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Title: Treating The Elderly

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Standfirst: How do we define who is elderly? What are the special considerations required for treating people in the later stages of their lives, with complex, multi-layered case histories, and often on a cocktail of prescribed drugs? This article explores the issues, with some case histories.

Defining Elderly

Who are the elderly? Anyone over the age of 65? No, the term 'elderly' more accurately describes a state of being, rather than a specific age category. We should resist the temptation to classify the elderly as a specific group; they are as diverse as the rest of us. Someone over 90 might have more energy than a lethargic teenager, but in a weak constitution the problems of ageing (such as tissue loss, rigidity or a failing memory) can occur in younger years.

One might at first think that the elderly can display the layers and sediments of their geological strata quite clearly; we might imagine that because of the duration of their lives they will be able to give a lengthy case history from which perfect patterns can be ascertained. In some cases this may be true. However, in many cases elderly patients are too suppressed with medication for the layers to be very clear. The undrugged patients certainly have clearer pictures, but it does not necessarily make it easier to treat them. While we might yearn to deal with their layers and 'never been well since' (NBWS) symptoms, we sometimes have to concentrate on the presenting symptoms of varicose veins, eczema, incontinence, pain, etc. Time is not on their (or our) sides, so we have to help them to be more comfortable physically before we can go deeper. Certainly their cases will be quite different to take, and analyse, to those of the young.

Homeopathically the elderly are fascinating, since they can teach us so much about the endurance of the vital force and miasmatic inheritance. Generally, our older patients are most likely to be *psoric*, that is: anxious, slow, worse from cold and worse in the mornings, or *sycotic*: demanding, suspicious, and worse at night. Perhaps we rarely see elderly *syphilitic* patients because they believe no one can help them. The *tubercular* patient remains as changeable and restless as they were in their younger days. Jack Lyle, an Australian psychologist, said, "The older people get, the more like themselves they become".

Older Patients' Needs

Older people may need more time and effort than other patients expect or require. Many of them cannot get to our clinics and if we see them in their own homes there may be interruptions from carers, the budgie, or the television. They may be lonely, deaf, cantankerous or confused. Almost all of them will be on prescribed drugs, sometimes seven or eight different ones daily, each one treating the side effects of the one prescribed before. If we offer to discuss medication with their GP almost all of

them will worry about "going against the doctor" with concern that they will be punished in some way.

Quote: "You understood; you knew what I was talking about. I don't think you *can* cure me; you made it easier for me. That's good enough. I don't expect any more." *The words of a patient of 12 years standing*

Often, an anxious family member with unrealistically high expectations will ask us to treat their relative, and occasionally we have to discontinue treatment because it is not what the patient actually wants. In such cases, supervision is advisable, to help us feel comfortable with this decision; it can feel like failure, and as if we are abandoning the patient or family.

We also have to consider how much ongoing support we can give if our patients go into residential or nursing care. It can take a lot of time to locate them as they move from one institution to the next, and as they often lose control over their money, it can be hard to get paid.

So why would we ever accept older patients? Because, so long as we can be flexible enough to modify our own principles and expectations, treating the elderly can be a very rewarding experience, and one that teaches us about the action of homeopathic medicines on the vital force in a specific way. I asked an 84-year-old patient today whether she thought homeopathy had helped her over the 12 years I have seen her. She said, "Oh, yes. After over 50 years of soldiering on (with only one lung after TB) I still feel broken, but I haven't lost the willpower; that belongs to another part, the soul. Homeopathy takes care of the body, mind and soul, which conventional medicine doesn't. You understood; you knew what I was talking about. I don't think you *can* cure me; you made it easier for me. That's good enough. I don't expect any more."

We all know how beautifully children react to a well-selected remedy. What about the supposedly declining vital force of the elderly patient? We may be homeopaths with high ideals *for ourselves*, but our older patients usually appreciate being supported in whatever way is appropriate *for them.* We have to try and see the person behind the medication or suffering. Sometimes we have to enlist the help of Age Concern or other agencies such as social workers, and sometimes we just need to sit with them.

Talking About Death

It may be appropriate to talk about death and dying, even long before it is likely: what are the patient's wishes, angers or fears? Some older people have no living friends or relatives: no one to talk to about the deeper things in life. Most have an abiding fear of, "becoming a burden" and it can be very reassuring for them to pay for a safe hour to share their concerns without being judged or jollied along inappropriately. Dr Elizabeth Kuebler-Ross[1], in her pre-hospice 1960's work with the terminally ill said, "The few who can do this will also discover that it can be a mutually gratifying experience; they will learn much about the functioning of the human mind, the unique

[1] *On Death and Dying,* Elizabeth Kuebler-Ross, Tavistock/Routledge, 1969

aspects of our human existence, and will emerge from the experience enriched and perhaps with fewer anxieties about their own finality". Wise words.

Recently I have wondered whether dying may be a much longer process for some people than we realise, perhaps taking years. For example, people in their 80s often have a fall from which they never properly recover. No amount of *Arnica* or anything else really gets them back to how they were before. Could the fall be a symbolic way of saying "I don't want to stand up any more?" I once had a textbook elderly *Arsenicum* case; she fired me because although her ulcers and bone pains were better, she said with some annoyance, "I'm still here, aren't I?"[2]

Modern nursing practice requires patients to be up and dressed every day. The more I speak to older people who can no longer look after themselves the more I wonder whether some of them wouldn't prefer to be gently nursed in bed, for however long it takes, without life-prolonging medication or surgery but certainly with painkillers if required. Struggling with life can sometimes be harder than accepting death.

Prescribing For The Elderly

There is a homeopathic myth that we should only prescribe low potencies to elderly patients, because we might harm or even kill them. However, perhaps because their powers of regeneration are actually slowing down, I have found that they often do best on very high potencies, sometimes repeated frequently. As ever, the individual circumstances should help us to choose, but fear is not a good guide.

It is important to consider *how* to administer the remedies. Poor memory, failing eyesight, and arthritic or shaky hands are definite obstacles. Sometimes I use a plastic sandwich bag, which can accommodate the whole hand, and label it with large black indelible writing. I may put the container by the bedside lamp so the patient remembers to take a daily pill before bed, or suggest the forgetful man with an enlarged prostate keeps his remedy container on the toilet cistern.

Many times I have been baffled that a well-indicated remedy apparently did not work, and occasionally I have even found the remedy not taken at all. Sometimes I have patients who will not admit to being better because they do not want to be abandoned; the knowledge that you will call again can be very reassuring. Increasingly, in certain circumstances, I have become a non-prescribing homeopath. The desire to give a remedy and feeling of inadequacy if I cannot select or administer the right remedy has given way to 'just being' and listening to the patient's wishes.

Case I, Female aged 70

Presenting Symptoms: An elegant lady, about to go on a cruise and embarrassed by flatulence. IBS, photophobia, migraines, twitching arms and legs.
Medication: Parstelin, Premarin, Co-proxamol, Co-phenotrope, Lomotil, Lormetazepam, Colofac, Calcium and vitamins.
History: Scoliosis. A "placid, weakling, cry-baby twin. Left handed – always felt left out." Artistic. In 1945 unwittingly bigamously married (NBWS). Felt "rejected, degraded and humiliated." Nervous breakdown, ECT x 4. Hysterectomy (fibroids) Cholecystectomy. Vertigo. Rheumatic feet.

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[2] *SOH Newsletter, pp*. 30-31, September 2003

Prescription: *Pulsatilla 30* weekly x 4 helped the IBS, but did not hold.
Prescription: *Arsenicum Album 30* daily (because of multi drugging) for two weeks.
Follow up: "Delighted. I don't know what you've done but it's wonderful." Twitching has gone. Sleeping pills stopped. Will discuss reducing other drugs with GP.
I gave more *Ars Alb 30* to be taken as and when required on the cruise and didn't hear from her again for ten years. By then her twin sister had died and she had been given, "too much Botox" for drooling, and could hardly speak or swallow. I tried eight remedies, including *Ars Alb* again, over the next three months but nothing helped at all. She was taking a vast cocktail of prescribed and over-the-counter medication. After much heart searching and supervision on my part, and distress on hers, I had to end the homeopathic contract.

Quote: Small miracles are usually good enough and our older patients tend not to share our own high expectations of cure.

Case II, Female aged 62
The patient looked 75: a frail, nervous 'little old lady'. Loved the sea but too travelsick to get there. Lifelong illness: rickets, rheumatic fever, and rheumatoid arthritis. Took responsibility for younger siblings when evacuated from Liverpool in the war. Realised that being ill took responsibility off her. Strong Catholic upbringing and rebelled age 21, and was one of the first to use the contraceptive pill. Very happily married despite husband being disapproved of by parents. Recently widowed, "a terrible shock". Very anxious about people and animals; oversensitive to everything. "Neurotic".
Prescription: *Cocculus 30.* Worked very well for travel sickness, then *Nux Vomica 30* to reduce over sensitivity. She went travelling again and took more *Cocculus* which promptly antidoted the *Nux Vomica*. A few further doses of *Nux Vomica 30* enabled her to resume her social life, travel without sickness, and look years younger. Ten years on she is energetic, cheerful and no longer has any homeopathy.

Case III, Male aged 73
Presenting Symptoms: Vertigo for 14 years, getting worse, often with nausea and stomach ache, < on standing; shaky legs, arms and hands; losing confidence, beginning to fall; sleeping badly; getting breathless; eczema hands and feet. "Always well in the past." NBWS nursing his wife who had cancer for seven years. She died seven years ago. Last year he gave up his job working in a shop and now he is depressed because vertigo stops him driving to the pub for a beer with friends. Instead he drinks large quantities of white rum at home, which I asked him to try and reduce.
Medication: Takes Stemetil, Serc, sleeping pills "which don't work", Betnovate for skin.
Prescription: *Cocculus 30* twice weekly for four weeks, for the ill effects of night watching, vertigo and falling, < alcohol and beer. Much better afterwards and able to resume beer drinking with his friends. No further treatment requested.

Case IV, Female aged 79
Presenting Symptoms: Total urine retention after gall-bladder surgery. Seen as an acute appointment one month after surgery, three weeks after catheterisation. The patient was uncharacteristically depressed because she had been told she would have

to self-catheterise for the rest of her life; she was already getting very sore because insertion was difficult.
Prescription: Causticum 6, a specific for post-operative retention/bladder paralysis. It enabled the passage of a small amount of urine but not enough. A full case history then revealed a history of catheterisation after childbirth in 1940, a prolapse in 1952, and bouts of stress incontinence and urine retention ever since. Combining this with her personality type and occupation (she had been a teacher), and a history of appendicitis, hiatus hernia, spastic colon I gave *Arnica 30* for a day for the soreness, trauma and bruising and then a single dose of *Lycopodium 30.* I had expected to give *Lycopodium* in ascending potency but normal bladder control quickly returned and she did not need any further treatment.

Conclusion
Of course, it is always troubling if remedies do not work, but the disappointments are counterbalanced by the rewards when they do more than could ever be expected. These simple cases show that small miracles are usually good enough and our older patients tend not to share our own high expectations of cure.

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