, Sinott JD. *The battered elder syndrome: an exploratory study*. Baltimore: Center on Aging, University of Maryland, 1979.
- 5 Fisk J. Abuse of the elderly. In: Jacoby R, Oppenheimer C, eds. *Psychiatry in the elderly*. Oxford: Oxford University Press, 1991.
- 6 US Congress Select Committee on Aging, Subcommittee on Human Services. *Elder abuse: an examination of a hidden problem*. Washington, DC: Government Printing Office, 1981.
- 7 Wolf RS. Abuse of the elderly: ten years later. *J Am Geriatr Soc* 1988;36:756-62.
- 8 Homer AC, Giulleard C. Abuse of elderly people by their carers. *BMJ* 1990;301:359-62.
- 9 Pillemer K. The dangers of dependency: new findings on domestic violence against the elderly. *Social Problems* 1985;33:146-58.
- 10 Ogg J, Bennett G. Elder abuse in Britain. *BMJ* 1992;305:998-9.
- 11 Social Services Inspectorate of the Department of Health. *Confronting elder abuse*. London: HMSO, 1992.
- 12 Secretaries of State for England and Wales. *Caring for people*. London: HMSO, 1990.

Corticosteroids in advanced cancer

If they are not working stop them

Systemic corticosteroids are used for their specific and general effects in patients with advanced cancer.¹ For their specific anti-inflammatory effects they are used in raised intracranial pressure, compression of the spinal cord, and obstruction of the superior vena cava or other hollow organ.²⁻⁴ In addition, in one third of elderly patients with breast cancer corticosteroids result in regression or cessation of progression of their cancer for as long as one year.⁵ Patients with prostatic cancer may obtain similar benefit.⁶

The general effects of corticosteroids include improved appetite, mood, and strength. In a controlled trial of methylprednisolone 32 mg a day for two weeks in 40 patients with terminal cancer, appetite increased in 77%, mood in 71%, and activity in 68%.⁷ Consumption of analgesics decreased in 71%. All patients continued taking methylprednisolone for a further 20 days; most measures had worsened by the end of this time, although there was still significant benefit compared with baseline values. This worsening could reflect either the loss of effect of the drug or the progression of disease, or both.

Another controlled trial also found that the effects diminished with time.⁸ In this trial dexamethasone 3 mg and 6 mg daily were compared with placebo—the higher dose being comparable with methylprednisolone 32 mg. Subjective improvement in appetite and strength was noted after two weeks but had disappeared by four weeks.

The benefits seen in time limited trials are much better than those reported in this issue of the journal by Needham *et al* (p 999).⁹ These authors surveyed corticosteroid use by 100 patients admitted to a hospice for terminal care. On admission 33 patients were taking corticosteroids, and seven had done so in the past. Of the 28 patients who completed the questionnaire, only eight said that they had benefited; nine were undecided and 11 said that they had not benefited. Five of the 11 who said that they had not benefited had started treatment more than one month before; among those who were

undecided was a woman who had been taking prednisolone 30 mg daily for two years. Patients who had taken corticosteroids were more likely to complain of anorexia, weight loss, or weakness than those who had not.

Needham *et al* initiated their survey after three patients had been admitted within a month with severe adverse effects from corticosteroids (proximal myopathy, excessive weight gain, and skin changes). Other reports have also highlighted proximal myopathy and, less commonly, avascular necrosis of bone.^{10 11} Furthermore, in a prospective survey of several hundred patients with advanced cancer who received corticosteroids nearly one third developed oral candidiasis, accounting for four fifths of all such cases in that unit.¹ One in 10 experienced hypomania, agitation, hyperkinesia, or insomnia, and in one in 20 treatment with corticosteroids was stopped because of unacceptable adverse effects.¹

Peptic ulceration may occur,¹² although the concurrent use of non-steroidal anti-inflammatory drugs may be responsible.¹³ Necropsy studies in patients with cancer have shown that death may be precipitated by complications of peptic ulceration (such as bleeding or perforation) in 5% of patients receiving corticosteroids compared with 1% of others.¹² Although a risk of this order is acceptable in patients with a specific need for corticosteroids, it cannot be ignored in other circumstances.

It is disturbing, therefore, that Needham *et al* found that more than half of the patients receiving corticosteroids did not know why they were taking the drug or how long they were meant to continue taking it. More than two thirds did not have a steroid card, and a similar proportion did not know that long term corticosteroid treatment should not be stopped suddenly. If this sample is representative it seems that, once started, corticosteroids are stopped only rarely and that the impact of the treatment is not adequately monitored. Needham *et al* conclude that many doctors do not exercise the same care with