A CONCLUDING RESPONSE*

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THIS conference has been highely successful in its immedate goal of presenting the multifaceted diagnosis of what is the major sociological "dis-ease" or malaise of our times, especially in our own country —still the richest and most powerful the world has even known. Let us examine some of the components of the disease process. These are well known and merely require listing. To deal with them therapeutically is difficult but not hopeless.

In consequence of advances in public health and preventive medicine, this century has witnessed a striking increase in the percentage and absolute number of individuals reaching old age. This signifies that more persons will be suffering from the cardiovascular, neoplastic, respiratory, and metabolic diseases that are prevalent in the aged. On the economic side, aging workers are forced to retire, often with no regard for their physical and mental capacity for coninuing productive work. Many cannot live decently, even on pensions and Social Security benefits, in the face of continuing inflation and other necessary expenses. The problems that confront aged people on public welfare need no elaboration here. It is only in recent years that the escalating costs of hospital and other medical care in continued or catastrophic illness have been subsidized by Medicare and Medicaid on a countrywide basis.

An additional aspect of the problem, which is in many ways the most important because of its devastating effects on the self image, the ego, and the very soul of the aging person, is the changing attitude of society (especially in this country) toward older persons. The traditional extended family of three generations living together or in close

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proximity is becoming a thing of the past. Even more damaging and denigrating is the worshipful culture of youth and the synthetic image of youthfulness held by persons who are in the middle years of life. This has produced a supercilious attitude toward the aged, their isolation from the homes and activities of younger persons, and a neglect of their capabilities, experience, and accumulated wisdom. The aged are forced to live in isolation—often alone if their partner has died—or in nursing homes or other homes of variable quality, and have little or no opportunity for recreation, creative work, or friendly association. Just because their bodies are no longer "youthful," their value as persons with inner worlds of their own, fulfilling the cycle of life, is ignored or misunderstood. Death is then considered the enemy of life instead of a natural process, and the aged dying person may be left without loving support and without the privilege of dying with dignity.

It is not surprising that in the presence of such cultural attitudes many of the aged develop mental disturbances or mixed organic and functional disturbances leading to admission to mental hospitals and a relatively high rate of suicide. At best their quality of life is diminished by fear and anxiety generated by the prevalent lack of respect.

When we consider measures of treatment for this spreading "epidemic" of the aging population, we face obstacles. Curiously, these are largely of our own making, especially in the sense that our culture, with all its scientific and technological achievements, has failed on the humane side and has permitted the development of a series of elements which affect the lives of the aged in many injurious ways.

In view of these problems, it is obvious that in order to achieve the desired results a therapeutic attack must be applied along a wide front and from many angles. Among the measures suggested at this conference, the major ones concern income adequate for decent living, good housing—either in private or group homes, with community homes for the reasonably healthy and nursing homes for the sick and incapacitated (preferably noncommercial)—easy access to medical facilities and preventive medical care, and good opportunities for recreation and useful and creative work. The various state and federal programs should be consolidated and radically revised to insure preservation of the integrity and self-respect of the person who receives supportive services. The aged must not be converted into child-like dependents; rather, all their residual strength must be supported and used. The quality of the life

of the older person rather than the quantity of years is the criterion of a concerned society.

Speakers have mentioned the importance of older people organizing to help themselves. In a democratic society such as ours, social change is often brought about through the development of what one speaker at last year's health conference described as self-serving intercessor groups (Steiner, G.Y.: A single standard of care. *Bull. N.Y. Acad. Med.* *48*:1500, 1972.) Such groups can improve the condition of the aged measurably. Organized nationally and locally, these groups not only can shape national policies toward the aged, but can introduce improvements in every local community. Aged persons who are healthy or affluent are in a superior position to exercise their rights of citizenship in order to improve the lot of all older people, especially of those who are disadvantaged. Such commitment and dedication not only will produce changes in the quality of life for all older people, but the immersion in creative activity will be a major source of continued good health for those directly involved.

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