GERIATRIC ATTENDANCE AT OUTPATIENTS DEPARTMENT ADDINGTON HOSPITAL, DURBAN

I.D. WALTERS MBChB (Glasgow)

"GERIATRICS"

Geron - Old Man.

Iataikos - Medical treatment was invented by the American Physician Ignaz Nascher in his book, 1919
Geriatrics - The Diseases of Old Age and Their Treatment.

Paul French and Trubner, London 1919

"You can judge a nation by the state of its old people.
They would much rather stay at home looking out of the windows watching the perambulators going by".

... Winston Churchill

SUBMITTED IN PARTIAL FULFILMENT OF THE REQUIREMENTS FOR THE FIRST PART OF THE M.MED (COMMUNITY HEALTH) OF THE UNIVERSITY OF NATAL.

DECLARATION

This dissertation is the candidate's original work and has not been submitted in any form to another University.

The sources of data have been duly acknowledged in the text.

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1. SUMMARY.

This is a cross section study of the White elderly patients who attended Addington Hospital, Durban, Out-patient Department during a two week period in July 1985. Screening was by means of systematic sampling, a standard questionnaire was administered to 321 of them and their characteristics and needs were identified.

In order to determine the attitudes of the medical and nursing staff who work in Addington Out-Patient Department, a further questionnaire was used.

It was found that 88,37% of health professionals did not have a particular leaning towards looking after the elderly, but 88% agreed that the needs of the elderly were different in comparison with other age groups. 92,8% considered that geriatrics is a speciality in its own right.

Recommendations are made for a 24 hour community geriatric service, the establishment of day centres to serve the needs of the greater Durban area, and for the establishment of a Chair of Geriatrics at the University of Natal.

2. INTRODUCTION.

As medicine continues to advance, so the life expectancy of the population in Western society increases. This has created a problem in that society has not geared itself up to meet the needs of the older section of the community. With this in mind it was decided to conduct a survey at Addington Hospital Out-patient Department which provides curative and primary health care services for geriatrics for the greater Durban area in order to obtain an indepth appreciation of these services and whether they are keeping pase with increasing demands made of it.

With future planning in mind, the geriatric attenders were questioned about their attitudes and origins in order to formulate their backgrounds and future needs. Planning for the future has to be done carefully and thoughtfully so that the elderly and the tax payer has value for money.

The medical and nursing staff who normally work at Addington Hospital Out-patient Department work with the elderly people every day so it was important that their feelings about their work was sought, because good-will and understanding created by them would go a long way towards the smooth running of the Out-patient Department.

Having studied this situation, proposals are made in respect of primary health care for the White geriatric people in the greater Durban area.

3. OBJECTIVES.

The following objectives were defined for the purpose of this study :

i) To determine the trend during the past 10 years of the numbers of geriatric attenders at Addington Hospital Out-patient Department.

ii) To ascertain in respect of geriatric attenders at Addington Hospital Out-patient Department :

a) their personal characteristics.

b) the geographical area of residence.

c) the reason for attendance.

iii) To ascertain the attitudes of the medical and nursing staff to the management of geriatric attenders.

iv) To make recommendations in respect of primary care of the geriatric population in the greater Durban area.

4. DEFINITION OF CRITERIA.

i) Geriatrics: Aged persons are defined by the Aged Persons Act (No 81) of 1967 of South Africa "that a male is an aged person at 65 years of age and a female at 60 years of age".

ii) Illness: Is defined as "unwell, having pain, find difficulty in leading a normal life (Williamson, 1966)".

iii) Addington Hospital Out-patient Department (AOPD).

The area of Addington Hospital which provides services for non-admitted patients.

Medical and Nursing Staff: Doctors and nurses who normally work in AOPD.
Personal characteristics: Age, sex, marital status, race, accommodation, living with/distance from nearest child, area, type of pension, medical aidr, car, means of transport, social and cultural environment.

Selection of sample and control groups :

i) Sample: The sample included every fifth patient who attended AOPD during the study period, and who met the criteria for inclusion in the study.

ii) Controls: No control group was drawn for the purpose of this descriptive study.

5. METHOD OF DATA COLLECTION

i) Permission to carry out the study was sought from the Senior Medical Superintendent of Addington Hospital, who discussed the problem with me and who requested certain additional questions to the questionnaire.

ii) The statistics of the number of geriatric attenders at AOPD for the past ten years were to be obtained from hospital records. It was found that this could not be done in the time available because these figures were not kept separately from the total OPD attendance figures. I was told that 70% of attenders at AOPD were geriatric patients. From a survey done in 1979 (Primary Health Care Services for the elderly in the greater Durban area - Professor Arbuckle), it was felt that 68% were geriatric attenders. It was decided to use 69% being the mean between the two figures.

iii) Every attender included in the sample was interviewed prior to attending their clinic by myself and no problems were experienced. The sample was every fifth geriatric person who attended AOPD during a two week period in July 1985.

iv) I was provided with a small room in OPD to interview the sample and over the period I interviewed 321 people.

v) When discussing my study with the Senior Medical Superintendent, doubt was expressed about the time factor in relation to the number of patients seen. This proved right in the pilot study. No amendments to the questionnaire were found necessary but the period of study was extended from one week to two weeks.

vi) The attitudes of the medical and nursing staff to the geriatric attenders was elicited by means of a standard questionnaire. 41 questionnaires were completed.

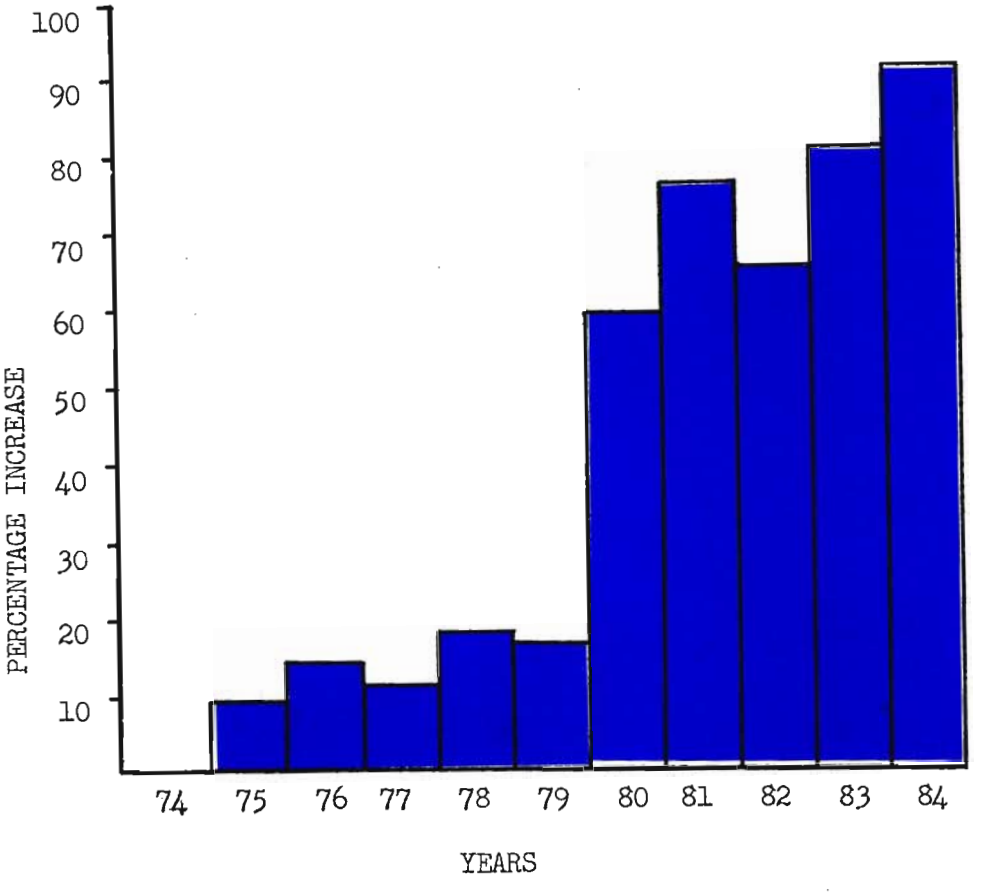
6. RESULTS.

i) THE TREND OF THE NUMBERS OF GERIATRIC ATTENDERS OVER THE PAST 10 YEARS. The total number of elderly white attendances from the year 1974 to 1984 inclusive were obtained from the Records Department and the percentage increase was worked out for each year. Starting with 1974 numbers of elderly attenders were 127,672. In 1975 the numbers were 139,413, an increase of 9,28%. In 1976 the numbers were 146,653, an increase of 14,87%. For 1977 the number of elderly attenders were 140,006, an increase of 9,66% on 1974 figures. 1978 figures were 149,531, an increase of 17,12%. In 1979 the number of geriatric attenders were 148,872, an increase of 16,16%.

However, in 1980 the number of geriatric attenders were 203,665, an increase of 59,52% on the 1974 figure. No explanation could be elicited from Mr. Nieuwoudt, Hospital Secretary Out-Patient Department at once, but after a long in-depth discussion it was found that in 1980 Addington's record system became computerised. Prior to 1980 this was done manually.

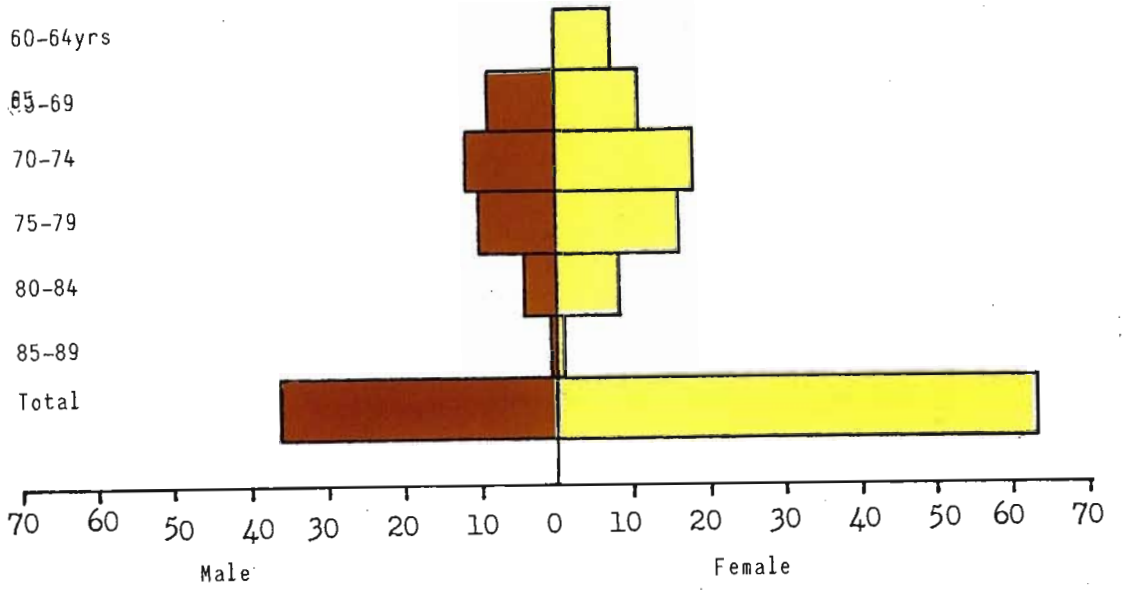
In 1981, the numbers of elderly attenders were still on the increase to 223,646, a percentage increase of 75,17% on 1974 figures. The figures for 1982 were 213,162, an increase of 66,92%. In 1983 the numbers were 229,921, an increase of 80,08%, whilst they rose even further in 1984 to 245,185, an increase of 92,4%. (see Figure I and Table I).

FIG. I INCREASE IN ATTENDANCE AT AOPD
1974 to 1984 INCLUSIVE
PERCENTAGES



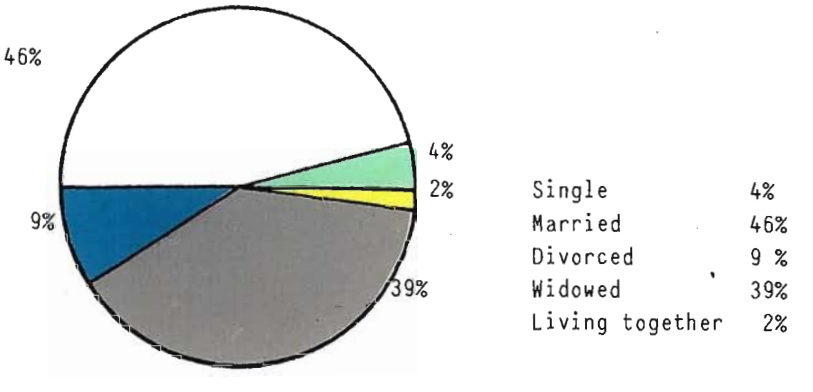
ii) AGE AND SEX. It was found that 118 (37%) were males and 203 (63%) were female. In the 60-64 year age group 24 (7,4%) were females - males are not geriatrics at this age group. In 65-69 year range 30 (9,3%) were males and 36 (11,2%) females. For the 70-74 year group 38 (11,8%) were males and 58 (18%) were females. In the 75-79 year group 33 (10,2%) were males and 28 52 (16,7%) were females. In the 80-84 year group 15 (4,6%) were males and (8,7%) females. In the 85-90 year group 2 (0,6%) were males and 5 (1,5%) were females. (see Figure II and Table II).

FIG. II. AGE AND SEX DISTRIBUTION: NUMBERS AND PERCENTAGE.



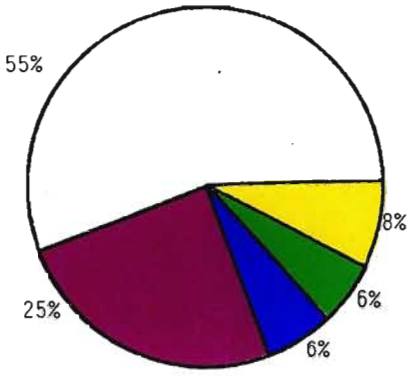
iii) MARITAL STATUS. 12 (4%) were single; 149 (46%) were married; 30 (9%) were divorced; 125 (39%) were widowed, whilst 5 (2%) lived together. (see Figure III and Table III).

FIG. III. MARITAL STATUS. NUMBERS AND PERCENTAGE.



iv) ACCOMMODATION. 176 (55%) lived in flats; 80 (25%) lived in houses; 19 (6%) stayed in a single room; 19 (6%) stayed in a hotel/boarding house and 27 (8%) lived in an old aged home. (see Figure IV and Table IV).

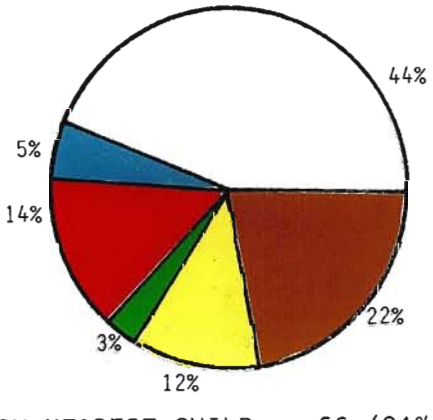
FIG. IV. ACCOMMODATION USED BY GERIATRIC ATTENDERS: NUMBERS AND PERCENTAGE.



Flats	55%
House	25%
Single room	6 %
Hotel|boarding house	6 %
Old age home	8 %

v) HABITAT. 143 (44%) lived with their spouse; 16 (5%) lived with a brother or sister; 46 (14%) lived with their children; 9 (3%) lived with other relatives; 37 (12%) lived with non-family/friends, whilst 70 (22%) lived alone. (see Figure V and Table V).

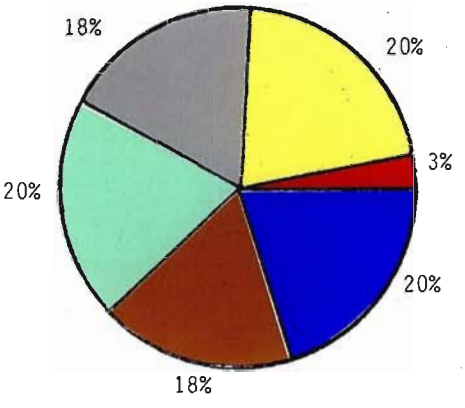
FIG. V. HABITAT STATUS OF GERIATRIC ATTENDERS: NUMBERS AND PERCENTAGE.



Spouse	44%
Brother|sister	5 %
Children	14%
Other relative	3 %
Non family	12%
Alone	22%

vi) DISTANCE FROM NEAREST CHILD. 66 (21%) lived with their family; 59 (18%) lived under 5 km from nearest child; 65 (20%) lived 5-20 km from nearest child; 58 (18%) lived over 20 km but under 100 km from nearest child; 63 (20%) have family living over 100 km, (the majority of this is at Johannesburg or Pretoria), otherwise they live overseas, (the most popular countries being United Kingdom), United States, Australia; 10 (3%) had no family. (see Figure VI and Table VI).

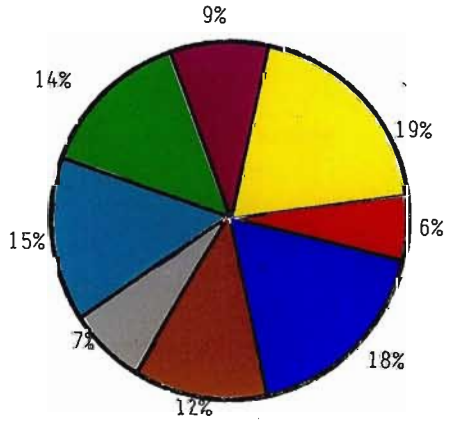
FIG. VI. DISTANCE LIVED BY ELDERLY ATTENDERS FROM NEAREST CHILD: NUMBERS AND PERCENTAGE.



Living with	21%
Under 5 km	18%
5-20km	20%
20 100km	18%
100km	20%
No child	3 %

vii) FAMILY VISITING HABITS. In order to maintain the moral of the elderly the family visiting habits were obtained. It was found that 62 (19%) lived with family; 28 (9%) visited daily; 44 (14%) visited twice weekly; 49 (15%) visited weekly; 21 (7%) visited fortnightly, and 40 (12%) visited monthly. 56 (18%) either visited less than monthly or never, (this figure includes children who lived overseas), 21 (6%) had no family and relied on relatives or friends to visit them. (see Figure VII and Table VII).

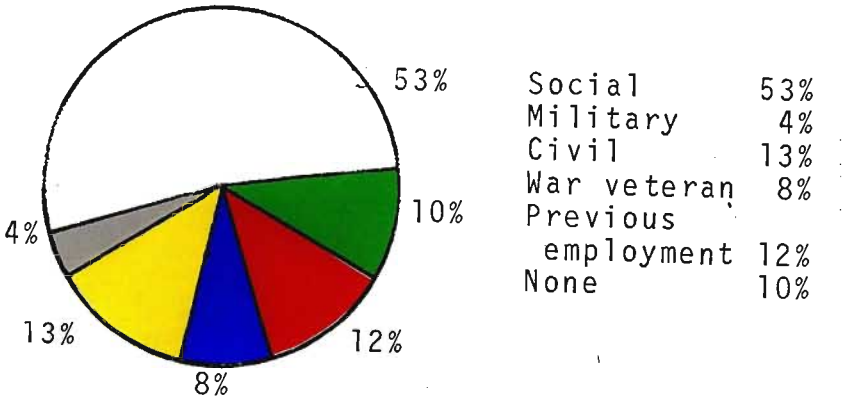
FIG. VII. FAMILY VISITING HABITS: NUMBERS AND PERCENTAGE.



Not applicable	19%
Daily	9 %
Twice weekly	14%
Weekly	15%
Fortnightly	7 %
Monthly	12%
Never	18%
No family	6 %

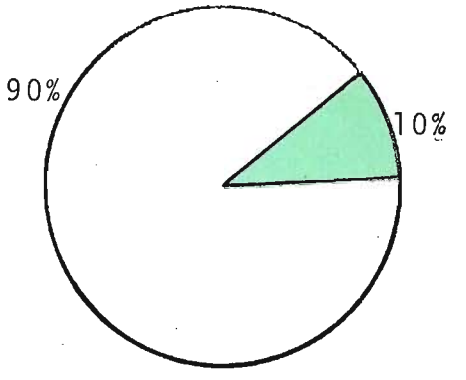
vii) PENSIONS. This is a very important aspect of retirement and the results are as follows. Social pensioners 169 (52,6%); military 13 (4,0%), (these are people who have had war wounds from 1914-1918 war or 1939-1944 world war). 41 (12,8%) were civil pensioners, (these people have worked or their husbands have worked in a government department during their working life and the amount of pension depends on the position held before retirement). War veterans 27 (8,4%) (are very similar to military pensioners though their war injuries have not been so severe). 39 (12,2%) have a pension from their employment, (these were a very cagey lot, being not prepared to reveal their income or pension and were afraid to enter conversation about it "incase I was a spy!!"), 32 (10%) had no pension, many of whom seemed to be genuine in their distress to make ends meet. (see Figure VIII and Table VIII).

FIG. VIII. TYPE OF PENSION RECEIVED BY GERIATRIC ATTENDERS: NUMBERS AND PERCENTAGE



ix) MEDICAL AID. 33 (10%) belonged to medical aid and 288 (90%) did not. (see Figure IX and Table IX).

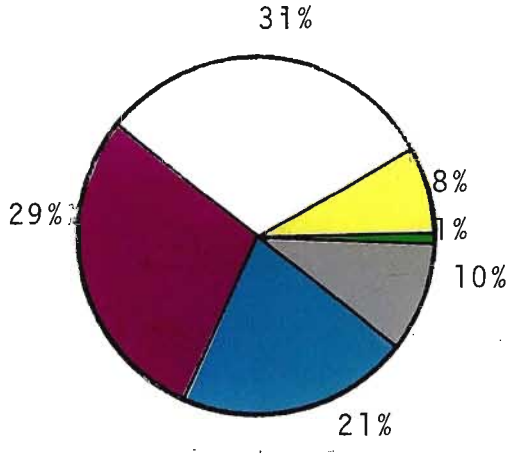
FIG. IX. MEDICAL AID FACILITIES:
NUMBERS AND PERCENTAGE.



Belong to M.A.	10%
No M.A.	90%

x) TRANSPORT. 27 (8%) walking; 98 (31%) using public transport; 92 (29%) used their own car; 68 (21%) used a friends car; 34 (10%) used voluntary transport, including the "Red Cross bus" from Hillcrest. and 2 (1%) had come by ambulance. (see Figure X and Table X).

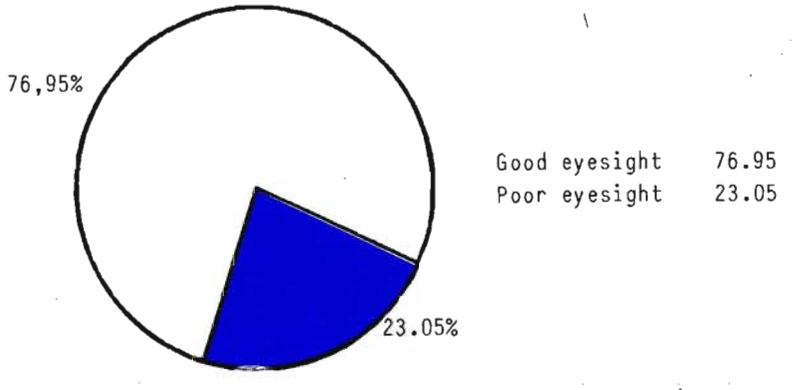
FIG. X. TRANSPORT USED BY GERIATRIC ATTENDERS:
NUMBERS AND PERCENTAGE.



Walk	8%
Bus	31%
Taxi	0%
Own car	29%
Friend car	21%
Voluntary body	10%
Ambulance	1%

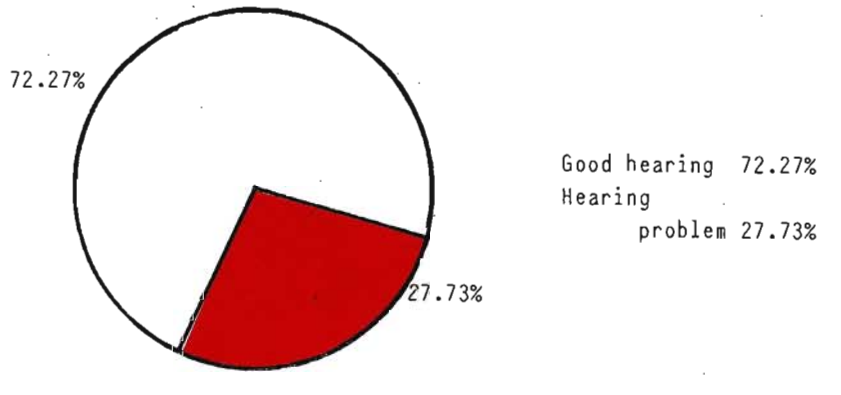
xi) EYESIGHT. 247 (76,95%) stated that they had good eyesight, whilst 74 (23,05%) admitted that their sight was poor. (see Figure XI and Table XI).

FIG. XI. EYESIGHT OF GERIATRIC ATTENDERS: NUMBERS AND PERCENTAGE.



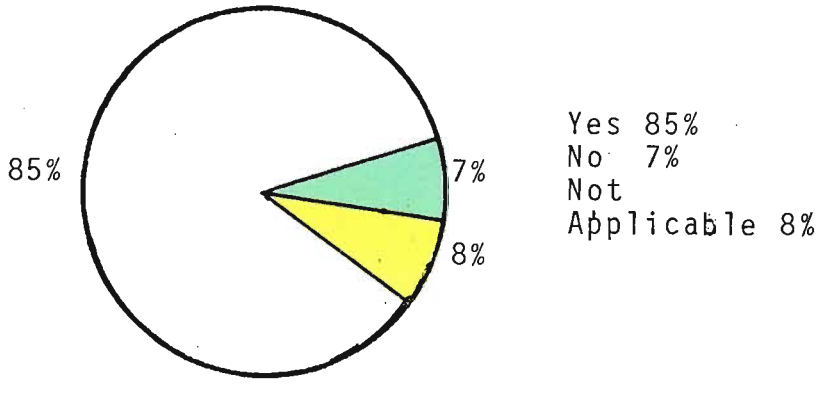
xii) HEARING. The problem of hearing was nearly similar to that of eyesight with 232 (72,27%) stating that their hearing was good, whilst 89 (27,73%) stated that they had hearing problems. (see Figure XII and Table XII).

FIG. XII. HEARING OF GERIATRIC ATTENDERS: NUMBERS AND PERCENTAGE



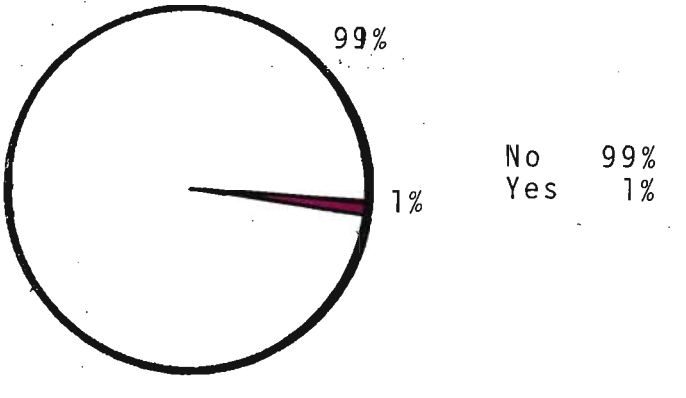
xiii) HOUSEWORK. 273 (85%) were able to do their own housework, whilst 22 (7%) were unable to do so. 26 (8%) lived in situations where this was provided. (see Figure XIII and Table XIII).

FIG. XIII. ASSESSMENT OF ABILITY OF GERIATRIC ATTENDERS TO DO HOUSEWORK: NUMBERS AND PERCENTAGE



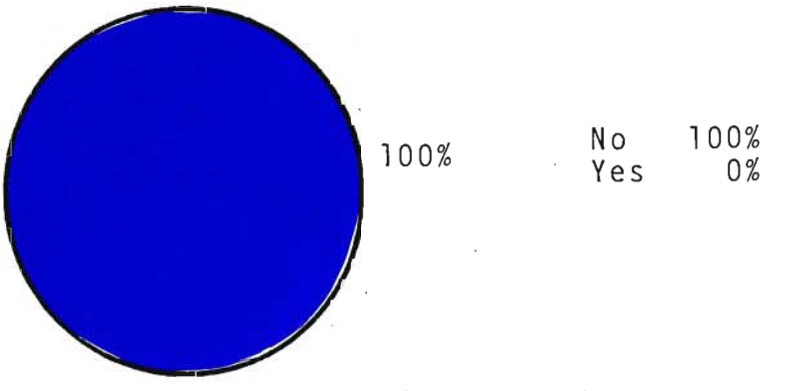
xiv) HOMEHELP. 318 (99%) stated that they did not need a homehelp. 3 (1%) felt that this was needed. (see Figure XIV and Table XIV).

FIG. XIV. ASSESSMENT OF NEED FOR HOMEHELP: NUMBERS AND PERCENTAGE.



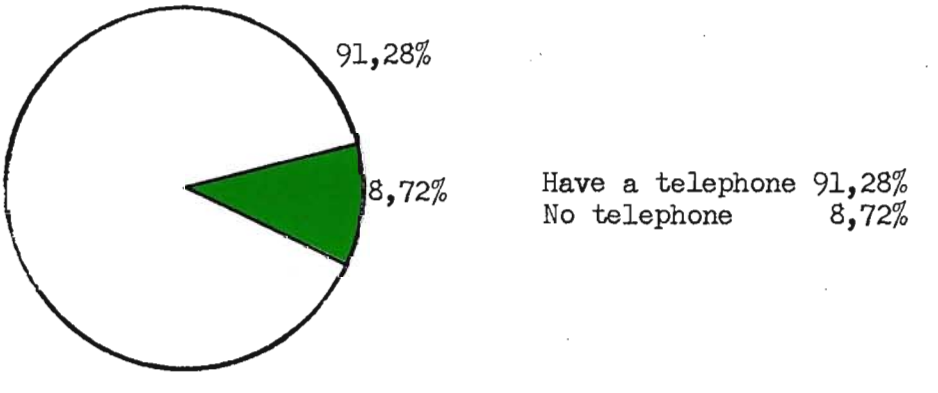
xv) MEALS ON WHEELS. 321 (100%) stated that meals on wheels was not needed. (see Figure XV and Table XV).

FIG. XV. REQUIREMENTS OF MEALS ON WHEELS: NUMBERS AND PERCENTAGE.



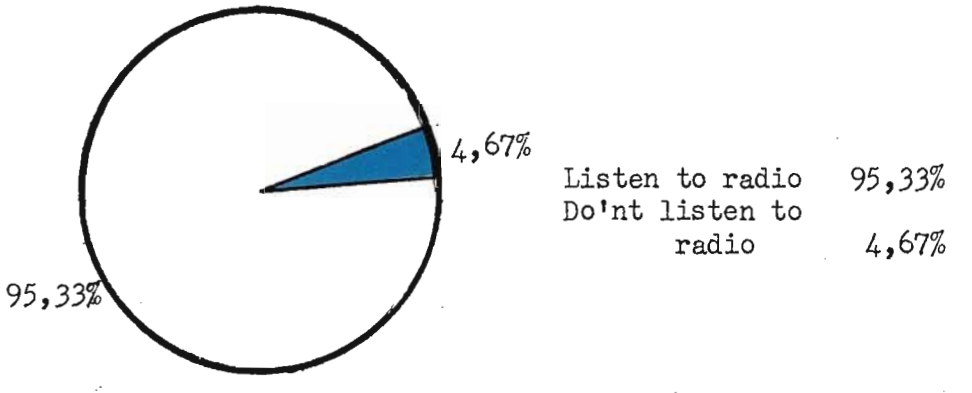
xvi) TELEPHONE. 293 (91,28%) had a telephone, 28 (8,72%) had no telephone. (see Figure XVI and Table XVI).

FIG. XVI. TELEPHONE FACILITIES: NUMBERS AND PERCENTAGES



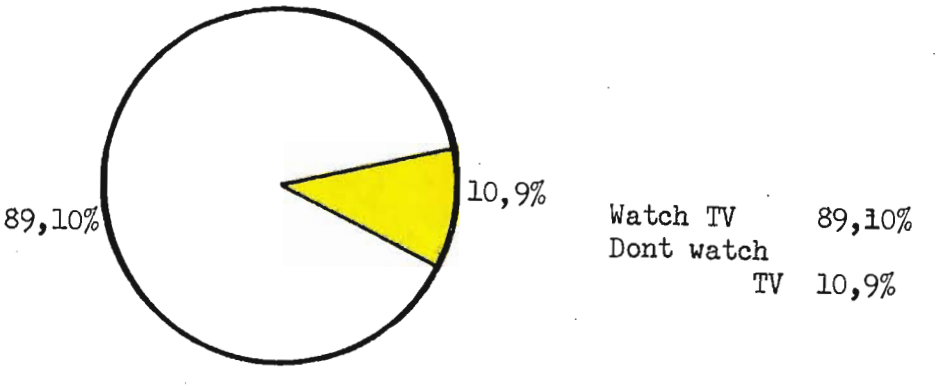
xvii) RADIO. 306 (95,33%) listened to radio, 15 (4,67%) did not. (see Figure XVII and Table XVII).

FIG. XVII. RADIO LISTENERS: PERCENTAGES.



xviii) TELEVISION. 286 (89,1%) watched television, 35 (10,9%) did not. (see Figure XVIII and Table XVIII).

FIG. XVIII. ATTITUDE TO TELEVISION: PERCENTAGE.

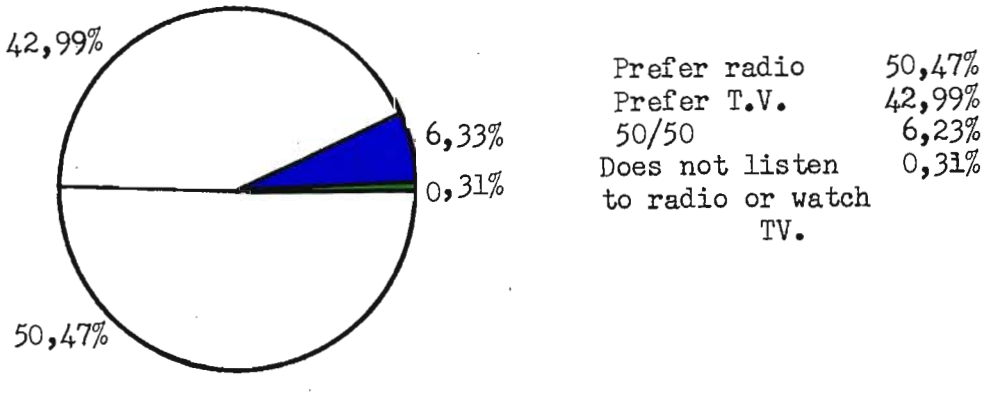


xix) CHOICE OF MEDIA.

162 (50,47%) preferred listening to radio.
138 (42,99%) preferred watching television.
20 (6,29%) had no preference.
1 (0,25%) did not listen to radio or watch television.

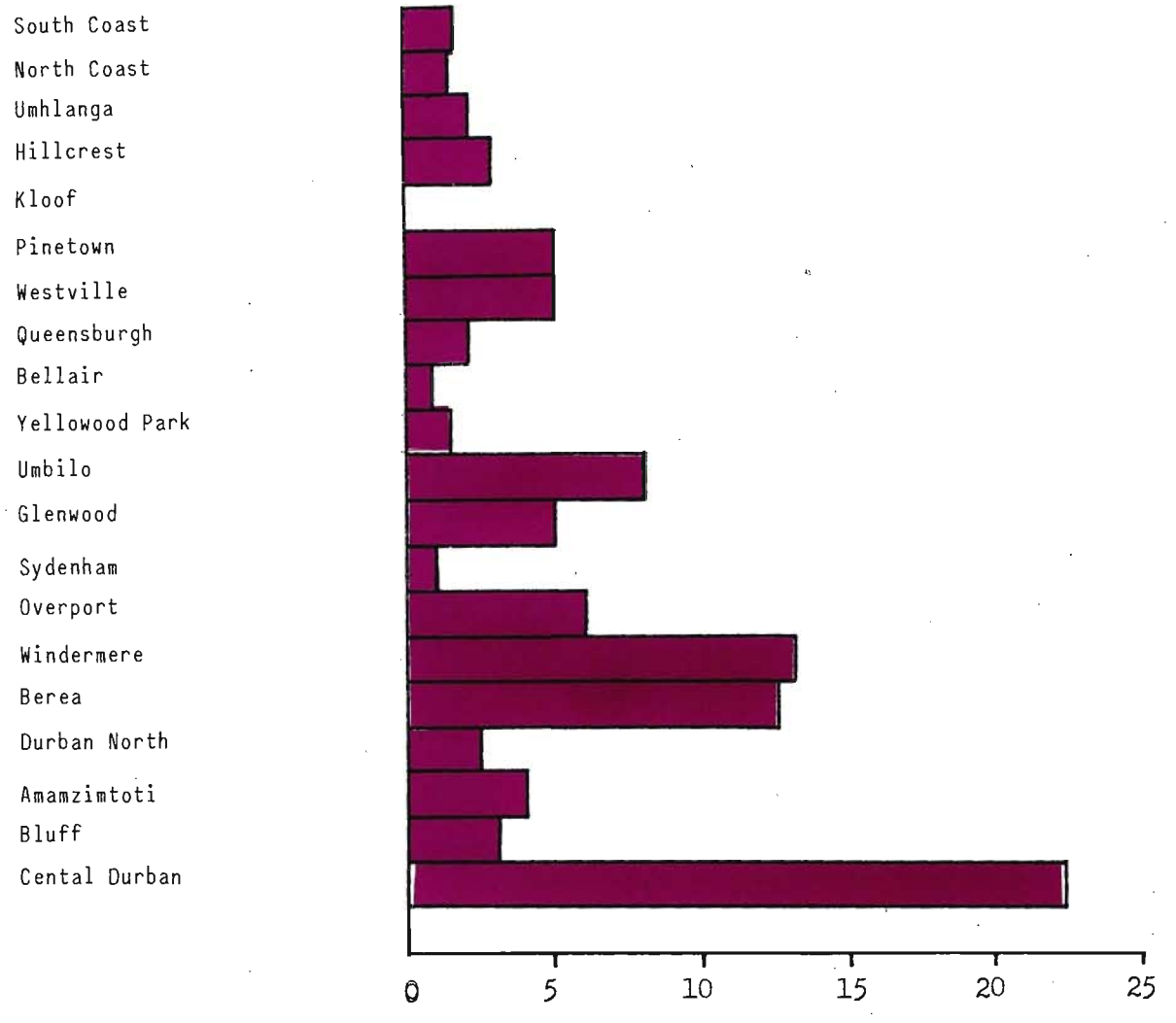
Of the 162 who listened to the radio 143 (88%) objected to the programme changes. (see Figure XIX and Table XIX).

FIG. XIX PREFERENCE BETWEEN RADIO AND TELEVISION PERCENTAGES



xx) GEOGRAPHICAL AREA OF GERIATRIC ATTENDERS. 72 (22,4%) came from the central Durban area; 10 (3,1%) came from the Bluff; 13 (4%) came from Amanzimtoti; 8 (2,5%) came from Durban North; 39 (12,5%) came from the Berea; 42 (13%) came from Windermere; 19 (6%) came from Overport; 4 (1%) came from Sydenham; 17 (5%) came from Glenwood; 22 (8%) came from Umbilo; 5 (1,5%) came from Yellowood Park; 3 (0,9%) came from Bellair; 7 (2,1%) came from Queensburgh; 16 (5%) from Westville; 17 (5%) from Pinetown; none came from Kloof; 9 (2,8%) came from Hilldrest; 7 (2,1%) came from Umhlanga Rocks; 5 (1,5%) came from the North Coast and 6 (1,6%) came from the South Coast. (see Figure XX and Table XX).

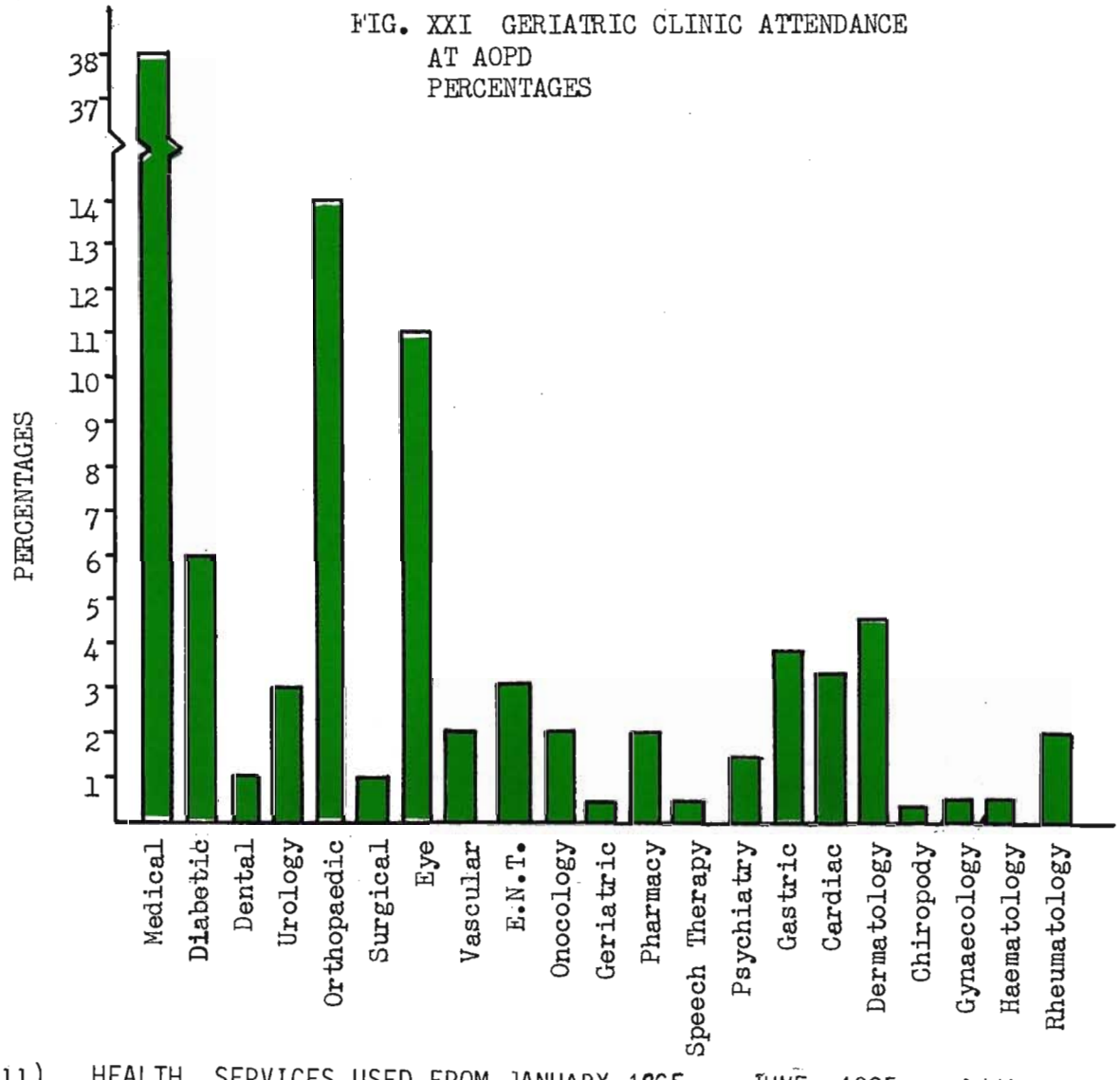
FIG. XX. GEOGRAPHICAL AREAS OF ABODE: NUMBERS AND PERCENTAGE



xxi) REASON FOR ATTENDANCE. 122 (38%) attended the Medical Clinic; 20 (5%) attended the Diabetic Clinic; 4 (1%) attended the Dental Clinic; 10 (3%) attended the Urology Clinic; 45 (14%) attended the Orthopaedic Clinic; 4 (1%) attended the Surgical Clinic; 33 (10%) atended the Eye Clinic; 6 (2%) attended the Vascular Clinic; 9 (3%) attended the ENT Clinic; 6 (2%) attended the Oncology Clinic; 1 (0,3%) attended the Geriatric Clinic; 7 (22%) attended the Pharmacy; 1 (0,3%) attended Speech Therapy; 5 (1,5%) attended the Psychiatric Clinic; 12 (3,8%) attended the Gastric Clinic; 10 (3%) attended the Cardiac Clinic; 15

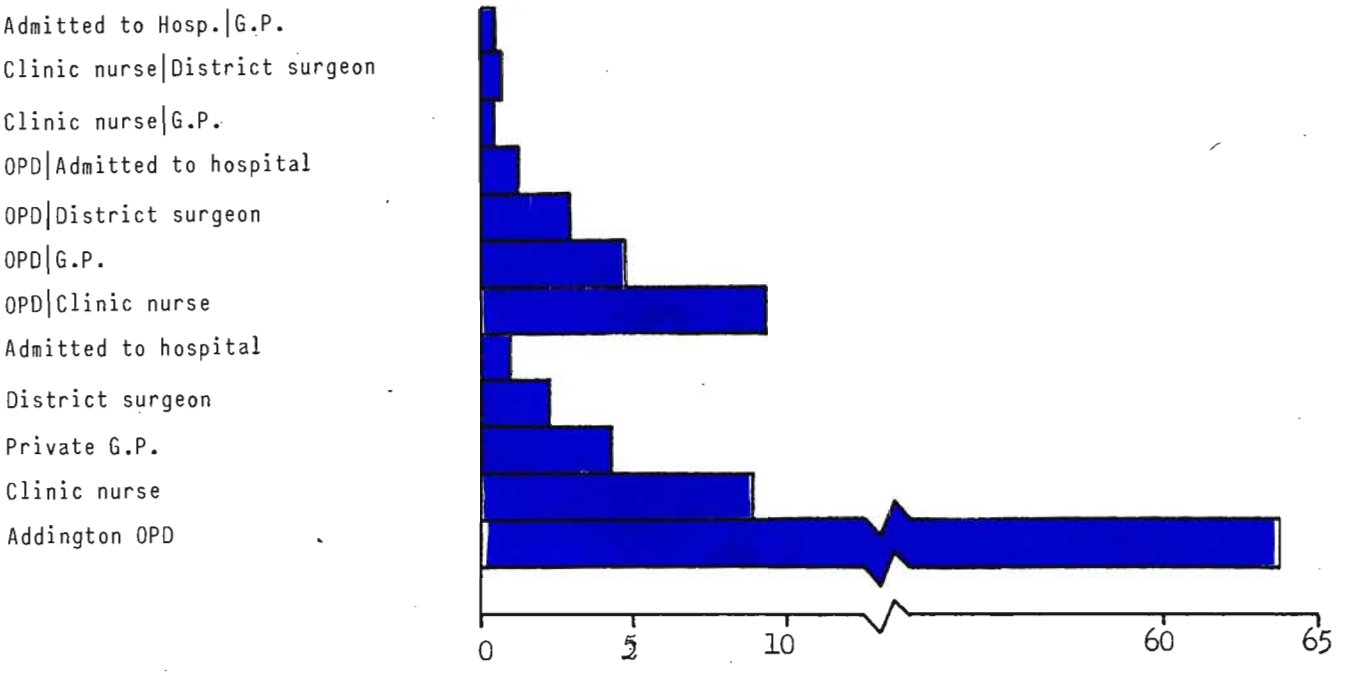
(4,6%) attended the Dermatology Clinic; 1 (0,3%) attended the Chiropody Clinic; 2 (0,6%) attended the Gynaecology Clinic; 2 (0,6%) attended the Haematology Clinic and 6 (2%) attended the Rheumatology Clinic. (see Figure XXI and Table XXI).

FIG. XXI GERIATRIC CLINIC ATTENDANCE AT AOPD PERCENTAGES



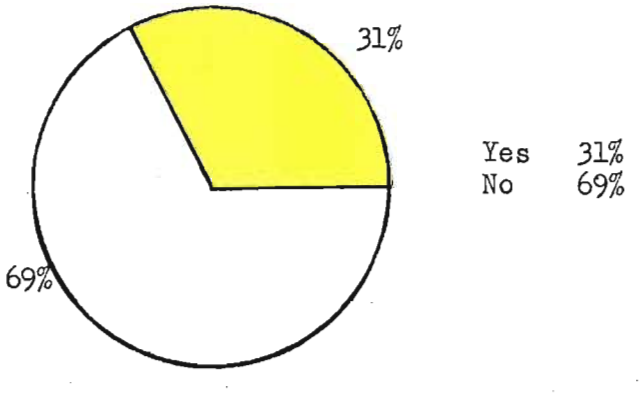
xxii) HEALTH SERVICES USED FROM JANUARY 1965 - JUNE 1985. Addington Hospital OPD 208 (64,7%); Clinic Nurse 28 (8,7%); private GP 14 (4,3%); District Surgeon 6 (2,3%); Admitted to hospital 3 (0,9%); OPD/Clinic Nurse 30 (9,3%); OPD/GP 15 (4,6%); OPD/District Surgeon 9 (2,8%); OPD/Admitted to hospital 4 (1,2%); Clinic Nurse/GP 1 (0,3%); Clinic Nurse/District Surgeon 2 (0,6%); Admitted to hospital/GP 1 (0,3%). (see Figure XXII and Table XXII).

FIG. XXII. HEALTH SERVICES USED BY ELDERLY JANUARY-JULY 1985
PERCENTAGE.



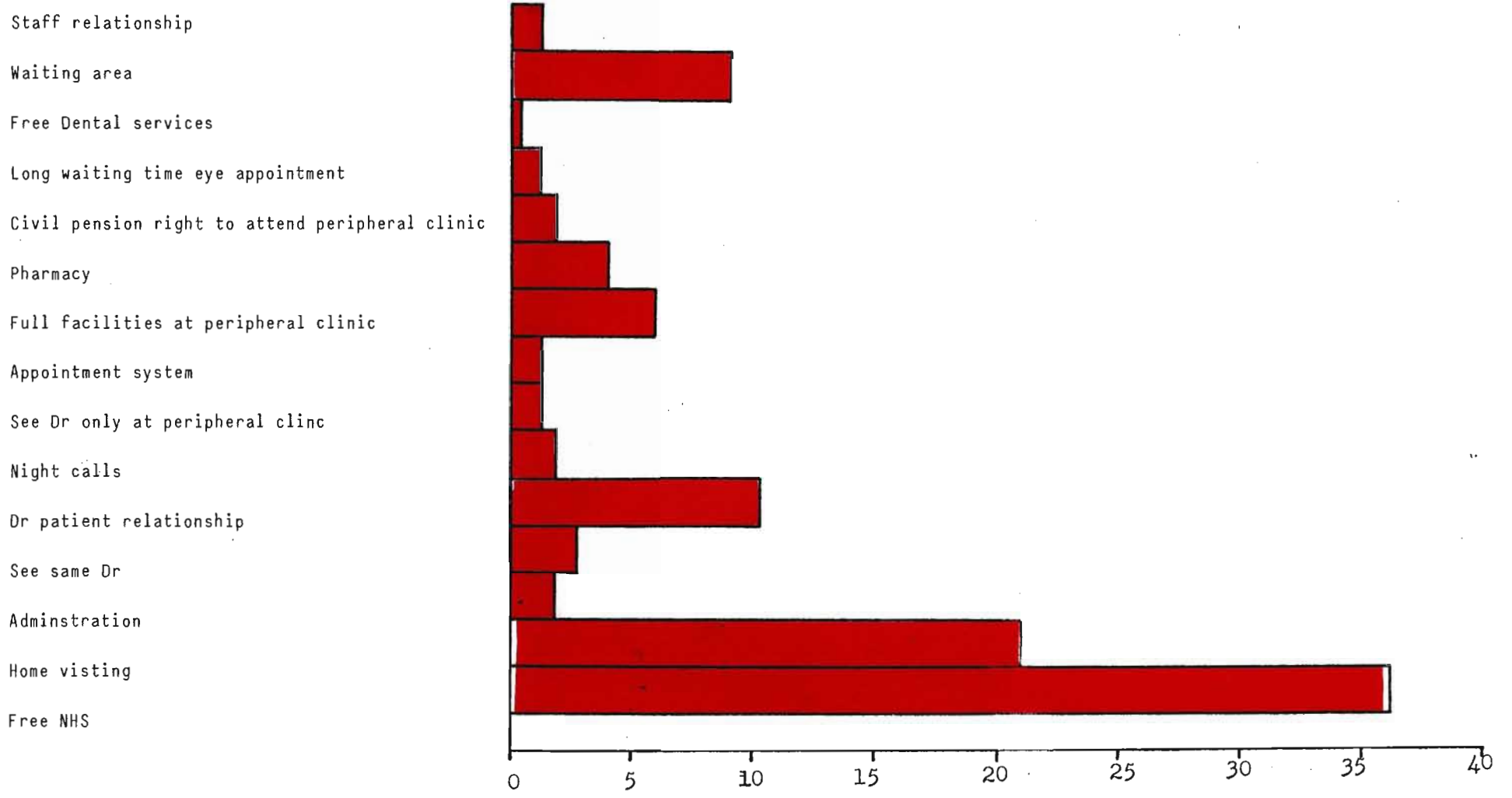
xxiii) ASSESSMENT OF ADEQUATE HEALTH CARE. 99 (31%) satisfied, 222 (69%) dissatisfied. (see Figure XXIII and Table XXIII).

FIG. XXIII. ASSESSMENT OF ADEQUACY OF HEALTH CARE:
PERCENTAGE.



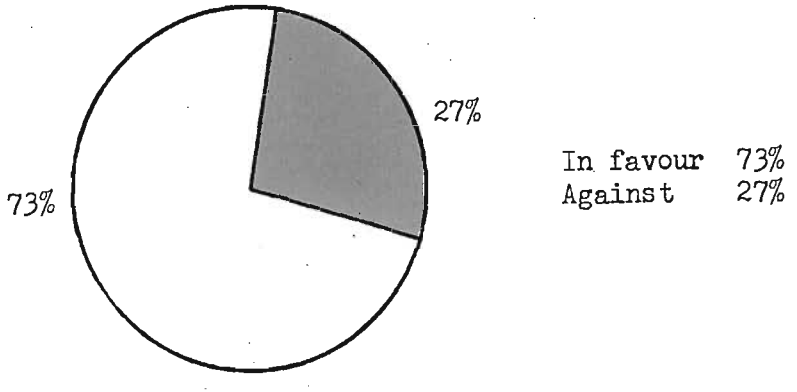
xxiv) IMPROVEMENT REQUIRED IN HEALTH CARE BY GERIATRIC ATTENDERS. 78 (36,2%) free National Health Service; home visiting 48 (21%); administration 4 (1,8%); see same doctor always 6 (2,7%); improved doctor/patient relationship 23 (10,3%); night calls 4 (1,8%); see doctor only at peripheral clinic 3 (1,3%); better arrangements in making an appointment 3 (1,3%); full facilities at peripheral clinic 13 (5,8%); a better pharmacy relationship 9 (4%); the right of civil pensioners to attend peripheral clinics 4 (1,8%); the eye appointment waiting list 3 (1,3%); free dental services 1 (0,4%); waiting area at Addington OPD 20 (9,0%), and staff relationship 3 (1,3%). (see Figure XXIV and Table XXIV).

FIG. XXIV. HEALTH CARE NEEDS OF GERIATRIC ATTENDERS AT ADDINGTON OPD: PERCENTAGE.



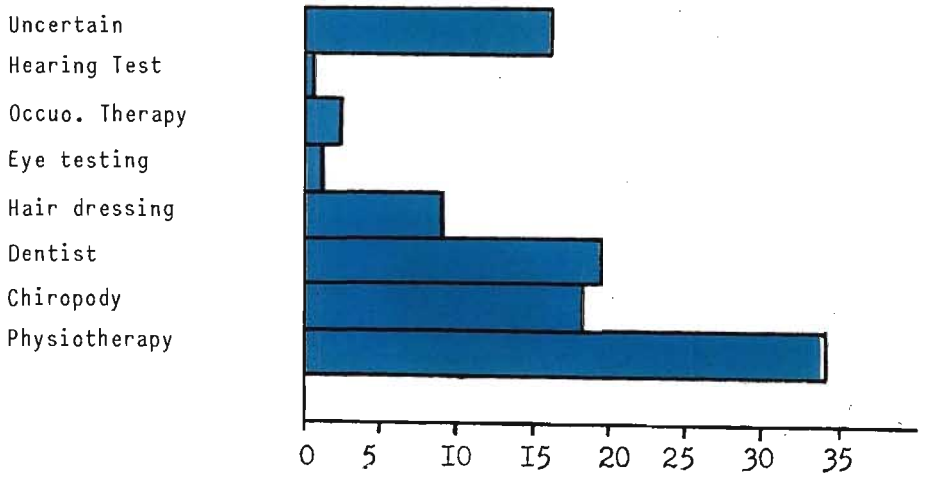
xxv) GERIATRIC ATTENDERS OPINION OF THE NEED OF A DAY CENTRE. 233 (73%) felt it was required, 88 (27%) felt it was not needed. (see Figure XXV and Table XXV).

FIG. XXV. NEED FOR DAY CENTRE: PERCENTAGE.



xxvi) PARAMEDICAL REQUIREMENTS FELT NEEDED AT DAY CENTRE BY GERIATRIC ATTENDERS. Physiotherapy 108 (34%); Chiropody 59 (18,3%); Dentist 62 (19,3%); Hairdressing 28 (9%); Eye testing 4 (1%); occupational therapy 7 (2,1%) and hearing tests 1 (0,3%); Uncertain 52 (16%). (see Figure XXVI and Table XXVI).

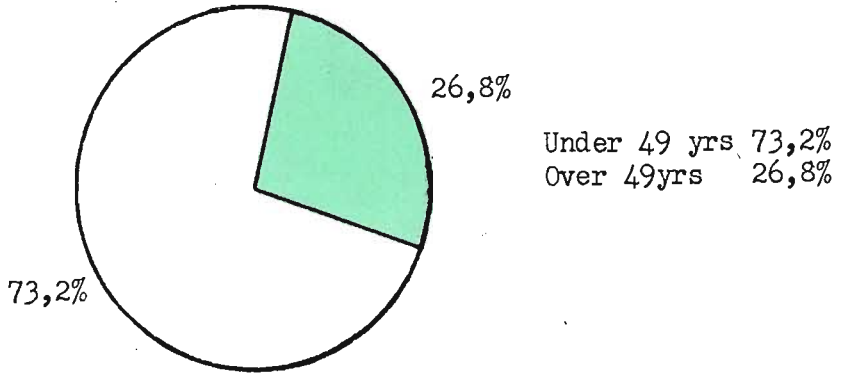
FIG. XXVI. REQUIREMENTS AT DAY CENTRE, PARAMEDICAL SERVICES: PERCENTAGES.



HEALTH PROFESSIONAL PROVIDING HEALTH CARE FOR GERIATRIC ATTENDERS IN AOPD.

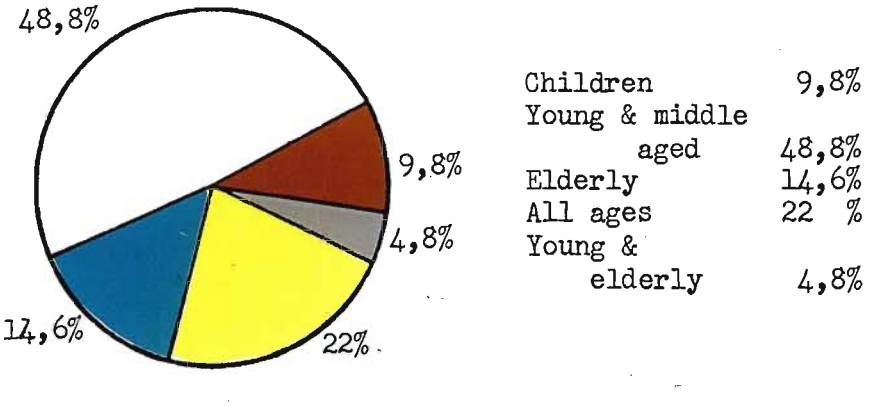
i) AGE GROUP OF HEALTH PROFESSIONALS. 30 (73,2%) were under 49 years of age and 11 (26,8%) were over 49 years of age. (see Figure XXVII and Table XXVII).

FIG. XXVII. AGES OF HEALTH PROFESSIONGAL: PERCENTAGE.



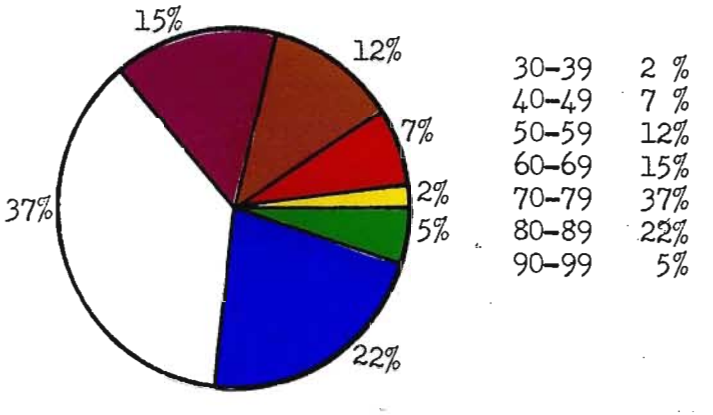
ii) HEALTH PROFESSIONALS PREFERRED OF AGE GROUP REQUIRING TREATMENT. 4 (9,8%) preferred to treat children; 20 (48,8%) preferred to treat young and middle aged group; 6 (14,6%) preferred to treat elderly; 9 (22%) preferred to treat any age group and 2 (4,8%) preferred to treat young and elderly. (see Figure XXVIII and Table XXVIII).

FIG. XXVIII. HEALTH PROFESSSIONALS AGE GROUP PREFERENCE FOR TREATING: PERCENTAGE.



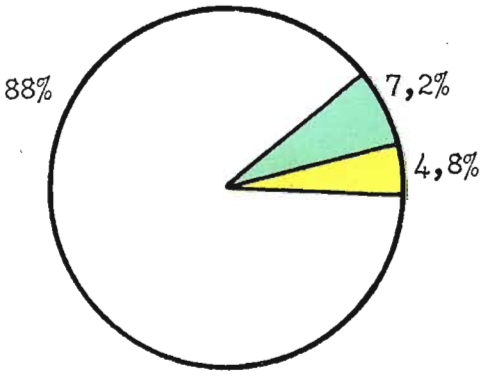
iii) AGE GROUP TREATED BY HEALTH PROFESSIONALS. 30-39 year group were seen by 1 (2%) of health professionals; 40-49 year group were seen by 3 (7%) health professionals. 50-59 year group were seen by 5 (12%) of health professionals; 66-69 year group were seen by 6 (5%) health professionals; 70-79 year group were seen by 15 (37%) health professionals; 80-90 year group were seen by 9 (22%) health professionals and 90-99 year group were seen by 2 (5%) health professionals. (see Figure XXIX and Table XXIX).

FIG. XXIX. AGE GROUPS TREATED BY HEALTH PROFESSIONALS AT ADDINGTON OPD: PERCENTAGE.



iv) GERIATRIC ATTENDERS NEEDS IN COMPARISON WITH OTHER AGE GROUPS. 36 (88%) health professionals stated that they were different to other age groups. 2 (4,8%) stated that the needs were no different than other age groups and 3 (7,2%) were uncertain. (see Figure XXX and Table XXX).

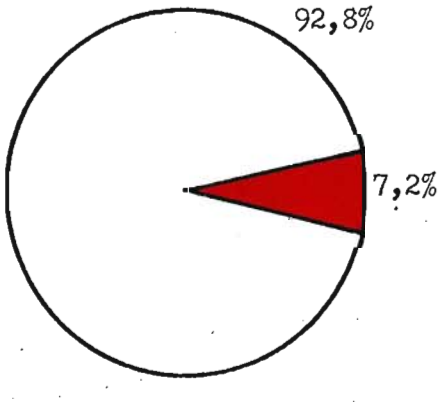
FIG. XXX. HEALTH PREOFESSIONALS OPINION OF GERIATRIC NEEDS IN COMPARISON WITH OTHER ATTENDERS: PERCENTAGE.



Different 88 %
No different 4,8%
Did not answer 7,2%

v) HEALTH PROFESSIONALS OPINION AS TO WHETHER GERIATRICS IS A SPECIALITY IN ITS OWN RIGHT. 38% (92,8%) stated that geriatrics was a speciality in its own right and 3 (7,2%) did not think so. (see Figure XXXI and Table XXXI).

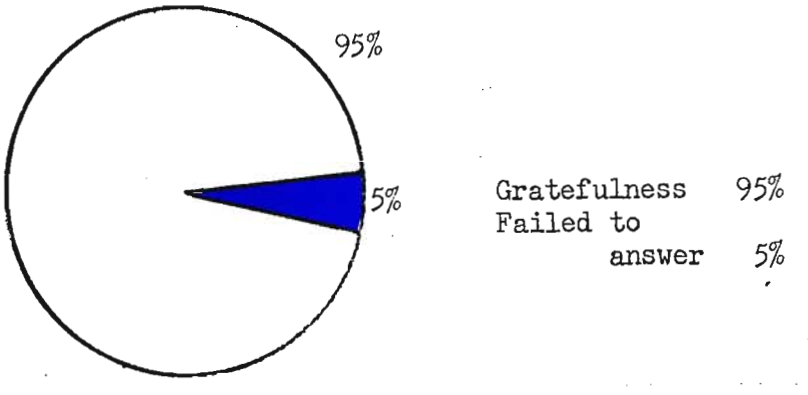
FIG. XXXI. HEALTH PROFESSIONALS OPINION OF GERIATRICS BEING A SPECIALITY IN ITS OWN RIGHT: PERCENTAGE.



Yes 92,8%
No 7,2%

vi) HEALTH PROFESSIONALS OPINIONS OF THE PLEASANT QUALITIES OF THE GERIATRIC ATTENDERS. 39 (95%) health professionals felt that the gratitude of the geriatric attenders was impressive and 2 (5%) failed to give an answer. (see Figure XXXII and Table XXXII).

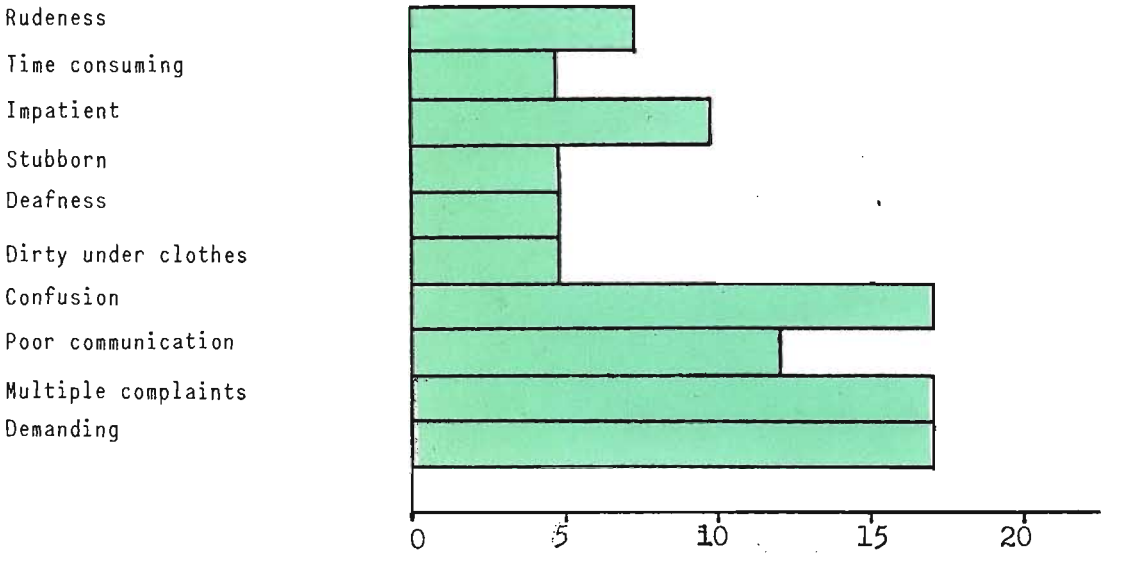
FIG. XXXII. WHAT HEALTH PROFESSIONALS APPRECIATE ABOUT WORKING WITH GERIATRIC PEOPLE: PERCENTAGE.



vii) HEALTH PROFESSIONALS OPINIONS ABOUT THE UNPLEASANT THINGS THEY EXPERIENCED WORKING WITH GERIATRIC PATIENTS. 3 (7,32%) felt rudeness they had experienced had upset them; 2 (4,8%) felt that the geriatric attenders were time-consuming; 4 (9,76%) felt that impatience by the geriatric attenders was intolerable; 2 (4,8%) felt that stubborness of the geriatric attenders was unpleasant; 2 (4,8%) found that deafness in the geriatric attenders impaired their relationship with them "having to repeat everything or shout at them" was annoying; 2 (4,8%) found that dirty underclothes by the geriatric attenders was totally unnecessary and

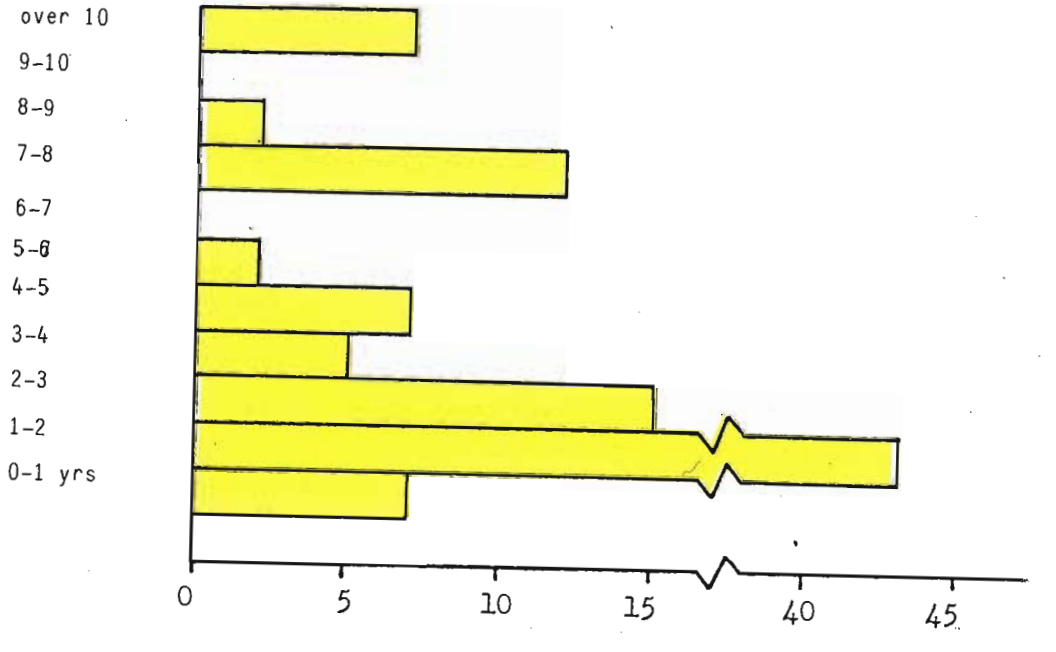
would not tolerate it; 7 (17,07%) found the confusion of the geriatric attenders to be very annoying, especially as the health professionals "are very busy"; 5 (12,51%) of health professionals felt that they "could never get through" as the geriatric attenders have poor communication; 7 (17,07%) of health professionals found that they were unable to cope with the multiple complaints or symptoms given by the elderly attenders. They stated that as they were busy people they "had no time for such nonsense!" and 7 (17,07%) of health professionals found that the geriatric attenders were very demanding "they were insistant that certain medicines or treatment were the only things that would be effective in their case". (see Figure XXXIII and Table XXXIII).

FIG. XXXIII. WHAT HEALTH PROFESSIONALS FOUND DISTASTEFUL ABOUT GERIATRIC PATIENTS. PERCENTAGE.



vii) YEARS HEALTH PROFESSIONALS HAVE WORKED AT AOPD. 3 (7%) had not worked for more than 1 year; 17 (43%) had only worked between 1-2 years; 6 (15%) had worked 2-3 years; 2 (5%) had worked between 3-4 years; 3 (7%) had worked 4-5 years; 1(2%) had worked 5-6 years; 5 (12%) had worked 7-8 years; 1 (2%) had worked 8-9 yeares and 3 (7%) had worked over 10 years in AOPD. (see Figure XXXIV and Table XXXIV).

FIG. XXXIV. NUMBER OF YEARS HEALTH PROFESSIONALS HAVE WORKED IN ADDINGTON OPD: PERCENTAGE.



THE RELATIONSHIP BETWEEN AGE, SEX AND MARITAL STATUS AND ACCOMMODATION.

i) 60-64 YEAR GROUP. Applies to females only as men are not geriatrics at this age group. 9 (3%) were married; 8 (2,5%) were divorced; 7 (2%) were widowed; 18 (5,6%) lived in a flat; 3 (1%) lived in a house; 2 (0,6%) lived in a single room; 1(0,5%) lived in a hotel/boarding house. Out of this 8 (2,5%) lived with their spouse; 2 (0,6%) lived with a brother/sister; 4 (1,2%) lived with their children; 2 (0,6%) lived with a relative; 1 (0,5%) lived with a friend and 7 (2%) lived alone.

ii) 65-69 YEAR GROUP.

a) Males: 23 (7%) were married; 2 (0,6%) were divorced; 5 (1,5%) were widowed. 16 (5%) lived in a flat; 9 (3%) lived in a house; 1 (0,5%) lived in a single room; 4 (1,2%) lived in a hotel/boarding house; 21 (6,5%) lived with a spouse; 1 (0,5%) lived with brother/sister; 2 (0,6%) lived with children; 1 (0,5%) lived with a relative and 5 (1,5%) lived alone.

b) Females: 16 (5%) were married; 8 (2,5%) were divorced and 12 (3,7%) were widowed. 24 (7,4%) lived in a flat; 8 (2,5%) lived in a house; 4 (1,2%) lived in a hotel/boarding house; 18 (5,6%) lived with a spouse; 1 (0,5%) lived with brother/sister; 6 (1,8%) lived with children; 2 (0,6%) lived with a relative; 1 (0,5%) lived with non-family and 8 (2,5%) lived alone.

iii) 70-74 YEAR GROUP.

a) Males: 29 (9%) were married; 2 (0,6%) were divorced and 6 (1,8%) widowed. 1 (0,5%) co-habitated; 25 (7,8%) lived in a flat; 9 (3%) lived in a house; 2 (0,6%) lived in a single room; 1 (0,5%) lived in a hotel/

boarding house; 1 (0,5%) lived in an old aged home; 27 (8,4%) lived with a spouse; 2 (0,6%) lived with a brother/sister; 2 (0,6%) lived with children; 4 (1,2%) lived with non-family and 3 (1%) lived alone.

b) Females. 23 (7%) were married; 6 (1,8%) were divorced and 26 (8%) were widowed. 3 (1%) co-habitated; 37 (11,5%) lived in a flat; 11 (3,4%) lived in a house; 3 (1%) lived in a single room; 4 (1,2%) lived in a hotel/boarding house; 3 (1%) lived in an old aged home; 21 (6,5%) lived with children; 3 (1%) lived with relatives; 9 (3%) lived with non-family and 18 (5,6%) lived alone.

iv) 75-79 YEAR GROUP.

a) Males: 3 (12%) were unmarried; 23 (7%) were married and 6 (1,8%) were widowed. 1 (0,5%) co-habitated; 11 (3,4%) lived in a flat; 15 (4,6%) lived in a house; 4 (1,2%) lived in a single room; 2 (0,6%) lived in a hotel/boarding house; 1 (0,5%) lived in an old aged home; 20 (6,2%) lived with a spouse; 2 (0,6%) lived with a brother/sister; 4 (1,2%) lived with children; 4 (1,2%) lived with non-family and 3 (1%) lived alone.

b) Females: 3 (1%) were single; 13 (4%) were married; 2 (0,6%) were divorced; 34 (10,5%) were widowed. 24 (7,4%) lived in a flat; 13 (4%) lived in a house; 3 (1%) lived in a single room; 3 (1%) lived in a hotel/boarding house; 9 (3%) lived in an old aged home; 9 (3%) lived with a spouse; 2 (0,6%) lived with a brother/sister; 13 (4%) lived with children; 10 (3,2%) lived with non-family and 18 (5,6%) lived alone.

v) 80-84 YEAR GROUP.

a) Males: 10 (3%) were married; 1 (0,5%) divorced and 4 (1,2%) widowed. 8 (2,5%) lived in a flat; 3 (1%) lived in a house; 4 (1,2%) lived in an old aged home; 10 (3,2%) lived with a spouse. 3 (1%) lived with childen; 1 (0,5%) lived with relatives and 2 (0,6%) lived with non-family.

b) Females: 1 (0,5%) was single; 5 (1,5%) were married and 22 (6,8%) were widowed. 16 (5%) lived in a flat; 6 (1,8%) lived in a house; 6 (1,8%) lived in an old aged home; 5 (1,5%) lived with a spouse; 2 (0,6%) lived with a brother/sister; 7 (2%) lived with children; 3 (1%) lived with other relatives and 10 (3,2%) lived alone.

vi) 85-90 YEAR GROUP.

a) Males: 1 (0,5%) was married and 1 (0,5%) was widowed. 1 (0,5%) lived in a house; 1 (0,5%) lived in an old aged home; 1 (0,5%) lived with a spouse and 1 (0,5%) lived with non-family.

b) Females: 5 (1,5%) were widowed. 1 (0,5%) lived in a flat; 3 (1%) lived in a house; 1 (0,5%) lived in an hold aged home;; 3 (1%) lived with children; 1 (0,5%) lived with non-family and 1 (0,5%) lived alone.

(Tables XXXV, XXXVI and XXXVII).

7. DISCUSSION

In the 10 year period 1974-1984, the number of geriatric attenders has increased by 92,04%. Analysis of the figures (Table I) shows that there was a rise of 16,61% between the years 1974-1979. In 1980 the attendance figures rose by a massive 59,52% in comparison with 1974 figures and 63,97% in comparison with 1979 figures.

However, one wonders whether this is the total explanation or has the socio-economic climate also been a factor. As the costs of medicine care in the private sector rise so it is that the elderly suffer the most as they are the non-earing sector of the community and have to rely on their pensions and savings to survive. In both cases pensions in South Africa are very poor - a subject which will be dealt with later on - whilst savings over the past few years have lost their buying power. The elderly are not able to make ends meet and look for help. Health care facilities as far as the elderly are concerned, are available at AOPD free if they are over 70 years of age.

To deal with the health care needs of the geriatric attenders the staff working in AOPD have been increased two-fold. However, this cannot continue and it is obvious that with the number of geriatric attenders rising 11,8% from 1980 to 1984 inclusive, a new concept of Primary Health Care will have to be introduced which will be discussed later under Day Centre discussion.

Personal characteristics of geriatric attenders AOPD.

During the period of study 321 geriatric attenders were interviewed of whom 118 (37%) were males and 203 (63%) were females, which is consistent with any world population group. It has been shown that women are more likely to attend for medical care concerning their helath (personal experience). The man tends to be more tolerant about debility, putting all things down to old age.

"Elderly people over 65 years have an average three disabling conditions, about half of which were unknown to the family doctor and probably unappreciated by the patient. Of these half were treatable!.

In general practice ill health is now accepted as being the result of the interaction of physical, social and psychological factors. The extension of the concept of problems from this to include adverse social and psychological factors tends to increase the number of active or unknown problems affecting the elderly patient"(1a).

J.R.A. Sanford in the British Medical Journal discussing tolerance of debility in the elderly states "The underlying feature is the fact that old people tend not to report medical and social difficulty. This produces three problems.

1) the presence of unmet need amongst the elderly.
2) vicious circle effect of severe minor unreported conditions leading to reduced functional ability, and
3) the very fact of why old people should fail to report need?"(1b)

However, Graeme Ford and Rex Taylor, Research Sociologists for the MRC Medical Sociology Unit at Aberdeen writing in the Journal of the Royal College of General Practitioner (May 1985)[2] states that earlier evidence from studies of unreported illness in the elderly is reassessed and new data are presented for the ratio of self-reported illness to number of consultations. It is concluded that underconsultation amongst the elderly is exaggerated".

Edwin Martin writing in the Journal of Royal College of General Practitioner (August, 1985)[13] "the elderly as underconsulters" states that "what is perceived as an ailment or medical symptom as opposed to a normal discomfort of living by a particular person depends on the expectations of this person. The definition of illness however depends on the patient's expectations and these may alter dramatically at different ages. Furthermore, many of the problems of the elderly are not related to illness. They are more related to whether they can open a tin of food, or get to the toilet easily or have enough money to heat their homes".

The highest age group of geriatric attenders in the study were 70-74 years (Table II), which is the group coming up to the "old aged" and the old aged group 75-79 years. The figures then fall which is consistent with the "allotted spasm of life". The female surviving more than the male population. This fact is further illustrated in that the study of marital status (Table III) shows that 12,4 (39%) of the geriatric attenders were widowed, of which 106 (33,02%) were female. Whilst females do tend to live longer than males due to their way of life and hormonal structure, they also tend to marry men who are older than they are. 60,14% of males over 65 years were married, whilst 39,86% of females were married. 82,81%

of females over 65 years wereare widowed in comparison to 17,19% of males over 65 years. 7,48% of females over 65 years were divorced and 1,25% were single (Table XXXV).

In 1978 Audrey Hunt conducted a survey in the UK and revealed that after the age of 65 years 38% of women were married and 75% of men. The female figures are compatable with this study: about 50% of women were widowed. My study shows a much higher percentage of widowed women (82,81%) but her figure of 19% of widowed men is compatable with my figure of 17,19%. 8% of women were single and 2% divorced, whereas in this study the figures are opposite - 7,48% being divorced and 1,25% being single.(25) The high figure of widowed women in South Africa is due to the fact that death of males in South Africa is one of the highest in the world.

The retention of the elderly in the community is one of the fundamental principles of Primary Health Care.

"The best place for the elderly is at home". That this is true is agreed by thinking members of the general public, by voluntary and local authority agencies concerned with old people welfare and by medical opinion. Most of all, it is what the majority of old people want themselves. Home to them is their natural habitat; it enshrines most of what they have worked for; it is familiar to them and the focal point in their lives, no matter if it does sometimes have its maternal shortcomings. Home also symbolises independence, even if the independence is not always as real as old people imagine it is.(3)

From the study it is shown that 176 (55%) live in flats and 80 (25%) in houses, either with their spouse 143 (44%) or family 44 (14%) or brother or sister 16 (5%), but 72 (22%) live alone. 10 (6%) live in a single room and 19 (6%) hotel/boarding house, giving a total of 294 (91,59%) who live in the community. Only 27 (8%) in this survey came from old aged homes. These figures are compatable with those of Professor Arbuckle (1981) (Primary Health Care Services for the Elderly in the Greater Durban area).

These figures show how well this principle is being carried out of nursing the elderly at home in the greater Durban area. There are two points which need discussion in the population :

1) Those living alone - 70 (22%). This number is large for besides those who are unwell and have survived there are those whose marriage is broken by the loss of their partner. These people are in the category of high risk group. The high risk group consists of :

a) those living alone.
b) those recently bereaved.
c) those just discharged from hospital.
d) those physically handicapped.
e) those with mental impairment.
f) those who have deliberately withdrawn from society. (5)

It is important to distinguish between loneliness and isolation. "Many people feel lonely but are not isolated". Loneliness is a function of boredom and is often seen by failure to plan activities. Elderly people living alone must be encouraged to develop routine habits, plans for each day, get to know other people of common interests which help to invigorate the mind. I had a patient who was a retired actress who used to have the most fabulous dinner parties which she used to prepare herself and care-

fully choose the guests - this was her life in retirement. She in other words became a director, and the dining room her stage.

2) Living with family :

a) "this is called extended family - two-generation home. When shared home is the original family home the mother's authority is usually maintained, especially over a daughter-in-law, but friction can easily occur when the older woman becomes frail - there is a danger of her becomming a subordinate housekeeper. Haromony can only be preserved by responsibilities being carefully defined. This is one reason why people prefer to live alone.

b) Unmarried children living with old parents is easier because the old mother retains her role. This can be affected by state of her health".(7)

In Table V 66 (21%) of the elderly live with their family and that 182 (56,7%) live within 100 km of their nearest child. Looking at Tables VI and VII it can be seen that only 77 (24%) were not visited by their family within a one month period. Some of their family lived overseas - UK, USA and Australia were the three most popular places. Those who had family nearer to them in Johannesburg or Pretoria were usually elderly people who had retured to Durban to gain the advantages of being by the sea and enjoy the warm climate Durban offers all the year round. By doing this they had cut themselves off from their family and life-long friends. These people have to have the right motivation and personality to be able to replace old friends and loved ones with new ones. A study of a Southern Californian retirement community showed that informal activity with friends was significantly related to life's satisfaction.(8)

Pensions.

These are divided into social, military, civil, war veterans and previous

employment (Table VIII). 169 (52,6%) are social pensioners which means that their income is nearly solely supplied by the State. These people have to be careful in their spending and are in no position to use the private medical sector.

State pensions are very poor in South Africa. In Europe, West German pensions are about two thirds of average income, whilst in the UK pensions are boosted by Social Security. A married couple in the UK get £38 per week each, without Social Security, no matter what their personal income is (savings, etc).

The whole pension structure in South Africa needs to be given an indepth study. Even in the UK pensions are poor by Scandanavian countries standards. In Scandanavia there is even a widower's pension and at present they are looking into a pension in cases of co-habitating so that the pension does not go to a widow who lives miles away and has not been seen for years.

The Honourable Chris Heunis in the House of Assembly (1982) stated that "South Africa is not a socialist country and further more had no intention of being one. It was up to the people of today to save up for their old age".

Such a statement is unrealistic in the present world conditions, because with the decline in the value of the rand people cannot save. One of the worse things for the elderly is financial insecurity and 32 (10%) of geriatric attenders had no pension they admitted, thus they had greater

worries about living from day to day - this situation leads to hypertension, ill health and malnutrition. 41 (12,8%) were civil pensioners which means that in their working life they had been employed by the State. These pensioners gave vent to bitter feelings that they were unanble to use Primary Health Care facilities provided by the Community Geriatric Services and were forced to use Addington OPD. The military pension 13 (4%) can use the military pensions office in the District Surgeon's Department at Commercial City. There are two full-time secretaries employed by this Department and about 70% of military pensioners attend this office where they are seen by the District Surgeon. A lot of these pensioners are chronic sick patients suffering from the effects of war wounds.

Medial Aid 33 (10%) geriatric attenders belonged to a medical aid. When interviewed about it the replies were - "need it for dental care", "need it for optician", "need it in an emergency if I have to see a doctor quickly", "need it if I am sick so that I can get a house call". They all felt it a great privilege to be on medical aid and were frightened to use it regularly in case the Medical Aid Society would withdraw this facility. Indeed some were suspicious of me in case I was a spy to have the Medical aid withdrawn because they were using AOPD!! Some used it to get medication from a private doctor Addington would not prescribe, eg. hypnotics. This point concerning medication is linked up with the dissatisfaction 9 (4%) showed in Pharmacy services because until recently their patients had been prescribed Benzodiazepines as hypnotics - this had been stopped because it has been shown that they have an accumulative effect and this is associated with a deterioration in reaction time. Numerous papers have been written concerning this which show personality

changes, poor driving next day, hangover effect, drug dependent and cerebral degeneration.[18]

However, the tremendous loop-hole in this policy is the fact that any elderly patient can go to the private medical sector and get a prescription for any hypnotic of his or her choice. This is freely recognised by the geriatric attenders who feel that Addington Pharmacy and medical staff are deliberately witholding tablets from them.

The only answer to the situation is for a total policy to be adopted at Medical Association Branch level - Natal Coastal area - to ban all prescriptions of hypnotics. Such a policy I have witnessed in the UK where Barbiturates were banned at Branch level of BMA and then this snow-balled to become national policy.

Environment.

In addition to age, sex, marital status, etc. further questions were asked the geriatric attenders concerning their ability to carry out their house-work, whether they needed meals on wheels, the condition of their eyesight and hearing, whether they had a telephone, whether they had a radio or watched television and which of these they preferred. The reasons for these questions was to get an indepth feeling how they actually lived at home. Listening to the radio and watching television gives insight as to whether the elderly person concerned is actually taking an interest in the outside world.

E. Cunning and W.E. Henry discussed this problem in their Disengagement theory where they postulated "that gradual disengagement is functional for society which would otherwise be faced with disruption by the sudden withdrawal of its members, and satisfying for the individual who is socialised. When disengagement is complete the equilibrium is characterised by greater distance and a changed basis for solidarity".(13) While this may be so, the positive approach is for the community workers to stimulate the elderly so that they do take an interest in the world around them until the very minute they die - this is what I believe.

Programmes for the elderly on television are non-existent in South Africa and at present their is one programme for the elderly on the radio English service at 11h30 on Fridays, which is repeated at 19h30 on Saturday evening. It is produced by the Cape Town studios of SABC. The media radio and television is not used to help the aged and yet it has great potential. In the UK, BBC television and radio frequently have programmes for the elderly on hobbies, cooking, and health care.

273 (85%) said that they could do their housework. It must be stated in the case of a male he was asked whether his wife was able to do her housework. 22 (7%) wives were uanble to do so, but did employ a maid to do this work. 318 (99%) did not wish a homehelp and 3 (1%) did and were on TAFTA's waiting list - one was a man whose wife had had a CVA.

There was a tremendous negative response to meals on wheels (321 (100%)). The reason given was "as long as I am able I would prefer to cook and eat the things I fancy to eat at the time". TAFTA runs an excellent meals on wheels service which is obviously being used by the frail aged. In the UK

nursing of the elderly patients "the root cause of the national geriatric problem in the UK is not shortage of money, equipment or personnel but a defective national attitude to old age in which the medical and nursing profession share"[30]. "Thus cultural conditioning discourages the flow of resources and produces poor working conditions which in turn influence the day-to-day experience of nurses and students and consolidate attitudes of indifference and even despair".

This is true in a personal communication in which I was told that a new nurse working in the geriatric unit is soon discouraged by the mocking and attitudes of the staff of other departments. Indeed nurses with low IQ are usually sent to geriatric wards! Table XXVIII analyses the age group seen. 32 (78,05%) of staff see geriatric attenders. From this 17 (41,4%) were happy to see the elderly.

However 36 (88%) agreed that the needs of the elderly differed in comparison with other age groups. Furthermore 38 (92,8%) felt that geriatrics is a specialisty in its own right.

In other words, the staff felt that the geriatric attenders should be seen only by specially interested and trained staff specialising in geriatrics. Sir Ferguson Anderson[14] states that "there is a differentiation between geriatric medicine and internal medicine in which understanding of the elderly in the community plays an important role. The promotion and maintenance of good health in old age is an extremely complex subject which extends beyond the traditional confines of medicine. It involves educationists, economists, architects, engineers and nutrionists as well as the medical and paramedical professions".

It is of the greatest urgency that a training programme should be started at undergraduate level in the education of doctors in the care of geriatric patients.

There is "great concern that under-graduate teaching pays scant attention to the elderly. During the under-graduate days the practitioner is taught to regard the very young as a special part of his practice. The doctor intending to enter general practice is inevitably affected by his early post-graduate experience when he often finds unfavourable attitudes to the elderly. It is frequently stated by those seeking vocational training schemes that they reject those offering geriatrics as part of the rotation. There is a danger that the young GP attitudes towards the elderly may be at the best lukewarm and at the worst hostile"(15)

In the opinions of good points concerning the elderly attenders 35 (95%) stated that the elderly were always grateful for what was being done for them. I know this is true for their upbringing was in an era of manners. Unfortunately today youths take most things forgranted.

Table XXXII shows the unpleasant points concerning the geriatric attenders and thare are ten categories. Summing up, lack of patience and the time consuming ways irkes the expert staff who are busy and under stress. Dirty underclothes 2 (4,8%) shows deterioration on the part of the elderly attender and is a danger sign of mental deterioration.

WHO in 1974 conducted a small survey in Prague amongst relatives of the elderly asking them about their tolerance of various traits - things like

irirascibility, forgetfulness, intolerance, lack of personal hygiene and spoiling of granschildren were the factors annoying relatives.(16)

In the elderly "training of mental function is important - motivation and reactivation. The inability for the elderly to learn is not true, the right stimulus is not often given and instructions are carried out at too great a speed plus their technique are of different generations. Older people learn if the material is clearly arranged. The elderly work more slowly but more carefully. The older person needs more time to grasp a situation and more time to obtain a comprehensive view of the facts".(16)

It can be seen therefore that while the "expert staff" recognise that geriatrics should be a speciality in its own right - they are admitting as seen to their replies to the questionnaire that they do not really understand or have the time to understand the elderly.

Dr. Prinsloo from Tygerberg Hospital in Parrowvallei Cape (personal communication) states that geriatrics should not be a speciality in its own right on the grounds that it is part of internal medicine and that this is the teaching at Stellenbosch University. This cannot be accepted because to look after the elderly as is shown needs skill and training just as much as paediatrics. Therefore, if paediatrics is a speciality in its own right so is geriatrics and the need for each University to set up a Chair in Geriatric Medicine is imperative so that the quality of care can be improved and secondly so that the attitudes of graduates and undergraduates will be positive and rewarding.

meals on wheels is very popular - perhaps because the people have been used to being regimented. This service in the UK is run from the local school kitchen (every school in the UK provides its school children with lunch) and delivered to the homes of the needy by the WRVS. This response shows that the elderly attending AOPD are still independent and capable of coping with cookery.

In conversation with one of the community geriatric professional nurses, she informed me that it is often impossible to visit the elderly in the morning because they are out shopping, or attending their social club, especially in the Durban central area (personal communication). Shopping therefore is their important contact with the outside world where they can see what is going on, meet their friends and have a chat over a cup of tea.

247 (76,95%) have good eyssight, whilst 74 (23,05%) have poor eyesight. It is noted that 33 (11%) attended the eye clinic. The sister-in-charge of the eye clinic stated that 80% of the attenders at the clinic were geriatrics.

233 (72,2%) had good hearing, whilst 89 (27,73%) stated that they had hearing problems. However, only 9 (3%) were attending the ENT clinic. It is a known fact that man tends to tolerate deafness more than poor eyesight. However, this may be related to the stigma attached to wearing a hearing aid where there is no stigma attached to wearing glasses. This is due to the early days when a great joke was made about the "old man and his ear trumpet". I remember being told a story as a boy of the old man

who went to the Kirk and as he was about to raise it to his ear to listen to what the Minister had to say - the Beadle rushed up to him and said "one toot and you're oot"!

Following the trumpet was the attachment with wires to an amplifier pinned to the shirt which also seemed to bring sounds of derision. Today the modern hearing aid behind the ear is non-obtrusive and acceptable. The problem now is the cost of R300-400 each. They are not made in South Africa, but have to be imported. This price is a tall order for the geriatric majority to pay, though I do know of cases where families have clubbed together and bought one for their elderly dependant.

There should be a new thinking by the State Health concerning deafness. In the UK every deaf or hard of hearing geriatric is supplied with a "behind the ear" model plus free batteries. There are centres in each large town attached to the local hospital where these hearing aids are serviced and faults rectified - all free including the hearing aid under the NHS.

Having a telephone in the home is regarded as the life-line for the elderly. It enables them to be in contact with the outside world - their friends and family, also when ill can summon help immediately. It is their home security, for often on my rounds as a GP I have seen the local police station number, the flying squad number and the fire brigade number pinned in a prominent place beside the telephone. 293 (91.28%) did have a telephone whilst 28 (8,72%) had no telephone. Everyone interviewed stated that they would like a telephone but could not meet the costs of installation (R70,00) and also the rentals. Some who had a telephone stated

that it was a hardship to keep the payments going but it was necessary.

In the UK installation of telephone services is free for the elderly on production of a doctors letter of after a note from the district social worker stating the need for the telephone. In cases where the elderly are unable to pay the rental charges this is paid by DHSS. This type of service is needed in South Africa.

The questions concerning radio and television discussed earlier brought interesting comment. 306 (95,37%) listened to radio and 286 (89,1%) watched television. Several people stated that television was better because it was easier to follow as "you can watch and listen", whereas the radio was "too quick".

162 (50,47%) preferred radio. 138 (42,99%) preferred television and 20 (6,25%) had no preference. Many peopale grumbled about the recent programme changes .."no Springbok radio", "no comedy programmes such as 'Man from the Ministry'". "no Squad Cars", "nothing but dull music!". Some stated that next January when the English and Afrikaans programmes are joined it will be worse - "nothing but mournfull music" was one comment.

Of 162 who preferred radio, 143 (88%) objected to the programme changes. Television was said to be poor - too many American programmes. TV4 had the best viewing but it was on late at night. A few had bought video recorders so that they could see these programmes during the day. Some stated that they felt that the Afrikaans programmes were better than the

English programmes.

The geographical area of residence of geriatric attenders.

This was divided into 22 areas as shown in Annexure D. The central Durban area consists of the area from the Beach front to Berea Road Station and from the Point to Old Fort Road. The highest proportion of geriatric attenders came from this area (72 (22,4%)). The Community Geriatric Services provide Primary Health Care services for the geriatric qualified attenders in the Durban area as shown. The doctors who attend these clinics are from the District Surgeon's Office in Durban. However, I am told that very shortly this will be changed. The geriatrics are not encouraged to use the District Surgeon's Office.

AREA	CLINIC VENUE	TIME
Upper Central Business District	United Congregational Church St. Andrews Street	Monday am
Windermere, Greyville, Morningside	Greyville Presbyterian Church Windermere Road	Friday am
Lower Central Business District	Baptist Church Hall, West St	Thursday am
Berea	NG Kerk Hall, Cleaver Road	Thursday am
Bluff	Mdumbi Moth Hall, Lighthouse Road	Wednesday am
Glenwood, Umbilo*	Presbyterian Church Hall, Frere Road	Monday am
Durban North**	St. Margaret's Church Hall	Tuesday am

* Glenmore Senior Citizens Club is not attended by Community Geriatric Nurses but Geriatric Professional Nurse from City Health attends.

** Durban North Clinic is run entirely by voluntary workers.

Doctors from District Surgeon's Office. Nurses all voluntary.

233 (72,59%) of geriatric attenders came from the areas covered by their clinics. Theoretically it can be argued as these clinics are offering Primary Health Care services the number of geriatric attenders from these areas should be small. However, the number of the patients seen at these clinics are small in comparison to numbers coming from that area to attend AOPD.

What are the reasons for this :

1) pink card system. Up until recently the doctors who work at AOPD were the only ones allowed to write out pink cards. By pink cards it is meant Pharmacy prescription cards enabling the geriatric attenders to obtain their medicines at Addington Hospital Pharmacy free of charge. Usually these pink cards are made up for three months supply and at the end of three months the patient returns to AOPD for a further check-up and re-issue of prescription for another three months. In the interim time these patients attend the Community Geriatric Service Clinics to receive their month's supply of medicine from Addington Hospital - they are used as collecting points and also to discuss any problems they may have.
Recently it has been agreed that the doctor attending clinics can now write pink cards which will be honoured by Addington Hospital Pharmacy. This should relieve congestion at AOPD. However, when discussing this point with the Community Geriatric Sisters it was stated that the patients still felt that they had to attend Addington for a "proper check-up" on the one hand and on the other hand some of the doctors at AOPD are

reluctant to give up their practice.

2) The Community Geriatric Services is used to obtain medicines not on Addington code, such as hypnotics other than Trichlomyl tablets and other medicines. There is a difference between the NPA code and the District Surgeon nursing code. This subject should have been rectified years ago - indeed as Chief District Surgeon of Pinetown, I attended two meetings concerning this subject 4-5 years ago and still today the problem is not resolved. This is disconcerting for the patient.

Whilst on the subject of drug codes - the District Surgeon's drug code is controlled by Dr. M. Brookes at Pietermaritzburg, but this code is not standard throughout South Africa because each Province has its own code or method of prescribing. The Transvaal for example have no code but prescribe anything out of "Mims". As a result, when elderly people come down to Natal, and Durban in particular, on holiday or to retire, one finds them on the most exotic drugs which cost the State a lot of money. This then causes friction and in some cases extreme friction between the Natal doctors and their patients. As in the UK there should be a uniform code for all Provinces - what about a South African National Formula.

3) Many geriatric attenders have always attended AOPD and do not wish to attend Clinics. I was told in one instance "if you are sick you are referred to Addington anyway". This is the centre of the problem which is that the majority of the elderly attenders have not as yet been educated to preventative medicine.

It is interesting to note that there were no geriatric attenders from

Kloof which is a high income area and its residents are fully integrated into private medicine.

There are Local Authority Clinics at Queensburgh, Amanzimtoti, Westville, Pinetown, Umhlanga Rocks, Hillary and Kingsburgh so that people coming from these areas are mainly referrals for specialist advice.

One geriatric attender came from Empangeni, being referred from there to the ENT Clinic, and the one from furthest down the South Coast came from Post Shepstone having been referred to the Skin Clinic.

In the days of increased fuel costs and therefore increased transport charges it is important to obtain insight into how the geriatric attenders cope with this problem inorder to help further planning.

Addington Hospital is not the easiest of sites to get to. It is situated on the Beach front, has a magnificent view out to sea and over the port, but to get to it from all areas except the North Coast and Beach area itself involves having to travel through the busy central business area of Durban. Most buses run from the suburbs into the centre and out again so people coming by bus have to catch two buses to get the right one for Addington Hospital. Table X shows the different types of transport used and as can be seen the public transport (Durban Corporation) was the most popular means of transport. 98 (31%) used this service and as stated most of these geriatric attenders had to change buses in the centre of Durban. It can be seen therefore that Durban Corporation Transport Services plays a vital role in conveying the elderly from their geographical areas - 233 (72,59%) live in areas covered by the transport system - 42,06%.

It has been suggested, studying various reports and letters in the Durban Press, that Durban should "give up its transport system as it is a severe burden on its rate payers". Studying these figures show that the system is a part of essential services for the community and that it should be viewed in this light.

An indepth study should be made, perhaps applying to Central Government for subsidy, as given to Non-White services. Better still, do away with this inapt segregation in buses. With a better service more people would probably use it, especially as transport costs are rising every day. The running and maintenance of a motor car is high and is likely to increase. I know Durban Corporation Transport Services are well aware of this problem (personal communication) and have tried several times to desegregate the buses, each time they have applied to the local transport Commission they are refused. Cape Town, Port Elizabeth and Johannesburg have mixed buses yet Durban, who were forced to change in 1968, are still being blocked by obviously reticent members of the local Transport Commission.

Those living near the hospital walk, but after the bus their own car (92 (29%)) and friend's car (68 (21%)) were the most popular means of transport. Fortunately in the Beach front around the hospital there are plenty of parking areas, though during the peak holiday times it can be a problem with the holiday makers.

The Red Cross have started a "Highway bus service" leaving Hillcrest at 06h30, calling at Pinetown, Westville and Queensburgh every day, returning

again from Addington at 15h00. There is an African trained nurse on the bus in case of an emergency, though I am not too happy about this because I feel it is exploitation of labour for her salary is nowhere near that of a White professional nurses salary.

The reason for attendance (Table XXI)

As previously stated civil pensioners, nor pensioners who receive a previous employment pension, or those who have no pension unless they have a letter from a magistrate are allowed to attend Community Geriatric Service Clinics.

199 (61,99%) of geriatric attenders were found to be attending speciality clinics, having been referred by the clinics, which is as it should be.

122 (38,1%) were attending for Primary Health Care. Table XXI shows the type of health services used by the geriatric attenders this year.

While the senior professional nurses who work at the clinics have undergone Primary Health Care training, a lot of them are still very unsure of themselves (personal experience). The geriatric attenders also tend to demand to see a doctor and it takes a long time for them to accept a senior professional nurse in the same way as a doctor is accepted. It must be remembered that the majority have always been used to a GP service when working with a medical aid where the doctor is the person they have to see. Secondly, the generation education gap where the older geriatric has always looked to the doctor as the "treater of sickness" while the nurse is the "comforter". Reassurance about physical health is important in the elderly because they have a secret fear of disease, it is relaxing

for them to talk about it so thus consultations with them must not be rushed. The staff at AOPD do not have this time, a better technique is needed at the clinics, the acceptance of nurse orientated clinics, and the establishment of day clinics, a subject which will be discussed later.

Until now the pattern of care given to old people, both socially and medically, has been characteristically "crisis orientated". "The services have waited for a problem to occur instead of the old tradition of visiting the elderly regularly". I was taught in my training year to have a visit book with weekly, fortnightly and monthly return visits for the geriatric patient.

In Newcastleton in Roxburghshire, Scotland, I used to visit 20 geriatric patients per week. I also did the same in Ipswich, Suffolk, England.

"The average number of people over 75 years on a list of 222,500 was 125. This would mean doing 30 calls per week in addition to other practice commitments which is impossible. This ad hoc visiting has been the pattern care of this decade and a new look at what needs to be done to bring methods of care up to date".[10]

Ageing is a very fluid process and there are long periods of health and social activity, interrupted by episodes of active physical or environment difficulty. These are often overcome and the old person returns again to a balance of equilibrium.

Edwin Master[13] states that "the definition of illness depends on the patient's expectations and these may alter dramatically in different ages.

Furthermore, many of the problems of the elderly are not related to illness. They are more related to whether they can open a tin of food or get to the toilet. If, as a Primary Health Care team, we hope to look after the physical, psychological and social needs of our patients, we should be screening for these problems. It is very unlikely that they will be volunteered in a consultation".

A lot of information can be obtained in home visiting. The need by the geriatric attenders of this service was expressed when they were asked whether the health services provided was adequate for their needs. Table XXII and Table XXIII show what improvements the geriatric attenders felt necessary.

222 (69%) were not happy with present health care. 78 (36,2%) felt that a completely free National Health Service as provided for in the UK should be provided for in South Africa. When this is analysed further, the main problem is home visiting. 48 (21%) expressed the need when they are sick. They felt that a doctor or community nurse should be available 24 hours to pay a visit. Whilst they admitted that they knew that they could call an ambulance to take them to Addington, it was stated by the geriatric attenders who had used this service hadthey found the Casualty Officers very intolerant and tended to belittle their illnesses.

If a National Health Service was in operation they would be able to have their own doctor or nurse to whom they could just talk to and then even a visit may not be necessary. A lot of information can be obtained in home visiting and it should be done by the Community Geriatric Professional

Nurse. This would mean that a lot of the geriatric attenders could be seen at an earlier stage of disease or disability and by so doing offer a more sound preventative service. Home visiting I find increases the intimacy of the patient/nurse/doctor relationship. "From visiting the attitudes and presence of other people at home can be learnt. The proximity and helpfulness of neighbours and relatives, nutritional and alcoholic habits. Hygiene habits and mobility and the safety of the home for the patient's functional level and advise modifications when required".(12)

All patients from Hillcrest attend Hillcrest Hospital Geriatric Clinic run by Dr. Hamilton. In Pinetown all patients are seen by the District Surgeon before they are referred to Addington Hospital.

4 (1,8%) complained about poor organisation at reception, especially at tea break where everybody is left standing in a queue for 30 minutes. Why not stagger the tea break. 6 (2,7%) felt that it was important to see the same doctor because it was annoying repeating themselves each time they attended clinic.

Doctor/patient relationship 23 (10,3%) and staff relationship 3 (1,3%) can be linked together. The geriatric attenders complained that neither the doctors or sisters listened to what they had to say, were in too great a hurry, and changed the tablets at will without prior instructions. 3 (1,3%) found it very difficult making an appointment because it had to be made in person and not by telephone. This led to extra expense.

The method used in the UK consisting of a letter form system, whereby this

is already addressed to Appointments Department. All the doctor has to do is to write the patient's details with a request to which particular OPD clinic he requires indicating whether or not it is urgent. There is a section for the letter to the consultant of the clinic, the whole thing is folded up and given to the patient to post. The Appointments Department then posts and appointment date to the patient.

3 (1,3%) criticised the peripheral clinic sisters who they said prevented them seeing the doctor! While nursing sisters have the reputation of being dragons the concept is not true of the modern nursing sister who is usually a very caring and understanding person. However, a lot of the elderly still feel that the doctor is the only person who can resolve their problems.

13 (5,8%) of geriatric attenders expressed the need for full facilities at peripheral clinics. Chiropody is the only extra facility at present offered at these clinics and is very much appreciated by the elderly. However, the main request here is the establishement of a Day Clinic which will be discussed later with its services for the ageing community.

20 (9%) expressed the view that the whole waiting area needed re-designing. It was stated that "waiting area is drab", "everybody is packed like sardines", "the noise of the loudspeaker is terrible", "it is a depressing area". Some said it should be an "uplifting atmosphere with soft music in the background". The method of announcing to the patients when their prescriptions are ready can be irritating, even the nursing staff agrees that the atmosphere of numbers booming out at intervals very

off-putting. An electrical score board could be the answer to this problem. Refreshments should be more attractively served in an area set aside for this purpose with tables and chairs.

The need for the establishment of Day Clinics was the opinion of 233 (73%) of the geriatric attenders (see Annexure E).

Day Clinics are the norm in the UK, Holland and in Norway and Sweden and are very popular and well used. Those of the geriatric attenders who have relatives in these countries went into discussion with great enthusiasm concerning them and stated the real need of them here. My experience of a Day Clinic is based on my experience in the UK where they do play a very important role in the life of the community. The literature is full of reports, especially in Scotland, of these clinics which are of two types :

a) a meeting place where old people can attend to see old friends, make new friends and engage in social activities. Hobbies are catered for, games and craft work. A little workshoip can be a source of a little income for them.

b) the above plus Primary Health Care facilities where all services are available[27] and is the answer for Durban.

This Day Centre would be run by a roster of trained staff opening at 06h00 to 18h00, a 12 hour service, and would be the crux of geriatric care in the greater Durban area in the future. The stress that occurs at AOPD would be relieved and the whole services of geriatric care would be linked up[28] (see Annexure C) with a Geriatric Unit at Addington Hospital.

Professor Arbuckle in 1981 in his study of "Primary Health Care services for the elderly in the greater Durban area" stated the need for a "poly-clinic" in Durban whose functions "should include, in addition to the diagnosis, monitoring and treatment of illness, facilities for the assessment of patients in respect of their life situation, physical, mental and social circumstances, the need for and type of treatment, scope of rehabilitation and the ultimate prognosis" as envisaged by other workers in respect of geriatric units.[29] A Day Centre would incorporate all these within it and uplift the community. Elderly people could be left by their children before going to work or perhaps going away for the day and collected at the end of the day. People should be kept at maximum independance with the social adventures provided - hobbies room; (many an elderly man stated that "since going to a flat on retiring he has had to give up his hobby because there is no room"), cooking classes, fashion shows and talks, chopping bargins, etc.

Table XXV shows the type of paramedical services required. Chiropody is the most popular after physiotherapy which was popular as a means of "keeping fit" - as it was put. The Dental services - 62 (19,3%) reflect a need for free dental services for the elderly. A canteen should be provided because in these socio-economic conditions do all the elderly have one good meal per day? A survey carried out in 1983 by Community Geriatric Nursing Services showed that there was a real risk that with the rising costs the elderly could suffer from malnutrition. This then reflects the need for a canteen, a subsidy could be applied for so that a full three course meal could be provided for R1,00.

Other facilities at the Day Clinic should be a reading room with magazines

and newspapers 96 (30%); television room with video and cooking facilities. The Centre should be run by trained geriatric workers with a nursing sister always in attendance as stated before with a doctor with geriatric training consulting daily.

In investigating the elderly the doctor concerned must be trained in geriatric medicine.

Expert staff.

In order to be able to understand the true feelings of AOPD 41 staff members - by definition these were the doctors and nursing staff who normally work in AOPD were interviewed by a standard questionnaire (see Annexure B).

31 (73,2%) were under 50 and 11 (26,8%) over 50 years (Table XXVI). 20 (48,8%) preferred to care for younger middle age group in comparison with 6 (14,4%) who showed preference to the elderly attenders (Table XXVII). The majority therefore, 35 (85,31%),do not have any particular leaning towards the care of the elderly.

In WHO report 1981 "Behavioural studies related to care of the aged" published in 1982, it was stated "poor standards included lack of consideration of patient feelings, failure to maintain dignity, privacy and personal identify". It goes on to state "The feelings and thoughts which activate our behaviour are themselves moulded by the culture and traditions of the society in which we live and are fashioned by our experience, education and training. In applying this rationale to the

8. CONCLUSIONS

In planning health care for the elderly three factors have to be considered :

1) Planning operation.

How many elderly are in the area?
What types of disabilities exist?
What kind of service is needed?

2) Value of care.

Is it right to concentrate on primary and community care for the elderly or should one concentrate on institutional care like Bill Buchannan or Morton Hall Pinetown.

Who comes first in priorities? - is it more important to build sheltered homes than increase the staff of the community geriatric services, train social workers, occupational therapists, assistants, physiotherapists, etc.

3) More positive decision making is needed.

Building of Day Centres.
Development of full community services for the elderly.

A door to door/street by street research is needed to develop an age/sex register of each district and then positive planning made.

The problem of cost effectiveness is important so that the maximum facilities are provided at the least expense. "Raising standards means higher costs so it is necessary to ensure value for money, marginal analysis overcomes some of these problems.

1) only those things which bring benefits greater than costs should be done.

2) activities whose benefits are less than their costs should be discontinued.

3) if no budget constraints costs then activity should be expanded until marginal benefit equals the marginal cost.(22)

In these very hard times that are being experienced in South Africa at the present time where the availability of money is very limited, even from the private sector, very careful planning is needed.

In 1979, WHO published "working guidelines to country health programming". The following pre-requisites were stated necessary(23) :

1) "A certain degree of political stability together with continuity of the overall goals of national development as agreed amongst the major political intersts". At this present moment South Africa does not have this for the needs of the Black population which are in the greatest sector of the population, are suppressed, and unless a multiracial Government is set up there will be civil war.

2) "Some degree of economic stability since large economic fluctuations are likely to jeopardise implementation of the plan". At present with the disinvestment campaign the South African economy is at a very low ebb.

3) "Political commitment by the National leadership to the implementation of the plan". It has always been the policy of the present Government to make the private sector carry most of the health service costs so until there is an indepth study by the leadership at Cabinet level any future development of geriatric services will be of lower

priority. Active senior citizen groups are needed who will lobby MPs.

As regards to the nursing and medical professions, a change of training programmes is needed at student nurse and under-graduate level. This also means a change of attitude of the administrators such as senior nursing managers and the teaching staff at medical schools.

9. RECOMMENDATIONS.

It is recommended

THAT DAY CENTRES SHOULD BE SET UP IN THE GREATER DURBAN AREA

A pilot centre should be set up in the central Durban area at first in order to iron out any problems encountered.

An establishment of a Day Centre will immediately relieve the stress of the AOPD. While the Geriatric Assessment Unit is operating it would be important to involve this unit in the functions and development of the Day Clinic. At present one cannot send a geriatric attender from OPD to Geriatric Assessment Unit without prior elaborate arrangements. The two must work hand in hand.

The future of the Children's Hospital has as yet to be decided and is the study of an inquiry under Mr. Mannie Steyn. If it is concluded to discontinue the Children's Hopsital as a separate entity, this building would be ideal for the establishment of the first Day Centre as it is next to Addington Hospital. Expense would be saved in many ways.

THE COMMUNITY GERIATRIC NURSING SERVICES SHOULD BE GEARED UP TO DO MORE HOME VISITING AND A ROSTER DUTY OF A COMMUNITY NURSE BEING ON CALL AT ALL TIMES IMPLEMENTED.

This would mean the provision of a radio-link with medical emeregency radio just as the duty distress surgeon is linked. By doing this the great insecurity that the elderly have at night time would be alleviated - the duty community geriatric nurse could be contacted and if necessary she

pays a house call. Often however, all is needed is some expert advice at the other end of the telephone. It would then be her duty to arrange for the elderly person to be seen at Addington late at night by an expert in geriatric care not by a casualty officer who has not the time or patience to be dealing with the elderly. In this way the care of the geriatrics could be improved with very little cost to the Government and psychologically the elderly who feel "cared for out of hours".

There should be a notice put over the radio and in the local newspapers informing them to contact "Medical Emergencies" who would contact the duty community geriatric nurse.

Once the first Day Clinic has been established and all problems ironed out a plan for setting up other Day Centres can be implemented. These Day Centres would in time do away with the existing peripheral clinics in the greater Durban area and the Community Geriatric Nurse would operate from these Day Centres and not from Commercial City as they do at present.

Full radio and television coverage is needed to inform the public about the functions and uses of the Day Centres in order that they will be used to maximum potential as well as the local newspapers.

As regards to the "expert staff",that is the nursing and medical profession

A CHAIR OF GERIATRIC MEDICINE IS REQUIRED TO BE ESTABLISHED AT THE UNIVERSITY OF NATAL

in order that the under-graduates receive proper training in geriatrics

and also that on the post-graduate level continuing research is carried out on the care and treatment of the geriatric people of all races.

The person appointed must have an aptitude for getting on with and understanding the elderly, should have the M.Med (Community Health) and perhaps an MD. He must have the character of leadership in management and also the ability to teach others. Once appointed he must have the full co-operation of the Heads of Addington, King Edward VIII, R.K. Khan and Wentworth Hospitals,which are the main teaching hospitals. Not only the heads of medical staff, but nursing staff. Liaison must be sought with the Department of Nursing Colleges so that a junior and post-graduate course is undertaken by the nursing professionals of all races.

Finally, thought must be

GIVEN TO THE ESTABLISHMENT OF A NATIONAL INSTITUTE FOR AGEING

as there is in the USA, so that more information can be gathered about the ageing process and that sound advice on problems facing the elderly should be available for its politicians and the health planners.

One of the secrets of success of any geriatric service is co-ordination, so that skilled services are not wasted.

In conclusion, the final say will consist as D. Black so aptly put it :

1) "what are the aims of the service?
2) how many people and what kinds are eligible?

3) what proportion of people get help?

4) what determines who gets help?

5) does the servcice make any difference and to whom?

6) what does it cost, who pays and how does the cost comapre with potential substitutes?

7) what do the public think about the service?

8) what impact might the service make upon the demands for and effectiveness of the service"?

Proceedings, Royal Society of Medicine
1974: Vol 67, p1306.

As a footnote may this never happen as described in this New York Times article (October 07, 1974) ...

"The British writer Anthony West visited a nursing home near Kansas City where he remarked that there were only spoons on the tables. The Director replied 'you wouldn"t want them fighting would you?'

Mr. West also asked about the iron divider separating the women's quarters from the men's. The reply he got was 'you wouldn't want them breeding would you?'"

10. ACKNOWLEDGEMENTS

Dr. M. Barlow, Senior Medical Superintendent, Addington Hospital for without her permission this project could not have been undertaken.

Mr. Nieuwoudt, Hospital Secretary, Addington Hospital Out-patients Department.

The Medical Staff Addington Out-Patient Department.

The Nursing Staff Addington Out-Patient Department.

Dr. Futeran, Head of Geriatric Assessment Unit, Addington Hospital.

The Community Geriatric Nursing Service Professionals.

Fiona Walters, my daughter.

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TABLE I. YEARLY FIGURES FOR GERIATRIC ATTENDANCE : ADDINGTON HOSPITAL OPD, 1974-1984.

YEAR	NUMBER	PERCENTAGE INCREASE
1974	127,672	-
1975	139,513	9,87%
1976	146,643	14,87%
1977	140,006	9,66%
1978	149,531	17,12%
1979	148,872	16,16%
1980	203,665	59,58%
1981	223,646	75,17%
1982	213,162	66,96%
1983	229,914	80,08%
1984	245,185	92,40%

TABLE II. AGE AND SEX DISTRIBUTION : NUMBERS AND PERCENTAGE.

AGE GROUP	MALE	FEMALE
60-64 years	-	24 (7,4%)*
65-69 years	30 (9,3%)	36 (11,2%)
70-74 years	38 (11,8%)	58 (18,0%)
75-79 years	33 (10,2%)	52 (16,7%)
80-84 years	15 (4,6%)	28 (8,7%)
85-89 years	2 (0,6%)	5 (1,5%)
TOTAL	118 (36,5%)	203 (63,5%)

*Males are not geriatric at this age.

TABLE III. MARITAL STATUS.
NUMBERS AND PERCENTAGE.

Single	12	(4%)
Married	149	(46%)
Divorced	30	(9%)
Widowed	125	(39%)
Living together	5	(2%)
TOTAL	321	(100%)

TABLE IV. ACCOMMODATION USED BY GERIATRIC ATTENDERS : NUMBERS AND PERCENTAGE.

Flats	176	(55%)
House	80	(25%)
Single room	19	(6%)
Hotel/boarding house	19	(6%)
Old Aged Home	27	(8%)
TOTAL	321	(100%)

TABLE V. HABITAT STATUS OF GERIATRIC ATTENDERS : NUMBERS AND PERCENTAGE.

Spouse	143	(44%)
Brother/Sister	16	(5%)
Children	46	(14%)
Other relatives	9	(3%)
Non-family	37	(12%)
Alone	70	(22%)
TOTAL	321	(100%)

TABLE VI. DISTANCE LIVED BY ELDERLY ATTENDERS FROM NEAREST CHILD : NUMBERS AND PERCENTAGE.

Living with	66 (21%)
Under 5 km	59 (18%)
Between 5-20 km	65 (20%)
>20 km but <100 km	58 (18%)
>100 km	63 (20%)
No child	10 (3%)
TOTAL	321 (100%)

TABLE VII. FAMILY VISITING HABITS : NUMBERS AND PERCENTAGE.

Not applicable (living with)	62	(19%)
Daily	28	(9%)
Twice weekly	44	(14%)
Weekly	49	(15%)
Fornightly	21	(7%)
Monthly	40	(12%)
Never (or more than monthly)	56	(18%)
No family	21	(6%)
TOTAL	321	(100%)

TABLE VIII. TYPE OF PENSION RECEIVED BY GERIATRIC ATTENDERS : NUMBERS AND PERCENTAGE.

Social	169	(52,6%)
Military	13	(4,0%)
Civil	41	(12,8%)
War veterans	27	(8,4%)
Previous employment	39	(12,2%)
None	32	(10,0%)
TOTAL	321	(100,0%)

TABLE IX. **MEDICAL AID FACILITIES : NUMBERS AND PERCENTAGE.**

Belonging to a medical aid	33	(10%)
Not belonging to a medical aid	288	(90%)
TOTAL	321	(100%)

TABLE X. TRANSPORT USED BY GERIATRIC ATTENDERS : NUMBERS AND PERCENTAGE.

Walk	27 (8%)
Bus	98 (31%)
Taxi	0 (0%)
Own car	92 (29%)
Friend's car	68 (21%)
Voluntary Body	34 (10%)
Ambulance	2 (1%)
TOTAL	321 (100%)

TABLE XI. EYESIGHT OF GERIATRIC ATTENDERS : NUMBERS AND PERCENTAGE.

Good eyesight	247	(76,95%)
Poor eyesight	74	(23,05%)
TOTAL	321	(100,00%)

TABLE XII. HEARING OF GERIATRIC ATTENDERS : NUMBERS AND PERCENTAGE.

Good hearing	232 (72,27%)
Hearing problems	89 (27,73%)
TOTAL	321 (100,00%)

TABLE XIII. ASSESSMENT OF ABILITY OF GERIATRIC ATTENDERS TO DO HOUSEWORK : NUMBERS AND PERCENTAGE.

Yes	273	(85%)
No	22	(7%)
Not applicable	26	(8%)
TOTAL	321	(100%)

TABLE XIV. ASSESSMENT OF NEED FOR HOMEHELP : NUMBERS AND PERCENTAGE.

No	318 (99%)
Yes	3 (1%)
TOTAL	321 (100%)

TABLE XV. REQUIREMENTS OF MEALS ON WHEELS : NUMBERS AND PERCENTAGE.

Yes	0 (0%)
No	321 (100%)
TOTAL	321 (100%)

TABLE XVI. TELEPHONE FACILITIES : NUMBERS AND PERCENTAGE.

Have a telephone	293	(91,28%)
No telephone	28	(8,72%)
TOTAL	321	(100,00%)

TABLE XVII. RADIO LISTENERS : NUMBERS AND PERCENTAGE.

Listen to radio	306	(95,33%)
Do not listen to radio	15	(4,67%)
TOTAL	321	(100,00%)

TABLE XVIII. ATTITUDE TO TELEVISION : NUMBERS AND PERCENTAGE.

Watch television	286	(89,10%)
Do not watch television	35	(10,90%)
TOTAL	321	(100,00%)

TABLE XIX. PREFERENCE BETWEEN RADIO AND TELEVISION AND REACTION TO RADIO PROGRAMME CHANGES : NUMBERS AND PERCENTAGES.

	RADIO	TELEVISION
Prefer	162 (50,47%)	138 (42,99%)
Object to programme change	143 (88,00%)	---
50/50		20 (6,23%)
Does not listen to radio or watch television		1 (0,3%)

TABLE XX. GEOGRAPHICAL AREAS OF ABODE : NUMBERS AND PERCENTAGE.

Central Durban	72	(22,4%)
Bluff	10	(3,1%)
Amanzimtoti	13	(4,0%)
Durban North	8	(2,5%)
Berea	39	(12,5%)
Windermere	42	(13,0%)
Overport	19	(6,0%)
Sydenham	4	(1,0%)
Glenwood	17	(5,0%)
Umbilo	22	(8,0%)
Yellowood Park	5	(1,5%)
Bellair	3	(0,9%)
Queensburgh	7	(2,1%)
Westville	16	(5,0%)
Pinetown	17	(5,0%)
Kloof	0	(0.0%)
Hillcrest	9	(2,8%)
Umhlanga Rocks	7	(2,1%)
North Coast	5	(1,5%)
South Coast	6	(1,6%)
Others	0	(0,0%)
TOTAL	321	(100,0%)

TABLE XXI. CLINIC ATTENDANCE AT ADDINGTON OPD : NUMBERS AND PERCENTAGE.

Medical	122	(38,0%)
Diabetic	20	(6,0%)
Dental	4	(1,0%)
Urology	10	(3,0%)
Orthopaedic	45	(14,0%)
Surgical	4	(1,0%)
Eye	33	(11,0%)
Vascular	6	(2,0%)
ENT	9	(3,0%)
Oncology	6	(2,0%)
Geriatric	1	(0,3%)
Pharmacy	7	(2,0%)
Speech Therapy	1	(0,3%)
Psychiatry	5	(1,5%)
Gastric	12	(3,8%)
Cardiac	10	(3,0%)
Dermatology	15	(4,6%)
Chiropody	1	(0,3%)
Gynaecology	2	(0,6%)
Haematology	2	(0,6%)
Rheumatology	6	(2,0%)
TOTAL	321	(100,0%)

TABLE XXII. HEALTH SERVICES USED AT ADDINGTON OPD JANUARY-JULY, 1985 : NUMBERS AND PERCENTAGE.

Addington OPD	208	(64,7%)
Clinic nurse	28	(8,7%)
Private GP	14	(4,3%)
District Surgeon	6	(2,3%)
Admitted to hospital	3	(0,9%)
OPD/Clinic nurse	30	(9,3%)
OPD/GP	15	(4,6%)
OPD/District Surgeon	9	(2,8%)
OPD/Admitted to hospital	4	(1,2%)
Clinic nurse/GP	1	(0,3%)
Clinic nurse/District Surgeon	2	(0,6%)
Admitted to hospital/GP	1	(0,3%)
TOTAL	321	(100,0%)

TABLE XXIII. ASSESSMENT OF ADEQUACY OF HEALTH CARE : NUMBERS AND PERCENTAGE.

Yes	99 (31%)
No	222 (69%)
TOTAL	321 (100%)

TABLE XXIV. HEALTH CARE NEEDS OF GERIATRIC ATTENDERS AT ADDINGTON OPD : NUMBERS AND PERCENTAGE.

Free NHS	78	(36,2%)
Home visiting	48	(21,0%)
Administration	4	(1,8%)
See same doctor	6	(2,7%)
Doctor/patient relationship	23	(10,3%)
Night calls	4	(1,8%)
See doctor only at peripheral clinic	3	(1,3%)
Appointment system	3	(1,3%)
Full facilities at peripheral clinic	13	(5,8%)
Pharmacy	9	(4,0%)
Civil pension - right to attend peripheral clinic	4	(1,8%)
Long waiting time for eye appointment	3	(1,3%)
Free dental services	1	(0,4%)
Waiting area	20	(9,0%)
Staff relationship	3	(1,3%)
TOTAL	222	(100,0%)

TABLE XXV. NEED FOR DAY CENTRE : NUMBERS AND PERCENTAGE.

In favour	233	(73,0%)
Against	88	(27,0%)
TOTAL	321	(100,0%)

TABLE XXVI. REQUIREMENTS AT DAY CENTRE, PARAMEDICAL SERVICES : NUMBERS AND PERCENTAGE.

Physiotherapy	108	(34,0%)
Chiropody	59	(18,3%)
Dentist	62	(19,3%)
Hairdressing	28	(9,0%)
Eye Testing	4	(1,0%)
Occupational therapy	7	(2,1%)
Hearing Test	1	(0,3%)
Uncertain	52	(16,0%)
TOTAL	321	(100,0%)

TABLE XXVII. AGES OF HEALTH PROFESSIONALS : NUMBERS AND PERCENTAGE.

Under 49 years	30 (73,2%)
Over 49 years	11 (26,8%)
TOTAL	41 (100,0%)

TABLE XXVIII. HEALTH PROFESSIONALS AGE GROUP PREFERENCE FOR TREATING : NUMBER AND PERCENTAGE.

Children	4	(9,8%)
Young and middle aged	20	(48,8%)
Elderly	6	(14,6%)
All ages	9	(22,0%)
Young and elderly	2	(4,8%)
TOTAL	41	(100,0%)

TABLE XXIX. AGE GROUPS TREATED BY HEALTH PROFESSIONALS AT ADDINGTON OPD : NUMBERS AND PERCENTAGE.

30-39 years	1	(2,0%)
40-49 years	3	(7,0%)
50-59 years	5	(12,0%)
60-69 years	6	(15,0%)
70-79 years	15	(37,0%)
80-89 yeras	9	(22,0%)
90-99 years	2	(5,0%)
TOTAL	41	(100,0%)

TABLE XXX. HEALTH PROFESSIONALS OPINION OF GERIATRIC NEEDS IN COMPARISON WITH OTHER ATTENDERS : NUMBERS AND PERCENTAGE.

Different	36	(88,0%)
No difference	2	(4,8%)
Uncertain	3	(7,2%)
TOTAL	41	(100,0%)

TABLE XXXI. HEALTH PROFESSIONALS OPINION OF GERIATRICS BEING A SPECIALITY IN ITS OWN RIGHT : NUMBER AND PERCENTAGE.

Yes	38 (92,8%)
No	3 (7,2%)
TOTAL	41 (100,0%)

TABLE XXXII. WHAT HEALTH PROFESSIONALS APPRECIATE ABOUT WORKING WITH GERIATRIC PEOPLE : NUMBERS AND PERCENTAGE.

Gratefulness	39 (95%)
Failed to answer	2 (5%)
TOTAL	41 (100%)

TABLE XXXIII. WHAT HEALTH PROFESSIONALS FOUND DISTASTEFUL ABOUT GERIATRIC PATIENTS : NUMBERS AND PERCENTAGE.

Rudeness	3	(7,32%)
Time consuming	2	(4,80%)
Impatient	4	(9,76%)
Stubborn	2	(4,80%)
Deafness	2	(4,80%)
Dirty underclothes	2	(4,80%)
Confusion	7	(17,07%)
Poor communication	5	(12,51%)
Multiple complaints	7	(17,07%)
Demanding	7	(17,07%)
TOTAL	41	(100,00%)

TABLE XXXIV. NUMBER OF YEARS HEALTH PROFESSIONALS HAVE WORKED IN ADDINGTON OPD : NUMBERS AND PERCENTAGE.

0-1 year	3	(7,0%)
1-2 years	17	(43,0%)
2-3 years	6	(15,0%)
3-4 years	2	(5,0%)
4-5 years	3	(7,0%)
5-6 years	1	(2,0%)
6-7 years	0	(0,0%)
7-8 years	5	(12,0%)
8-9 years	1	(2,0%)
9-10 years	0	(0,0%)
>10 years	3	(7,0%)
TOTAL	41	(100,0%)

TABLE XXXV. AGE AND MARITAL STATUS OF GERIATRIC ATTENDERS : NUMBERS AND PERCENTAGE.

AGE	SEX	SINGLE	MARRIED	DIVORCED	WIDOWED	LIVE TOGETHER
60-64 years	M	-	-	-		-
	F	-	9 (3,0%)	8 (2,5%)	7 (2,0%)	-
65-69 years	M	-	23 (7,0%)	2 (0,6%)	5 (1,5%)	-
	F	-	16 (5,0%)	8 (2,5%)	12 (3,7%)	-
70-74 years	M	-	29 (9,0%)	2 (0,6%)	6 (1,8%)	1 (0,5%)
	F	-	23 (7,0%)	6 (1,8%)	26 (8,0%)	3 (1,0%)
75-79 years	M	3 (1,0%)	23 (7,0%)	-	6 (0,5%)	1 (0,5%)
	F	3 (1,0%)	13 (4,0%)	2 (0,6%)	34 (10,5%)	-
80-84 years	M	-	10 (3,0%)	1 (0,5%)	4 (1,2%)	-
	F	1 (0,5%)	5 (1,5%)	-	22 (6,8%)	-
85-90 years	M	-	1 (0,5%)	-	1 (0,5%)	-
	F	-	-	-	5 (1,5%)	-

TABLE XXXVI. AGE AND ACCOMMODATION OF GERIATRIC ATTENDERS : NUMBERS AND PERCENTAGE.

AGE	SEX	FLAT	HOUSE	SINGLE ROOM	HOTEL/BOARDING HOUSE	OLD AGED HOME
60-64 years	M	-	-	-	-	-
	F	18 (5,6%)	3 (1,0%)	2 (0,6%)	1 (0,5%)	-
65-69 years	M	16 (5,0%)	9 (3,0%)	1 (0,5%)	4 (1,2%)	-
	F	24 (7,4%)	8 (2,5%)	-	4 (1,2%)	-
70-74 years	M	25 (7,8%)	9 (3,0%)	2 (0,6%)	1 (0,5%)	1 (0,5%)
	F	37 (11,5%)	11 (3,4%)	3 (1,0%)	4 (1,2%)	3 (1,0%)
75-79 years	M	11 (3,4%)	15 (4,6%)	4 (1,2%)	2 (0,6%)	1 (0,5%)
	F	24 (7,4%)	13 (4,0%)	3 (1,0%)	3 (1,0%)	9 (3,0%)
80-84 years	M	8 (2,5%)	3 (1,0%)	-	-	4 (1,2%)
	F	16 (5,0%)	6 (1,8%)	-	-	6 (1,8%)
85-90 years	M	-	1 (0,5%)	-	-	1 (0,5%)
	F	1 (0,5%)	3 (1,0%)	-	-	1 (0,5%)

TABLE XXXVII. AGE AND HABITAT OF GERIATRIC ATTENDERS : NUMBERS AND PERCENTAGE.

AGE	SEX	SPOUSE	BROTHER/ SISTER	CHILDREN	OTHER RELATIVE	NON-FAMILY	ALONE
60-64 years	M	-	-	-	-	-	-
	F	8 (2,5%)	2 (0,6%)	4 (1,2%)	2 (0,6%)	1 (0,5%)	7 (2,0%)
65-69 years	M	21 (6,5%)	1 (0,5%)	2 (0,6%)	1 (0,5%)	-	5 (1,5%)
	F	18 (5,6%)	1 (0,5%)	6 (1,8%)	2 (0,6%)	1 (0,5%)	8 (2,5%)
70-74 years	M	27 (8,4%)	2 (0,6%)	2 (0,6%)	-	4 (1,2%)	3 (1,0%)
	F	21 (6,5%)	1 (0,5%)	6 (1,8%)	3 (1,0%)	9 (3,0%)	18 (5,6%)
75-79 years	M	20 (6,2%)	2 (0,6%)	4 (1,2%)	-	4 (1,2%)	3 (1,0%)
	F	9 (3,0%)	2 (0,6%)	13 (4,0%)	-	10 (3,2%)	18 (5,6%)
80-84 years	M	10 (3,2%)	-	3 (1,0%)	1 (0,5%)	2 (0,6%)	-
	F	5 (1,5%)	2 (0,6%)	7 (2,0%)	3 (1,0%)	-	10 (3,2%)
85-90 years	M	1 (0,5%)	-	-	-	1 (0,5%)	-
	F	-	-	3 (1,0%)	-	1 (0,5%)	1 (0,5%)

ANNEXURE A.

GERIATRIC ATTENDANCE AT OUTPATIENTS DEPARTMENT ADDINGTON HOSPITAL

1 THE PROBLEM

Characteristics of geriatric attendance at Addington Hospital Outpatients Department (AOPD).

2 DEFINITION OF OBJECTIVES

(a) To determine the trend during the past 10 years of the number of geriatric attenders at AOPD.

(b) To ascertain in respect of geriatric attenders at AOPD

(i) their personal characteristics
(ii) the geographical area of residence
(iii) the reason for attendance

(c) To ascertain the attitudes of the medical and nursing staff to the management of geriatric attenders.

(d) To make recommendations in respect of the primary care of the geriatrics population in the greater Durban area.

3 DEFINITION OF CRITERIA

Geriatrics : Aged persons as defined by the Aged Persons Act (No 81) of 1967 of South Africa "that a male is an aged person at 65 years of age and a female at 60 years".

Illness : Is defined as "unwell, having pain, finds difficulty in leading a normal life" (Williamson 1966).

Addington Hospital Outpatients Department (AOPD) : The area of Addington Hospital which provides services for non-admitted patients.

Medical and Nursing Staff : Doctors and nurses who normally work in AOPD.

Personal Characteristics : Age, sex, marital status, race, accommodation, living with, distance from nearest child, area, type of pension, medical aid, care, means of transport, social and cultural and environment

4 SELECTION OF SAMPLE AND CONTROL GROUPS

(i) Sample : The sample will include every 5th patient who attends AOPD during the study period and who meets the criteria for inclusion in the study.

(ii) Controls : No control group will be drawn for the purpose of this descriptive study.

5 METHOD OF DATA COLLECTION

(i) Permisssion to carry out the study will be sought from the senior medical superintendent of Addington Hospital.

(ii) Statistics of the number of geriatric attenders at AOPD for past 10 years will be obtained from hospital records.

(iii) Every attender included in the sample will be interviewed prior to medical consultation and a standard questionnaire will be administered (Annexure A).

(iv) The attenders selected will be issued with a card with a large "S" written on it so as to facilitate subsequent identification.

(v) A pilot study to test the protocol and the questionnaire will be conducted and where necessary ammendments will be made.

(vi) The attitudes of the medical and nursing staff to the management of geriatric attenders will also be elicited by means of an interviewer-administered standard questionnaire (Annexure B).

6 REDUCTION OF BIAS

(i) A systematic sampling will be employed.
(ii) Interview of all attenders will be carried out by a single interviewer.
(iii) Standard questionnaires will be used.

7 SETTING OF TIME BARRIERS

(i)	Drawing of Draft Protocol and Questionnaire	21 June 1985
(ii)	Completion of Pilot study	05 July 1985
(iii)	Finalisation of Protocol and Questionaire	12 July 1985
(iv)	Completion of Data Collection	21 July 1985
(v)	Collation and Analysis of Data	31 July 1985
(vi)	Submission of Report	30 September 1985

8 APPRAISAL OF THE LITERATURE

Study of Government publications, medical journals and other relevant literature will be ongoing throughout the study.

9 COLLATION AND ANALYSIS OF COLLECTED DATA

(i) A standard prepared collation sheet will be used for this purpose.
(ii) Analysis will be undertaken manually using a pocket calculator.

5 PUBLICATION OF FINDINGS

A report on the above study will be submitted in partial fulfilment of the requirements for Part 1 of the M.Med.(Community Health) of the University of Natal.

ANNEXURE B.

QUESTIONNAIRE ON GERIATRIC ATTENDANCE AT AOPD

STUDY NO ☐

AOPD NO ☐

A PERSONAL CHARACTERISTICS

AGE (completed years)		☐
SEX	1=male; 2=female	☐
MARITAL STATUS	1=single; 2=married; 3=divorced; 4=widowed; 5=living together	☐
RACE	1=white; 2=coloured; 3=other	☐
ACCOMMODATION	1=flat; 2=house; 3=single room; 4=hotel/boarding house; 5=old age home	☐
LIVES WITH	1=spouse; 2=brother/sister; 3=children; 4=other relative; 5=non-family; 6=alone	☐
DISTANCE FROM NEAREST CHILD	1=living with; 2=under 5km; 3=5-20km; 4=>20km but <100km; 5=>100km	☐
AREA	1=Central Durban; 2=Bluff; 3=Amanzimtoti; 4=Durban North; 5=Berea; 6=Windermere; 7=Overport; 8=Sydenham; 9=Glenwood; 10=Umbilo; 11=Yellowwood Park; 12=Bellair; 13=Queensburgh; 14=Westville; 15=Pinetown; 16=Kloof; 17=Hillcrest; 18=Umhlanga Rocks; 19=Others 20=North, 21=South, 22=Inland	☐
TYPE OF PENSION	1=social; 2=military; 3=civil; 4=war veterans; 5=previous employment; 6=none	☐
MEDICAL AID	Do you belong to one ? (1=Yes; 2=No)	☐
	If yes, how much does it cover you per year ?	☐

B CARE

PHYSICAL

What health care have you used this year ? (Probe if necessary)

District Surgeon	☐
OPD	
Private GP	☐
Clinic Nurse	
Admitted to Hospital	☐

Reason for attendance today ? .....

.....

How do you get to Addington ? (1=walk; 2=bus; 3=taxi;
4=own car; 5=friend's car; ☐
6=voluntary body; 7=ambulance)

Is the health care you use adequate for your needs ?
(1=Yes; 2=No) ☐

What improvement would you like ? .....

.....

C SOCIAL AND CULTURAL

Would you like to attend a day centre where you could meet people of your age group and have a meal and a chat ? (1=Yes; 2=No) ☐

Would you like films or talks ? .....

What health services would you like there ? .....

.....

What social activities would you like ? .....

.....

Which one of the following services would you most like to have at the day centre:
(1=physiotherapy; 2=chiropody; 3=hairdressing; 4=dental care;
5=eye testing; 6=occupational therapy; 7=hearing tests) ☐

D ENVIRONMENT

Are you able to carry out your housework ? ☐

Do you need a home help ? (0=No; 1=daily; 2=2xweek; 3=3xweek) ☐

Would you like Meals on Wheels service ? (1=Yes; 2=No) ☐

Do your family visit you ? If yes, how often ?
(0=N/A (live with family);
1=daily; 2=twice weekly; 3=weekly; ☐
4=fortnightly; 5=monthly; 6=never)

Is your eyesight good ? (1=Yes; 2=No) ☐

Are you hard of hearing ? (1=Yes; 2=No) ☐

Have you a telephone ? (1=Yes; 2=No) ☐

Do you listen to radio ? (1=Yes; 2=No) ☐

Do you watch TV ? (1=Yes; 2=No) ☐

Do you listen to radio more than you look at TV ? (1=Yes; 2=No) ☐

ANNEXURE C.

ADDINGTON HOSPITAL OUTPATIENTS DEPARTMENT

GERIATRICS

EXPERT STAFF QUESTIONNAIRE

1 For how long have you worked in Addington Outpatients Department ? (years) ☐

2 Which age group of outpatients do you prefer to attend : (Tick one)

children ☐

young and middle-aged people ☐

elderly people ☐

3 Of patients you attend what percentage do you estimate to be over 65 years of age ? ☐

4 Do you consider that the health care needs of the elderly require different medical and nursing skills compared with other patients ? ☐

5 Do you consider that "geriatrics" is a "speciality" in its own right ? Yes | No

6 What do you find most pleasant about dealing with elderly patients ?

.....

.....

7 What do you find most unpleasant about dealing with elderly patients ?

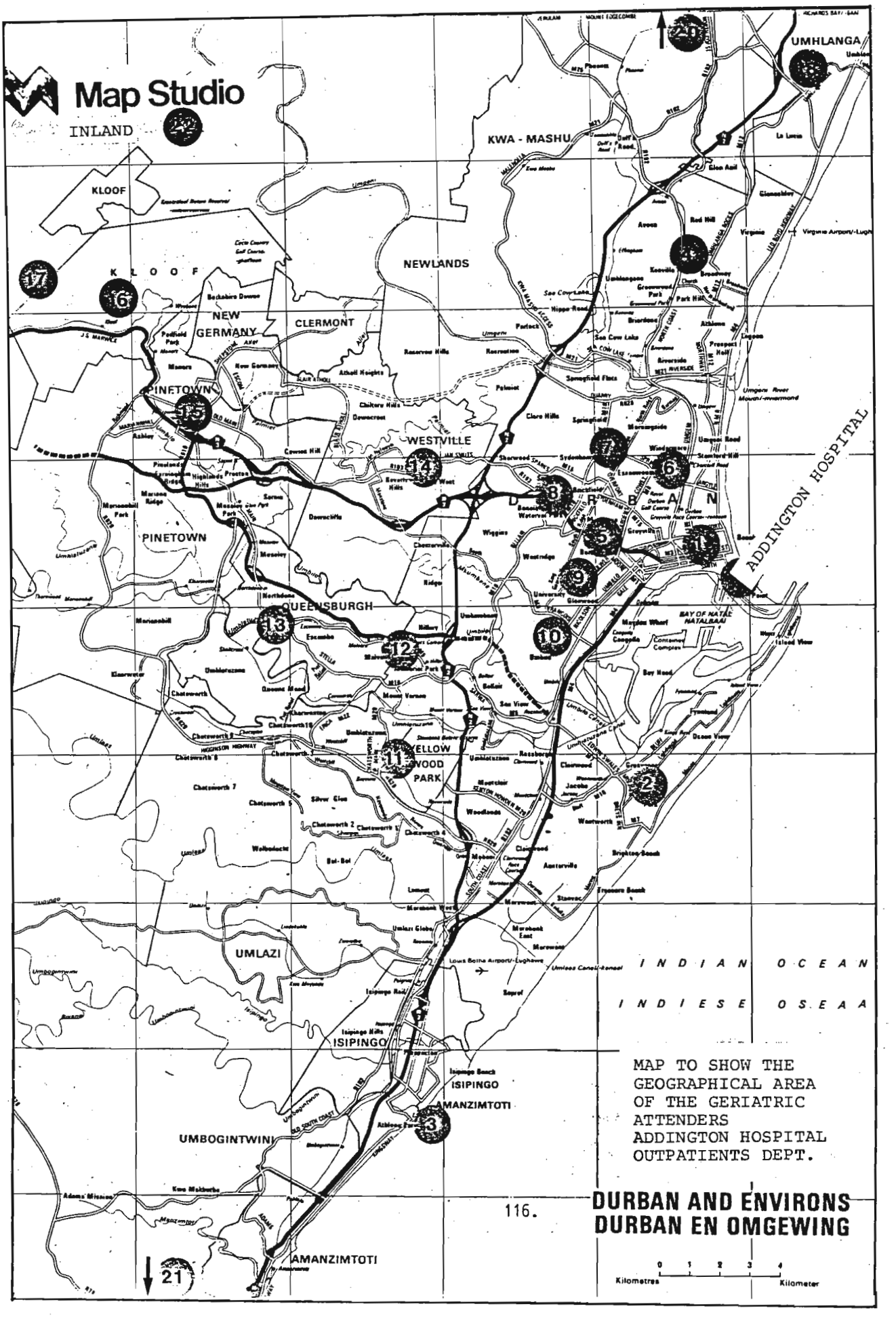
.....

.....

.....

8 Age : Please indicate your age group 0-49 yrs ☐ 50 yrs plus ☐

ANNEXURE D

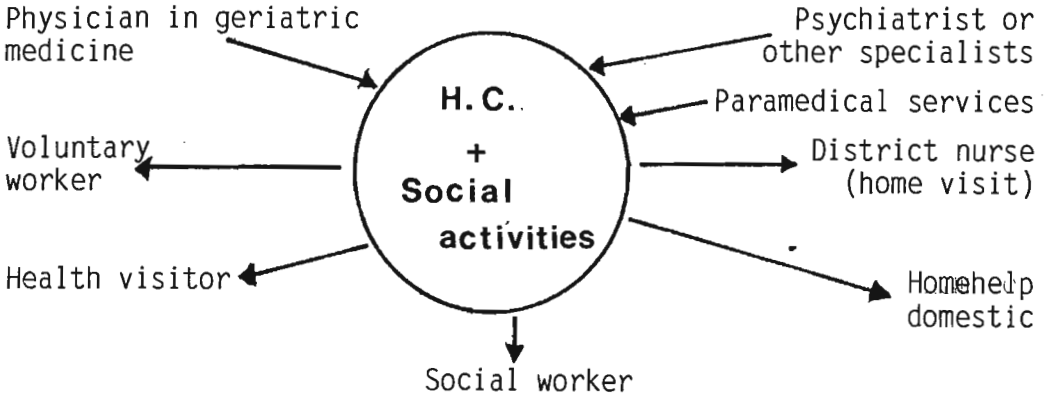

Map Studio
INLAND
UMHLANGA
KWA - MASHU
KLOOF
NEWLANDS
NEW GERMANY
CLERMONT
PINETOWN
WESTVILLE
QUEENSBURGH
YELLOW WOOD PARK
UMLAZI
ISIPINGO
AMANZIMTOTI
UMBOGINTWINI
ADDINGTON HOSPITAL
BAY OF NATAL
NATALBAAI
INDIAN OCEAN
INDIESE OSEAA
MAP TO SHOW THE GEOGRAPHICAL AREA OF THE GERIATRIC ATTENDERS ADDINGTON HOSPITAL OUTPATIENTS DEPT.
DURBAN AND ENVIRONS
DURBAN EN OMGEWING
Kilometres
Kilometer

AREAS

1. Central Durban
2. Bluff
3. Amanzimtoti
4. Durban North
5. Berea
6. Windermere
7. Overport
8. Sydenham
9. Glenwood
10. Umbilo
11. Yellowood Park
12. Bellair
13. Queensburgh
14. Westville
15. Pinetown
16. Kloof
17. Hillcrest
18. Umhlanga Rocks
19. Others
20. North
21. South
22. Inland

APPENDIX E. HEALTH OR DAY CENTRE (CO-ORDINATING SERVICE).

This ensures a one door service for all old people in a local community where they or their relations can go for advice or help if need arises.



ADOPTED FROM :

Sir Ferguson Anderson, Professor of Geriatric Medicine, University of Glasgow.

IDEA OF GERIATRIC CARE.