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Information for health now, with a happy retirement in view

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Few of us, other than by a contribution to a superannuation plan or pension's scheme, think positively about retirement. For many people retirement assumes the role of an enormous hurdle they will be forced to jump and with nothing but a gaping void on the other side.

Self planning of life is already built in to some societies, particularly in Scandinavian cultures, to a much greater degree than in this country. Here there is a failure to make available factual information about physical and psychological health aspects *throughout the whole of our lives,* particularly at times when people are sufficiently independent to make self-caring decisions. Under these circumstances an unplanned retirement can be a social catastrophe as devastating as unplanned pregnancy or redundancy and can assume the role of a bereavement to those who have made their work their whole life.

Premature retirement through redundancy is a major current problem and perhaps draws the attention of many members of the public to the difficulties of filling in unwelcome leisure time. Retirement is still regarded by many people no more imaginatively than as an unavoidable space of time between working, active and productive life, and death. It tends to be a time of increasing physical frailty and financial hardship and it is not surprising that many view it with terrible foreboding.

Few people arrange for their children to go to school prior to investigation of the facilities, few people leap into marriage lightly and few people start a family without some form of planning. Neither should the major step of retirement be taken without appropriate planning. Retirement brings an abrupt end to the disciplines and obligations of a working life and is often not taken at the moment most appropriate to the individual. It has been suggested that approximately 75% of employed people say they look forward to approaching retirement. When it actually arrives only 30% actually say it is what they expected and that they are enjoying it. The realization of the event often appears to fall short of expectation and in some cases people become obsessed with old age, infirmity and impending death and retreat into despair and apathy. At the other end of the scale are those who in the early stages remain grossly over optimistic about what they can achieve, take no proper account of their financial situation and the constraints of an older body and attempt too much, fail and experience an even worse reaction to the whole process.

It is clear from this overall view of the trauma of retirement that work *itself* does not prepare one for retirement. A definite scheme of pre-retirement preparation during working life should be able to help relieve the traumatic experience and ease the transition from one stage to the next. The earlier this is thought about the better as there are areas which are amenable to forward planning and where the provision of helpful instruction will lead to a positive approach through better understanding.

The rules of self-help for the preservation of health do not come into operation solely at the time of preparation for retirement nor suddenly on the first day of retirement. The sight does not dim nor the joints stiffen up, the bowels do not become constipated nor the bladder incontinent one day after the 65th birthday. Many of the medical problems which assail the retired person are a result of many years of physical neglect. What is needed is a positive approach to personal health, not solely as a preparation for old age but to develop a life pattern that encompasses much more than simply doing an everyday job and supporting the home. It requires a concentration on healthy and stimulating pastimes and an awareness of bodily functions and how to care for them throughout the whole of adult life. This message often cannot be got across and panic measures are often taken too late. Furthermore it is not easy to separate those matters which are strictly physical problems from those which could be called psychological or result from life experience. There are a number of easily identifiable physical problems which produce difficulties in later years.

Hearing

Poor hearing leads to social isolation in later life. Unfortunately, relatively few of the causes of deafness are amenable to treatment. What can be done is to remind people of the risks of deafness due to occupational noise and press for regular hearing tests for those at risk. It is important to make sure that the ears are kept clear of wax and any question of loss of hearing should lead to simple examination and cleansing of the outer ear. Getting people to wear a hearing aid where this is appropriate is notoriously difficult but when successful an aid can make a remarkable impact on social isolation. Information on the different models of hearing aid rather than insistence on remaining with an NHS model may offer a way forward, although technically the National Health Service aid is a good instrument. Where deafness is already profound in earlier or middle adult life then the tolerance and camaraderie of a known working environment is lost at retirement. Planning ahead by making contact with local organizations for the deaf is to be recommended and information should be available about the names and addresses of local contacts and an introduction made before retirement.

Eyesight

There are a number of ocular conditions which can be remedied. Opticians detect some of the medical conditions in the eye although their principal task is to provide spectacles for the eye as it stands. It is therefore incumbent upon us to encourage older people to ask for an *expert medical opinion* on their eyesight if there is any question of progressive deterioration.

The question of domestic lighting from the point of view of easier reading and safety in the home, is greatly understated and any documentary advice about vision should include or be supported by recommendations for proper illumination. Advice about the benefits of registration as blind or partially sighted can be helpful.

Diet and health

Useful advice about maintaining regular bowel actions by dietary methods is often ignored. The problem of fats and health has been well publicized but by the time retirement comes damage due to a lifetime of inappropriate eating is unlikely to be rapidly corrected. Increasing the fibre in the diet to maintain good bowel action is never too late and correcting the fibre intake for its purely mechanical effect in the bowel may remove the need for laxatives in later life. Many problems of incontinence in later years could be resolved if people would follow advice to increase the amount of fruit, green vegetables and bran in the diet.

The problem of malnutrition in the lonely and those unable to shop and cook for themselves has been very well explored and publicized. Diet sheets for *simple*, easily prepared, properly balanced meals, consisting of small quantities of fresh food are invaluable. Complex diet sheets involving endless preparation or involving expensive foods are largely irrelevant to those approaching retirement. Weight in old age is a very vexing problem. Elderly people may reduce weight whilst in controlled hospital situations but this is rarely maintained after they return home. Weight control is a matter for middle age rather than the immediate pre-retirement period.

Preventive dental treatment prior to retirement should include a dental check for the removal of loose and damaged teeth, clearance of gum infection and the fitting of appropriate dentures if required.

Incontinence

Approximately 50–60% of any group of adult women will have been incontinent at some point. The concealment and acceptance of this situation can only lead to further deterioration in bladder control and may lead to isolation during retirement if the problem is worsening and the person is frightened to leave the house and go out into company. Approximately half the people with incontinence of urine can be completely cured and the vast majority of the others will see considerable improvement in their situation if provided with devices or appropriate clothing which will give them greater freedom. This type of information is not widely available to the public. Time should be invested in finding ways to help people overcome their understandable embarrassment and to encourage them to ask about this problem. Information could be transmitted, for example, through the district nurse or through a nurse with specialist knowledge of incontinence problems; through posters and handbooks which help the patient to understand why incontinence may have occurred, and examples of simple measures which can be taken to cope with the situation. There is often a need for medical advice and the fact that this is available should be publicized. One of the greatest problems which remains is communicating the information about the management of incontinence to the medical profession itself. The patient with a dribble will not necessarily get a sympathetic hearing on going to see the family doctor. The patient must be armed with the right questions to ask and encouraged to ask a second opinion.

Mobility

The wearing of damaging footwear by young people and would-be elegant middle-aged ladies causes problems for later years. Advice about footwear and chiropody services for the younger age groups must be made more readily available. A regular appointment with a chiropodist on at least an annual if not a three- to six-monthly basis is valuable for middle-aged and retired people. This will cost anything from £5 upwards for those who go privately. Chiropody services are not well funded in the Health Service. It might be more realistic to develop a simple advice sheet on home footcare.

Arthritis and rheumatism are the main culprits in joint pain leading to diminished mobility and full assessment and proper treatment are the realm of the doctor and the physiotherapist. There is no doubt that sensible exercising in the home or in clubs is helpful and should be recommended.

Safety in the home

This is highly relevant to preservation of good health. Much useful advice can be given by a good occupational therapist, however, it is too late in the day to give practical advice for the rehabilitation of a lady who has already fallen and broken her hip because she did not realize the risks of her slip mats at an earlier stage. It is difficult to change the habits of a lifetime when it comes to handling cooking and heating equipment and to the re-arrangement of furniture. There is widespread ignorance about the best height of bed and seating furniture and its relationship to safety and mobility in the home. Simple advice of this nature and an address where the community occupational therapist's advice can be obtained is a necessary part of health care.

I have touched only on some of the most important physical problems facing people who are growing older and facing retirement. From the psychological point of view the most important matter is a positive view of retirement and the *advantages* gained by freedom to occupy one's time without constraint of regular working hours, the absence of fatigue caused by work and the wearing effects and frustrations associated therewith should be emphasized. The greatest problems arise for many who see success, conscientiousness and reliability as important goals during their working life. These virtues could positively mitigate against a successful retirement if not properly harnessed. The general practitioner can do much in this direction by learning to enquire about those people in his practice who he knows must be about to retire or by making a positive effort to see those who have been made unexpectedly redundant without prospect of re-employment. Ideally he should try to have useful discussion on a positive basis while undertaking a general health screen. We use the voluntary services increasingly in the care of those who can no longer look after themselves. Encouraging retired people to give at least a period of their earlier retirement to voluntary work in meals-on-wheels, Church and local political organizations, charitable and money

raising events and encouraging them to understand that their enormous experience gained through life will be invaluable in helping others in great need is surely the direction we should be taking. Social benefits to the individual belonging to such a group are enormous and can realistically compensate for the loss of the social contacts at work.

General practitioners have been put under pressure to do this kind of work although it comes with some reluctance as there is no doubt that a five minute consultation is no use for this kind of problem. The use of the health visitor to carry out such research and as a vehicle for information, at least in initial exploratory discussions, might be a more realistic approach for the future. We should look, therefore, to how well we are passing information on later adulthood into the health visitor specialty, a service which has been heavily committed for so long to the very young.

It is very ambitious to set up a full scale pre-retirement course involving other agencies such as social workers, tax experts and local housing officers, but these patterns of involvement of experts are on the increase and represent another way to get more detailed and extensive information across to a receptive public. The problem remains with those people who are in need of the appropriate advice but who will not seek it out for themselves or whose firms have not made arrangements for them to have pre-retirement counselling. Television and radio are beginning to take up the role of counsellors in these areas and there are, of course, suitable magazines which are running appropriate series. Hopefully, those who have benefitted from the growing body of knowledge will pass on the information by example to their children and grandchildren and one would then expect that the demands for more detailed information on self-care will gradually increase.

We must face up to the fact that the average person may now spend up to 30% of his or her life in retirement and the medical profession must be prepared to play its part in giving advice at a timely stage rather than moralizing and pontificating on the consequences of a mis-spent middle-age. Towards this end, we are trying in Bath to establish an Information Centre for older people. We are compiling small packages on each of the important health aspects which can be a problem in later years. We hope that these will include a spectrum of advice ranging from general measures which can be taken to cope with the problems without referral to specialists but with strong indicators as to when specialist advice is necessary or when contact with specialist voluntary organizations would be helpful. Our idea is that these packages should be displayed in an area through which all patients, visitors and professional staff visiting the hospital will pass. The material will be on both a take-away basis and for reference so that those who are too reluctant to ask for help will not be denied access to the information. All patients discharged from the unit will be shown what is available and the Information Centre will be used as an educational tool for all junior doctors and nursing staff. In due course access to a wider public is planned in association with voluntary organizations in Bath. The rural hospitals will ultimately have a representative selection of packages and the facility to refer to the main centre.