

Getting old a luxury, being old a challenge

B. MEYBOOM – DE JONG

This final contribution presents a summary in English of the Introduction to this issue; the insets, moreover, contain summaries of 15 of the 21 articles and four tables.

Introduction

During a visit to a 92-year-old patient, life and death came to be discussed. She told me of her fear of death, even though in fact she had done with life. In her statement *I don't mind getting old but I don't want to be old* lies the tragic of living long.

Aged patients are already demanding much of the time and attention of the general practitioner, and in future this can but increase with the increasing number of old persons, due to policy decisions and as a result of social changes. The prospects today are the following:

Particularly categories demanding much of the general practitioner, e.g. women, the very old and those living alone, are increasing in the number. The number of aged persons will gradually increase from 1.6 million (11.5 percent of the population) to 2.3 million (14.5 percent) in 2010; as a result of the pensioning off of the postwar birth wave, it will then increase more quickly to 3.2 million (21 percent) in 2030. The number of persons over 85 was 120,000 in 1980; it will double to 240,000 in 2000 and then increase to 300,000 in 2030. These very old include twice as many women as men, and some 90 percent of them are without a partner.

Developments

A sign that the health care system anticipates the problems posed by the increase in aged patients was the recognition – after years of struggle – of the specialism *geriatrics* in 1981.

The policy of minimizing institutional care will cause more and more aged patients to require additional medical care from the general practitioner. It is a striking fact that self-care and voluntary care are mentioned only with reference

to aged persons living at home, while for aged persons in institutions only professional care is envisaged. A decentralized and district-oriented organization of nursing homes and other institutions for the aged would enable these institutions to assist and support the home sector. On the other hand, relatives, neighbours and friends could do more for aged persons in institutions.

In 1961 the Netherlands Association of General Practitioners devoted its annual congress to the care of aged patients. Very few general practitioners have since published articles on this subject. Most publications on aged patients are therefore based on data from selected populations, and thus the literature reinforces the biased view that old age is accompanied by illness and ailments. It is partly for this reason that the Groningen University Institute of General Practice has given research into the care of aged patients a central place in its research programme.

Quantitative information and friendly visiting

This special issue has been used as a means to encourage a number of general practitioners to write down their findings and experiences in practice and their knowledge of the literature. This has resulted in 21 articles by 26 authors.

True to tradition, this *special* stresses quantitative information from general practice, as the contributions by *Schellekens and Hilderink*, *Voorn*, *Branbergen* and *Rijpm* demonstrate.

In addition, attention is paid to a well-known controversy: should general practitioners take an expectant attitude and be available on request, or should they take the initiative and visit aged persons without being called? *Kingma* and *Van der Werf* discuss the advantages and disadvantages of *friendly visiting* – a general practice approach burdened by standards and values, which has never been systematically investigated.

Here we are confronted with the fundamental difference between aged persons and aged patients. No general practitioner will doubt the necessity of a

consistent follow-up and critical monitoring of aged patients taking multiple medication. The effect of spontaneous visits to aged persons in good health, however, is still being debated. Many aged persons derive a sense of security from friendly visits by the general practitioner. Recent reports, moreover, describe favourable effects from regular house calls (once every three months) by a care provider.

Quality of life

Since efforts to postpone death to a very old age have been largely successful in The Netherlands, the quality of life demands more attention: measures against morbidity and measures to maintain physical, emotional and intellectual functions until shortly before death. The old maxim that *it is more important how one gets old than how old one becomes*, can be translated into questions about physical, mental and social functioning. The criterion is no longer death but rather the loss of independence, the terminal point of active life.

Katz et al. calculated that the 65-year-old can expect 10 more active years, and those over 85 years of age still have three such years. In this respect there was no difference between men and women. Women, with their longer life expectancy, had the prospect of more dependent years of life. There were unmistakable differences, however, between the rich and the poor. The prospect of active years for the 65-year-old in the lowest income brackets was 2.5 years less than that for those in the higher brackets; at the age of 75 this difference had diminished to only one year.

Colvez and Blachet assessed and compared (not especially for the aged) the influence of various diseases on mortality and functional limitations; they found striking differences in this respect. Cardiovascular diseases are the principal cause of death and rank second among the functional limitations. Diseases of the musculoskeletal system, including neurological disorders, cause most functional limitations but rank seventh among the causes of death. Neoplasms, the second most important cause of death after cardiovascular diseases, rank low among the functional limitations. The contribution on total hip replacement by *Van Boven and Van 't Veer* shows that the general practitioner can play an important role in diagnosis, but especially in rehabilita-

Schellekens JWG, Hilderink CMA. Morbidity of the aged in general practice. *Huisarts en Wetenschap* 1985; 28(suppl Huisarts & Praktijk 9): 7-9.

The morbidity pattern in the aged is discussed on the basis of the Continuous Morbidity Registration project of the Nijmegen University Institute of General Practice. The best known characteristics of the morbidity pattern in the aged in general practice are the increasing number of chronic diseases and the greater severity of the pathology. About half the problems presented by aged patients are continuing problems.

The most frequent problems in aged patients are listed in *tables 1* and *2*. These twenty problems account for almost two-thirds of the total morbidity and the top-10 comprise nearly half the total.

Tables 3 and *4* present a selection of serious problems and figures on dementia and urinary incontinence.

Schure LM, Bremer GJ. What should be done when I become seriously ill? Views and wishes of a number of aged persons. *Huisarts en Wetenschap* 1985; 28(suppl Huisarts & Praktijk 9): 10-1.

In 1983 we inserted a notice in three widely read senior citizen magazines to write to us about the question *What should be done when I become seriously ill?*, giving a stroke as example.

We received a total of 133 usable letters. The vast majority of the responders was over 65 years old; nearly half were even 75 or older. Of the responders, 19 percent had themselves been seriously ill, 48 percent had previously cared for one or more seriously ill persons, and 33 percent had to do with serious illness from a distance.

About half the letters contained an answer to the question what was to be done when an aged person suffers a stroke or has some other serious illness; 56 percent of the responses opted in favour of „remaining at home”. The principal alternatives mentioned were „to a hospital” (17 percent) and „euthanasia if necessary” (9 percent). In a wider context nearly 28 percent of the responders expressed a positive attitude to passive or active euthanasia. Some 20 percent of the responders stated that it would be useful to stipulate early what one would want in the case of serious illness; some respondents, however, doubted the effect of such stipulations.

Voorn ThB. Defective hearing in the aged. *Huisarts en Wetenschap* 1985; 28(suppl Huisarts & Praktijk 9): 16-8.

Defective hearing is an important chronic problem in general practice. Table 1 on page 16 shows that defective hearing in the aged is usually caused by accumulation of cerumen and presbycusis (including noise deafness) and to a lesser extent by chronic otitis media, otosclerosis and Ménière's disease.

The general practitioner confronted with defective hearing in the aged can either rely entirely on the complaints presented by the patient or adopt a more active attitude, making use of encounters to ask patients whether they still hear well, examining ears and having audiograms made. In two practices affiliated with the Nijmegen University Institute of General Practice all registered chronic problems have been divided since 1984 into problems with which the general practitioner deals actively, and „passive” problems. Preliminary results show that in both practices about 20 percent of the known cases of presbycusis are registered as „active”.

A simple examination of the ear can eliminate all readily tractable forms of defective hearing such as accumulation of cerumen or an infection. Next, the degree of hearing loss can be objectively determined by an audiogram. Referral to an ENT-specialist does not complete the task of the general practitioner; it is advisable to ask the patient to report back about the condition; in some cases a house call is even required to give advice (low-pitched bell, separate telephone, audio-column, ring system, etc.).

Van Boven C, Van 't Veer WJ. Zip, zip, total hip. A look at total hip replacement. *Huisarts en Wetenschap* 1985; 28(suppl Huisarts & Praktijk 9): 22-3.

Seven general practitioners with a total practice population of 15,000 patients performed a retrospective study of their patients who had undergone total hip replacement. All these patients were visited: 77 women and 13 men, of whom 54 women and 5 men had had a unilateral hip replacement while 23 women and 8 men had had both hips replaced.

There were six early complications (thrombosis in 3 cases, pulmonary embolism in 1, fissure of the femur in 1, and a very large haematoma in 1 case) and twelve later complications (loosening of the prosthesis

in 8 cases, broken prosthesis in 1 and infection about the prosthesis in 2 cases). Reoperation followed in nine cases. All later complications occurred within nine years of the operation.

In ten cases patients were referred to a nursing home for rehabilitation after the operation; 70 received physiotherapy at home; 35 received no physiotherapy. In view of this variation it seems advisable that the general practitioner keeps an eye on the rehabilitation of his patient.

De Graaff WJ, Hupkens PEM. Dementia as a general practice problem. *Huisarts en Wetenschap* 1985; 28(suppl Huisarts & Praktijk 9): 25-9.

A study group representing all hospitals, psychiatric institutions, psycho-geriatric nursing homes and local societies of general practitioners in the region South Holland North developed a dementia protocol in the course of 1983. They proceeded from the postulate that all persons showing behavioural disorders in advanced age require a physical examination, especially if institutionalization is being considered. It is important that examination by the general practitioner should take into account somatic as well as psychological and social sources of mental deterioration. Extensive laboratory studies ordered by the general practitioner (cost f 500) can contribute to the detection of possible somatic causes of deviant behaviour in the aged.

Branbergen HTC. What medication is used by those over 65? *Huisarts en Wetenschap* 1985; 28(suppl Huisarts & Praktijk 9): 34-5.

The consumption of medicines among aged persons was studied in two places: a rural community with a population of 10,000, including 1260 aged persons (A), and a town with a population of about 30,000, including 4317 aged persons (B).

Cardiovascular agents were evidently prescribed most widely: one out of five persons over 65 used a diuretic. Digoxin was prescribed more frequently in A, while more beta-blockers and strong loop diuretics were prescribed in B. Slightly more nitrates were used in A. Benzodiazepine derivatives were used by one out of ten aged persons in A and by one out of five in B. Antidepressants, too, were used much more frequently in B. Vasodilators were used by 1.5-2 percent of the aged persons.

tion; thus he can make an important contribution to the quality of life for aged patients with disabling diseases.

Emancipation

The question is whether emancipation will exert an influence on the life expect-

tancy of men and women and on their independence. Most publications make no distinction between the influence of emancipation on future generations of aged persons and its influence on professional and voluntary care. For both areas it is overlooked that emancipation is a process that influences both men

and women. Attention focuses largely on the decline in voluntary care resulting from increased participation of women in the labour process. The fact that men, as a result of reduced working hours and earlier pensioning, could provide more voluntary care is meanwhile ignored. Among the aged themselves,

Table 1. Prevalence of the twenty most frequent health problems in patients aged 65-74 years. Per standard practice 1980 and per 1000 patient years. Based on the Continuous Morbidity Registration 1978-1982 of the Nijmegen University Institute of General Practice (n = about 12.000).

Men	Standard practice	Per 1000 patient years	practice	Standard	Per 1000 patient years
1. Obesity	15.8	189	1. Obesity	39.4	361
2. Common cold	15.6	186	2. Hypertension	32.7	300
3. Chronic bronchitis ^a	12.3	146	3. Emotional disorders	28.7	264
4. Osteo-arthritis, all forms	11.9	141	4. Varicose veins of legs	26.6	244
5. Hypertension	11.8	140	5. Osteo-arthritis, all forms	25.2	231
6. Deafness, incl. presbycusis	11.3	134	6. Common cold	20.1	185
7. Fibrositis, myalgia	11.2	134	7. Fibrositis, myalgia	18.8	173
8. Emotional disorders	10.0	119	8. Acute urinary infection	12.0	110
9. Acute myocardial infarction	7.8	92	9. Deafness, incl. presbycusis	11.4	105
10. Myocardial degeneration ^b	7.1	85	10. Febrile common cold	9.4	86
11. Angina pectoris	6.7	79	11. Small superficial injuries ^c	9.0	83
12. Diabetes mellitus	6.5	78	12. Diabetes mellitus	7.9	72
13. Cerumen	5.6	67	13. Cerumen	7.7	71
14. Varicose veins of legs	5.4	64	14. Uterovaginal prolapse	7.3	67
15. Arterial vascular diseases ^d	5.3	63	15. Angina pectoris	7.1	65
16. Hyperplasia of prostate	5.3	63	16. Myocardial degeneration ^b	6.4	59
17. Small superficial injuries ^c	4.6	55	17. Dermatitis ^c	5.7	52
18. Acute bronchitis	4.3	51	18. Gastro-enteritis	4.6	42
19. Febrile common cold	4.1	49	19. Acute bronchitis	4.3	39
20. Cerebrovascular disturbances	3.9	47	20. Cataract	4.2	38

Table 2. Prevalence of the twenty most frequent health problems in patients aged 75 years and older. Per standard practice 1980 and per 1000 patient years. Based on the Continuous Morbidity Registration 1978-1982 of the Nijmegen University Institute of General Practitioners (n = about 12.000).

Men	Standard practice	Per 1000 patient years	Women	Standard practice	Per 1000 patient years
1. Chronic bronchitis ^a	10.3	214	1. Osteo-arthritis, all forms	31.0	398
2. Deafness, incl. presbycusis	9.7	203	2. Obesity	25.1	321
3. Osteo-arthritis, all forms	9.5	198	3. Hypertension	22.9	294
4. Common cold	9.4	195	4. Varicose veins of legs	20.0	257
5. Myocardial degeneration ^b	8.5	177	5. Emotional disorders	16.2	208
6. Obesity	8.4	176	6. Deafness, incl. presbycusis	15.2	194
7. Hypertension	6.7	139	7. Common cold	15.0	193
8. Hyperplasia of prostate	6.5	136	8. Myocardial degeneration ^b	14.9	191
9. Cerebrovascular disturbances ^f	5.9	122	9. Diabetes mellitus	10.4	134
10. Angina pectoris	5.1	107	10. Angina pectoris	10.3	133
11. Fibrositis, myalgia	4.7	97	11. Acute urinary infection	10.1	130
12. Acute myocardial infarction	4.5	93	12. Fibrositis, myalgia	10.1	130
13. Varicose veins of legs	4.4	91	13. Cerebrovascular disturbances ^c	9.6	123
14. Arterial vascular diseases ^d	4.1	86	14. Small superficial injuries ^c	9.5	122
15. Cerumen	3.8	80	15. Cataract	8.1	104
16. Diabetes mellitus	3.7	78	16. Uterovaginal prolapse	6.3	81
17. Small superficial injuries ^c	3.7	78	17. Acute bronchitis	5.2	66
18. Acute bronchitis	3.5	74	18. Febrile common cold	5.1	66
19. Emotional disorders	3.4	72	19. Other diseases of the eye ^g	5.1	66
20. Paralysis agitans (Parkinson's disease)	3.1	65	20. Other diseases of the musculo-skeletal system and connective tissue	5.1	66

^a incl. emphysema. ^b incl. atrial fibrillation. ^c or contusions. ^d incl. claudicatio. ^e excl. due to occupation. ^f incl. spasms. ^g incl. blindness.

Table 3. Frequent serious and riskful health problems in older patients. New problems per 1000 patients per year. Based on the Continuous Morbidity Registration 1978-1982 of the Nijmegen University Institute of General Practice (n = about 12.000).

Health problems	65-74 years		75+ years	
	M	F	M	F
<i>Malignant neoplasms</i>				
- digestive system	2	3-4	14	9
- respiratory system	8	0-1	9	-
- urinary and genital organs	7	1-2	8	1
- breast	-	1	-	4
<i>Cardiovascular diseases</i>				
- acute myocardial infarction	17	7	31	17
- angina pectoris	10	10	11	10
- myocardial degeneration, incl. atrial fibrillation	23	15	53	35
- cerebrovascular disturbances, incl. spasms	13	9	35	34
- arterial vascular diseases, incl. claudicatio	16	6	24	15
<i>Pulmonary diseases</i>				
- chronic bronchitis, incl. emphysema	11	3	15	3
- acute bronchitis	51	39	74	66
- pneumonia	14	17	46	33
<i>Other (possibly) riskful problems</i>				
- hypertension	11	13	5	14
- diabetes mellitus	10	7	2	14
- osteo-arthritis	21	40	28	39
- acute urinary infection	33	110	48	129
- hernia of abdominal cavity, incl. inguinal, femoral, diaphragmatic and other	16	5	12	6
- cholelithiasis	1	6	4	6
<i>Other (not serious) problems mentioned in this issue</i>				
- Senile psychosis, incl. senile dementia, excl. senility	1	1	8	13
- Incontinence of urine, incl. stress incontinence	2	5	5	1

Table 4. Frequent serious and riskful health problems in older patients. Continuing (per 1-1-1980) problems per 1000 patients per year. Based on the Continuous Morbidity Registration 1978-1982 of the Nijmegen University Institute of General Practice (n = about 12.000).

Health problems	65-74 years		75+ years	
	M	F	M	F
<i>Malignant neoplasms</i>				
- digestive system	10	9-10	31	14
- respiratory system	7	1	21	3
- urinary and genital organs	14	11	19	14
- breast	-	19	-	33
<i>Cardiovascular diseases</i>				
- acute myocardial infarction	76	28	62	43
- angina pectoris	69	55	96	123
- myocardial degeneration, incl. atrial fibrillation	67	45	131	162
- cerebrovascular disturbances, incl. spasms	34	15	87	89
- arterial vascular diseases, incl. claudicatio	54	14	95	36
<i>Pulmonary diseases</i>				
- chronic bronchitis, incl. emphysema	156	29	208	42
<i>Other (possibly) riskful problems</i>				
- hypertension	129	287	134	280
- diabetes mellitus	68	65	76	120
- osteo-arthritis	121	191	170	358
- hernia of abdominal cavity, incl. inguinal, femoral, diaphragmatic and other	22	12	69	34
- cholelithiasis	1	11	17	31
<i>Other (not serious) problems mentioned in this issue</i>				
- Senile psychosis, incl. senile dementia, excl. senility	1	1	8	13
- Incontinence of urine, incl. stress incontinence	2	5	5	1

New problems are defined as acute diseases, often transient, and first presentations of chronic diseases. Continuing problems are diseases already registered during a preceding year but still requiring medical attention.

Only presented morbidity is considered here; this is to say: all problems of which the general practitioners in the four registration practices became aware either from a direct encounter with the patient or from information supplied by colleagues. The figures therefore indicate the mean prevalence of registered cases per 1000

patients per year, based on observations during the period from 1st January 1978 through 31st December 1982.

The term *standard practice 1980* refers to an imaginary general practice constructed with the aid of Central Bureau of Statistics data on the composition of the Netherlands population in 1980. The registered morbidity in the four general practices had been converted to this *standard practice*. This has proved to give students and general practitioners (in training) more insight than the traditional epidemiological notation per 1000 patient years.

Soesbeek KH, Bremer GJ. Reactions of general practitioners to a CVA. *Huisarts en Wetenschap* 1985; 28(suppl Huisarts & Praktijk 9): 36-7.

What do general practitioners do (or say they do) for a patient who has probably had a CVA? This question is answered on the basis of an enquiry among 50 general practitioners (response: 32).

Of the respondents, 80 percent would immediately visit the patient; the remainder would do so in the course of the day. During the visit 93 percent would make an extensive examination, and 60 percent would then decide in principle in favour of care at home, while the others would tend to prefer hospitalization or refrain from advice. In the case of care at home, 74 percent would prescribe medication.

On the basis of the diverse answers the authors urge that a protocol be developed for general practitioners confronted with a CVA; the primary question should not be when a patient with a CVA is to be hospitalized but rather what adequate care should consist of.

Wachters-Kaufmann CSM. Evaluation of instructive literature for patients with a CVA. *Huisarts en Wetenschap* 1985; 28(suppl Huisarts & Praktijk 9): 38.

The quality of seven brochures providing information on cerebrovascular accidents was evaluated systematically on the basis of ten criteria. The brochures written by professional care providers scored high on *medical content* but rather low on *sympathy*. The *guide function* (is the reader put on the right road?) was entirely lacking in five of the seven brochures.

Sommers JCA. Dying and mourning among the aged. *Huisarts en Wetenschap* 1985; 28(suppl Huisarts & Praktijk 9): 42-3.

In my Amsterdam practice (2000 patients, of whom 25 percent are over 65), 22 aged patients died in 1984. About half of them retained their vital powers until immediately before their more or less acute death. Eleven (including eight with cancer) had a long sick-bed. The question of euthanasia was raised in two cases.

In 1984 an enquiry among 50 Amsterdam general practitioners concerning their views on dying at home and difficulties experienced in practice yielded the following. In the home situation the place of dying is usually discussed; in hospitals this is done only occasionally; in homes for the

aged this is done less frequently than at home but more often than in hospitals. The subject is discussed, not only with the patient but also with relatives, the district nurse, the specialist and the observer group.

When a patient has died I attach a tab to the patient record of the surviving partner, noting the date of death. I make a condolence visit, which can be regarded as an important ritual; I usually leave a folder about mourning. The general practitioner can play an important role in guiding the mourning process, e.g. by sanctioning both the mourning and its termination.

Meyboom-De Jong B. Maintaining the independence of the aged. *Huisarts en Wetenschap* 1985; 28(suppl Huisarts & Praktijk 9): 45-7.

The annual number of requests for admission to a home for the aged is almost 40,000 (i.e. 2.3 percent of all aged persons).

An analysis of my own practice shows that the practice population on 1st January 1985 included 330 aged persons (13 percent). Eleven of them were living in a home for the aged, and in the two preceding years seven other inmates of the home had died or been transferred to a nursing home. Physical impairments were the reason for admission in two-thirds of these 18 cases; psychological factors played the most important role in one-third. Social factors were never the sole reason for admission but did play an important role.

The age of the institutionalized persons is an important factor. In the four persons under 80 years of age, psychological reasons were always an important factor in admission. For instance three women had so become accustomed to the environment after the death of their husbands that they did not want to return to their own home, even though at that time they did not require institutional care. In these cases the inadequate number of available so-called „annex“-apartments begins to tell.

It is suspected that a hospital admission and especially an operation may lead to decompensation of the independence of aged persons. Early consultation with their general practitioner is imperative in such cases.

Van der Werf G. Friendly visiting. *Huisarts en Wetenschap* 1985; 28(suppl Huisarts & Praktijk 9): 50-1.

Friendly visiting can be defined as: regular spontaneous visits of the general prac-

itioner to aged persons even when they have not reported illness. There is no study which demonstrates that friendly visiting by the general practitioner may be regarded as an effective method of early detection or preventive care. But there are reasons to assume that a spontaneous visit by the general practitioner may entail some risks.

I confronted a group of 21 general practitioners with a number of questions about friendly visiting; 15 of them more or less regularly paid visits to aged patients who had not asked for it, while 6 did not. The general practitioners who made friendly visits did so with widely varying frequency, ranging from less than one per week to one or two visits per day (average duration 8-15 minutes). Most of them had no rigid systematic friendly visiting programme; only one systematically visited all his patients older than 75 years. Five mentioned the threat of loneliness as reason for friendly visiting; nine visited certain groups at risk (domestic care problems, loneliness, neglect, nutritional problems, motor disorders and especially medical problems).

Kingma J. The general practitioner as medical roundsman. *Huisarts en Wetenschap* 1985; 28(suppl Huisarts & Praktijk 9): 52-4.

Regular encounters at the general practitioner's initiative – more especially at the patient's home – enable him to follow the course of the terminal phase of life. This interpretation of a general practitioner's task, however, leads to a large number of unscheduled visits. On 1st January 1985 my practice population included 317 registered patients aged 65 and over. Of the 249 visits I made between 15th January and 15th February 1985, 128 concerned a total of 64 aged patients; 103 visits (80 percent) were made at my own initiative (figure on page 53). Nevertheless I would wish to make a plea in favour of regular visits – as a form of secondary prevention – to aged patients who are no longer very active, develop various physical problems and have entered a psycho-social crisis situation. A friendly visit by the practitioner may be prompted by discharge from hospital, partner loss, contact with a colleague, information obtained from a district nurse, malignant or depressive conditions, unstable chronic diseases or multiple pathology. In addition the general practitioner may play a coordinating role for patients receiving treatment from a number of specialists.

men contribute more to voluntary work than women. More than 50 percent of the men over 65 are active in voluntary work, and more than 10 percent would like to do more.

There are indications that emancipation

has a positive effect on women in the sense that they are able and willing to remain independent to a later age. Positive effects of emancipation on the life expectancy of men may perhaps also be expected in future.

Fundamental change

What do these aspects mean to general practitioners in terms of their care of aged patients?

A gradual but rather fundamental

Bakker C. Periodical medical examination of the aged in a general practice. Huisarts en Wetenschap 1985; 28 (suppl Huisarts & Praktijk 9): 55-7.

An attempt was made to evaluate periodical examination of aged patients over a period of 18 years. Problem definition: what diseases were detected, what were the follow-up findings, and is there a correlation between the findings at periodical medical examination and the causes of death?

A total of 756 persons were examined once, 430 were examined twice and 211 three times or more. The principal pathology found at these examinations is listed in *table 1*; *table 2* lists the new problems detected in this way.

The effect of periodical medical examinations is shown in *table 3*. Evidently the aged persons examined were more inclined to do (or omit) something in view of a „true” problem such as hypertension, anaemia or glycosuria than in view of overweight. In about half the cases there was no correlation between cause of death and the previously detected problem(s); the role of cancer as cause of death is conspicuous in this context (*appendix 1*). In cases in which cause of death and previously detected problem(s) did correlate, cardiovascular diseases played an important role (*appendix 2*).

Rijpma S. Voluntary care in its optimal form. Huisarts en Wetenschap 1985; 28(suppl Huisarts & Praktijk 9): 60-2.

The 59 patients aged 80 years and over in a rural practice in the Eastern part of The Netherlands were all interviewed on the basis of a questionnaire about the extent to which activities of daily life, domestic tasks and transportation tasks were performed by the aged and their partner or by specific care providers, about the care provided to the bedridden, the frequency of visits to the aged, and the relational care.

Of the 59 patients interviewed, 19 participated in an integrated multiple-generation household, and 16 lived „partly” together with a younger generation (semi-detached homes). Only four (7 percent) were living in a home for the aged (the percentage for The Netherlands is almost 30).

Only three aged patients were dependent permanently on care provided by others, and six incidentally relied on such care. The widowed patients (25 women and 5 men) received relatively much care and assistance in domestic tasks.

Ten of the persons interviewed were still able to ride a bicycle and five were still driving a car; nearly all could otherwise rely on others (household members, neighbours, acquaintances) for transportation to more remote relatives. Many visited their own children and their families, other relatives and neighbours and friends. On the other hand, many frequently received visitors, often monthly and weekly. Only three women received no weekly visits

from relatives. Only two (living alone) had nobody for an intimate conversation.

The above described care for the aged is often provided in exchange for a transfer of the farm. Quite apart from this the aged generation are busy: gardening, taking care of cattle and pet animals, cleaning house and yard, mowing grass, peeling potatoes, doing the dishes, making tea and coffee, knitting, sewing, mending, minding the children and even preparing the main meal of the day for the entire household.

Van Lamoen FK. General practice care of the aged. Huisarts en Wetenschap 1985; 28(suppl Huisarts & Praktijk 9): 63-5.

The practice I run jointly with my wife has a population of 3400 registered patients, of whom nearly a quarter (23 percent) are older than 65; some 4 percent are even over 80. The number of encounters with aged patients roughly corresponds with their representation in the practice population, but they account for by far the most house calls (3.5 hours per day), which mostly take longer than visits to younger patients.

In encounters with an aged patient it is advisable to pay attention to such matters as: social contacts, mental capability, possible depressions and incontinence, mobility, sensory functions, retention and memory, condition of the skin and sensory disturbances in the feet. Aged patients should be treated with careful reserve. It is important, moreover, to adjust to the patient's pace.

change in which attention shifts from life expectancy, mortality and diseases to quality of life, functioning and health. Respect for the views of the aged themselves. Acquisition of knowledge and skills through refresher courses and continued training, because the teaching of geriatrics is still in its infancy at most medical faculties. Practice organization

and accessibility to be attuned to the needs of the aged. Possibly an extension of curative care in the form of a general practice clinic as exemplified by the British *community clinic*, the Norwegian *sykestua* or the treatment ward in a nursing home as in Denmark. Collaboration with others in primary and secondary health care. Anticipation with-

out screening; alertness without meddling. And, last but not least, conversion of the efforts and commitment of general practitioners demonstrated in these articles to factual data, which could be used in support of my favourite hypothesis:

The general practitioner is the primary care geriatrician par excellence.