Changing the mindset of young & old

Bulletin

C O N N E C T

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▲ *Our new council members in action...*

▲ *After AGM... Passing over the baton...*

GERONTOLOGICAL SOCIETY AGM 2006

IMM. PAST PRESIDENT'S REPORT...

The Annual General Meeting, held on 26th August 2006 at the YWCA, Fort Canning Road was attended by 46 members.

Reports were presented by the Treasurer, Mr Laurence Wee and by the President, Mr Henry Lim who went through the Annual Activities Report with the members present. Among other things, Mr Lim also reported that total membership is 205 including 133 Ordinary members, 34 Life members, 2 Corporate members and 36 Associate members.

Mr Lim highlighted that we not only need to look for more Corporate members, but also to increase our membership as well.

In the area of public education, Mr Lim said that more could be done to re-orientate the common and "entrenched" mindset that people who are living longer are a burden to society. Mr Lim stressed that in the years ahead, the Society needs to continue to look at ageing issues from a holistic approach with its multi-disciolinary dimensions in the context of a rapid changing world brought about by globalisation and technological advancement.

Mr Lim in his 'sayonara' message thanked all Council Members who have dedicatedly and faithfully served the Society during their term of office 2005-2006. He hoped the incoming President and his team of experts will expand the territory of gerontology and consider the challenges of future agendas by painting a picture of gerontology in action to address rapid changing needs of older persons.

INSIDE

Exclusive Interview with
Dr Anne Merriman
GS Founder Member

Book Launch

Responding To An Aging Society...

by Mr. HENRY LIM

▲ *Launching of Book "Responding To An Ageing Society" by MP Cynthia Phua, Chairman of Aljunied Senior Citizens' Advisory Committee*

Immediately after the AGM, we had a successful launch of 'The Quest For Longevity – Responding To An Aging Society' by Mdm Cynthia Phua, Member of Parliament For Aljunied GRC. There was a fairly strong turnout from GS members including the contributors to the volume. I am very grateful indeed to all those who provided chapters for the book – I think the standard is fairly high indeed, although as one of the editors there may be an element of bias here. My other co-editor, Mr Laurence Wee would I think want to join me in expressing our gratitude to:

(1) Dr Anne Merriman, one of the founder members of the Society with long standing connections in geriatric and gerontology gave us considerable benefits of her insights into the Global Perspective of Palliative Care,

(2) Prof Kua Ee Heok, who provided the consistent leadership and creative ideas which the project required. Prof Kua also served with distinction in our Council and we are very much in his debt. In any event, I do hope the book proves a useful contribution to the intellectual and other service providers about the various futures of aging. I hope the proceeds from the sales of the book will make a modest contribution to the economic health of the Society. We urge members and their friends to buy a copy of this book. Price for a copy of this book is $15.00 including of postage. If you wish to order, please contact, Mr Tristan Gwee at 6786 6826. GS

▲ *In rapt attention... participants listening to Dr Anne Merriman*

Council Members - 2006/2007

President	Mr Laurence Wee
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2nd Vice President	Mdm Kwek Puay Ee
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Perspectives On Pain & Death :

An Interview with Dr Anne Merriman, MBE, FRCPE Founder Member of GS Society …

by Dr. CHOW YEOW LENG

Dr Anne Merriman was trained as a geriatrician in Edinburgh. She came to Singapore in 1984 as a teaching staff in the NUS Department of Community, Occupational and Family Medicine. She went to Africa as a missionary doctor 20 years ago to work with AIDS patients in Uganda.

C: From your perspective, an older person's attitude towards dying. There are different schools of thought that says older people accept death more than younger people. What is your perspective?

M: I don't think you can generalize. As a person gets older, he starts to withdraw from the activities of life. As they withdraw, they begin to have more time to think and hence begin to accept that they are dying. "The work is now completed and I'm letting go." And it is found in England that the people who were coming towards death and were composmentis, were quite accepting. In fact they will even say "why does God hold me if I want to go?" So I think as you get older, and you sit back and think about it, I think these people do but it also depends very much on their growing up years. Some people are afraid to die because they have done some very bad things in life and are afraid of what's going to face them in the afterlife. They are afraid to die and they need to talk through it and I think we as carers need to be available to talk through with them.

C: Is it because of two things: unfinished business in life and religion? Maybe we look at unfinished business first.

M: Yes, I think that does have a big influence on how you go. If you think I've got a disabled child and I don't know what's going to happen to him and that's not sorted out. They will want to stay and sort it out. Those kind of things need to be completed before they can feel at peace about death.

C: What about religion?

M: Well, I think religion has many facets and aspects. I think religion is a way for us to get even with God. We learn it as children and it helps us to know about God. And very often people as they get older, they formed a religion in a box and they move on towards God and they get that spirituality. And I think people who have made peace with God, they die very peacefully. People who believe were happy to die. People who were atheists were happy to die. But people who had a problem dying, people who were not sure and agnostics, had the most difficult time coming to terms with death. So belief has a lot to do with it but I think we need to know the difference between religion and spirituality.

C: What about cultural factors?

M: I think culture has a lot to do with it as well. Certain cultures demand that certain rituals are carried out before death. Here of course it's very interesting. You have the Indians, Malays and Chinese and they all have different cultures. And they all want to go back to their own traditional medicine. And I learnt a lot from that, because I always say if I am sick I am going back home. For the Chinese, they want to go back to China before they die to try the Chinese medicine,

▲ *MP Cynthia Phua... token of appreciation for speaker Dr Anne Merriman*

and the Indians want to try theirs and the Malays have their own. That was very interesting for me to see. They have all their life sent their children to doctors who practice western medicine.

Many people don't want to die.

C: Doesn't that create a contradiction?

M: Traditions die very hard. What you learn in childhood, it goes with you all the way through life.

C: How would you handle that? Let's say if you have an older person who has cancer and wants to go to the temple and yet you are treating him with chemotherapy. How would you counsel the older person?

M: We must remember the patient is our guest and they have choices right up to the end of life. And if they want to go back to China, then you let them go. If they confide in you, show them that you are willing to listen.

C: Even if in your professional judgment it may not be the right thing to do?

M: Yes. I think we always have to remember as health professionals, that the patient knows far more about his/her body than the doctor.

C: Let me relate to you a case. My student came to me very upset because the elderly person is dying. The family actually kept the elderly person alive through artificial means in order to wait for the son to return from overseas. What do you think?

M: To me, in palliative care and geriatric medicine, ventilators are out of the question. We don't use them. If somebody is elderly and has a life threatening disease, we shouldn't use them. People want to die peacefully with their family around them. With a ventilator, she can't even talk and tell you what she wants. To me that is completely out.

C: What is your opinion about euthanasia?

M: Euthanasia is completely out as far as I'm concerned. Euthanasia is advocated by people who want to control pain. Pain is not just physical, but psychological, social and spiritual. One of the worse case I had was a doctor who had cancer of the prostrate and he was a very proud man. He was very upset because he was paraplegic. He gave everyone a very hard time including his wife. But we learnt a lot from him.

C: Could it be he was at a very angry stage and it was not resolved, that's why he was such a difficult person?

M: But he was difficult all his life. If you have problems in your life, it is only going to get worse as you get older.

C: So you are saying that a person's personality doesn't change much as he ages?

M: Yes. But sometimes doctors and nurses are the worse patients because we want to be in charge and tell them what to do.

C: So coming back to euthanasia…

M: I think it is wrong to take it out of God's hand. And I don't think it is necessary if we can control pain. Though we can control pain but only a small percentage in the world benefit each year. We are not reaching everybody so many are going to die in pain. But I'm not practicing euthanasia because they actually live longer if you can control the pain. Only a few continents in the world actually have euthanasia, like Holland and Oregon.

C: You know in Singapore we have an Advanced Medical Directive a few years back. A lot of people will argue that it is a slippery slop towards euthanasia. Now, what do you think?

M: No, there is a difference. If a person is on the point of death and he doesn't want them to do anything extra to keep him alive, that is his choice. He just wants to die comfortably. And that is what palliative care and geriatric medicine should do: to keep these people comfortable and maintain quality of life right up to the point of death.

C: In our culture, patients can be quite superstitious and they don't want to know about death and things related to death.

M: But they have to know. And they get such peace once they know someone's going to talk to them. And then you bring in the relatives. You have husbands and wives who share everything all their lives and once they come to this they stop talking to one another. And that is very sad.

C: So what you are saying in general is that healthcare professionals are too protective to say that they cannot take it.

M: But there are people who don't want to talk about it. You have to do it very gradually.

C: Coming back to palliative care, what do you think of the statement since these people are going to die anyway, why should we waste our resources on them?

M: Well, I think you are wasting resources if you bring in intensive care, but palliative care is very cheap.

C: In western countries where they have the best medicines and technology available, people might think that if they can be on intensive drugs and prolonging life for a few years, they might still be a hope for a cure.

M: Yes but I think you've got to be very open with them so that they can make informed choices. What is the percentage chance of recovering?

C: But can the doctors be so accurate as to give a percentage?

M: Yes. There are statistics from the world. You can get them from the internet.

C: Right. Is there anything else you would like to elaborate with regards to an older person attitude towards dying?

M: I think an older person is going to face death in a better way compared to one who is in their 30s to 40s. Yes, I think ageing does have an effect on the way you die but there are individual variations.

C: So variations would depend very much on their individual circumstances and thinking.

M: Right.

C: Thank you very much.

Heartiest Congratulations to our 1st Vice President, Dr Kalyani K.Mehta on her recent appointment as Nominated Member of Parliament

"Challenges and Issues faced by Family Caregivers of Elderly"

Caregiver's Forum by GS and AWWA on 25 Nov 06 YWCA, Fort Canning Lodge, Singapore

by Dr. KALYANI K.MEHTA,
Assoc. Professor, Department of Social Work, National University of Singapore

About 40 enthusiastic participants gathered on Saturday 25th November 2006 to engage in a lively forum on the challenges and issues that face family caregivers of older relatives in Singapore. Dr Mehta opened the forum with a short summary of the demographic profile of our ageing population. In 2030, one in every four Singaporeans will be 65 years old or above. In absolute numbers, there would be an increase from about 296, 000 in June 2005 to 873, 3000 in 2030.

Caregiving for older persons is significant for an Asian society like Singapore, where the notion of filial piety is prevalent and the government emphasizes the family as "the first line of support." As people age, even if they have resources e.g. financial, they still need support such as emotional or social support because health conditions can change at any time. It is estimated that there are about 210, 800 caregivers in Singapore looking after seniors, disabled children, and physically and mentally ill people (Straits Times 12/4/04). With more older persons living alone (a rise from 3.4% of all persons 65 years and above in 1995, to 7.3% in 2005) and more singles (a rise from 11% in 1994 to 14-16% in 2004) more community-based resources will be required to help them if they lack practical and social support.

The main challenges faced by family caregivers relate to firstly shortage of time to take care of other responsibilities and commitments, and secondly difficulties in juggling work and home duties. These two main sources of stress can push a family caregiver, who may be a spouse, adult child/child-in-law, grandchild, sibling, or adopted/step-child to the brink of depression.

The person providing the major part of the practical, emotional and financial support is referred to as the primary caregiver and the secondary caregiver is the person who helps the primary caregiver when he/she needs respite or unavailable e.g. when handling work responsibilities. The foreign maid is another source of support either as primary or secondary caregiver, who resides in the family household.

The third challenge is financial, as the caregivers have to bear financial costs of medical expenses in addition to struggling with other family expenses, and inflation. Issues that may emerge in the course of the caregiver journey could be related to the nature of the prior relationship with the care recipient. If it was conflictual, there would be negative effects on the quality of caregiving, possibly elder abuse and/or neglect.

An earlier piece of research on 61 caregivers of older homebound Singaporeans revealed that females reported higher levels of stress than male caregivers. At this point of the presentation, the participants were asked their views. One male participant responded that male caregivers also have stress but perhaps due to Asian cultural norms, they were less inclined to admit it in research interviews.

Another important issue that was elaborated was the need for understanding employers, if the primary caregiver was working. In an ongoing research on family caregivers it was found that adult children and children-in-law reported some instances of employers who criticized employee caregivers who were late occasionally, even though they were aware of the family situation. Lack of training of family caregivers in special skills related to caring for a dementia patient, or someone who has suffered from stroke, was another issue that required to be addressed.

Caregivers often report the issue of not being recognized for their sacrifices, nor being appreciated by other family members, sometimes including the care recipient. It is not uncommon for the caregiver to be taken for granted. Resentment towards other siblings who do not contribute in any way towards the care of elderly parents is sometimes felt by the primary caregiver.

Illiterate as well as caregivers who are not fluent in Mandarin and/ or English encounter stresses in dealing with the various "systems" such as the medical, social service agencies, legal system, and bureaucratic organizations. This compounds their other practical problems.

Some policy recommendations that were offered were:

1. Integration of policies for caregivers.
2. Family leave in lieu of child care leave for singles/middle-aged employees to be made a policy for all organisations.
3. Flexibility to be exercised by employers when their employees have genuine reasons.
4. Innovative ideas for caregiver recognition e.g. free movie tickets, or waiver of training fees for relevant course.
5. To support low income family caregivers who do not benefit from tax relief, NTUC food vouchers or transport vouchers can be given.
6. Support groups for family caregivers to be organized at all Family Service Centres/ or Neighborhood Links.
7. Caregiver centres to be encouraged to do more outreach e.g. AWWA Caregiver Centre.

The latest Committee on Ageing Issues report (2006) was a well conceived plan for the next 5 years. However, in addition to the role of family physicians, Dr Mehta suggested that educational counseling at the point of discharge of all geriatric wards of hospitals would be helpful for family caregivers, and would reduce readmission in the long run.

The government has taken a step forward in allocating one week in April annually to be dedicated to caregivers. It should be an ongoing exercise throughout the year for more effective reach to all caregivers of elderly. One groups that needs to be targeted is the spousal caregiver group, who are themselves ageing and lacking resources in most cases.

Dr Mehta ended her presentation by saluting all family caregivers of elderly, as she could empathise with their struggles, having been a caregiver of older parents-in-law in the past.

"Are Caregivers' Needs Being Met?"

by Ms. JENNY GOH,
Medical Social Worker, Alexandra Hospital

Supporting caregivers in their caregiving journey is both "economically and ethically necessary" (Mittelman, M. 2005). Most elderly persons prefer to live at home and be cared for by their loved ones. In supporting and enabling caregivers, repeated hospitalization of elderly persons can be reduced, institutionalization may be delayed which can in turn reduce cost to society. Supportive interventions that focus on caregivers mental and physical well-being reduces the risk of illnesses such as depression and undoubtedly reduces the cost of caregivers own healthcare.

Many caregivers strive to provide good care to their loved ones. However, the practical realities of caregiving and life's demands are often challenging. Possessing the will and love to provide good care is insufficient. A caregiver needs adequate knowledge of medical condition and skills to equip him/her in the caregiving task. Time and untiring effort to manage caregiving demands that will only increase as the elderly age, is also crucial. Money for medical attention, medications, hired primary or secondary helper, day care activities to improve quality of life etc. A caregiver also needs emotional and psychological support that can either be derived from his/her own support system or from the larger healthcare and social service system that has to be sensitive to a caregiver's needs. Finally, caregivers should also take breaks and adequate respite in order to continue thriving positively in the caregiving journey.

Since caregivers often do not have solely this single role to play in life, it is inevitable that caregivers are often faced with a dilemma on how to apportion their time, energy and finances. Common breaking points for caregivers comprise of:

1. Increased, complex care needs of elderly which demands increasing time.
2. Caregiver stress that resulted in own physical and mental health breakdown.
3. Unsustainable loss of finances when caregiver gives up job to take on caregiving role.
4. Conflictual family relationship resulting in difficulty in negotiating care arrangement.

These factors often lead to caregivers requesting institutional care arrangement for their loved ones.

The following case scenarios are raised to highlight real caregiver needs and some of our current social service gaps:

Case 1:

Mdm A is an 86-year old lady

with moderate stage dementia. She has difficulties identifying objects, thus rummages rubbish bins in search of food, even drinks detergent and cooking oil if unsupervised. She is often restless and has poor sleep pattern. She is occasionally incontinent and needs prompting in all activities of daily living.

Mdm A is widowed with 6 children but none are supporting or concerned of her. She lives with her daughter-in-law and a granddaughter who is a single parent to her own 9 year-old daughter. Both daughter-in-law and granddaughter are working but income is low.

Mdm A attends a dementia day care centre. Transport is provided daily but at an inflexible drop-off time. Granddaughter has to leave work punctually daily in order to pick up Mdm A from the void deck. She has tried negotiating a later drop-off time with the centre but to no avail. Neither has her efforts of engaging a neighbour to help with pick up, even with payment, been successful. She felt constrained by the caregiving demands, limiting her opportunity of a social life and career advancement. Yet, torn between providing good quality of life and care for Mdm A.

Granddaughter resorted to seeking help with a Medical Social Worker to place Mdm A in a nursing home. However, as Mdm A does not fit the functional criteria to a government subsidized dementia nursing home yet, the request has been turned down. Neither is this family capable of financing a maid as paid caregiver or a private nursing home. Granddaughter has to be resigned to the practical realities and social service limitations.

Case 2:

Mdm B is an 83 year-old lady with multiple medical condition, bedbound, with contractures and bedsores. She is fully dependent on all activities of daily living. Her bedsore condition requires regular turning and dressing.

Mdm B's husband is 84 years old. He is visually, hearing and cognitively impaired. He is capable of self-care but incapable as a caregiver to Mdm B. Mdm B's only daughter is 43 years old and single. She is the sole breadwinner of both elderly and their sole caregiver. She works as a piano teacher earning only $700 a month. She has no social life and very limited social support.

Mdm B's daughter cannot afford to place her in a voluntary nursing home, even with the highest tier of government subsidy. She has no choice but to select sub-optimal means of home care ie. Mdm B only gets turned and repositioned when daughter returns home during lunch time to feed her. Daughter has accepted her role as caregiver and the level of care she can afford. However, it is questionable how long she can uphold her role without affecting her physical and mental health.

A caregiver in such a circumstance will benefit from occasional respite service whereby he/she can rejuvenate while the loved one is in the good hands of a trusted facility. However, the lack of affordable respite services often leads to its inaccessibility for low-income caregivers. Alternatively, can community support be gathered to provide relief? For instance, a group of willing retirees can be trained on basic caregiving techniques and volunteer to help turn Mdm B every 2 hourly when daughter is at work. Finally, can financial aid, in cash or kind, be made more available and accessible to support the work of genuine family caregivers?

Caregivers should not be left alone as they plough through their caregiving duties. As our population ages and family size shrinks, it is inevitable that every individual will become a caregiver one day. As a society, it is every individual's social responsibility to provide understanding and support to these unsung heros.

CREATIVITY, AGEING and MENTAL HEALTH

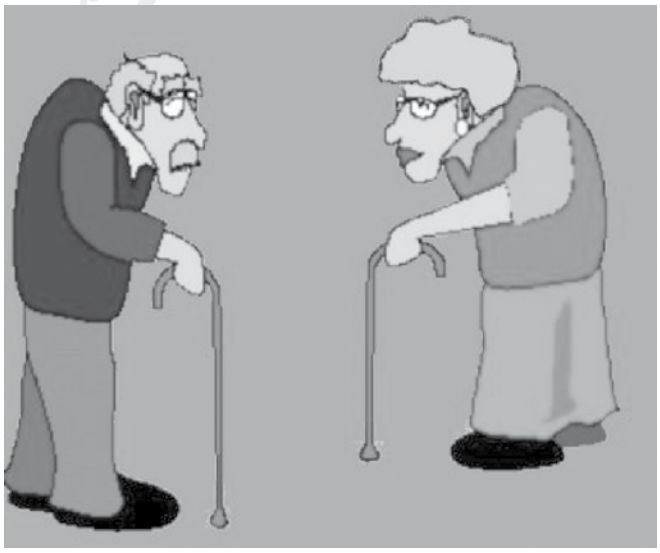
by Prof. KUA EE HEOK,
Senior Consultant Psychiatrist, NUS

In old age, there is an association between Quality of Life (QOL) and mental health. Our community study in Singapore of elderly people showed that those with good life satisfaction were those with no cognitive deficit or depression. There are misconceptions that old people in general are depressed or demented. Our research has indicated that the prevalence of depression is 6- 7% and dementia 3-5% for people 65 or more. An important question is : Can we prevent mental illness and improve QOL?

There was a myth that the brain cells stopped to multiply when we reached 45 years. Recent studies have shown that arborization of these cells continue albeit at a slow pace in late life. Mental activities can stimulate brain neurons to grow. Art and music can activate the brain in creativity. For many years, art and music therapies have been used in psychiatry for treatment of depression. At the cellular level such activities help to modulate the affect and influence the secretion of neurotransmitters responsible for regulating mood. Can art and music stimulate the neurons and help prevent dementia or Alzheimer's disease? This is an important research question because there are many other methods of mental stimulation, eg. reading, playing chess, playing mahjong, tai-chi, hobbies, etc.

If we can harness the natural process of healing in a person, then we can improve the mental health and QOL of the elderly person.

I'm Fine - How are you?



There's nothing the matter with me,
I'm just as healthy as can be,
I have arthritis in both knees,
And when I talk, I talk with a wheeze.

My pulse is weak, my blood is thin,
But I'm awfully well for the shape I'm in.
All my teeth have had to come out,
And my diet I hate to think about.

I'm overweight and I can't get thin,
But I'm awfully well for the shape I'm in.
And arch supports I need for my feet.
Or I wouldn't be able to go out in the street

Sleep is denied me night after night,
But every morning I find I'm all right.
My memory's failing, my head's in a spin.
But I'm awfully well for the shape I'm in.
Old age is golden — I've heard it said,

But sometimes I wonder, as I go to bed.
With my ears in a drawer, my teeth in a cup,
And my glasses on a shelf, until I get up.
And when sleep dims my eyes, I say to myself,
Is there anything else I should lay on the shelf?

The reason I know my Youth has been spent,
Is my get-up-and-go has far-up-and-went!
But really I don't mind, when I think with a grin,
Of all the places my get-up has been.

I get up each morning and dust off my wits,
Pick up the paper and read the obits.
If my name is missing, I'm therefore not dead,
So I eat a good breakfast and
jump back into bed.

The moral of this as the tale unfolds,
Is that for you and me, who are growing old.
It is better to say "I'm fine" with a grin,
Than to let people know the shape we are in.

Author Diamond C Aloes

We wish all our readers a Happy New Year!

From: Council Members of Gerontological Society of Singapore

GS Membership Renewal

Members are kindly reminded to renew their membership if they have not done so.
Thank you

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