A SOCIOLOGICAL REVIEW AND APPLICATION OF ILLICH'S THEORY OF IATROGENESIS WITH SPECIFIC REFERENCE TO PROBLEMS CONCERNING THE AGED

by

MARLIEN PORTER

(née LEMMER)

submitted in fulfilment of the requirements for the degree of

MASTER OF ARTS

in the subject

SOCIOLOGY

at the

UNIVERSITY OF SOUTH AFRICA

SUPERVISOR: PROF. S. MARAIS
JOINT SUPERVISOR: DR. V.I. MCKAY

NOVEMBER 1994

With love and appreciation to my parents

"Rise in the presence of the aged, show respect for the elderly and revere your God. I am the LORD."

- Leviticus 19: 32 -

The financial assistance of the Human Sciences Research Council towards this thesis is hereby acknowledged. Opinions expressed in this thesis and conclusions arrived at, are those of the author and cannot be attributed to the Human Sciences Research Council.

I declare that **A SOCIOLOGICAL REVIEW AND APPLICATION OF ILLICH'S THEORY OF IATROGENESIS WITH SPECIFIC REFERENCE TO PROBLEMS CONCERNING THE AGED** is my own work and that all the sources that I have used or quoted have been indicated and acknowledged by means of complete references.

M Porter
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SIGNATURE
(M. PORTER)

1994-11-30
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DATE

ACKNOWLEDGEMENTS

I would like to thank my God and Lord Jesus Christ for the grace in allowing me to complete this work, while teaching me so much about life through this study. SOLI DEO GLORIA.

A number of people deserve acknowledgement for their help and support in making this study a reality. I would like to express my sincere thanks to the following persons:

Professor Sandra Marais, my supervisor, for wisdom, patience and guidance. I appreciate your help, encouragement and friendship.

Doctor Veronica McKay, for wise council, sound advice, inspiration, as well as for acting as joint supervisor.

Annekie Jansen, for typing the thesis. Your excellence and hard work is greatly appreciated.

Talana Erasmus, for faithfully compiling bibliographies and searching for books and articles.

Roger Loveday, for meticulously editing my work.

Mike Sarakinsky, Veronica McKay and Berra Kemp, for help in completing the graphs.

Professor Jan Pretorius, Professor Tina Uys and Charles Puttergill, for time and effort in reading and commenting on sections of my work.

The respondents of this study, for your co-operation, as well as your time and hospitality. Without you this study would not have been possible.

Colleagues and friends in the Sociology Department, UNISA, for guiding my thoughts through listening, reading and commenting. I appreciate your invaluable contributions.

Gavin Porter, my husband and best friend, for patience, understanding and many ways of concrete assistance.

My parents, Rus and Sonia Lemmer, for love, encouragement, interest and various ways of assisting and supporting me.

My sister, Estelle de Villiers and her family, James, Jamesie, Lemmer and Nicole, for always being a great source of encouragement and inspiration.

Hilary Davis, Anette Benadé and Sandy Franz, for interest, prayers and commitment through the years.

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ABSTRACT

Illich, a critic of the medical profession in industrial societies, researched the "damage done" by the medical establishment on three levels. This study presents an application of Illich's three-level theory of iatrogenesis to a sample of elderly people in old-age homes in and around Pretoria. Fifty in-depth interviews were conducted with old-age home residents. In the focus on clinical iatrogenesis, the aspect of defenceless patients was investigated. With regard to social iatrogenesis, focus was on the interpretation of attitudes revealing an increased medical dependency. Cultural iatrogenesis, which involves the influence of values and norms on thinking patterns, is investigated in terms of the impact of institutionalisation on the autonomy, independence and personal responsibility of residents. Illich's solution to the problem of medicalisation is to be found in the de-bureaucratisation and de-industrialisation of society. Based on the assumptions of critical theory, the emancipation of the individual is suggested as a basis of Illich's proposed structural societal changes.

KEY TERMS

Medicalisation; Iatrogenesis; Polymedication; De-bureaucratisation; Elderly people; Old-age homes; Institutionalisation; Radical monopoly; Medical bureaucracy; Medical establishment; De-professionalisation; Personal autonomy.

TABLE OF CONTENTS

Page

CHAPTER THREE:

MEDICALISATION AND THE ELDERLY

Page

CHAPTER SIX:

CONCLUDING REMARKS AND RECOMMENDATIONS

Page

LIST OF TABLES

Page

LIST OF FIGURES

CHAPTER ONE:

STATEMENT OF THE PROBLEM AND PURPOSE OF THE STUDY

1.1 INTRODUCTION

> The true miracle of modern medicine is diabolical. It consists in making not only individuals but whole populations survive on inhumanly low levels of personal health (Illich 1976a: 275).

Industrialised people have become accustomed to taking some or other form of medicine for even the slightest complaint. Various authors, such as Illich (1976a), Kennedy (1983), and McKeown (1979), have described this phenomenon and called it *medicalisation*. The following question can possibly be regarded as the essence of the medicalisation debate: Is medication *the only* effective solution to the problem?

The aims of this study are twofold. First, the phenomenon of medicalisation will be explored with an emphasis on the *medicalisation of elderly people*. The reason for this emphasis is that elderly people are particularly vulnerable to medicalisation. As a result of the aging process and their deteriorating physical condition, elderly people take more medicines than any other age group and they are therefore at risk of suffering from the consequences of excessive medicalisation which frequently exerts a detrimental influence on their quality of life.

Second, this study aims at investigating whether institutionalisation in an old-age home contributes to the medicalisation of elderly people. The

fact that many old-age homes are equipped with frail-care units, raises the question of whether elderly people *not* in need of medical services might request such services only because of their availability.

It is often suggested that many elderly people take handfuls of tablets daily without knowing the purpose of each pill. This could be the result of socialisation from childhood to take a tablet for every problem. In the opinion of the author, this practice is both dangerous as well as sad, especially when viewed in the light of the loss of autonomy among the elderly and their consequent diminishing interest in personal health matters.

Illich's (1976a) sharp criticism of the way in which the medical profession operates is evidenced in the introductory sentence to his book, *Limits to medicine. Medical Nemesis: the expropriation of health* (hereinafter referred to as *Medical Nemesis*). He states (1976a: 11): "The medical profession has become a major threat to health", and his interest is specifically focused upon the phenomenon of medicine becoming an integral part of life to the extent that some people become dependent on it. A detailed discussion of Illich's theory will follow in chapter 2.

1.2 ASSUMPTIONS UNDERLYING THE INVESTIGATION

The research expectations underlying the investigation are derived from the following assumptions:

- Elderly people in old-age homes suffer from clinical iatrogenesis as a result of their ignorance about their own medication practices.

- Elderly people in old-age homes suffer from clinical iatrogenesis as a result of their ignorance about the adverse effects of the medicines they use.

- Elderly people in old-age homes suffer from clinical iatrogenesis as a result of their ignorance about their own health problems.

- Elderly people in old-age homes suffer from social iatrogenesis as a result of uncritical approaches towards taking medicines.

- Elderly people in old-age homes suffer from social iatrogenesis as a result of indifference towards improvement of their health and prevention of disease.

- Elderly people in old-age homes suffer from social iatrogenesis as a result of social dependence on their doctors.

- Elderly people in old-age homes suffer from cultural iatrogenesis in terms of a loss of control as a result of staying in an old-age home.

- Elderly people in old-age homes suffer from cultural iatrogenesis in terms of a loss of privacy as a result of staying in an old-age home.

- Elderly people in old-age homes suffer from cultural iatrogenesis in terms of a loss of independence as a result of staying in an old-age home.

1.3 DESCRIPTION OF KEY CONCEPTS

1.3.1 Elderly people

In South Africa an aged person is described in *The Aged Persons Act, Act 81 of 1967*, as "a male person of 65 years or older, or a female person of 60 years or older." In contrast with this legal description, the concept "elderly people" is, for the purposes of this study, described as any person, whether female or male, of 65 years or older.

1.3.2 Iatrogenesis

The concept "iatrogenesis" is derived from the Greek *iatros*, which means "physician", and *genesis*, which means "origin" (Illich 1976a: 3). Illich (1976a: 3) employs this concept to describe what he terms a "new epidemic" caused by the medical profession in the process of treating or curing people. Iatrogenesis is thus defined as the detrimental impact of modern medicine on society.

According to Illich (1976a: 8), it is impossible to understand the concept of iatrogenesis unless it is seen as the "specifically medical manifestation of *specific counterproductivity*". In other words, he regards iatrogenesis as a negative process in the physical, social and cultural spheres of life. In a systematic way Illich describes the harm done by modern medicine (iatrogenesis) by using three separate categories, i.e. clinical, social and cultural/structural iatrogenesis.

This study aims to investigate these three levels of iatrogenesis among a sample drawn from a population of white elderly people in old-age homes in and around Pretoria. For reasons which will be mentioned in chapter 4, this study was limited to white people only.

1.3.3 Modern medicine

In this study, the concept of "modern medicine", as understood by Illich, will be employed. Following Illich, the comprehensive application of this concept refers to the orthodox approach to medicine in both the treatment of disease and the provision of medical care in modern societies.

Twaddle and Hessler (1977: 77) locate the origins of modern medicine in the so-called germ theory. They point out that:

> The discovery of germs marked a dramatic shift in medicine

> from a people-oriented to a disease-oriented profession. Physicians became absorbed in the study of disease, and their mission and training shifted from the care of sick people to the diagnosis and cure of disease.

The implication of this shift is that treatment was transformed into a technical efficiency. The human being failed to be acknowledged as a whole person and was regarded as a physical machine.

According to Doyal and Pennell (1981: 12), the positivist principles to which modern medicine subscribes, may be encapsulated as follows:

> It is assumed that it is possible to separate the doctor from his/her subject matter (the patient) in much the same way as a natural scientist is assumed to be separate from his/her subject matter (the natural world), and medical progress is said to be based on the use of the "scientific method" which supposedly ensures certain and objective knowledge.

The point that Doyal and Pennell make is that modern medicine resonates with the principles of positivism. In practice this implies that the doctor (who has access to objective knowledge) is separated from the patient - a practice whereby the patient is excluded as a participant in the medical encounter. In this sense, the view of Doyal and Pennell echoes the suggestion by Twaddle and Hessler cited above, namely that the shift towards technical efficiency results in the patient being regarded as a "human machine".

The concept "modern medicine" or "professionally organised medicine", as used by Illich may, in the same way, be compared to what Capra (1982: 118) terms "the biomedical model". This concept is synonymous with that of the orthodox approach referred to earlier. Capra (1982: 119) describes the most serious shortcoming of the biomedical approach in the following words:

> By concentrating on smaller and smaller fragments of the

> body, modern medicine often loses sight of the patient as a human being, and by reducing health to mechanical functioning, it is no longer able to deal with the phenomenon of healing.

This so-called biomedical model resulted from the influence of the Cartesian paradigm on medical thought, i.e. that

> the human body is regarded as a machine that can be analyzed in terms of its parts; disease is seen as the malfunctioning of biological mechanisms ... [and] the doctor's role is to ... correct the malfunctioning of a specific mechanism (Capra 1982: 118).

1.3.4 Medicalisation

The concept of medicalisation refers to the process by which different areas and facets of life are increasingly being subjected to medical definition and intervention. The concept therefore refers to the increasing role played by modern medicine in the everyday lifeworld of people. The medicalisation of society is thus also regarded as an extension of the role of modern medicine. This view of medicalisation is debatable and various authors have different opinions about it.

According to Zola (in Abercrombie et al. 1988: 153), medicalisation refers to the increasing attribution of medical labels to behaviour which is regarded as socially or morally undesirable. In this sense, the emphasis is mainly on socio-pathological behaviour such as alcoholism. The implication is that modern medicine can cure all problems when these problems are acknowledged and labelled as "diseases". For the purposes of this study, Zola's definition is not sufficient since he employs the concept of medicalisation in a limited way. No reference is made to general medical treatment, for example, the treatment for colds. General medical treatment accounts for the greater part of medicalisation. It

defines, not only socio-pathological behaviour, but also problems which are truly medical.

In his conception of modern medicine, Michel Foucault (in Kennedy 1983: 6) argues that a new kind of power relationship came into being in modern society. With regard to modern medicine in general, he points out that too often no clear dividing line exists between *an interest in the well-being of others*, and *control over their lives*. He suggests that medicine constitutes a form of control over the lives of people at the cost of their well-being and autonomy.

Kennedy (1983: viii) also raises certain questions concerning the ways in which medicine is conceived and practised. He points to what he regards as a problem, namely that medicine as both profession and discipline is a political enterprise. He mentions the power of and competition in, for instance, the pharmaceutical industry in advertising and representing products to the extent that people might become aware of certain medicines on television and start using these. Kennedy (1983: ix) draws the attention to the need for greater individual responsibility towards life and health.

McKeown (1979: xv) too regards medical science and services as problematic in modern life. He argues that society's investment in health is not properly appropriated. The reason for this, McKeown indicates, is that medical science rests on an incorrect assumption concerning the foundation of medical care, namely that the body is viewed as a machine of which protection against disease is primarily dependent on intervention by means of, for example, surgery or drugs. According to McKeown (1979: xvi), this approach has led to indifference to health in general. Furthermore, McKeown (1979: 177) argues that, as a result of this approach, doctors are inclined to overestimate the effectiveness of their interventions, while, at the same time, they underestimate the risks involved.

It is evident that each of the above-mentioned authors focuses on a particular aspect of modern medicine:

- Zola emphasises the role of modern medicine in socio-pathological behaviour.

- To Foucault, modern medicine represents a power relationship to control people's lives.

- Kennedy regards modern medicine as a political enterprise.

- McKeown views modern medicine as being based on the positivist assumption that the body is a machine.

Except for Zola, who does not explicitly criticise the power of modern medicine to harm people in some or other way, one central thought that is common to these criticisms of modern medicine is the belief that medicalisation represents an ill-considered, unethical and careless exercise of power over people which causes them to lose control over the state of their own health.

It could be argued that Illich offers a comprehensive view of medicalisation which includes the above-mentioned views. Illich vehemently criticises the medicalisation of modern society and argues that excessive medical intervention is the cause of worldwide dependence on health care. According to him, a medical "throne" is built "... which is one of the threats to the real life of human beings - a threat which so far has been disguised as care" (Illich 1975a: 73). Illich therefore directs his attack towards the medical profession itself. Medicalisation, he argues, results in depriving the individual of autonomy and responsi- bility for his/her own health. According to Illich, people reach a stage where they become unable to function independently of the medical profession. Illich argues that life in its entirety - from before birth until after death - is being consolidated into the hands of the medical profession. Illich's view of medicalisation is discussed in detail in chapter 2.

1.3.5 Health

The concept of health has had so many different meanings in different ages that it would be beyond the scope of this thesis to define them all. Capra refers to the relative nature of the concept of health. He stresses that the notion of health is informed by one's view of the human organism as well as by the context of time and space. As Capra (1982: 119) puts it:

> What is meant by health depends on one's view of the living organism and its relation to its environment. As this view changes from one culture to another, and from one era to another, the notions of health also change.

Illich too refers to the cultural relativity underlying the concept of health. Illich (1976a: 134) describes the coincidence of culture with the definition of health as follows:

> Each culture gives shape to a unique Gestalt of health and to a unique conformation of attitudes towards pain, disease, impairment, and death ... Each person's health [implies] a responsible performance.

Given Illich's critical position, it can be assumed that the above responsible performance rests on the shoulders of the individual and not on the medical profession.

The World Health Organization (WHO) defines health as "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity" (Capra 1982: 119). Although this WHO definition can be regarded as somewhat unrealistic (because it pictures health as a static state of perfect well-being), it nevertheless conveys an ideal of the holistic nature of health. This ideal is closely linked to specific principles of healing and is in vivid contrast to the principles underlying the orthodox approach or biomedical model.

Illich (1976a: 14) also proposes a holistic conception of health: he describes health as "an everyday word that is used to designate the intensity with which individuals cope with their internal states and their environmental conditions". However, for Illich (1976a: 14), the responsibility for "health" does not entirely rest on the shoulders of the individual, but also implies ethical and political actions:

> The health of a population depends on the way in which political actions condition the milieu and create those circumstances that favor self-reliance, autonomy, and dignity for all, particularly the weaker.

By focusing on a variety of dimensions of health such as physical, psychological, and social health, Illich comes to define health as both a right and a virtue. It can be argued that his holistic view of health mirrors the entire social and cultural system. In this sense health can never be represented by single indicators such as the death rate or life expectancy.

Throughout this study the concept of health will refer to the holistic notion which opposes the germ theory idea that illness is the result of micro-organisms invading the human machine.

1.3.6 Polymedication

This concept refers to the use of a variety of medicines at the same time. Multiple states of disease and disorders frequently lead to multiple drug use or polymedication. Lenhart (1976: 135) provides the following summary of geriatric conditions for which drugs are most frequently prescribed:

- Heart problems
- Hypertension
- Arthritis

- Mental and nervous conditions
- Gastrointestinal disorders
- Urinary tract infections
- Diabetes
- Coughs, sore throats, influenza
- Circulatory and related foot conditions
- Chronic skin conditions

Although polymedication provides a convenient basis for the misuse of medicine, it should be stated clearly that the misuse of drugs cannot as such be included in the definition of or attributed to polymedication. Raffoul (1986: 197) defines drug misuse as "the inappropriate use of drugs, [and the resultant] negative effects [thereof] on the user". For the purposes of this study, special attention will be paid to the drug taking practices of the elderly consumer.

According to Page (1988: 45), the use of drugs increases with age: "It is clear that both prescription drugs and over-the-counter (OTC) drugs multiply in older people." In a typical study conducted by Page (1988), 83% of persons age 60 or more were using two or more prescription drugs, and 70% were also taking OTC drugs. The problem created by polymedication in elderly people is that older drug users are prone to err in their management of drugs and "many errors are potentially serious" (Page 1988: 46).

The extent to which medication is overprescribed for the elderly is difficult to analyse, as a certain drug regime is related to "highly individual factors and dependent on the individual physician's clinical expertise" (Gianetti 1983: 262). Although physicians and other health professionals do not receive sufficient specialised training in both gerontology and pharmacology, the purpose of this study is not to evaluate the efficiency of the doctor, but to investigate whether institutionalised elderly people suffer from negative effects due to polymedication and, by implication, medicalisation.

1.3.7 Old-age home

The concept "old-age home" is defined as comprising a physical location where elderly people live together on a permanent basis, staffed by personnel necessary for the smooth functioning of this organisation. When entering an old-age home, "a new resident is faced with an institutional setting and a congregate living environment ... he or she must now operate according to [a new] schedule, so that the facility can accommodate the needs of all of its residents" (Fried et al. 1993: 145).

A special specification is made for the purposes of this study: only old-age homes equipped with frail-care units are included. A specific qualification for the study is, however, that respondents have not been admitted to these units, and were not therefore in immediate serious need of fulltime medical attention. They merely had at their disposal professional medical personnel, as well as the opportunity to, when necessary, be admitted without delay.

1.3.8 Institutionalisation

In this study, institutionalisation does not refer to the sociological process of social practices becoming continuous. Rather, this concept simply refers to the placing of elderly people in institutions. Lieberman (in Van Zyl 1980: 8) defines an institution as being "a residential facility providing one or more central services that meet some particular need of the client and/or society".

Fried et al. (1993: 145) refer to both the negative and positive effects of long term institutional care for the elderly: "relocation means parting with treasured keepsakes, one's home, one's neighbourhood, one's friends ... [This leads to] feelings of loss, fear, isolation, and confusion." On the other hand, for many older adults "taking care of a home, shopping, and preparing meals becomes difficult, and there is a sense of relief over being able to relinquish these responsibilities"

(Fried et al. 1993: 145).

For the purposes of this study, it is assumed that institutional care of the elderly is common in industrialised societies with large populations of elderly people. In the light of this, the study aims, inter alia, to investigate whether institutionalisation contributes to the misuse of medication among elderly people, and therefore also to investigate whether old-age homes have any significant role to play in the medicalisation of the aged.

1.4 THE SOCIOLOGICAL RELEVANCE OF THE STUDY

The use of medicine among the aged and an institutionalised elderly population is becoming a universal phenomenon in industrialised societies. As a result of the aging process and the various related health conditions, elderly people are more prone to medicalisation than any other segment of society. Chronic disease and disability constitute a large proportion of health problems among the elderly. The treatment of geriatric multiple pathologies has given rise to new problems resulting from the utilisation of new and powerful drugs that may produce ill effects in themselves or in combination with each other. Hence the danger of clinical iatrogenesis or physical damage in the elderly population.

It is often found that elderly people in Western industrialised cultures are lonely and isolated because of an unsuccessful disengagement process after retirement, loss of significant roles, institutionalisation, loss of a spouse, and so on. These feelings of alienation may cause elderly people to misuse medication for psychological reasons. So-called social iatrogenesis or medicalisation of life due to addiction, constitutes a problem, particularly for the elderly population in industrialised countries. For these people, old age has become a distressing ordeal.

By contrast, among some peoples and cultures, especially those in traditional societies, the elderly have traditionally occupied a position of respect. In countries of the World Health Organisation's South-East

Asia Region, for example, the elderly have traditionally enjoyed a privileged place: they have been revered and their advice has been sought on matters ranging from the sowing of crops, a marriage in the family, or the settling of a village dispute, to prescribing a remedy for a stomachache (Toth 1985: 4). Also, among the Tiriki tribe of Kenya, grandparents and other old people play a dominant role in the informal instruction of children. Grandchildren in their turn come to view grandparents, not only as very kind and pleasant people, but as the storytellers and tutors of worldly wisdom, and, most importantly, as the people they can depend on to help in times of real trouble or distress. Similar examples of respect towards senior citizens are also found among the Kung Bushmen of the Kalahari Desert, the Chagga in Tanzania, the Aborigines of Australia, and among peasant people of Yugoslavia, India and Arabia. The Chinese philosopher, Lin Yutang, wrote a few decades ago:

> How can one be thought wise unless one is thought to be old? The symphony of life should end with a grand finale of peace and serenity and material comfort and spiritual contentment, and not with the crash of a broken drum or cracked cymbals (Toth 1985: 6).

It seems as though the affluent Western world's values have changed. The tendency is to stereotype older people as forgetful, less productive, stubborn, slow and inflexible. When this is done, older people are thought of as "non-people".

Psychological factors related to drug misuse are highly individualised and may, according to Raffoul (1986: 200), be summarised as the loss of employment, decreased physical abilities, loss of family and friends, and the development of negative attitudes to growing older:

> For some, old age is a time of introspection and social withdrawal that can result in reliance on drugs in response to

> psychosomatic illness or in the misuse of antidepressants and sleeping pills.

Structural iatrogenesis results when people lose their autonomy over health matters, as well as their responsibility for individual issues concerning health. Major themes in the process of institutionalisation seem to be the uprooting of the older person from his or her old and familiar environment, as well as experiences of new relationships and a new way of life.

> Thus, admission to an institution inevitably creates the dual problem of separation from the individual's previous home, his/[her] family, and community, and adjustment to group living in an institution, which involves a change of role (Van Zyl 1980: 2).

It can furthermore be argued that old-age homes establish a specific routine, and although residents may make minor decisions, in most instances they have little say in the timing of meals or the kinds of recreation they pursue. They therefore, to some extent, lose control over daily decisions. For these residents, the loss of autonomy begins after admission. According to Retsinas and Garrity (1988: 59), literature on the effects of institutionalisation suggests an inevitable iatrogenesis characterised by, inter alia, induced dependence and loss of autonomy. Given the specific medical sociological field of this study, attention will also be paid to structural iatrogenesis from a medical point of view, in other words, the loss of autonomy over their personal health as experienced by the aged.

Binney et al. (1990: 761) state that any discussion of aging and the aging process is often linked to a discussion of aging as a health and medical problem. This refers to the tendency of *medicalising* human affairs and making it a medical problem. The term "medicalisation" is increasingly being used by critics of the medical profession.

In view of the above arguments, and because sociologists have for a long

time been involved with the problems encountered by elderly people in industrialised societies, it is hoped that the present study will make a contribution to the sociological input in improving the quality of life for elderly people.

1.5 EXPOSITION OF THE INVESTIGATION

Including the introductory outline, this study comprises six chapters. The motivation for the study and definition of key concepts, are dealt with in chapter 1.

Chapter 2 contains a broad literature review of issues pertaining to Illich's theory of iatrogenesis. Attention is paid to the three categories of iatrogenesis, as well as various positive and negative criticisms of Illich's theory. A discussion of Illich's view of society is followed by the theoretical founding of his theory which is highlighted against the background of Marxism and critical theory. Finally, an exposition of the usefulness of Illich's theory is provided.

The literature pertaining to the problem of medicalisation and elderly people is dealt with in chapter 3. Particular emphasis is placed on the following issues:

- life satisfaction
- the use of medicines
- the problem of polymedication and drug-induced iatrogenesis
- the role of the doctor in caring for elderly people
- the role of old-age homes in relation to the effects of institutionalisation

Chapter 4 deals with the methodological problems and decisions of this study, namely the research design and techniques employed in the collection of data. The area of investigation is delimitated in this chapter. Chapter 5 contains the empirical element of the study. The data is

analysed and interpreted, and a summary of the research findings is provided. The analysis of data is executed according to specific dimensions, namely clinical, social and cultural (structural) levels of iatrogenesis.

Since the results of the study have implications for both medical intervention and for the personnel in institutions for the aged, chapter 6 embodies this discussion together with general conclusions drawn from the study. Certain recommendations for further related research are made.

CHAPTER TWO:

A CRITICAL EVALUATION OF ILLICH'S THEORY OF IATROGENESIS

2.1 INTRODUCTION

According to Illich (1976a: 11), the medical establishment itself has become a threat to health. Professional control over medicine results in damage that assumes epidemic proportions. Illich (1976a: 12) refers to the mid-twentieth century as "the age of disabling professions", and argues that the current era of crisis reflects a general distrust in modern medicine. The theory of *iatrogenesis* systematically criticises the nature and practice of contemporary medicine and pleads for an investigation into, as well as a public discussion of its effects on society.

The title of Illich's book is derived from the Greek word which is the name of a goddess, Nemesis, who punished over-arrogant people who tried to appropriate for themselves powers which belonged to gods and goddesses. The book serves as a direct condemnation of the medical establishment as a threat to health. Self-care is regarded as the most important reliable aspect of health and medical care.

This chapter provides an exposition of the underlying assumptions of Illich's theory of iatrogenesis as revealed in his book, *Medical Nemesis* (1976a) which, for the purposes of this study, is used as the most important source of his theory. An evaluation of related journal articles written by Illich is also included in this study, as well as the various positive and negative critiques of his work.

Certain ideas in Illich's theory, which are regarded as social critique, bear some resemblance to Marxism and critical theory. These ideas can, however, not consistently be described as being either Marxist or critical theoretical. In this chapter, these resemblances are elaborated on in an attempt to situate Illich's argument theoretically. Finally, the reasons why Illich's theory is useful for investigating the damage done by modern medicine, will be considered.

2.2 ILLICH'S THEORY OF IATROGENESIS

2.2.1 Key concepts of the theory

Illich (1976a: 23) refers to damage done by the medical profession as iatrogenesis. Iatrogenesis, that is, the detrimental impact of medical care on society, is divided into the following three categories:

- clinical
- social
- cultural or structural

Illich selects the term *iatrogenesis* as the key concept in explaining his theory. The reason for this is that iatrogenesis literally means "doctor-made disease". He seriously questions the effectiveness of the medical "establishment" by arguing that modern medicine causes more harm than good.

Illich also criticises the medical establishment for what he calls the *medicalisation of life*. In other words, Illich (1976a: 11) regards *society's dependence on professionally based health care* as a threat to health. Illich (1976a: 95) strikingly describes his viewpoint on medicalisation as follows:

> Like the baby bottle filled with costly infant formula, it seems to be "progress". It fills the coffers of various businesses while taking away people's capacity for self-health.

A number of problems exist with bottle feeding in third world countries. For example, mothers overdilute the milk in order to economise, and safe drinking water is often not available to prepare the infant formula. Therefore, it seems that the export of infant formula to third world countries cannot succeed in addressing the two major health problems in these countries, namely malnutrition and infectious diseases.

In the light of Illich's view regarding the detrimental impact of modern medicine on society, the resulting three categories of pathologies (or iatrogeneses) need to be examined in detail. As previously mentioned, these are results of the orthodox view of the medical profession within modern industrialised societies.

2.2.2 Clinical iatrogenesis

Iatrogenesis is regarded as being clinical when pain, illness and death result from medical care. In other words, it refers to *physical* damage caused by medical practitioners in their attempts to cure people. Illich (1976a: 21) refers to clinical iatrogenesis as "the epidemics of modern medicine", and discusses it under the following subheadings:

2.2.2.1 The illusion of the efficiency of doctors

According to Illich (1976a: 26), the fact that people today live to a much greater age is not due to the incorporation of modern medical procedures and techniques into the layperson's culture, but rather to the level of purity of, for instance, water and air.

Furthermore, Illich maintains that an improved life expectancy and a decrease in mortality rates associated with certain diseases (this is generally known as "medical progress") may be attributed to factors such as improved sanitation and nutrition, rather than medical intervention.

2.2.2.2 Futile medical treatment

Treatment with medicine is often accompanied by the risk of serious side-

effects. These side-effects might outweigh the possible benefits of the medication. For example, antibiotics which are antibacterial chemicals are often prescribed for possible secondary infections of a common cold which is a viral infection. In addition to the fact that antibiotics cannot cure a common cold, general side-effects of broad spectrum antibiotics may be, inter alia, allergic reactions such as skin rashes, teeth staining in infants, abdominal discomfort or cramping, nausea, vomiting and diarrhoea. Some of these side-effects can break down a person's natural resistance against diseases, thus leaving the person weakened. The ultimate effect might be a prolongation of the cold.

2.2.2.3 Doctor-inflicted injuries

Illich (1976a: 37) points out some of the dangers caused by chemical medication, such as their physically addictive or mutilating properties. According to Illich, many doctors are well aware of the damage caused by the medications they prescribe. For example, as a result of their physical condition characterised by certain aging processes, elderly people are particularly exposed to polymedication (the use of many different medicines at the same time). Since they are less capable of metabolising most medicines than younger people, they are more susceptible to undesirable chemical reactions caused by certain medicines. Even though these facts are common knowledge among medical professionals, it still seems that elderly people form the largest group of victims in this regard.

2.2.2.4 Defenceless patients

Clinical iatrogenesis also refers to attempts by doctors to protect themselves at all costs against the possibility of different forms of malpractice suits. According to Illich (1976a: 41), this occurs even at the expense of their patients. This category also includes negligence and professional apathy. These are, Illich points out, matters between the doctor and his or her conscience, or between the doctor and the law. Another situation which can cause patients to become defenceless is the lack of attention which sometimes occurs when doctors continue to repeat

prescriptions for months or even years without examining the patient before writing out such a prescription. Since the role of the doctor requires a certain level of knowledgability and responsibility, many patients become defenceless in the sense of being ignorant while trusting the integrity of the doctor.

According to Solo (1977: 916), Illich regards the actual clinical practice of the medical profession as destructive, that is "a sickening, disabling, crippling, and pain and anguish producing force".

2.2.3 Social iatrogenesis

Social iatrogenesis refers to the *medicalisation of life* in the sense that the individual becomes addicted to medical care as a solution to all his or her problems. Illich claims that this second category of iatrogenesis manifests in the medical practice's virtual guarantee or "perpetuation" of illness. This is because it cultivates a morbid society that encourages people to become consumers of an assortment of medicine and medical treatments as found in, for instance, curative, preventive and industrial medicine. Social iatrogenesis is characterised by various symptoms such as overmedicalisation which is regarded as a general attitude of social addiction and a condition of overconsumption of medical services. It results in the expropriation (or dispossession or deprivation) of a person's health. Social iatrogenesis occurs under varied circumstances.

2.2.3.1 Increased stress

According to Illich (1976a: 49), the "medical bureaucracy creates ill-health by increasing stress". For example, a person who takes a sleeping tablet every night will become tense when these pills run out and will return to the doctor for a repeat prescription. This increased level of stress might be relieved if the doctor were to do a lifestyle analysis and consider alternative ways of managing the problem of sleeplessness without the prescription of sleeping tablets. In this form of social iatrogenesis, the doctor fails to view the patient holistically, that is,

as essentially one person comprising physical, psychological and social modalities.

2.2.3.2 Increased medical dependency

As suggested in the above example, Illich points out the general trend among people to return to the doctor for repeat prescriptions. People do this instead of investigating the causes of their ailments (for instance, sleeplessness) or instead of trying to find alternative solutions to their problems. Emphasis in this instance is on the patient failing to consider harmful behavioural patterns or habits in his or her life, such as giving up caffeine or being more physically active during the day, instead of going to the doctor for a prescription of sleeping tablets. The person, therefore, becomes increasingly dependent on the medical profession for solving problems that actually stem from ignorance or incorrect lifestyle practices. Illich thus highlights increased medical dependency as an example of social iatrogenesis.

2.2.3.3 Removing the right to self-care

According to Illich, the medical profession leaves the patient no other choice but to comply with doctors' prescriptions. Social iatrogenesis thus assumes that the patient's right to self-care is obliterated. For example, a patient suffering from chronic bronchitis will be treated with antibiotics and some form of expectorant to get rid of excess mucus in the lungs. However, simple, basic and effective measures for self-care are generally not discussed with patients, that is, health education concerning avoiding mucus-forming foods such as dairy products, wheat and refined starches. When the right to self-care is removed, it is assumed that the treatment provided by the doctor is sufficient and there is nothing more the patient can do to enhance the healing process.

2.2.3.4 The awakening of "new and painful needs"

Under this condition, social iatrogenesis is closely related to the way in which modern medicine can lead to a condition of increased stress.

Treatment with, for instance, anti-depressants, can lead to psychological addiction. Although it might be necessary to treat symptoms, it is, however, often found that intense feelings of tension, anxiety and depression are treated with anti-depressants without searching for and addressing the cause of the problem. Once a patient has become unable to function without taking anti-depressants, new and painful needs have been awakened.

2.2.3.5 The medical bureaucracy as a "radical monopoly"

According to Illich (1976a: 49), the *medical bureaucracy* is responsible for social iatrogenesis. Social iatrogenesis becomes the main product of the medical organisation when professional autonomy degenerates into a *radical monopoly*. This is what results when people are considered to be incapable of handling their environment.

According to Illich (1976a: 69), the basic reason why bureaucracies have a disabling influence on people's health, may be found, not in the instrumental but in the symbolic functioning of a bureaucracy: bureaucracies "stress delivery of repair and maintenance services for the human component of the megamachine". From birth, people are labelled as patients who, if they wish to live "correctly", need various types of treatments at various times in their lives. In this sense, it seems that medical care has also become a solution for unhealthy work conditions, dirty cities and nerve-racking transport problems affecting human beings.

Radical monopolies encroach on people's freedom and independence: "A radical monopoly feeds on itself" (Illich 1976a: 51). It serves to legitimise social arrangements or regulations, which many people fail to adapt to. As a radical monopoly, the medical profession labels people with defects as "unfit" and this continues to create new categories of patients. Illich (1976a: 81) identifies two groups of addicts with whom doctors work: those for whom they prescribe medicines and those who suffer from the effects of medicines.

Medical policy makers appear to be under the impression that society is

eternally trapped in this "drug age". To Illich, the reason for this fallacy is that industrialised people have learned to purchase everything they desire and the environment has made it impossible for them to feel in control of their bodies. He thus argues that industrialisation and medicalisation mutually reinforce one another.

In summary, social iatrogenesis occurs when a society is organised in such a way that medicine can change people into patients, purely because they are unborn, newborn, menopausal or in some or other so-called risk age group. According to Illich (1976a: 86), "the ritualisation of the stages of life is nothing new; what is new, is their intense medicalisation". Subsequently, lifelong medical supervision reduces life to a series of risk periods. This state of affairs has made healthy people dependent on professional care and this, claims Illich (1976a: 129), has given rise to a morbid society that demands universal medicalisation. This morbid society then also requires a medical establishment to "certify" its universal morbidity.

Social iatrogenesis thus refers to people, both healthy and sick, who become dependent on professional care. They come to rely on it to such an extent that some form of medical intervention is required for solving problems that in many cases do not even have a medical origin.

2.2.4 Cultural iatrogenesis

Cultural (also called "structural") iatrogenesis encompasses a *symbolic dimension*. It refers to the existence of certain symbols for action within a particular culture, which make it impossible for the individual to maintain personal autonomy over his or her life. Illich (1976a: 140) maintains that "cultures are systems of meanings" and, according to Illich (1976a: 137), the values in modern "culture" then lead to a "mechanical system" which in turn leads to the destruction of personal autonomy and to the deprivation of personal responsibility for self-care.

A person's potential to handle his or her human weakness, uniqueness, and vulnerability in a personal, autonomous way, is destroyed by this cultu-

ral health-denying effect of the so-called health professions. For example, in modern Western societies, cultural iatrogenesis occurs when the medical enterprise breaks down a person's will to "suffer" or endure his or her reality, and consequently, a person's ability to accept pain, deterioration and death. In the modern medical civilisation, certain symbols and values for action are planned and organised so as to anaesthetise pain and destroy the need to master the "art of suffering and dying".

Illich (1976a: 142) believes that more and more of the pain associated with industrial development is "human-made" and adds that the painkillers handed out by industrial society give rise to "artificially induced insensibility, unawareness, and even unconsciousness". Therefore, pain has become a political problem for Illich (1976a: 142). In a society that attaches great value to anaesthesia, both doctors and their potential clients are socialised to suppress the intrinsic "question" underlying pain. By this Illich means that pain is suppressed without its cause being sought, whether it be biological, social or psychological. In this process of medicalisation, society has changed into a clinic, says Illich (1976a: 171), and all members of society have become patients, incapable of managing their environment.

2.2.5 Summary

Illich has criticised modern medicine both as science and as practice. His criticism is a condemnation of the values and norms that direct the modern mode of living, in which the autonomy of the individual is lost. The theory of iatrogenesis implies serious charges against modern medicine - at least some of which will be acceptable and recognisable to many people.

To summarise, it can be said that Illich (1976a: 16) levels the following three criticisms against modern medicine:

- It leads to clinical damage which often outweighs its potential advantages.

- It leads to an unhealthy society.

- It tends to obscure individuals' power to cure themselves and to manage their environment.

Illich's proposed solutions to these problems are the *de-industrialisation* and *de-bureaucratisation* of society. Moreover, he notes the incompatibility between professionalism and individual autonomy in modern medicine, which is described by Nisbet (1976: 49) in the following words:

> As long as the public bows to the professional monopoly in assigning the sick-role, it cannot control hidden health hierarchies that multiply patients.

Illich's most serious accusation against modern medicine is as follows: the primary problem of health care is situated in over-medicalisation, and this is a result of the *professionalisation* of the doctor's role. This tendency has resulted in many people becoming hypochondriac slaves. "Civilised" people become addicted to periodical medical check-ups irrespective of any specific complaints. The medical monopoly is therefore reinforced through this undesirable cycle.

According to Illich (1975b: 75), "overmedicalisation" in society refers to a level of medical care that is so intense that people's ability to survive depends mainly on inputs from specialised medical care. Consequently, it is overmedicalisation or the excessive expansion of medicine that is diagnosed in society

> when in that society the ability of people to deal on their own or in the primary group and in their natural unspecialized environment with pain, with disease, with incompetence or impairment ... begins to decline thanks to increasing offers of heteronomous professional services (Illich 1975b: 80).

To put it simply, a society is overmedicalised when "survival" depends on the medical industry. A link therefore exists between the medicalisation of health and the demand for services. Furthermore, the power of the medical profession in terms of specialised and autonomous knowledge creates a blind faith in the doctor which in turn creates a demand for services. In other words, people *believe* that medicine is their only salvation.

In the following section, Illich's view of society will be discussed.

2.3 ILLICH'S VIEW OF SOCIETY

According to Illich (1977a: 62), the contemporary medical enterprise which developed over the past half generation has become a major obstacle in forming moral values within society. Thus far in western society, medicine has served to legitimise changes which occurred in a cultural context (Illich 1974b: 17). Professional experts within this enterprise are assigned the power to decide, for instance, that old age should be regarded as disease. They are therefore passing judgements about whom to declare socially unfit, as well as what will be done to such a person.

For Illich (1976b: 190), in order to become and to be human, "the individual of our species has to find his/[her] destiny in his/[her] unique struggle with Nature and neighbor." Although the human being is alone in this struggle, the weapons, rules and style are provided by the culture in which he or she is situated. Every culture is the sum of certain rules which the individual must take into account in case of pain, illness and death. Each culture sets the myths, the rituals, the taboos, and the ethical standards necessary to handle the tenderness of life.

In a society where all citizens are from birth to death subjected to different therapies, those conditions which enable people to enjoy and to suffer reality, vanish quickly from the social, physical and psychological environment. The overexpansion of the medical enterprise which inhibits freedom as well as morally grounded rights, is practised by means

of a bureaucratic set of criteria containing no personal or moral values.

In an intensely industrialised society people are conditioned to obtain things rather than to do things; they are trained to purchase rather than to create. "They want to be taught, moved, treated, or guided rather than to learn, to heal, and to find their own way" (Nisbet 1976: 49). Personal functions are assigned to impersonal institutions. Healing is no longer regarded as a task for the sick person:

> It first becomes the duty of the individual body repairman, and then soon changes from a personal service into the output of an anonymous agency (Nisbet 1976: 49).

In this process, society is rearranged for the sake of the health system and it becomes all the more difficult to care for one's own health. Illich (1976a: 218) claims that "goods and services litter the domains of freedom." Illich (1974b: 12) refers to the modern tendency of people to be regarded as highly respectable when they are clients of a famous doctor. Disease becomes an entity and therapy becomes a proce- dure which is only effective when a doctor administers it. Hospitals become industrial institutions for the mass production of health services.- repair shops for human beings. In other words, Illich regards the position of the individual in industrialised society as largely determined by factors such as the medical bureaucracy - a situation which he views as undesirable.

In the following discussion, an attempt will be made to determine the way in which Illich's theory makes use of certain ideas belonging in a Marxist framework, as well as in the framework of critical theory.

2.4 THEORETICAL FOUNDATION OF ILLICH'S ARGUMENT

Although it could also be said that Illich's work is atheoretical, Pauly (1983: 266) argues that Illich has, on certain points, in fact updated and revived a conventional Marxist argument. Marx was one of the first modern thinkers who understood the way in which modern technologies

negatively influence and change traditional ideas of personal responsibility and mutual obligation. According to Pauly (1983: 266) - the only critic who undertook an in-depth study of Illich's other works as well - *Tools for conviviality (1973a)* may be regarded as Illich's personal attempt to rewrite Marx in a way that takes into consideration twentieth century experience.

2.4.1 Situating Illich's work within a Marxist framework

Navarro (1975: 351), a Marxist, views Illich's work as being characterised by the main properties of the ideology of industrialism. This ideology is based on technological determinism, that is, that the process of technology leads inevitably to the industrialisation of society. According to Navarro's (1976: 440) view of industrialism as ideology, the nature of society is defined as a result of ideological manipulation by bureaucracies (including professional bureaucracies). In other words, the bureaucracy has assumed the place of the capitalist class as the chief agent of oppression. Ownership has also lost its meaning as the legitimation of power, while control has been separated from possession. Control has shifted from the capitalists to the technocrats and thus, by implication, also to the bureaucracies.

According to Casalino (1975: 756), Illich, in his book, *Medical Nemesis*, uses health care as a paradigm of the industrial mode of production. He claims that any health care system which is organised according to the industrial mode of production - be it in a capitalist or a socialist society - must necessarily produce clinical damage which outweighs the potential advantages.

What exactly Illich means by "the industrial mode of production" can be derived from the following three contradictions:

- There will be a contradiction between the size and complexity of industrial instruments and the need of human beings to understand and form the environment they live in.

- There will be a contradiction between the industrial mode of production and what Illich calls the "autonomous or communal" mode of production. The industrial society changes a basic need of people, such as the need for health care, into a commodity which can only be produced through capital intensive methods.

- The third contradiction corresponds with the contradiction described by Marx, that is, between the possibility of material abundance and non-alienating labour that is made possible for the first time by the industrial mode of production, as well as the frustration of this by capitalist control.

Illich (1974a: 9) argues that the crisis in medical institutions cannot be solved by rearranging them under public or professional control. What needs to be cleared up is the power of these institutions to generate expectations to which they cannot reply.

According to Illich (1976a: 55), the cause of social iatrogenesis (addiction to medical care) is to be found in the manipulative conduct of the medical bureaucracy. Illich believes that this bureaucracy plays a part in encouraging and aggravating passive and addictive consumer behaviour - a pattern of behaviour which can be likened to a false consciousness.

Illich (1975b: 79) provides a detailed indication of how people, in virtually every stage and area of their lives, are forced to become dependent on the medical system - a dependence which causes great suffering. According to Illich (1974a: 9), public trust in the medical profession is rapidly declining, while, at the same time, public dependence on medical care has reached unparalleled heights.

Borremans and Illich (1978: 9) regard the fragmentation of health (antenatal care, industrial health, environmental health) as token of the monopolised multi-professional approach to health. The industrial system spreads a set of bureaucratic instructions for the manufacturing, marketing and consumption of commodities. The degree to which these

instructions prevent autonomous activities, generates needs and expropriates health. According to Borremans and Illich (1978: 12), health should never be defined as a goal which can be reached by a third person.

Illness is taken away from the patient and it becomes material for an enterprise. Assigning of the sick role becomes a medical monopoly. The person who feels *sick* has to go to the clinic to be labelled with a name for a *disease*, and to be legally certified as member of the minority group of so-called "patients" - people who are excused from work, entitled to assistance, placed under doctor's orders, and ordered to heal in order to become useful again.

In summary, Nisbet (1976: 49) argues that Illich's polemic is a peculiar mixture of neo-Marxist economy and an extreme attitude of liberty: capitalism uses people's bodies for its blundering purposes. To Illich, the medical system actually causes large-scale disease ("iatrogenesis"), as a result of overtreatment and maltreatment. He suggests that the only escape from this medicalised nightmare is to expose the rituals of modern medicine and to move in the direction of self-treatment and therefore autonomy (Nisbet 1976: 49).

2.4.2 The relationship between critical theory and Illich's argument

Irrespective of the Marxist concepts and ideas used by Illich, Pauly (1983: 263) indicates that Illich's criticism of the industrial mode of production is greatly indebted to critical theory in so far as it focuses on:

- the division of the world into producers and consumers
- the expropriation of human reason due to technical causes
- alienation as a result of human needs having been converted into commodities

Critical theory originates from situations of social unhappiness - "a situation which it interprets as the result both of the ignorance of

those experiencing these feelings and of their domination by others" (Fay 1987: 82). Critical theory envisions an emancipated society as being positively emancipated and thus autonomous where people can reflexively choose what type of people they want to be. This emancipation in the sense of individual autonomy implies that members of an emancipated society take responsibility for the kind of life they have chosen.

Illich resonates critical theory when he argues that most institutions in industrial societies have now reached a counter-productive stage. This criticism is not only aimed at economic monopolies (one producer being dominated by another), but also at the domination of one mode of production. "Radical monopolies" therefore refer to both the psychological and economic effects of industrial instruments.

Since Illich systematically criticises the nature and practice of modern medicine, his work could be regarded as an important contribution to the critical viewpoint. He does not merely accept the way in which medicine is practised as a given, but he is also concerned with the broader meaning of the medical practice for the individual. It is important to note that Illich does not entirely reject the use of medicine. For example, he explicitly acknowledges the effectiveness of antibiotics when administered correctly. His criticism is aimed at the excessive and often unnecessary use and abuse of medicine.

The similarities between Illich's theory and critical theory may be summarised in terms of the following contributions of critical theory:

2.4.2.1 Improving the political situation

Since we live in a world characterised by immense suffering and discontent, critical theorising promises a way in which intellectual attempts may assist in improving the political situation:

> In the broadest terms, critical social science is an attempt to understand in a rationally responsible manner the oppressive features of a society such that this understanding

> stimulates its audience to transform their society and thereby liberate themselves (Fay 1987:4).

Illich hopes that the oppressive character of industrialised society will be relieved by the processes of de-industrialisation and debureaucratisation.

2.4.2.2 A cure for a crisis

Critical theory wishes to understand society in order to change it, and, according to Fay (1987: 4), "it wishes to do this in a scientifically respectable manner". Put differently, critical social science can be described as "a cure for the disease of people living in a crisis" (Fay 1987: 60). To Illich, the widespread phenomenon of the medicalisation of life spells out a social crisis.

2.4.2.3 Social critique

Social critique deals with the choices available, the exercising of which enables people to become free and rational individuals. In this way the bureaucracy is regarded as a form of manipulation and domination, and therefore as the enemy of individual freedom (Hearn 1985: 5). According to Illich (1976a: 51), the cause of social iatrogenesis is to be found in the manipulative conduct of the medical bureaucracy. Illich believes that this bureaucracy plays a part in encouraging and aggra- vating passive and addictive consumer behaviour. The promise of human emancipation is thus conveyed by the concept "social critique". In the language of Mills, social critique is involved with the promise of sociology which requires that the ideals of reason and freedom are cherished (Hearn 1985: 3).

2.4.2.4 The rejection of the orthodox assumption

Critical theory rejects the orthodox assumption that the social and natural sciences share the same goal, that is, an empirical theory existing in a moral vacuum (Hearn 1985: 189). To both Mills and

Habermas, the responsibility and promise of a social theory refer to the cultivation of the public sphere (Hearn 1985: 165). In this regard, Illich (1976a: 12) explains that he

> uses a model of social assessment of technological progress ... [which he applies] to the criticism of the professional monopoly and of the scientism in health care that prevail in all nations that have organized for high levels of industrialization.

2.4.2.5 Power of human reason

Critical theory is based on a faith in the power of human reason. It asserts that people can understand themselves by means of rational analysis and reflection and that they can rearrange their collective existence on the basis of this understanding (Fay 1987: 143). Fay (1987: 203) recognises three basic claims about human existence:

- People are typically dominated by conditions which they do not understand or cannot control - a situation giving rise to their leading unfulfilled lives.
- Human existence need not be like this.
- An increase in knowledge is the way in which the oppressed can free themselves and, in doing so, also improve their destiny.

Illich (1976a: 12) pleads for "thoughtful public discussion" and warns that "a passive public" is dangerous. He adds that "the crisis in medicine could allow the lay[person] effectively to reclaim his[/her] own control over medical perception, classification, and decision-making (Illich 1976a: 12).

2.4.2.6 Empowerment

Critical theory strives to be a practical force "by galvanizing its audience" in socially transformative behaviour - this is what is meant by "empowerment" (Fay 1987: 204). The three concepts of enlightenment, empowerment and emancipation constitute the essence of the adage of critical theory that "the truth shall set you free" (Fay 1987: 205). It needs to be mentioned that critical theory acknowledges the fact that there are limits to the power of reason: it is erroneous to refer to "*the* truth", because no final and only truth exists about ourselves. Critical theory exclusively regards knowledge as self-knowledge and, by implication, therefore, as knowledge of society since the identity of the self is so narrowly interwoven with the nature of the society in which it exists (Fay 1987: 204). Illich (1976a: 12) argues "that the lay [person] and not the physician has the potential perspective and effective power to stop the current iatrogenic epidemic".

2.4.2.7 Mass characteristics

Regarding the population under study, mass characteristics could in many instances be applied to elderly people in old-age homes, such as purposelessness, homogeneity, alienation, and a reduction in creativity and individuality, where, according to Giner (1976: 125), the individual becomes but a "specimen" of a group. In Illich's terms it could be argued that an explanation of the mass person will take root in the dimension of cultural iatrogenesis. Illich's view of cultural iatrogenesis as a loss of autonomy and personal responsibility, is echoed in the words of Mills (1973: 304), namely that the masses have no authority within institutions. "On the contrary, agents of authorized institutions penetrate this mass, reducing any autonomy it may have in the formation of opinion by discussion" (Mills 1973: 304).

The "cheerful robot" is an ideal construction formulated by Mills (in Hearn 1985: 6) with a degree of exaggeration "to highlight what it is that characterizes the person with rationality but without reason". Since the cheerful robot flourishes in modern society, a link could be

drawn between this concept and Illich's thoughts regarding both social and cultural iatrogenesis.

2.4.2.8 Social reform or reconstruction

The requirement for social reform or reconstruction, according to critical theory, is to make people aware of causal, oppressive conditions, "... so that, being enlightened, these people might change these conditions and so transform their lives" (Hearn 1985: 191). Social reform is therefore aimed at the reform of what once looked like unchangeable patterns of social life. It is also aimed at the increased emancipation of the individual. Since reason is a prerequisite for emancipation, social reform appeals to the values of reason.

The crux of social reform is to create an awareness of people's roles in the establishment of a changed lifeworld. Social reform implies that people are granted the necessary freedom to, by means of their "reason", reflect on their existence, and to exercise choices accordingly.

Although Illich speaks about de-industrialisation and de-bureaucratisation, the implication of his plea for social reform is aimed at the individual. Illich never envisioned a radical overthrow of existing society structures. However, he proposes an emancipatory education of the individual which would lead to autonomous and responsible thinking.

For both Illich and critical theory in general, the main issue centres around an attempt to understand the oppressing features of society in a rationally responsible manner, "such that this understanding stimulates its audience to transform their society and thereby liberate themselves" (Fay 1987: 4).

2.5 EVALUATION OF ILLICH'S THEORY

In spite of much criticism, both positive and negative, Illich hopes to indicate that irreversible damage has already been done in terms of the three levels of iatrogenesis.

2.5.1 Positive critique

A general feeling exists among the critics mentioned below that Illich's book, *Medical Nemesis* (1976a), is a work worth reading. According to Norling (1976: 641), it is not merely a collection of cheap mortal blows, but "a major work, a powerful indictment of the medical wonderland we all inhabit". Since Norling is in agreement with Illich's point of view regarding the damaging effects of modern medicine, Norling believes that this comprehensively documented book demands a re-evaluation of present modern attitudes regarding medicine.

As explained in detail under point 2.2.3.5, Illich (1976a: 50) terms the domination by industrial instruments such as medicine, a "radical monopoly". Pauly (1983: 263) states that this is one of the most useful terms designed by Illich since it describes the nature, functioning and limitations of the medical profession, as well as its influence on people in industrialised societies.

Specific points of positive critique of Illich's work will subsequently be discussed under the following subheadings:

- the humanist aspect: the patient as subject
- a challenge to society
- psychological and sociological aspects

2.5.1.1 The humanist aspect: the patient as subject

In contrast to the over-technologised medical model, Illich emphasises the importance of taking responsibility for one's own health. Behind the self-help aspect of Illich's protest is the legitimate claim of the patient to being fully informed and treated as a responsible adult - not merely as an object. Illich's aim is to completely change the view of what disease is, by changing the perspective concerning good health. Consequently, according to McDonald (1976: 50), Illich wishes to *humanise* this perspective. McDonald feels that Illich is successful in providing a suitable, coherent analysis of present misconceptions regarding health

by means of his three-level theory of iatrogenesis. McDonald (1976: 51) argues that although Illich has not provided all the answers, he asks the right questions, and this, he suggests, is a remarkable achievement.

2.5.1.2 A challenge to society

Stroman (1977: 931) regards Illich's challenging and expanded evidence as being not just an investigation into the effectiveness of modern medicine. In addition, it explores the total impact of modern medicine on culture, as well as on the individual human being. Stroman argues that *Medical Nemesis* should be read by those who are concerned about the effectiveness of health care, or the cultural and structural changes that result from efforts to understand and control disease.

Pauly (1983: 263) does not regard Illich's theory as a mere romantic return to "a golden image of peasant life or primitive society". According to him, Illich's argument is much more challenging: he believes that modern societies have an opportunity they simply have to choose to use. Pauly argues that Illich's interest lies in utilising human potential to the full by educating and emancipating people to take responsibility for their own health matters.

2.5.1.3 Psychological and sociological aspects

Birley (1975: 508) regards *Medical Nemesis* as an important work and suggests that it should be read by psychiatrists who need to be aware of the hostility that is often evoked by the medical profession.

In addition, it is generally felt that *Medical Nemesis* has made a valuable contribution towards the generation of a new sociological focus: an attempt to understand the negative (dysfunctional) influence of health care. This shift in focus encompasses the health of society members as social actors, as well as the social world of these actors.

In summary, several theorists argue that *Medical Nemesis* provides a valuable and enriching critique of the medical model in industrial

society (Fletscher 1978: 53). Illich succeeds in highlighting the damaging effects of modern medicine on both the individual and society as a whole.

Subsequently, an exposition will be provided of negative criticisms levelled against Illich's book.

2.5.2 Negative critique

Although sometimes in direct contrast to certain points of positive critique, Illich's theory is often regarded as being disturbing, challenging, extreme and simplistic. Negative criticisms of various authors will be discussed by attending to the following points:

- Reducing social issues to personal problems
- The lack of concrete alternatives
- A neglect of socio-economic structures
- The need for a more specific analysis
- Support for the reduction of social programmes
- Romanticising the dangers of technological progress

2.5.2.1 Reducing social issues to personal problems

Waitzkin (1976: 401) regards *Medical Nemesis* as both an important and dangerous book. He argues that, although the criticism of modern medicine is convincing, "social issues" are still reduced to "personal problems" (to use the language of Mills). Therefore, according to Waitzkin, the problem of health care is distorted.

In a similar vein, Imershein (1977: 831) acknowledges that Illich asks relevant questions, but in view of the absence of further analyses and alternatives, he sees Illich's suggestions as little more than a moral reprimand. Therefore, instead of making recommendations at the social policy level, Illich relocates the burden of medicalisation to the individual. To Haggerty (1977: 63), Illich's view is oversimplified and he queries Illich's plea for an individualistic answer to global problems.

2.5.2.2 The lack of concrete alternatives

Furthermore, many critics find Illich's solution, that is, the total de-professionalisation of medicine, disturbing. Solo (1977: 917) regards Illich's radical conservatism as a powerful, potentially successful force, even though he maintains that the de-professionalisation of medicine will not succeed. Solo argues that few people will follow this road of reform and, moreover, the lack of proposals for any concrete alternatives to replace the current system, is especially disappointing.

2.5.2.3 A neglect of socio-economic structures

Critics following a Marxist viewpoint argue that Illich's analysis does not penetrate socio-economic structures, including structures that determine the doctor's behaviour. They suggest that the destruction of medicine will not contribute to a repair of the structural basis of poor health. In addition, an accompanying structural change is felt to be necessary in many other institutions of modern society. At a point of clarification, however, it needs to be stated that Illich never suggested the "destruction of medicine".

Doyal and Pennell (1981: 20) depart from a Marxist framework and maintain that Illich is avoiding an investigation into the economic and political aspects of industrial society, as he provides no way of distinguishing between capitalism and other forms of industrialisation. Doyal and Pennell (1981: 20) regard the avoidance of socio-economic factors as an impossibility. Any explanation of the nature of problems is theoretically linked to the nature of capitalism, and not merely to the process of industrialisation.

2.5.2.4 The need for a more specific analysis

For Imershein (1977: 831), Illich's discussion represents an expanded description of the problem rather than an analysis of causal factors. He criticises Illich for focusing on issues such as the following:

- Doctors are not as effective as they pretend to be.
- Many unnecessary medical interventions take place.
- The biggest part of life has become medicalised.
- Pain and death are torn away from their historically earlier spiritual context.

Imershein maintains that the "what" is stated in a provoking manner, but the "why" is less visible. He suggests that, although Illich's assertion that industrial society should be regarded as the underlying cause is acceptable, it is not specific enough to be of value. Imershein thus calls for a more specific analysis. Moreover, Imershein (1977: 831) regards Illich's proposal that lay persons abandon their dependency and regain control of their lives, as a need for a historical analysis of the structural roots of that dependency. It is therefore argued that Illich fails to take into account the historical and structural factors concerning consumer dependency, for instance, the emergence and structure of capitalism in modern industrialised society.

2.5.2.5 The absence of explicit policy proposals

Some critics (Waitzkin, 1976 and Krause, 1977) contend that Illich does not provide explicit policy proposals in order to rectify the situation he criticises. Instead, Illich presents a negative critique of the present policy possibilities which, according to him, will not work. Thus, in the absence of any positive programme, this criticism provides policy makers with grounds to actually *legitimise* any cutting or reduction of essential health and welfare programmes. It is therefore felt that Illich's criticism serves as legitimation for a reduction in social responsibility towards health care. These reductions will, according to Waitzkin (1976: 403), disproportionately affect the lower-income groups, since they cannot afford regular access to the private medical system.

It is felt that Illich's arguments continuously overlook the importance of social class. In a class society, Illich's view will not affect the ability of the rich to "buy" the health care they need. On the other

hand it is argued that *Medical Nemesis* provides a justification for policy changes which will further the deprivation of the poor. It is for this reason that Krause (1977: 727) maintains that Illich provides an *ideological* argument.

2.5.2.6 Romanticising the dangers of technological progress

Illich's discussion of suffering and death also evokes severe criticism. In terms of this discussion, Illich is regarded as reactionary. His argument is viewed as a romantic criticism of the dangers of technological progress in medicine. To some medical professionals, Illich's commendation of "dignified suffering" and cultural mediation (instead of technological anaesthesia), represents a conservative anti-modern argument.

In summary, in contradiction to those critics who argue that Illich provides no explanation of why medicalisation takes place, the author maintains that Illich explains this extensively by means of a threefold analysis of the damage that may be done by modern medicine. Furthermore, the author wishes to differ from those critics who maintain that Illich does not provide a solution to the problem of medicalisation. Although he refers to de-industrialisation and de-bureaucratisation, Illich proposes an implicit solution, namely the emancipation of the individual.

In consideration of both the positive and negative criticisms of Illich's argument, several critics contend that Illich's message in *Medical Nemesis* is better understood against the background of his former works. Waitzkin (1976: 402) points out that the arguments in these works correspond with those in *Medical Nemesis*. Illich's thinking is along the line of criticising the effects of technological advancement on people in industrialised societies. Illich not only focuses on the medical profession, but his writings contain, inter alia, criticisms of the modern school system, as well as other professions.

Doyal and Pennell (1981: 19), two Marxists, express certain criticisms

of Illich's view of modern medicine. They regard Illich's problem as being situated in the fact that he views the basic character of the society upon which he focuses his analysis, as *industrial* rather than capitalist. Since Marxists concentrate specifically on capitalist societies, it is obvious that Doyal and Pennell would criticise Illich's work as deviating from a Marxist line of argument. One could perhaps argue that Illich is more profoundly analytical than what he would have been if he had concentrated merely on the structural problems of capitalist societies.

According to Casalino (1975: 756), who is also critical of Illich's solution, Illich claims that any health care system organised according to the industrial mode of production, will do more harm than good. Doyal and Pennell (1981: 19) also regard Illich's solution, i.e. the de-bureaucratisation and de-industrialisation of society, as far-fetched. They again emphasise the fact that Illich does not attend to the economic and political factors which play a role in the health status of the societies concerned.

Illich disagrees in principle with a Marxist analysis, since he does not view radical change as a solution. He does not advocate a sudden overthrow of the medical establishment. Illich pleads for the education of the individual through changing the values and norms characteristic of industrialised societies. He thus upholds the ideal of everyone having the freedom (free from the restrictions placed on people by the medical profession) and autonomy to assume responsibility for his or her own health.

Hart (1985: 47) points out certain similarities between Illich and the Marxists and he explicitly mentions Doyal and Pennell in this comparison. He argues that, in both Illich's writing and that of the Marxists, there is a strong theme of dehumanisation: *alienation* in the case of the Marxists and *expropriation* of health through the medical profession in the case of Illich. Hart considers the reactions to advanced technology and machinery, which restrict human abilities, to be a common factor in both points of view.

Furthermore, Hart (1985: 47) maintains that these two "pessimistic" views are united by an element of romantic idealism. Each promises a vision of better health under new social conditions. In Illich's case this would be de-industrialisation while, in the Marxist case, it would be socialism. However, "neither offers any guidance on how their model societies could be made a reality" (Hart 1985: 47). The critical question raised by Hart (1985: 48) is: How can a complex industrial economy be controlled and managed without bureaucratic power structures? It is this singular emphasis on the negative dimensions of modern capitalist civilisation which, in Hart's (1985: 46) view, puts Illich's anti-industrial viewpoint in the same category as the Marxist perspective.

In the opinion of the author, however, Illich is not a Marxist since his fundamental analysis is focused on industrial society with its concomitant evils of industrialisation, and not on capitalist society as such. Although Illich displays certain similarities with Marxism in, for instance, speaking of two classes, and although he talks of *exploitation* (Illich 1975a: 76), and *social inequality* (Illich 1975b: 78), he cannot simply be characterised as Marxist. Marxist sociologists examine the relationship between the economy and medical power in capitalism. Illich, on the other hand, is interested in the relationship between industrialisation and the medical profession, whether it be in a capitalist *or* a socialist society. A Marxist analysis of health and health care would, therefore, *centralise* the concept of power in order to make sense of the medical profession and its associated practices. Contradictory to this point of view, Illich considers the monopoly of medicine as a "malign outgrowth" of industrialisation.

To Illich, de-professionalisation does not mean the elimination of modern medicine. It means that no professional person should have the power to hand any patient a package of curative services "larger than that which any other can claim on his/[her] own" (Illich 1974a: 9). At a certain point in the expansion of an institution, the clients begin to pay a higher price each day for their continued consumption, despite the evidence that they will inevitably suffer more. Thus, Illich (1976a: 219)

argues that any health care system which is organised according to the industrial mode of production, regardless of whether it is in a capitalist or a socialist society, cannot help perpetrating clinical harm which outweighs its potential benefits.

In conclusion, Illich's argument represents a valuable contribution to the fight against the domination of consumer behaviour. Haggerty (1977: 62) suggests that this book is not based on scientific principles, but should rather be regarded as a philosophy. For the purposes of this study, the author concurs with Haggerty's suggestion. Questions of a philosophical nature arise precisely in the implications of the title where "nemesis" refers to retribution. In this study, Illich's work on social and structural iatrogenesis is regarded as a valuable contribution to the debate about the medicalisation of life.

In the following section, an explanation will be provided of the usefulness of Illich's theory for this study.

2.6 THE USEFULNESS OF ILLICH'S THEORY FOR THIS STUDY

In the opinion of the author, Illich's fierce criticisms of the medical profession could, on the one hand, be regarded as justifiable, and on the other hand as often exaggerated. However, for the purposes of this study, Illich's view of clinical, social and cultural iatrogenesis can be made applicable to the following sociological themes which are descriptive of some of the problems of elderly people:

- elderliness as a normal stage in the life course or as a social problem
- the abuse of medicine by elderly people
- the institutionalisation of elderly people
- the functioning and purpose of old-age homes
- the handling of elderly people as patients

These themes briefly refer to the medicalisation of elderliness. By making use of Illich's theory, the focus is aimed at a critique of

consumerism and an in-depth investigation of existing problems. It could thus be argued that such a study would be useful, given the degree to which some elderly people are seen to have become addicted to the medical profession in terms of, for instance:

- the knowledge and understanding they reveal about taking medicines (clinical iatrogenesis)

- their attitudes towards health improvement and prevention of disease (social iatrogenesis)

- the influence of institutionalisation on their medical routines (cultural iatrogenesis)

Although a vast amount of literature is available on the medicalisation of life, the idea is to test Illich's theory by undertaking a micro level investigation of only one stage of the life cycle, that is, elderliness as the final phase of life. Since the positive effects of medicine will be acknowledged in this study (where consensus about effectiveness exists, such as in the correct use of antibiotics), the idea is not to criticise medicine per se.

The main reason for the selection of Illich's theory is in its *systematic exposition* of the three levels of damage done by the medical profession. Illich does not merely criticise medicine in general. His categorising of the three different forms of iatrogenesis imbues his thinking on the topic with a certain order. Thus, the theme of elderliness and the medicalisation of the elderly, can be investigated on different levels and so be attributed to the three categories of iatrogenesis.

For the purposes of this study, specific nuances of Illich's theory will be emphasised. Despite existing problems in situating Illich's work within a certain theoretical framework, his *criticism* is indeed relevant and useful. By focusing on the individual, an element of existentialism can be extracted from Illich's theory in order to highlight the promise of critical theory, i.e. the emancipation of people to enable them to

become autonomous and responsible individuals.

In spite of the fact that some critics regard his work as radical, Illich nevertheless draws the attention to a fundamental societal problem which cannot be ignored. Illich's *overarching message* deserves attention, namely that modern medicine succeeded in dividing different normal life phases into risk periods. Consequently, elderliness is regarded as a "disease". Illich uses diverse examples to illustrate his argument and thus does not provide a detailed study of one specific aspect of the medicalisation of life. However, his *systematic classification scheme* does indeed provide the necessary guidelines to undertake an unique study of medicalisation, with the aid of a *previously worked-out analysis* which concentrates on different categories of pathologies.

By means of applying the three forms of iatrogenesis, elderliness could, for instance, be classified as follows:

- *clinical iatrogenesis*: the misuse and abuse of medication by elderly people as a result of being uninformed and ignorant about the adverse effects of medication

- *social iatrogenesis*: the elderly person's addiction to medical care as a solution for, inter alia, problems related to social isolation, loneliness and insecurity

- *cultural/structural iatrogenesis*: the way in which institutionalisation strips elderly people of their autonomy and responsibility for their own health matters

2.7 CONCLUSION

This chapter provided a discussion of Illich's theory, including his view of society. The theoretical foundation of Illich's theory is discussed with reference to Marxism and critical theory. Specific points of the positive and negative critique of Illich's theory are evaluated, whereafter an indication is given of the usefulness of Illich's theory

for this study.

Medical Nemesis can be regarded as a critical attempt to focus the attention on the threefold damage or iatrogenesis (discussed in section 2.2 above) caused by the medical profession. Following critical theory, this work also appeals to people to free themselves, by means of rational thinking, from the total hegemony of the medical establishment. Illich's hope for a better society is directly linked to the intervention of the individual on personal, social and cultural levels.

In the final instance, Illich has not merely provided criticism - he has formulated a well thought-out and pertinent framework, which can be applied in a systematic way. To Illich (1976a: 275), medical nemesis is

> the negative feedback of a social organization that set out to improve and equalize the opportunity for each [person] to cope in autonomy and ended by destroying it.

Borremans and Illich (1978: 12) suggest that we accept a lesson from Netzahualcoyotl, the Prince-Poet from Cuautla, the city of flowers, namely "that we recognise the fragility of our sun".

CHAPTER THREE:

MEDICALISATION AND THE ELDERLY

3.1 INTRODUCTION

In his book *Medical Nemesis*, Illich reveals a specific view on aging. In this chapter, Illich's view on aging will be linked to a discussion of the problem of medicalisation of the elderly in terms of certain general factors, namely their medication practices, and the resultant condition of medicalisation which occurs in some instances. The role of old-age homes in this process will also be investigated. Since the aging process does not progress according to a prescribed plan, people age differently. Therefore, an exposition will be provided of life satisfaction and attitudes among the elderly. Crucial in this regard is whether elderly people have a physically, psychologically and socially healthy lifestyle.

This study aims at making Illich's view on clinical, social and cultural or structural iatrogenesis applicable to already widely researched sociological themes regarding elderly people, namely:

- the view of the aging process as a "disease" and the consequential treatment of elderly people as "patients" (Scrutton 1988; Binney et al. 1990; Raffoul et al. 1981)

- the abuse of medicine by elderly people (Cartwright & Smith 1988; De Vries et al. 1982; Levy & Glanz 1981; Scrutton 1988; Raffoul 1986; Page 1988)

- the institutionalisation of elderly people and the effect of such institutionalisation on them (Wingard et al. 1987; Kayser-Jones 1982; Shulman & Mandel 1988; Van Zyl 1980; Saup 1986)

By means of an investigation and exposition of these above-mentioned

themes, this study hopes to indicate whether institutionalised white elderly people are overconsumers of medical services and medication, and, if so, what the reasons might be. In terms of critical theoretical argumentation, an evaluation and extrapolation will subsequently be done of Illich's view of medicalisation among elderly people.

3.2 THE PHENOMENON OF MEDICALISATION AMONG THE ELDERLY

In South Africa, old-age homes tend to be a "white" rather than a "black" phenomenon. Given the history of this country, black people have for many years not had the same access to health services as white people have had. Because of these historical disadvantages suffered by black elderly people, it was decided to examine the phenomenon of medicalisation among the elderly, among "white" elderly people.

3.2.1 Demographic features

The following statistics concerning the demographic features of the South African aged community were obtained from Population Census CSS Report (1991: 123):

> The number of white persons 65+ is presently 159 936 compared with 274 090 of black, 44 204 of [so-called] coloured and 15 278 of Indian persons.

Although the number of black elderly people is much higher than that of white elderly people, the number of institutionalised black elderly people is much lower (see statistics provided in chapter 4, section 4.3.2) than the number of institutionanalised white elderly people in South Africa.)

3.2.2 Medicalisation as a process

Binney et al. (1990: 761) view the phenomenon of medicalisation among elderly people as a "powerful process". According to them, the medicalisation of community-based services for elderly people is the

long-continued development of a policy which increasingly views elderliness as a medical problem. Furthermore, Draper (1983: 29) notes that "we live in a society which expects a prescription with every medical consultation". In similar vein, Louw (1992: 14) refers to modern society as being characterised by a "quick-fix" culture which demands instant solutions to each unwanted health condition. For example, he argues, there is a pill for everything: a pill to lose weight, a pill to gain weight, a pill to fall pregnant, a pill to prevent pregnancy, a pill to sleep, a pill to stay awake, and so on. Mullen and Granholm (1981: 113) also draw attention to the problem of medicalisation: they point out in this regard that "a surprising number of people have been conditioned through life to 'take something' for every symptom. People who are left alone tend to become introspective and to dwell on symptoms." In focusing on the problem of medicalisation among the aged, they suggest that "older people in such circumstances are in greater need of diversion than of medicine" (Mullen & Granholm 1981: 113). In other words, certain belief patterns exist in society about medication and the pervasive use of medicine.

3.2.3 The history of medicalisation of elderly people

It seems that the problem of the overmedicalisation of elderly people in industrialised countries is nothing new. Under the descriptive heading of "Bourgeois death", Illich (1976a: 195) discusses at length historical events which contributed to the medicalisation of elderly people. For example, he refers to the Industrial Revolution (1770-1815) as a time when "technology had made it possible for the old and rich to hang on while doing what they had done in middle age" since "ageing had become a way of capitalizing life" in the sense that "years at the desk ... began to bear interest on the market" (Illich 1976a: 196).

Just before the French Revolution (1789-1799) the health aspirations of the rich and powerful were described as "the ability to survive longer, the refusal to retire before death, and the demand for medical assistance in an incurable condition" (Illich 1976a: 198). According to Illich (1976a: 198), these aspirations "had joined forces to give rise to a new

concept of sickness: the type of health to which old age could aspire". Significantly, Illich (1976a: 198) notes:

> It did not matter at all if the treatment doctors could provide ... had any effect on the progress of the sickness; the lack of such treatment began to mean that they were condemned to die an unnatural death, an idea that fitted the bourgeois image of the poor as uneducated and unproductive. From now on the ability to die a "natural" death was reserved to one social class: those who could afford to die as patients.

Could it perhaps be argued that the process of medicalisation underwent gradual shifts in emphasis from a mere desperate attempt to survive physically (eighteenth century) to a means of economic survival (early nineteenth century) to a means of *social survival* (twentieth century)? Often the doctor is the only person visiting a lonely elderly person in an old-age home. Has the medicalisation of old-age home residents become the price paid for relieving social isolation?

3.2.4 Drug dependence among the elderly

Referring to the hazard of "drug dependence" among the elderly, Scrutton (1988: 14) argues that "nowhere is the medication of life more significant than in the lives of older people". The apparent dependence of many elderly people on drugs, together with the attitude of their having handed responsibility for their own health to their doctors, suggest that doctors are playing a fundamental role in the care of elderly people. This, Scrutton (1988: 14) points out, is in spite of the fact that "ageing is not a disease [and that] it is possible to age without illness or disease". He argues that, because old age is being increasingly accepted by medical personnel as a medical problem requiring medical solutions, a debilitating pessimism regarding elderliness has resulted among medical professionals.

The phenomenon of medicalisation of elderly people will be discussed in

terms of the following issues which could be regarded as representing a specific level or levels of iatrogenesis as described by Illich:

- aging differently: life satisfaction and elderly attitudes (social and cultural iatrogenesis)
- medicines and elderly people (clinical and social iatrogenesis)
- drug-induced iatrogenesis in the elderly: the hazard of multiple drug therapy (clinical iatrogenesis)
- health care of the elderly: the role of the doctor (clinical and social iatrogenesis)
- institutionalisation: the role of old-age homes (cultural iatrogenesis)

In the following section, a discussion will be provided of how different individual and social factors related to medicalisation influence the aging process in terms of various attitudes revealed by elderly people.

3.3 AGING DIFFERENTLY: LIFE SATISFACTION AND ELDERLY ATTITUDES

Since the late sixties, the field of gerontology - which is defined as the scientific study of aging, old age and the problems of the elderly - has been stimulated by the growing proportion of elderly people in the populations of industrialised societies, and by public concern with the aged as a social problem.

In chronological terms, elderliness constitutes the end of a lifespan and ranges from 65 years of age until death. This phase is characterised by an acceleration of the decrease in physical and psychological skills. According to Eloff (1980: 14), a negative connotation was perpetuated, namely that elderliness as such constitutes a problem both to the elderly person and to society. For example, in an industrialised society where great emphasis is placed on economic productivity, elderly people who are

physically unable to make a contribution towards economic progress in a country, are often regarded as useless and a financial burden to society.

Concerning the current economic deprivation suffered by the aged in some western societies, Illich (1976a: 222) regards elderly people as "an example of the specialization of poverty which the overspecialization of services can bring forth", and he comments as follows:

> Having learned to consider old age akin to disease, they have developed unlimited economic needs in order to pay for interminable therapies, which are usually ineffective, are frequently demeaning and painful, and call more often than not for reclusion in a special milieu.

Hooyman and Kiyak (1988: 526) point out that, due to defective and, in some instances, unscientific knowledge about elderly people and their life circumstances, personal opinions and myths result in social, psychological and even biological convictions about elderly people. They say that some of these myths became so dangerously institutionalised that they may have serious implications for elderly people and society as a whole. According to Hooyman and Kiyak (1988: 525), "a negative stereotype ascribes unfavorable characteristics to all objects or persons in a certain category; for example, 'All older people are [regarded as being] cognitively impaired'".

Hendricks and Hendricks (1981: 15) also suggest that the concept of *ageism* has unfavourable connotations. In their work, *Aging in mass society: myths and realities* (1981: 15), they refer to an element implicit in the term "ageism" (as it is coined by gerontologists who study the biological, psychological and social aspects of aging "to refer to the pejorative image of someone who is old simply because of his or her age") and state that "part of the myth ... is the view that the elderly are somehow different from our present *and* future selves and therefore not subject to the same desires, concerns or fears". The important question to be asked concerning ageism, is "what stereotypes does a society as a whole hold of old age?"

As a result of the tendency in the literature to portray aging as being a defective phase of life which is often devoid of social context, this study proposes to focus on the social aspect of aging and elderliness. This focus is based on the assumption that elderly people live and age in a social context - a context which influences a person's experience of the aged phase of life, as well as whether this experience will be negative or positive. The meaning of age and aging is interpreted in terms of social meanings: it is contextualised within a particular social matrix. It could therefore be argued that behaviour is contextualised in the social environment or culture. People are thus influenced by general patterns of behaviour.

According to Hughes (1990: 95): "To speak of meaning is to begin to point to that most important fact, that human beings have a rich and highly varied mental life." Hughes (1990: 95) argues that the process of giving meaning to one's life-world is regarded as "a subjective or internal component of behaviour" within a particular culture. Different attitudes assigned to certain experiences regarding aging and elderliness should therefore be interpreted with regard to the *meanings* these experiences have within the culture and for the individual. These attitudes are thus made up of different experiences and particular meanings are attributed to these experiences.

Regarding the specific *culture/cultural milieu* involved in this study, the focus is on white elderly people in cities as opposed to rural areas. The social relationships in which elderly people are involved are influenced by, inter alia, the following characteristics of industrial societies as described by Abercrombie et al. (1988: 122):

- the urbanisation of society
- the application of science to all spheres of life, especially industrial production
- the gradual rationalisation of social life

- the dominance of machine-production

These characteristics influence the elderly person's experience of aging in such a way that relationships between individuals in industrial society can be said to be weak and secondary, kinship ties become less important, and individuality is increasingly lost while individuals become more alike and less differentiated.

What follows is an overview of three theories of aging that developed over time - all having their foundations in basic sociological and psychological value systems as they relate to society. Basically, each theory represents an ideal typical set of norms for what "should happen" in old age. According to these theories, life satisfaction is dependent on one of the following:

- how much stress a person endured
- whether or not a person disengages himself or herself and takes on fewer roles
- whether a person remains active

With regard to the three theories of aging, Hooyman and Kiyak (1988: 63) note the following:

> Each theory suggests some important factors that may be related to aging and thus serves as a guide for further inquiry and possible intervention in the aging process.

This study revealed that life satisfaction depends on a number of factors and that quality of life in old age is influenced by the values and norms in a particular cultural milieu. For example, elderly people who are financially independent are generally more satisfied with their lives than poor people. Wealthy people could cope better with their circumstances for various reasons. The consequence of having money in old age in an industrial society is often related to the type of old-age

home in which the aged person lives: many poor people in public old-age homes lose their control and independence as a result of, for instance, not having transport. An overview of multiple stress theory, disengagement theory and activity theory is included to provide an idea of some of the different models for behaviour in old age.

(1) Multiple stress theory

Multiple-stress theory (Lowenthal 1967 in Kuypers & Bengtson 1973:185) states that impairment in old age results from the accumulation of stress over a lifetime. Since some people's lives are more stressful than others, and since they may experience continuous bouts of stress over periods of time, high demands are made on adaptive strengths and this may lead to breakdown. Kuypers and Bengtson (1973: 185), however, criticise multiple-stress theory in terms of certain critical questions that are left unanswered, questions such as:

- What constitutes stress?
- How does stress accumulate?
- Where is it stored?
- Are certain stressors common to the elderly?

Kuypers and Bengtson (1973: 185) argue that

> stress theory ... only posits the association but not the mechanisms of causality between stress and impairment; nor does it directly deal with the possibility of the stresses of social reorganizations.

Such social reorganisations may be, for example, changes in one's social life as a result of, for instance, the death of a spouse. Whilst Kuypers and Bengtson focus on the mechanisms of causality, this study aims, in terms of its critical theoretical orientation, to show how individuals perceive, interpret and respond in a multiplicity of ways to occurrences in their social worlds.

(2) Disengagement theory

Using the term "disengagement", Cumming and Henry (1961: 26) refer to

> an inevitable social process in which there is mutual withdrawal or disengagement resulting in decreased interaction between the aging person and others in the social systems he[/she] belongs to.

According to Fischgrund (1976: 410), the implications of this approach are situated in the process of disengagement which forms part of normal personality development, as well as in old people feeling happier when they are disengaged from former interaction patterns. A concern arising from this model is the *timing* between social and individual changes: when changes in roles or loss of roles occur before the individual is ready for them, disequilibrium may result.

(3) Activity theory

According to activity theory, as described by Lemon et al. (1972: 11), the continuity of lifestyle is carried on into old age, "for it suggests that psychological well-being is a function of the degree to which a person can maintain patterns of activity and involvement into late life". Following this theory, the maintenance of middle age activity patterns should be continued in old age. According to this model, no change does or should occur between the social and personal systems when an individual passes from middle to old age. Elderly persons are still expected to keep as "active" in the middle years. When roles are taken away, as in retirement and loss of spouse or friends, successful adaptation is measured in terms of the ability to compensate by increasing activity in other spheres. Furthermore, this theory postulates that good adaptation and happiness correlate positively with social involvement.

Authors such as Maddox (1987), and Brubaker and Powers (1976) pay attention to specific individual responses to certain aspects of aging

and elderliness. In this study, life satisfaction was influenced not so much by activity patterns as by a feeling of being in control of one's life.

In summary, disengagement theory claims that high satisfaction in aging is a result of an acceptance of the "inevitable" reduction in interaction. This theory therefore predicts the maintenance of high morale in spite of disengagement. Activity theory, on the other hand, maintains that reduction in activity leads to a reduction in satisfaction. Palmore (1968: 263) found that

> normal aging persons tend to compensate for reductions in some activities or attitudes by increases in others, or to compensate reductions at one point in time with increases at other times.

The above-mentioned study revealed that people in old-age homes expect and accept that they will become less active than before. Disengagement and reduced activity are parts of their reality even before they move to an old-age home. It is thus not possible to regard one of these three theories as correct or supreme.

Since life satisfaction in the industrialised culture is influenced by a diversity of factors, an explanation will subsequently be provided of some of the factors which can influence the life satisfaction of an elderly person.

3.3.1 Factors which may influence the life satisfaction of elderly people

3.3.1.1 Feelings of integrity versus despair

According to Louw (1982: 225), elderliness is characterised by a feeling of integrity versus despair. In reviewing one's life, an individual may experience a feeling of satisfaction (life was good). On the other hand, this may lead to a feeling that life has gone by without having accomplished anything of lasting value (despair). The latter may result

in depression. Therefore, influenced by past individual experiences, differences may occur in the level of satisfaction felt by elderly people.

In a lecture on "Aging Differently", Maddox (1987: 557) makes the point that people age differently and, therefore, generalisations about so-called "normal aging" should be regarded as relative and not as absolute.

3.3.1.2 Self-definitions concerning old age

According to Brubaker and Powers (1976: 442), chronological age is not sufficient to determine a person's self-definition as old, although, obviously, there is some relationship between chronological age and self-perception.

Certain events or experiences enforce the acceptance of being old, such as poor health, low income, institutionalisation, retirement, loss of independence, and loss of spouse. In spite of these so-called "old" events and experiences, not all elderly people hold a negative stereotype of old age. These events have merely been identified as "symbols of passage into late life" and are not always viewed negatively by an elderly person.

3.3.1.3 Heterogeneity of elderly people

Heterogeneity of older people stems from diverse factors such as different socio-economic characteristics, mental status, marital status, health status and cognitive functioning. Maddox (1987: 558) describes ways in which older adults, differently and realistically, "assess their health status and live their lives in the interest of achieving and sustaining a sense of well-being". Health, for instance, is predicted by factors relating to self-assessment of health, as well as personal characteristics such as cognitive functioning, pattern of social involvement, and perceived well-being. Different adaptive capabilities may either lead to successful adaptation in certain environments or a failure to adapt in later life to, for instance, institutionalisation.

It was found in this study that elderly people are heterogeneous in their personal perceptions of old age with regard to the physical processes of aging. Furthermore, elderly people view themselves as heterogeneous in their personal, social and spiritual experiences.

3.3.1.4 Self-ratings of health among elderly people

With regard to ratings of health among elderly people, evidence was found to suggest that physicians' assessments of their patients' health are age-biased (Kucharski et al. 1979 in Ferraro 1980: 377). For example, because the doctor will expect to find certain conditions in an elderly person, he will examine the person in ways that might reveal these conditions. However, in order to establish the factors which influence a person's assessment of his or her own health, it is essential to analyse the validity of self-ratings of health among the elderly. In a study entitled "Explaining life satisfaction: it's the elderly's attitudes that count", self-rated health was found to be the most important factor influencing individual assessments of life satisfaction (Snider 1980: 253). Therefore, subjective measures of assessing health status should be taken into account when an evaluation of life satisfaction is done.

3.3.1.5 Psychological well-being

According to Neugarten et al. (1961: 134), various attempts have been made to define and to measure the psychological well-being of elderly people, "usually with the goal of using such a measure as an operational definition of 'successful' aging". In approaching this problem, diverse terms have been used, terms such as adjustment, competence, morale, feelings of efficacy, or happiness. Neugarten et al. (1961: 134) states that "it [often] becomes necessary to establish some measure of success or well-being in relation to which other social and psychological variables can be studied". For example, when studying the link between psychological well-being and the extent of social participation, one might tend to only focus on the overt behaviour of the individual and will therefore, in a biased way, overemphasise social criteria in the

measurement of psychological well-being.

With regard to psychological correlates, Adams (1971: 65) arrives at the finding that the "self-perception of age does appear to show a decline in satisfaction as one moves from 'middle-age' to 'elderly' to 'old' self-concepts". Other psychological variables which negatively relate to satisfaction are, inter alia, feelings of inadequacy, rejection, unwantedness, and perceptions of relative deprivation (Adams 1971: 66). Doyle and Forehand (1984: 432) suggest that, "in order to understand the subjective well-being of older [people], we must understand how happy they are relative to other [people]". In this study, psychological well-being has much to do with feelings of control and independence, as well as feelings of being cared for.

3.3.1.6 Age as biological correlate

In a study entitled "Correlates of satisfaction among the elderly", Adams (1971: 65) found an inconsistency regarding the effects of age as biological correlate of satisfaction:

> Some investigators have found a decline with age, others have found no relationship, and still others have indicated a curvilinear relationship with decline to age 75 or 80 and a levelling or increase thereafter.

The suggestion is rather to view age as an index to a combination of factors than as an independent variable. According to Doyle and Forehand (1984: 433), both the general public and a number of social gerontological researchers regard decreased happiness as being linked to advanced aged. However, Herzog & Rodgers (in Doyle & Forehand 1984: 434) found - in their re-examination of eight major studies - "that satisfaction with many domains of life tends to increase with advancing age". Given the fact that some studies show a negative relationship between age and life satisfaction while others show a positive relationship or even no relationship at all, it can be concluded that no consistent relationship exists between age and life satisfaction. What

constitute the most important predictors of satisfaction therefore remains an unsettled question.

3.3.1.7 Spiritual well-being

For the religious person, another domain exists where satisfaction might pose a question, i.e. the spiritual domain. In a study entitled "Subjective measures of spiritual well-being", Moberg (1984: 352) defines spiritual well-being (in this case specifically within the Christian faith) as "the affirmation of life in a relationship with God, self, community and environment that nurtures and celebrates wholeness". Quality of life encompasses a complex multidimensional phenomenon which, according to Edvardsson and Vegelius, Krendel, Terleckyj and Gerson (in Moberg 1984: 353), involves both material and spiritual well-being. Nevertheless, as indicated by different studies (Moberg & Brusek 1978 and Hadaway & Roof 1978 in Moberg 1984: 353), religion is almost completely ignored. Given their significant place in the classical theories of Weber (1930; 1963) and Durkheim (1915), among others, Moberg (1984: 353) argues for the incorporation of religious variables in the measurement of individual well-being and quality of life.

Components of spiritual well-being are described in terms of "the human need to deal with sociocultural deprivations, anxieties and fears, death and dying, personality integration, self-images, personal dignity, social alienation, and philosophy of life" (Moberg 1984: 351). To Moberg (1984: 360), the continuous ignoring of spiritual variables in studies of life satisfaction by regarding religious faith as "downright esoteric", implies the neglect of spiritual health as an important component of holistic well-being.

In summary, Kovar (1977: 9) writes:

> Aging is a process that continues over the entire lifespan at differing rates among different persons. The rate of aging varies among populations and among individuals in the same population. It varies even within an individual because

> different body systems do not age at the same rate. There are, therefore, no biological reasons for defining "elderly" in terms of a specified calender age. The reasons for using age 65 to mark the beginning of old age are mostly social and legislative.

For the purposes of this study, Kovar's point of view is supported. The fact remains that aging processes must never be regarded as absolute nor as a finality, as is found in the concept of *the* aging process.

In terms of Illich's theory, social iatrogenesis (as discussed in chapter 2, section 2.2.3) is described as a mental attitude towards medicines and medication practices, while cultural iatrogenesis (as discussed in chapter 2, section 2.2.4) manifests itself in a person losing his or her autonomy and responsibility for personal health matters. Certain meanings assigned by elderly people to their experiences of aging and elderliness (feelings of despair, events which demand an acceptance of being old, socio-economic characteristics, psychological and spiritual well-being) could increase an elderly person's susceptibility to social and cultural iatrogenesis.

A discussion of some aspects of how elderly people are medicated follows.

3.3.2 Medicines and elderly people

Research has revealed a significant increase, with increasing age, in the use of drugs in industrial societies. Cartwright and Smith (1988: 1) emphasise the worldwide concern about the extent and nature of prescribing for elderly people. Lenhart (1976: 135) comments that "geriatric multiple pathologies" are treated with powerful yet dangerous drugs and, consequently, result in problematic side effects.

According to Mullen and Granholm (1981: 108), people over 65 years of age "take more than three times as many drugs as their juniors". A study conducted by Page (1988: 45) revealed that "83% of persons age 60 and over were using two or more prescription drugs". Straughan (in Sarzin

1987: 1) accuses South African society for being over-reliant on medicine:

> Many disorders are essentially self-limiting and may well improve at least as well without the administration of any medicines as with their use. In fact, medicines may introduce new problems or complications.

While acknowledging the benefits of certain drugs for the aged, Mullen and Granholm (1981: 108) warn that an appreciation should be developed of the risks involved in the use of drugs: "No drug is devoid of toxicity, and useful, effective drugs can cause illness and death." It is also evident that many elderly people consume large quantities of drugs with little knowledge of the dangers involved in combining certain drugs.

According to Wynne and Heller (1973: 15), elderly people are less physically tolerant of most drugs than younger persons, especially tranquilizers and other psychoactive drugs that are among those most frequently prescribed. The elderly are less capable of metabolizing most drugs, more susceptible to direct, side and interaction effects and may require smaller dosages. Because of common pathological processes, they are likely to be receiving a variety of drugs that can produce complex and little understood antagonistic or mutually potentiating interactions.

As a result of life being turned "into a series of periods of risk, each calling for tutelage of a special kind", Illich (1976a: 87) views elderly people as "victims of treatments meted out for an incurable condition". Illich (1976a: 89) refers to conditions associated with old age, such as rheumatism, most cancers and many other degenerative diseases, and states that these cannot be cured by medical treatment, but they have nonetheless "recently been put under doctor's orders". According to Illich (1976a: 90), "medicine just cannot do much for the illness associated with ageing, and even less about the process and experience of ageing itself". He does, however, acknowledge the usefulness of painkillers for the suffering brought about by diseases and conditions

specifically related to old age.

In conclusion, Fletcher and Fletcher (in Petersen & White 1989: 451) state that

> medical interventions are, of course, intended to improve patients' health. But nearly every effort to help is, unfortunately, accompanied by potential for harm.

This potential for harm represents the danger of clinical iatrogenesis as described by Illich (1976a) and discussed in chapter 2, section 2.2.2 of this study.

The following discussion will focus on actual harmful effects suffered by elderly people as a result of drug therapy.

3.3.3 Drug-induced iatrogenesis in the elderly: hazard of multiple drug therapy

German and Burton (1989: 228) define a serious adverse drug reaction as "an adverse drug experience that is life threatening, is permanently disabling, requires inpatient hospitalization, or requires prescription drug therapy". According to Conoley (1984: 709), health professionals are in the powerful position of being able to "create" ill-health. This "creation" of ill-health by health professionals is described by Illich as clinical iatrogenesis. The danger of clinical iatrogenesis becomes a reality when a person suffers physical harm as a result of medical care.

Lenhart (1976: 138, 140) describes the effects of sleeping tablets in the following way:

> Psychotropic drugs are used in the treatment of [inter alia] insomnia. While these drugs seem to have a smooth effect ..., they affect coordination and ambulatory function. This can be especially serious in the elderly already predisposed

> to falls ... [These drugs] may [also] ... lead to development of tolerance and dependence. All of these drugs are enhanced by alcohol.

Old age and chronic ailments go hand in hand. Craig and Eves (1987: 86) express a concern for the fact that little attention has been paid by both doctors and pharmacists to health risks resulting from unsupervised *polymedication*. (This concept is defined and discussed in chapter 1, section 1.3.6). One study found that physicians were aware of only 64% of the drugs their patients were taking (Craig & Eves 1987: 88). D'Arcy (1976: 277) puts forward a suggestion that a modern and more logical version of the term "iatrogenic disease" should include the practice of drug therapy. According to D'Arcy (1976: 282), "awareness of the problems of drug interaction and iatrogenic disease is surely the first step in reducing the hazard of some medication and bringing it into manageable proportions".

Scrutton (1988: 15) argues for more thorough research of the iatrogenic nature of much elderly illness, especially those resulting from the careless use of potent drugs. According to Trounce (1975: 290), "evidence ... suggests that the process of ageing alters the response to drugs in a number of ways and it seems probable that the result in any individual may be the sum of several variables". The prescriber needs to be cautious of the drug-related problems encountered by elderly people. Trounce (1975: 290) suggests a radical reduction in the administration of medication.

In arguing that "prevention is the best course of action" for iatrogenic disease, Steel (1984: 445) calls for "the importance of obtaining information about a typical day in the life of the patient". In other words, the plea is for a holistic view of the person. To Petersen and Thomas (1975: 555), common geriatric problems such as loneliness, boredom, and depression often lead to doctors prescribing a variety of drugs in elderly people. According to the above-mentioned study, the most frequently misused drugs among the aged include Valium, Tuinal, Phenobarbital, and Darvon. Supporting these findings, Cartwright and

Smith (1988: 19) found hypnotics and sedatives representing the group of drugs most commonly prescribed to elderly people.

According to an article in *The Economist* (1989: 17), "medicine has increased the quantity of life far beyond its capacity to preserve the quality of it, and a greater proportion of old age is now spent in chronic illness and misery." This article (*The Economist* 1989: 17) warns

> that life should never be extended at the cost of worsening it. There is room for plenty of theories about what makes life worth living, but none of them can include longevity as an end in itself. When a person (or relatives) can see that a biography is finished, it is not for doctors to try to write a painful extra chapter.

The health care of the elderly with particular emphasis on the role of the doctor will now be discussed.

3.3.4 Health care of the elderly: the role of the doctor

Ergang (1967: 633) describes the eighteenth century as the Age of Enlightenment - an enlightenment made possible (according to rationalist philosophers) by the use of the power of "reason". Emphasising the influence of social values on the medicalisation of the aged, Illich (1976a: 198) states that "the enlightenment attributed a new power to the doctor, without being able to verify whether or not he had acquired any new influence over the outcome of dangerous sickness".

From the previous discussion, it seems evident that elderly people are particularly susceptible to adverse drug reactions, and they can suffer from debilitating drug side effects. The doctor, as the main prescribing agent in the health care of the elderly, needs to exercise caution and bear in mind the declining physiological state of the elderly person. Since clinical iatrogenesis, as described by Illich and discussed in chapter 2, section 2.2.2, represents the dimension of *physical* damage caused by medical practitioners in their attempts to cure people, the

role of the doctor is of vital importance in controlling and preventing the problem of clinical iatrogenesis.

Wessels (1991: 22) suggests the following recommendations for effective medication in the elderly:

- Generally, the elderly patient requires smaller doses of drugs than are normally prescribed for the young adult.

- Care should be taken to give as few drugs as possible, namely only those which the patient really needs.

- As a result of the many physiological impairments due to old age, the doctor should ensure that the patient understands her/his intentions as prescriber.

- In order to discontinue unnecessary drugs, drug regimens should be reviewed regularly.

3.3.4.1 Communication between doctor and patient

It is clear that *communication* between doctor and patient is crucial. In their study, "Clinicians, the elderly and drugs", German and Burton (1989: 233) report the following significant findings:

- Patients were told the purpose of 74,6% of their prescribed drugs.

- Patients were told about potential side effects of 8,4% of all their prescribed drugs.

Much emphasis is placed on the importance of and need for better communication (Kazis & Friedman 1988; Fincham 1988; Maloney & Ury 1988; Johnston et al. 1986; Green et al. 1986; D'Arcy 1976; Hulka et al. 1976; Schwartz et al. 1962). Kazis and Friedman (1988: 1161) state that the doctor should take "specific time to outline in very clear language ... the purpose of the medication, its dosage, frequency, and duration of

administration". Furthermore, they suggest that doctors need to make an assessment of their patients' capabilities and limitations in order to identify problems that might adversely affect their ability to take their medications as prescribed.

Reeder (in Beisecker 1988: 330) provides the following distinction between the patient as client and the patient as consumer:

> The client comes to the professional for advice and accepts the professional's opinion, whereas the consumer listens to the thoughts of the provider, or of several providers, but ultimately makes his or her own decisions (Beisecker 1988: 330).

The medical consumer thus assumes more bargaining power in the relationship with the medical provider than the client. However, given an empirical finding by Reeder (in Beisecker 1988: 330) that older patients "behaved in a manner consistent with the traditional Parsonian passive patient role", it seems that the responsibility for communication rests with the doctor. This responsibility implicitly includes measures to overcome patient passivity when interacting with physicians.

Furthermore, Fincham and Wertheimer (1988: 60) found that "physicians often may be too ready in the eyes of the patient to write prescriptions". In terms of Illich's explanation of social iatrogenesis (as discussed in chapter 2, section 2.2.3), medicalisation sets in when the person becomes increasingly dependent on medical care, for instance, when a pattern of repeating prescriptions is followed by the doctor without evaluating the person's lifestyle for possible alternative ways of solving the problem.

3.3.4.2 The need for specific education

According to Radecki et al. (1988: 719), "several national conferences and reports have acknowledged the need to educate physicians and other health professionals concerning the special clinical care needs of

elderly patients". This view is supported by Raffoul et al. (1981: 146), as well as Libow (1977). Radecki et al. (1988: 719) found evidence of insufficient time spent with elderly patients as a "proxy indicator of deficiencies in quality". Snyder (1984: 475) summarises the implications for health education in the following words:

> Personal health problems, including small unaccounted-for aches and pains and major diagnosed diseases, become very important in the daily life of the older person. Older people seek explanations and understanding of these events.

This study recommends that health education should be undertaken by the medical staff working in the old-age home or specifically in the frail-care unit of the old-age home, or by the patient's doctor.

Yet another problem which prejudices the effective treatment of patients arises out of a *team approach*. Kriel (in Beeld 1985: 5) warns about the "'I am God'syndrome" - a state of affairs in which a doctor arrogantly assumes a god-like and sole responsibility in matters of disease and health. Such assumptions obviate a doctor's effectiveness and alienate him or her from other colleagues in the health care team.

In the following section, the role of old-age homes will be considered in the medicalisation of elderly people.

3.3.5 Institutionalisation: the role of old-age homes

In terms of Illich's three-level theory of iatrogenesis and the role of old-age homes, cultural iatrogenesis represents a symbolic dimension which refers to the destruction of autonomy, as well as to the deprivation of personal responsibility for self-care. Cultural iatrogenesis is discussed in chapter 2, section 2.2.4, of this study. For the purposes of this research, the effects of institutionalisation in old-age homes, as experienced by elderly people, are investigated as possible causes or contributing factors of cultural iatrogenesis.

3.3.5.1 Loss of independence

Townsend (1981: 5) claims that this twentieth century phenomenon of dependency of elderly people on social services "is being manufactured socially and that its severity is unneccesary". He refers to certain major influences aggravating the incidence of dependency, such as the acceptance of earlier retirement (Townsend 1981: 5). Furthermore, Townsend (1981: 22) states that dependency is reinforced by viewing elderly people "as the grateful and passive recipients of services administered by an enlightened public authority".

Wack and Rodin (1978 in Van Zyl 1980: 25) point out that

> the bureaucratic structure and staffing patterns of nursing homes tend to increase deindividuation and dependence, [and add that] such homes are simply easier to run when the residents are docile and dependent.

Supporting this view, Hofland (1988: 3) states that "others tend to make a variety of decisions for [elderly people], resulting in an erosion of personal autonomy". In a comparative study concerning the quality of care for the institutionalised aged, Kayser-Jones (1982: 936) found that elderly people were very satisfied where they were granted opportunities to exercise some choice, freedom, and independence.

To Illich (1976a: 91), specialised institutions for elderly people "seem to be the contemporary strategy for the disposal of the old". Illich (1976a: 91) states: "The mortality rate during the first year after institutionalization is significantly higher than the rate for those who stay in their accustomed surroundings", and, in addition to this statement, he goes so far as to claim that "some old people seek institutionalization with the intention of shortening their lives".

In a study of institutionalisation, Van Zyl (1980: iv) emphasises the intense tension caused by relocation, and states that "most people need to grieve the loss of their home and the independence it symbolized, in

order to adjust to institutional life". Bennett (in Van Zyl 1980: 15) notes that a specific way of life is developed in every institution "to which residents are socialized and expected to adjust". Following this line of argumentation, Shapiro and Tate (1988: 237) emphasise the costliness of institutionalisation in both human and economic terms, and state that "most elderly value their independence and prefer to remain at home as long as they can". Eckley (1989: 1) comments on the unhappy and unhealthy situation in South Africa where many elderly people in old-age homes could still have maintained their independence in society. Schulz (1976: 563) states that loss of control gives rise to feelings of depression and helplessness in the institutionalised aged.

Regarding their loss of independence as a result of institutionalisation, Illich (1976a: 90) states that, the higher the incidence of acquiring "rights to professional care", the more the "opportunities for independent ageing decline". This has given rise to more elderly people seeking refuge in institutions. Furthermore, the problem with elderly people is aggravated "as more of the elderly are initiated into treatment for the correction of incorrigible impairment or for the cure of incurable disease" (Illich 1976a: 90).

3.3.5.2 Loss of privacy

MacLean and Bonar (1983: 16), focusing on the reality of an increased likelihood of being placed in an old-age home, emphasise the elderly person's need for respect with regard to individual differences, for instance "the opportunity to break away occasionally from his[/her] group, eg by eating or going to bed earlier or later than the established pattern". According to Myles (1979: 174),

> this loss of privacy and the inability of inmates to separate their private and public worlds create a situation where the 'forced' interaction among inmates of the institution is a source of dissatisfaction rather than satisfaction.

3.3.5.3 Depersonalisation

Christopher et al. (1988: 52) found individual competence likely to deteriorate with prolonged institutionalisation. In addition to this, Minichiello (1987: 353) refers to studies of the effects of institutionalisation on the well-being of older people which revealed serious dehumanising and depersonalising effects, such as increased anxiety, low self-image, and feelings of hopelessness and helplessness. "Depersonalisation" is defined as a denial of the recognition of the person as an individual and, thus, a denial of a holistic view of the resident (Van Zyl 1980: 38).

3.3.5.4 Institutional medicalisation

Myles (1979: 174) points out that institutions for elderly people generally "adopt a medical model to govern staff-client relations". According to Binney et al. (1990: 762), "medicalization on the institutional level occurs when the physician is elevated to the position of 'gatekeeper' to authorize eligibility for services". Institutional medicalisation can thus be defined as occurring when the structure, mission or procedures of the institution are changed in a way that will allow for a person to become dependent on the available medical services. Following this line of argumentation, Page (1988: 46), in a paper entitled "Research issues in geriatric drug use", focuses on the fact that patients in institutions are always on complex drug schedules. He maintains that seventy-four percent are on two or more psychoactive drugs. According to Ray et al. (1980: 485), "the powerful tranquilizing effect of these [psychoactive] drugs has led to their use among the aged for the control of both disruptive behaviour and nocturnal restlessness". Page (1988: 46) claims: "It is difficult to escape the conclusion that these are used more to mold the patient to the institutional schedule than to relieve symptoms." Wynne and Heller (1973: 16), commenting on the serious and irreversible neurological side effects produced by those tranquilisers which are usually prescribed for elderly people, state that "long-term tranquilizer use ... seems to contribute to a permanent state of institutionalization by reducing drive, initiative and planning

ability of the elderly patients".

Wood and Estes (1988: 41) summarise the problem of institutionalisation and medicalisation as follows:

> If the appropriate service delivery system for the elderly becomes defined as one primarily of medical or medically related services ..., [this tendency] exemplifies not only the strength of medicine, but also the cultural acceptance of aging as a medical problem.

3.3.5.5 Staff attitudes

In a study entitled "Staff attitudes and caring practices in homes for the elderly", Booth et al. (1990: 118) argue that institutionalisation should be the personal choice of the elderly person, as well as a positive experience in terms of exercising control over their own lives. Booth et al. (1990: 118) recognise that successful practical application of these principles depends on staff attitudes. The staff is thus acknowledged as being of vital importance in any attempts to improve or change the nature of residential care. The study by Booth et al. (1990), as well as a study conducted by Eckley (1989) highlight, inter alia, the following essential values which should characterise staff attitudes:

- the preservation of human dignity
- a respect for individuality
- a recognition of the need for privacy
- freedom of choice in matters of lifestyle and relationships
- a regard for the rights of residents as citizens

3.3.5.6 Loss of autonomy

With regard to loss of personal autonomy, Saup (1986: 32), in a study entitled "Lack of autonomy in old-age homes: a stress and coping study", found that coping strategies imply a relinquishing of personal control. Studies supportive of this view were conducted by Wolk and Telleen

(1976), and Schulz and Brenner (1977). For the purposes of this study, loss of autonomy is inclusive of the loss of independence, privacy and control suffered by elderly people in old-age homes. According to Illich's theory of iatrogenesis, loss of autonomy is a direct result of cultural iatrogenesis (as outlined in chapter 2, section 2.2.4). Furthermore, it could be argued that loss of autonomy leads to depersonalisation which in turn leads to the deprivation of personal responsibility for self-care.

Cath (in Safford 1989: 2) regards institutionalisation as "one of the most traumatic transitions which might occur in a lifetime". In terms of the symbolic meaning transferred by cultural iatrogenesis, it could perhaps be argued that this level of damage implies a general condition of loss of interest in oneself. This could happen to elderly people in old-age homes as a result of external control being exercised in old-age homes in such a way that people lose their autonomy and feeling of responsibility towards their own health matters. Tibbit (1983: 241) claims that "aged persons in our society are neglected and rejected and discriminated against", and continues by stating that "large numbers of them are forced to remain in institutions simply because ... their place in the community has been permitted to close in behind them".

3.4 CONCLUSION

According to Illich (1976a: 89),

> the demand for old-age care has increased, not just because there are more people who survive, but also because there are more people who state their claim that their old age should be cured.

To Illich (1976a: 90), both modern social policy and the medical establishment are responsible for converting the privilege of old age into a disease. He regards the "transformation of old age into a condition calling for professional services" as having cast elderly people "in a role of a minority who will feel painfully deprived at any

relative level of tax-supported privilege" (Illich 1976a: 92).

Although many negative points about institutionalisation have been stated, one major advantage of old-age homes should be emphasised, namely that elderly people do not become as isolated as when they stay on their own. Furthermore, elderly people in old-age homes receive regular meals which is another advantage of old-age homes, since elderly people can easily become malnourished or undernourished.

In this chapter, Illich's view of aging was linked to a discussion of the problem of medicalisation among elderly people. Special attention was paid to factors such as, inter alia, elderly people and their medication practices, the dangers of drug therapy, the role of the doctor, and the role of old-age homes. In each section which dealt with the phenomenon of medicalisation among elderly people, specific indications were provided of how Illich's three-level theory of iatrogenesis could be applied.

In the following chapter, a discussion will be provided of how this information will inform the methodology for this study, as well as the analysis of the data.

CHAPTER FOUR:

RESEARCH METHODOLOGY

> How can one carry out holistic research? Can one address the whole person? It is possible to be responsive to the cues that the individual offers; to recognise that two-way communication will be both verbal and non-verbal. Holistic research is not the result of woolly thinking but of an informed and clear-headed approach to the complexities of "reality". The holistic researcher needs self-awareness, sensitivity, and responsiveness (Reason & Rowan 1981: 388).

4.1 INTRODUCTION

In this chapter certain methodological and theoretical decisions underlying this study will be considered. Methods used in conducting the study, namely the sample and the different stages of the sampling procedure, will be discussed. Also discussed will be the running of the pilot study, the interview guide and the procedure of using interviews as the method of data collection.

The study was carried out by means of in-depth individual interviews. These were analysed and interpreted in terms of the interpretive approach which forms part of descriptive qualitative research. The study was largely exploratory.

In the following section, an exposition will be provided of certain basic principles underlying qualitative research.

4.2 QUALITATIVE RESEARCH

According to Sampson (1987: 72), *qualitative research* teaches and enables the researcher to listen with three ears:

> ... with one ear ... to what people were saying. With the second ear ... to what people were not saying. And with ear number three... to what people wanted to say, but either couldn't, or didn't know how to.

He regards the latter as the most difficult form of listening. In their explanation of the interpretive approach, Haralambos and Holborn (1990: 707) argue that people "see, interpret and experience the world in terms of meanings [which] are constructed and reconstructed by actors in the course of social interaction". In this study, qualitative methods are used, because they are more sensitive to this kind of information than quantitative methods.

Hughes (1990: 93) describes the interpretive method of inquiry as the method of *Verstehen* which, "given the theoretic interest of understanding or interpreting meaningfulness, is attempting to reconstruct the subjective experience of social actors". For the researcher to be able to do this, it is necessary to imagine yourself to be in the position of the person whose behaviour you were seeking to explain.

Haralambos and Holborn (1990: 19) mention Weber as one of the first sociologists who fully outlined this method of *Verstehen* which entails the interpretation of the internal logic which directs the actions of the actor. According to Hughes (1990: 95), "actions are reciprocally oriented ... because actors *interpret* and give meaning both to their own and to others' behaviour". He continues by stating what he calls "the most important fact ... that human beings have a rich and highly varied mental life reflected in all the artifacts by which, and institutions in which, they live" (Hughes 1990: 95).

The aim of "verstehen" or interpretive understanding is therefore to provide social observers with a method to research social phenomena in a way that will capture the meanings underlying certain human actions. According to Mouton and Marais (1990: 43), this process of exploration involving the use of in-depth interviews usually leads to "insight and comprehension rather than the collection of replicable data".

Quantitative research methods do not allow for the richness of interpretation that is required in this study. This accounts for the choice of qualitative data.

Referring to qualitative research in general (which also applies to this study), Reason and Rowan (1981: 490) make the following statements:

- Significant knowledge of persons is generated primarily through reciprocal encounter between subject and researcher.

- People have the capacity for self-awareness and for autonomous, self-directed action within their world, that they may develop the power to change their world.
- We see human inquiry not only as a systematic coming-to-know process but also as learning.

- We are interested in generalization, not in order to make deterministic predictions, but as general statements about the power, possibilities, and limits of persons acting as agents. We are interested in describing the general patterns within which the particular may exist, and accept that often the most personal and particular is also the most general.

- We make every attempt to do justice to the person-in-context as a whole, and find in practice that this entails multi-level models of understanding.

- What we contend for most of all is awareness of what is being done to self and others, and of what follows from that - both meant and unmeant.

Since Illich's view implies a change in people's everyday life circumstances, the point of developing the power to change one's world is of vital importance for this study. Furthermore, this process of inquiry can be regarded as a learning process for both the researcher and the respondent. This emphasises the idea of exploring and interpreting.

The in-depth interview is one of the most frequently used types of collection of non-numerical data in qualitative research. Ferreira (1982: 92) describes qualitative research as "based on induction, holism and subjectivism, and ... concerned with sensitivity for cultural context and subjective meaning".

For the purposes of this study, it is necessary to investigate the *meanings and experiences* which elderly people attach to their own health status, their medication practices, the way they feel about their age, as well as life in an old-age home. In order to research meanings and experiences, it becomes desirable to consider qualitative research - which allows for the *understanding* of phenomena - for undertaking the investigation. The main question in this regard is "What causes people to behave in the ways they do?" In order to get behind people's motives, it is essential to make people tell their stories and not to restrict them to structured questions and answers. The questions in the in-depth interview are formulated around broad themes in a way that would lead to a conversation. The respondent is therefore encouraged to speak freely.

The purpose of this study is to follow a holistic research approach by conducting in-depth interviews in order to understand certain behavioural patterns. Once this is accomplished, the issue of changing these patterns can be addressed. Reason and Rowan (1981: 491) conclude on a powerful note: "The outcome of research is knowledge. Knowledge is power. The right kind of research gives the right kind of power."

In the following section, the focus of the study will be outlined.

4.2.1 Focus of study

Data collected from fifty in-depth interviews was interpreted in order to understand and explain the experiences and approaches of old-age home residents towards their medicine-taking habits and routines, as well as institutional life. In addition, biographical details regarding, inter alia, their ages, the length of stay in the old-age home, occupation for most of their lives, and the most important reason for moving to an old-

age home, were gathered. These results were then interpreted in terms of Illich's analytical framework as indicated in chapter 2, section 2.2, namely:

- clinical iatrogenesis which refers to physical pain and disease as a result of medical care

- social iatrogenesis which refers to addiction to medical care as a solution to every problem

- cultural/structural iatrogenesis which refers to the destruction of personal autonomy and deprivation of personal responsibility for self-care

This study is directed by the following key questions which emerged from the researched literature and are representative of the three iatrogeneses:

- Does the medical profession contribute to the medicalisation of elderly people by regarding the normal aging process as well as elderliness as disease?

- Do elderly people become addicted to medicines or medical care as a result of social isolation and alienation?

- Do old-age homes contribute to the medicalisation of elderly people due to older adults' loss of autonomy?

- Should socio-economic status be regarded as a critical variable or at least an important intervening variable in the medicalisation levels of elderly people in public and private old-age homes?

- Is there an existing link between the level of autonomy and type of old-age home?

According to Haralambos and Holborn (1990: 19), Weber "did think it was

possible to produce causal explanations of human behaviour so long as an understanding of meanings formed part of those explanations". Cole (1980: 121) also regards one purpose of using qualitative research as "understanding *causal processes*". Since this study can be regarded as an *exploration* of the behaviour of elderly people as it relates to medicalisation, no definite hypotheses were tested.

The *pilot study* influenced the study in different ways. A discussion will now ensue of three pilot studies that were conducted in order to check the feasibility and to improve the design of this research procedure.

4.2.2 The pilot study

From the literature review certain issues were identified which the researcher wanted to explore and, through conducting three pilot studies, final changes and refinements were made to the fieldwork.

The *first pilot study* involved eight semi-structured interviews with elderly residents in private old-age homes. This study brought to light certain problems with regard to taking notes (as opposed to tape-recording the interviews), as well as problems with the formulation of some questions and deficiencies in the questionnaire. For example, the researcher realised the necessity of enquiring about the respondent's occupation for most of his or her life. This could shed some light on existing knowledge and frame of reference especially in those cases where the person had been involved in the medical profession.

After the first pilot study, it was decided to use an interview guide with certain themes rather than a structured questionnaire, and also to tape-record the interviews. The researcher realised that much valuable information and interpretations have been lost in the process of taking notes. More often than not, the precise way in which a respondent said something revealed a certain formulation or nuance of experience that would have been significant for this study.

In the *second pilot study*, which included six respondents from both public and private old-age homes, an interview guide was used and the interviews were tape-recorded. Although this second pilot study ironed out previous technical problems concerning the interview technique, significant and substantial differences between public and private old-age homes were revealed. These differences appeared to be so fundamental that a further decision regarding this research was taken, namely to interview respondents from both public and private old-age homes in order to compare the results, for instance, in terms of autonomy, independence and control over personal matters.

For the purposes of this study, the researcher arrived at the following definitions for public and private old-age homes:

- A *public home* is regarded as an old-age home where the resident pays monthly rent, usually a percentage of his or her monthly pension. Generally, meals are included.
- In a *private home* the resident buys the occupation right of a unit or a flat. This unit is usually equipped with a kitchen and is furnished with the resident's personal belongings. In private homes residents pay a monthly levy which usually covers two or three meals a day, as well as domestic cleaning services.

The second pilot study also revealed the following differences between the experiences of residents of public and private old-age homes:

- It became evident that an excessive amount of prescription drugs are consumed in *public old-age homes*. Usually the person does not know what medication he or she is taking, nor do they know what effect the drugs are supposed to have. These people generally do not mind taking the medicines handed out to them.

- In *private old-age homes*, where residents buy occupation rights, the following pattern was revealed by the second pilot study and is interpreted by the researcher as follows: Residents seem to be

more autonomous concerning their health matters. They know what medication they are taking; they purchase medicines themselves; they generally do not like taking medicine unnecessarily; they tend to be independent and in control of their own lives; they think in a self-reliant way and seem to take responsible decisions regarding their own health.

A *minor pilot study* which served as an exploratory investigation regarding the attitudes of medical staff in old-age homes was also conducted. This study proved to be important in informing and directing the research especially in defining certain categories in the interview guide. Three nursing sisters working in two different old-age homes were asked questions about elderly people and their medication practices, as well as medical practices in old-age homes. (See Appendix 2 for an interview guide in this regard.) Since old-age homes are dealing with a considerable number of diseases and conditions related to old age, they might contribute to the fact that elderly people in old-age homes are medicalised. This idea was also confirmed by the opinions expressed by the three nursing sisters.

For this study, an interview guide (see Appendix 1) consisting of five sections was constructed. These sections were informed by the pilot study and sections B, C and D correspond with Illich's theory in the following way: (Since section A dealt with biographical data and section E with recommendations, these two sections do not specifically correspond with Illich's theory in a particular way.)

- Section B: Perceived health status and approach towards medication practices: social iatrogenesis and to a lesser extent clinical iatrogenesis.

- Section C: The aging experience and life satisfaction: social and cultural/structural iatrogenesis.

- Section D: Approach towards life in an old-age home: cultural/structural iatrogenesis.

In the following section a consideration will be given to certain methodological decisions underlying this study, namely the sample, sampling procedure, interview guide, and the interview.

4.3 TECHNIQUES FOR THE COLLECTION OF DATA

4.3.1 The sample

Initially, it was decided to select a population of elderly people in general, but, in order to address the third level of Illich's theory, namely that of cultural/structural iatrogenesis (which refers to the destruction of personal autonomy and the deprivation of personal responsibility for self-care), the study was delimited to a population of elderly people in *old-age homes*. This delimitation allows for investigation of the loss of personal autonomy as well as the deprivation of personal responsibility for self-care as a result of institutionalisation.

A particular qualification of this delimitation is that the old-age home, whether it is public or private, is equipped with a medical care unit, such as a frail-care unit which is medically staffed on a twenty-four hour basis. However, respondents for this study are specifically *not* admitted to these units as patients. They are self-supporting with regard to their daily activities, but they do have access to medical services on a day and night basis.

This study does not aim to criticise the medicalisation of elderly people who are under long-term medical care and, as a result of deteriorating conditions related to aging, will necessarily be most medicalised. The purpose is to investigate the medicalisation of elderly people who are still able to function independently and to take autonomous decisions regarding their health matters. In other words, this research attempts to determine whether otherwise presumably independent people become or are medicalised as a result of, inter alia, the availability of medical services.

In order to test Illich's three-level theory of iatrogenesis on one particular population, a certain extent of homogeneity of the sample is required, inter alia:

- a high possibility of *established medication practices* as found in elderly people
- a high degree of *changing social patterns*, such as loss of spouse through death, and loss of circle of friends by moving to an old-age home
- *institutionalisation* of elderly people in old-age homes

The above characteristics, which were assumed to influence the findings significantly, are best met in an old-age home environment where elderly people live together under more or less similar conditions and under medical supervision. An advantage for the researcher of this choice of population is that respondents are easily accessible in the closed environment of an old-age home.

The sample size included fifty subjects who met the criteria of being over the age of 65 years and stayed in old-age homes (private or public) equipped with frail-care units. Only white elderly people in old-age homes in and around Pretoria were sampled. According to Population Census, 1991 (CSS Report No. 03-01-01: 115), only 69 black elderly people live in retirement complexes in and around Pretoria, and 117 black elderly people have rooms in old-age homes in and around Pretoria. Furthermore, it could be said that white people in this country are generally more "industrialised" and therefore more medicalised than black people. Due to these low figures, as well as a consideration of Illich's critique in terms of influences on industrialised people, it was decided to focus this study on white elderly people.

After sampling of different private and public old-age homes in and around Pretoria, a systematic random sample was drawn from the name register at each old-age home. The sampling procedure will be explained

in the following section.

4.3.2 The sampling procedure

A multi-stage cluster sampling procedure was followed in this study. This is a form of probability sampling where "the probability of selection of each respondent is known" (Bailey 1982: 91).

In the first stage, a list of all old-age homes in Pretoria was obtained from the Council of Care for the Aged. For the purposes of this study, the different old-age homes in and around Pretoria were regarded as clusters with more or less similar characteristics in terms of the provision of accommodation, meals, social activities, and medical services. For instance, old-age home residents are a homogeneous group exhibiting characteristics such as:

- living together with other elderly people in a close unit
- having meals in a communal dining room at strictly set times every day
- having moved out of the privacy of their own homes
- having in all probability lost a spouse

However, within these clusters individuals are heterogeneous with regard to their experiences and interpretations of medication practices, aging, life satisfaction and life in an old-age home. This confirms the point about the heterogeneity of unit characteristics made by Leedy (1993: 208).

According to Haralambos and Holborn (1990: 723), *stratified random sampling* involves "the division of the sampling frame into groups in order to ensure that the sample is representative." In the universum of old-age homes, a distinction was made between homes which are publicly funded and homes which are privately funded. The category of public or subsidised old-age homes was treated as a complete one: no further distinctions were made between subsidising sources, such as churches or other religious or welfare organisations.

The list of old-age homes only provided information concerning old-age homes for white people. Only 117 black elderly people, 6 Indian people and 136 coloured people stayed in old-age homes in and around Pretoria in 1991, as opposed to 3 606 white people (CSS Report No. 03-01-01: 61; 79; 97; 115). Therefore, homes for black, Indian and Coloured people were excluded from the universum. Old-age homes without frail-care units were excluded as explained in chapter 1, section 1.3.7, as well as in the previous section of this chapter. For the purposes of this study, respondents had to have at their disposal professional medical care on a twenty-four hour basis. Homes for the weakened elderly were purposively excluded since these are highly medical in orientation.

Finally, the sampling frame for the first draw consisted of old-age homes that were selected in terms of two primary criteria, namely whether the home is private or subsidised. This stratification was done in order to ensure an equitable distribution of the old-age homes on the list. These homes were thus divided into separate categories, namely public and private old-age homes, and a random sample was selected from each of these categories. Eight public and seven private old-age homes were randomly selected from the list of thirty-two public homes and thrity-one private homes. This selection could be regarded as a proportional representation, since approximately one quarter of each category was included in the sample.

In the second stage of the multi-stage cluster sample, a list with all the names of the residents was obtained at each old-age home selected. To construct the sampling frame for the selection of elements in each cluster, certain exclusions were made. First, at the time the interviews were being conducted residents who were admitted to the frail-care unit were excluded from the sampling frame, since frail-care units are fundamentally medical in nature. Second, due to the fact that some elderly people are mentally frail (confused, demented) and therefore unable to converse coherently or sensibly, it was necessary for the person in charge (who is also familiar with the residents in the old-age home) to eliminate some names purposively (only those of senile and semi-senile residents). The above-mentioned elimination procedure was chosen

instead of a so-called "mental status" questionnaire consisting of questions such as "Where are we now?"; "What is the date?"; "In what year were you born?" and so on. This type of questionnaire is usually used in research with elderly people to assist in scoring a person according to mental ability. However, since a "mental status" questionnaire could have a dehumanising effect on a mentally sound elderly person, it was decided not to risk this possible negative influence on trust placed in the researcher.

In addition to the deliberate elimination of names done by a person familiar with the residents, it was decided that section A of the interview guide which dealt with biographical data would also provide an indication of the person's ability to take part in the interview. For instance, section A concentrated on recalling by asking questions like, inter alia, "What is the name and address of this old-age home?"; "What was your date of admission to this old-age home?"; "How many children, grandchildren and great-grandchildren do you have?"; "What was the most important reason why you moved to an old-age home?". Although this was never necessary, section A could have served as an additional means of excluding mentally frail (senile) respondents from the analysis of data.

A further exclusion from the sampling frame during the second stage of the multi-stage sampling procedure, was that of names of those residents who were absent from the old-age home at the time the interviews were conducted. Due to higher mobility, it was found that more residents from private old-age homes were on holiday or visiting family members or friends than from public old-age homes. In final tally, thirty respondents were interviewed in public old-age homes and twenty in private old-age homes.

From the list of remaining names, a systematic random selection was made. Leedy (1993: 211) describes systematic sampling as "precisely what the name implies: the selection of certain items in a series according to a predetermined sequence".

Only two sampled subjects refused to be interviewed. The first one was

not interested, and the second one stated that her husband was sick in bed and he did not want to be disturbed.

4.3.3 The interview guide

> The interview guide provides a discipline to think through the likely responses to the questions and to rehearse the ways into topics that are unlikely to be raised spontaneously by respondents (Robson & Foster 1989: 10).

The interview guide can never anticipate all the question areas or precise questions in advance but, according to Robson and Foster (1989: 26), "the good interviewer is always alert to other relevant things said - or perhaps unsaid. The interviewer is also the interpreter of the research."

The different themes relevant for this study were identified in the following sections of the interview guide (see Appendix 1):

- Section B: perceived health status and approach towards medication practices
- Section C: the aging experience and life satisfaction
- Section D: approach towards life in an old-age home

The main purpose of these sections was to explore the respondent's approach towards medication practices, the aging experience and life in an old-age home respectively. Often, it was not necessary to ask certain questions appearing in the interview guide, because respondents talked spontaneously about themselves and thus gave useful information about many unasked questions. Although the interview guide was constructed in English, interviews were conducted in the language preferred by the respondent, i.e. either English or Afrikaans.

An attempt was made to treat Illich's three categories of iatrogenesis as distinct groupings in the interview guide. This, however, was not altogether possible. The borderlines of the three iatrogeneses are

sometimes very close to one another and overlaps do occur. An example of such an overlap is, for instance, found in the information obtained in response to a question like, "Are you sometimes afraid to take medicines?" The answer to this question could have effects on all three levels of iatrogenesis, namely:

- clinical : physical harm
- social : indication of susceptibility to medicalisation
- cultural/structural : indication of personal responsibility regarding health matters

Perceived health status in this study was assessed in terms of questions in section B of the interview guide on respondents' current health status. In their study, Peterson, Maier and Seligman (1993: 279) found that "those with an optimistic explanatory style were healthier than those with a pessimistic style". Or were those who were healthier perhaps more optimistic?

The question about their self-care practices (question B8 [see Appendix 1], namely "What do you actively do on a regular basis to improve your health and prevent disease?") also provided some information about their personal attitude to and responsibility with regard to their own health matters (e.g. optimistic or pessimistic/positive or negative). According to Peterson, Maier and Seligman (1993: 179), "a pessimistic explanatory style was associated with poor health". Since this view is somewhat deterministic, it could not be accepted in every instance of poor health.

Section C of the interview guide was aimed at the person's experience of aging, as well as how satisfied the person was with his or her life. Factors which may influence the life satisfaction of elderly people are discussed in chapter 3, section 3.3.1.

Section D of the interview guide, which dealt with life in an old-age home, focused on interaction patterns, sleeping patterns, exercises, social activities and some general aspects of life in an old-age home.

According to Illich (1976a: 55):

> The medical bureaucracy strove to manage the responses to more and more critical life events. ... [M]edicine was taking more control over social problems and reducing the ability of people to handle their own lives.

The function of old-age homes, namely the institutionalisation of elderly people, will be investigated in terms of Illich's description of cultural/structural iatrogenesis. The following question concerning structural iatrogenesis arose: "In which way do old-age homes contribute to the medicalisation of elderly people?"

In the following section, the interview and how it was conducted will be discussed.

4.3.4 The interview

With reference to the informal, unstructured type of interview which served as the method of collecting data for this study, Robson and Foster (1989: 57) describe the individual interview as "the unique technique, for if used correctly, it is *the* deep digging tool".

In the following instances, Robson and Foster (1989: 47) regard the individual in-depth interview (as opposed to a group interview) as the most essential research technique:

- This method (the in-depth interview) is optimal when socially and personally sensitive subject matters need to be investigated. In this case, one needs to ask questions such as "How do you feel today?"

- Some questions such as "Are you afraid to die?"; "How do you feel about your age"; "Is there something you particularly dislike about being in an old-age home?" often led to personal discussions.

- This method is optimal when over-claiming and showing off could become a problem in a group discussion, especially with a question like "Did you get most of the things you wanted and expected out of life?" According to Robson and Foster (1989: 48), "respondents are not immune to showing off, keeping up with the Jones' or lying".

- This method is optimal when the researcher wishes to be alerted to the "truth" of various attitudinal responses, as well as in those cases where individual interviews can provide insight into attitudes and can help to prioritise the issues that are involved.

- This method is optimal when the population under study necessitates the use of individual interviews rather than group discussions. Due to widely different responses in elderly people and physical disabilities such as poor hearing, it is not possible "to keep track of each individual respondent and his or her comments in a group situation" (Robson & Foster 1989: 48).

To Cole (1980: 101), the major disadvantage of in-depth interviewing is that respondents may distort reality. On the other hand, Cole (1980: 101) describes the advantage of interviewing several people who have experienced the same thing as follows: "[it] enables the researcher to see what elements all those interviewed agree on and what elements there is disagreement on. .... What is interesting is the different perceptions of reality."

Access to old-age homes was telephonically arranged with the matron or superintendent. There were no refusals. Furthermore, asking sampled subjects their permission to be interviewed, as well as permission to tape-record the interviews, presented few problems. The person who granted access to the old-age home (either the matron or the superintendent) explained to the sampled subjects the purpose of the interview. This person served as contact person who reduced the strangeness of the situation for both the researcher and the respondents. After having assured respondents of confidentiality, subjects were generally

eager to receive the researcher and to participate in the interview. No one objected to the fact that the interview was tape-recorded.

Interviews were mainly conducted in the respondent's living quarters in the old-age home. In some exceptional cases, and for specific reasons, such as the cleaning and tidying of rooms that took place at that particular time, interviews were conducted in the lounge or dining room of the old-age home. However, since individual interviews should not be conducted in the presence of an observer, privacy was the main consideration in the choice of an alternative venue.

Robson and Foster (1989: 52) stress the importance of the researcher *not* being the unnerving and threatening silent observer, "for it is impossible to know what influence his or her presence has on the respondent". The researcher must therefore be interactive in conducting the interviews. Benson and Hughes (1983: 77) suggest that the interviewer must try to:

- create an atmosphere that encourages the respondent to talk freely in the knowledge that what is said is a private and anonymous matter

- [create an atmosphere in which] he[/she] can talk about the more private and intricate details of his[her] life without consequence

Robson and Foster (1989: 51) describe qualitative research fieldwork as "essentially informal and variable" and continue by stating that "it has to be, as it is dealing with living material". When the respondent holds the territorial right, probing - to name but one activity - becomes less threatening. According to Robson and Foster (1989: 51), "the intention is to build an intimate atmosphere in which the respondent feels inclined to express his or her natural opinions and feelings rather than distorting or suppressing them".

Due to the fact that many elderly people in old-age homes are fond of receiving visits and they especially like talking about themselves, their

medicines and their health matters, the researcher had to exercise control with regard to the length of the interview. The average time it took to complete an interview was forty-five minutes. Some interviews took one hour or even longer, while very few interviews took less than thirty minutes.

In some interviews the interviewer had to take on an active role through probing, while in most interviews respondents talked spontaneously. In these latter cases, the interviewer adopted a passive role in allowing respondents to tell their stories. One respondent significantly remarked: "You know, everybody has got a story ... a lifestory. If one wants to write a book of an everlasting story that's got no end, start at the old-age home. ..." Worth mentioning in this regard, is the fact that most of the respondents thanked the interviewee at the end of the interview and stated that they had enjoyed the interview.

In general, more time was spent with respondents in private old-age homes. Because they have kitchens in their units, they offered coffee or tea. It seems that people in private old-age homes are more socially orientated and are more used to receiving visitors than are residents in public old-age homes.

The interviewer personally transcribed each tape-recorded interview as closely as possible to the actual words of the respondent. This process took approximately one and a half months to complete. Robson and Foster (1989: 88) mention the following advantage of transcriptions:

> Listening to the tapes allowed the researcher to "look at" the data again, to determine whether the hypotheses he/she has already generated are there, or whether, on reflection, alternative ways of looking at the data are more valid. Further, listening to the tapes gives the researcher the opportunity to begin to structure the data in his/her mind, to determine the patterns of responses that are occurring across the sample as a whole and therefore to decide the framework within which they are going to analyse and

interpret the data.

In summary, Haralambos and Holborn (1990: 737) describe interviews as more flexible than any other research method: they can be used to ask people about their attitudes, their past, present, or future behaviour, their motives, feelings and other emotions which cannot be directly observed.

4.4 CONCLUSION

In this chapter, certain methodological and theoretical decisions underlying this study were outlined. The following topics were discussed: methods used in conducting the study, namely the sample and the different stages of the sampling procedure; the pilot study; observations about the interview guide; and the conduct of the interviews as a method of data collection. Chapter 5 will provide an analysis and interpretation of the data derived from the interviews, as well as a summary of the research findings.

CHAPTER FIVE:

ANALYSIS, INTERPRETATION AND PRESENTATION OF DATA

5.1 INTRODUCTION

The aim of this study is to test Illich's theory of iatrogenesis by establishing whether elderly people in old-age homes suffer from clinical, social and structural iatrogenesis. The focus is on the perceptions and experiences of elderly people in particular. Following the systematic manner in which Illich (1976a) investigates the three levels of damage, namely clinical, social and cultural iatrogenesis, an analysis is made on the basis of these three analytical categories as they were outlined in chapter 2, section 2.2.

Fifty in-depth interviews were conducted with residents of both public and private old-age homes in and around Pretoria. The sample and methodological issues regarding the interviews are discussed in chapter 4.

In this chapter, an analysis, interpretation and presentation of the gathered data are provided. Subsequently, an outline will be provided summarising the structure of this chapter.

Data on the category of *clinical iatrogenesis* is analysed, interpreted and presented in four subsections, each with responses grouped according to specific criteria which will be outlined in the discussion. Responses are grouped in the following way:

(1) **Knowledge and understanding of the proper way to take medicines on a regular basis.** Responses to questions in this regard are grouped

in terms of respondents revealing:

- a good knowledge and understanding of their medication practices
- an average knowledge and understanding with regard to their medication practices
- a poor knowledge and understanding of their medication practices

(2) **Knowledge about the adverse effects of medicines used by respondents.** Because of the nature of the responses, two groups are identified in this instance (no "average" group is identified). Responses are grouped in terms of respondents revealing:

- poor or no knowledge about the adverse effects of the medicines they use
- good or basic knowledge about the adverse effects of their medicines

(3) This subsection is an application of subsection 2. Since the taking of sleeping tablets is such a general and widespread practice in old-age homes, it was decided to investigate elderly people's perceptions of why they take sleeping tablets. This subsection is called **reasons for taking sleeping tablets.** Here responses are grouped in terms of:

- respondents taking sleeping tablets on a regular basis
- respondents taking no sleeping tablets at all

(4) **Knowledge about respondents' personal health problems.** Here responses are grouped as follows:

- respondents revealing poor or no knowledge about their own health problems
- respondents revealing good or basic knowledge about their own health problems

An investigation of whether residents of old-age homes suffer from *social*

iatrogenesis is conducted in terms of certain approaches and interpretations revealed by them. The following four subsections are used and responses are grouped as follows:

(1) **Approaches towards taking medicines.** Under this subsection, responses are grouped in terms of respondents revealing one of the following approaches towards taking medicines:

- a critical approach
- an uncritical approach

(2) **Approaches to health improvement and prevention of disease.** These responses are grouped according to respondents revealing:

- a positive approach
- a negative or indifferent approach

(3) **Reliance on the doctor.** This subsection is analysed in terms of responses grouped in the following way:

- respondents revealing a social dependence on their doctors
- respondents not revealing any form of social dependence or reliance on their doctors (independence)

(4) **Approaches towards aging.** Here responses are grouped according to the following approaches towards aging revealed by respondents:

- a positive approach
- a negative approach
- an approach of acceptance

The third category, namely *cultural iatrogenesis*, is analysed, interpreted and presented in terms of four subsections, each with its responses grouped in the following way:

(1) **Influence of institutionalisation on medical routine.** For example,

whether the fact that respondents stay in an institution had an influence on the way they use medicines, namely whether or not they take more medicines since being in an old-age home. In this regard, responses are grouped in terms of whether the respondent stayed in a private or public old-age home.

(2) **Approaches to life and life satisfaction.** In this subsection, responses are grouped in terms of the following approaches towards life and life satisfaction revealed by respondents:

- a positive approach
- a negative approach
- an indifferent approach

(3) **Approaches to life in an old-age home.** In this regard, responses are grouped in the following way:

- a positive approach towards life in an old-age home
- a negative approach towards life in an old-age home
- an indifferent approach towards life in an old-age home

(4) **Feelings of loss of privacy, independence and/or control.** Here responses are divided into two groups, namely:

- a "yes" group indicating that they suffer from feelings of loss of privacy, independence and/or control
- a "no" group declaring that they do not suffer from feelings of loss of privacy, independence and/or control

Furthermore, in order to provide a summary of the picture of medicalisation in old-age homes, an analysis and interpretation of some of the biographical characteristics of the sample are done. This section is followed by the analysis, interpretation and presentation of data according to the three categories as described by Illich. Finally, a summary of the research findings will be provided.

In order to give some idea of how respondents reacted to questions posed during interviews, detailed transcriptions of a selection of interviews (eight of the fifty) are provided in Appendix 3. These interviews were selected as being representative of different categories so as to give an indication of responses provided in the sample. The following characteristics of the sample are revealed in the eight interviews included in Appendix 3:

- both male and female respondents
- both English- and Afrikaans-speaking respondents
- positive, negative and indifferent attitudes
- respondents from both public and private old-age homes

What follows is a summary of the demographic distribution of the sample, as well as a number of findings regarding biographical information.

5.2 BIOGRAPHICAL CHARACTERISTICS OF RESPONDENTS

Since relevant literature regarding elderly people revealed certain consequences based on age, gender, home language and occupation, the following biographical information was included in the interview guide:

- age
- gender
- home language
- occupation for most of life
- membership of a medical fund

For the purposes of this study, it was assumed that the above-mentioned biographical information could reveal certain relationships concerning the three levels of iatrogenesis. However, it was found that the biographical information discussed here revealed no significant relationship. It was therefore decided not to relate this information to all the variables used in the study.

The sample consisted of more female respondents (74%) than male

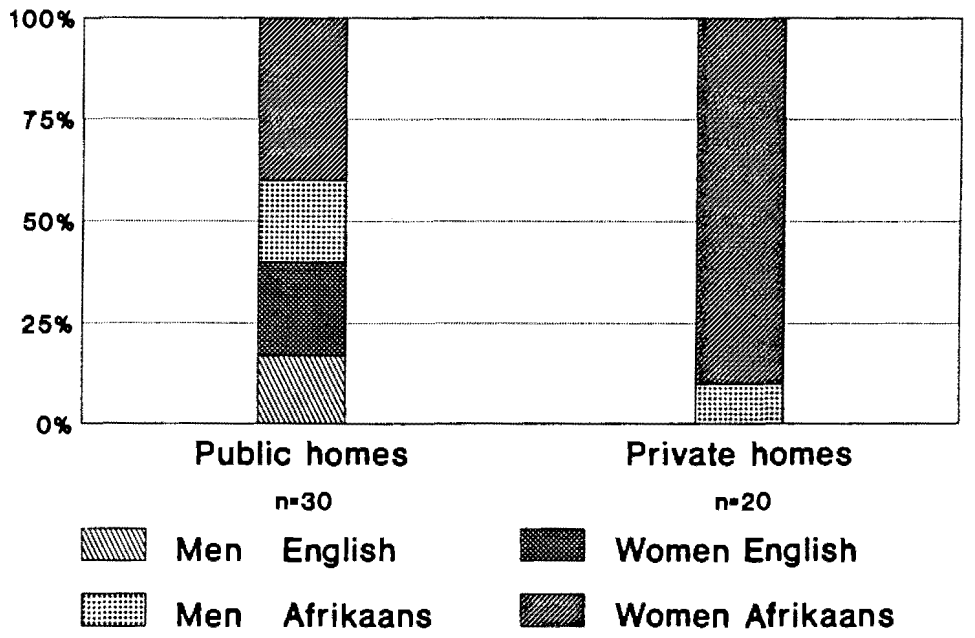
respondents and this corresponds to the demographic profile referred to in Population Census 1991, CSS Report no. 03-01-01 (1991: 123), namely that the total number of women in the age group 70-74 exceeds the number of men by 17 851. In the age group 75-79 there are 57 292 women as opposed to 36 848 men. This difference becomes even more evident in the higher age groups. Concerning the population of residents in old-age homes equipped with frailcare units, this study required no specific qualifications with regard to age group (except that respondents had to be at least 65 years of age), gender or language preference.

Regarding *gender*, only one evident difference was revealed between elderly men and women in old-age homes: generally, men tend to be bored and lonely, sitting around all day doing nothing and feeling worthless, while women keep busy by engaging in activities such as sewing, knitting and visiting friends in the home. In response to the question of what she found particularly difficult to get used to when she first came to the old-age home, respondent 22 explains: "Toe ek ingekom het ... dit was maar moeilik ... maar nou, ek het my man gehad, jy weet. Dis al 'n groot ding gewees. Ek dink hy was meer ongelukkig gewees. Ek kry die mans jammer, want die mans kan niks doen nie. Kyk, 'n vrou doen iets, maar hulle [the men] sit ledig rond. As daar een is wat hulp nodig het, dan is dit hulle." On the other hand, respondent 23 an eighty-one year old divorced man replies: "Jy weet, ek was 'n persoon ... ek het alles gedoen wat ek wil doen ... ek het gewerk. Nou kan ek nie meer nie ... nou sit ek net. Jy bly sit. ..." According to respondent 14, it was easier for her to move to an old-age home than for her husband: "Die mans is 'n bietjie skepties oor hierdie soort van bly. Hulle dink dit gaan hulle verveel en hulle wil net uitloop op hulle eie plekkie en stukkie grond."

With regard to *language preference*, 76% of the sample were Afrikaans-speaking and 24% were English-speaking. Specific language distributions in the sample between male and female respondents of public and private old-age homes can be presented graphically as follows:

FIGURE 5.1

LANGUAGE DISTRIBUTION BETWEEN MALE AND FEMALE RESPONDENTS OF PUBLIC AND PRIVATE OLD-AGE HOMES



The above statistics regarding language preference proved to have had no relevance for this study. It was also found that age and home language had no significant influence on the research results. For example, those with a good knowledge and understanding of their medicine practices ranged between 68 and 85 years of age with a language distribution of 24% Afrikaans and 10% English-speaking.

The *ages* of respondents ranged from 68 to 90 years, with the average age being 78,74 years. The average age of respondents in *public* old-age homes was 79,9 years, while the average age of respondents in *private* old-age homes was 77 years.

Regarding the distributions of respondents in *public and private old-age homes* in terms of age groups, the age group 80 - 84 was best represented in public old-age homes (13% men + 30% women = 43%). In private old-age homes, the best represented age group was 75 - 79 years (40% women only).

It could be argued that the older and physically weaker a person, the less likely it would be for that person to be found in a private old-age home where a high premium is placed on self-care. On the other hand, it seems that respondents staying in private old-age homes are slightly younger than respondents in public old-age homes. This could be the reason why people in private old-age homes are generally more mobile than those in public old-age homes.

With regard to *occupation* for most of their lives, it seemed that people with a background in health care professions such as nurses, revealed an outstandingly good understanding of their medication practices.

Since *membership of a medical fund* could influence a person's approach towards the taking of medicines in the sense that medicines could be easier to obtain, responses were interpreted with reference to membership of a medical fund. No obvious pattern was revealed in this regard. As mentioned in section 5.3.2.3, there was also no specific pattern discernible with regard to membership of a medical fund and reliance on the doctor.

In instances where biographical information had a definite influence on the analysis of data, the relevant information was included and indicated as such in section 5.3.

Subsequently, the analysis and interpretation of data is presented according to the three categories as described by Illich, namely clinical, social and cultural iatrogenesis.

5.3 ANALYSIS, INTERPRETATION AND PRESENTATION OF DATA ACCORDING TO SPECIFIC CATEGORIES

As discussed in chapter 4, section 4.3.3, certain overlaps are evident in the three categories of clinical, social and cultural iatrogenesis. For example, sections B and C in the questionnaire provided information with regard to more than one category such as the following:

- Section B : clinical and social iatrogenesis
- Section C : social and cultural iatrogenesis

Although the gathering of data was not done in terms of distinct categories, the analysis and interpretation of data were conducted according to specific indicators relating to each of the three categories respectively. An outline will now be provided of the different subsections derived from each category in order to test Illich's theory.

5.3.1 Clinical iatrogenesis

Clinical iatrogenesis, as discussed in detail in chapter 2, section 2.2.2, refers to direct or indirect damage done by the medical profession as a result of, for instance, mistakes made by doctors, side-effects of certain medicines, prescriptions of wrong medicines, and unnecessary medical treatment.

Illich (1976a: 21) discusses clinical iatrogenesis as "the epidemics of modern medicine" in terms of the following themes:

- doctors' effectiveness - an illusion
- useless medical treatment
- doctor-inflicted injuries
- *defenceless patients*

For the purposes of this study, only the theme *defenceless patients* was used as representative of the category of clinical iatrogenesis. In other words, the level of clinical iatrogenesis occurring in the lives of elderly residents in old-age homes was investigated in terms of the extent of respondents' defencelessness regarding certain aspects of "modern medicine". In this sense, defencelessness refers to the *ignorance* of:

- taking medicines on a regular basis
- the adverse effects of medicines used by respondents
- the reasons for taking sleeping tablets

- personal health problems

The argument in the above-mentioned instances is that an ignorant person becomes *defenceless*.

The following questions in Section B of the questionnaire (see Appendix 1, as well as chapter 4, section 4.3.3) were designed to obtain information regarding clinical iatrogenesis:

- Tell me about the medicines you use on a regular basis. What is each one for? How is it supposed to help you? For how long have you been taking it? Do you take any medicines that are not specifically prescribed by the doctor? What are they for? Does the doctor know about these?

- Are you sometimes afraid that the medicine might harm you?

- Do you take sleeping tablets? If yes, why?

- Do you have any health problems? How would you describe your health today? Are you able to move around freely and independently or do you need some form of assistance?

These questions pertaining to clinical iatrogenesis were operationalised to respectively elicit the following information:

- knowledge and understanding of the taking of medicines on a regular basis
- knowledge about the adverse effects of medicines
- reasons for taking sleeping tablets
- knowledge about the respondent's personal health problems

In the following section, an outline will be provided in terms of the above-mentioned four subsections of the analysis and interpretation of data gathered to test Illich's first category, namely clinical iatrogenesis.

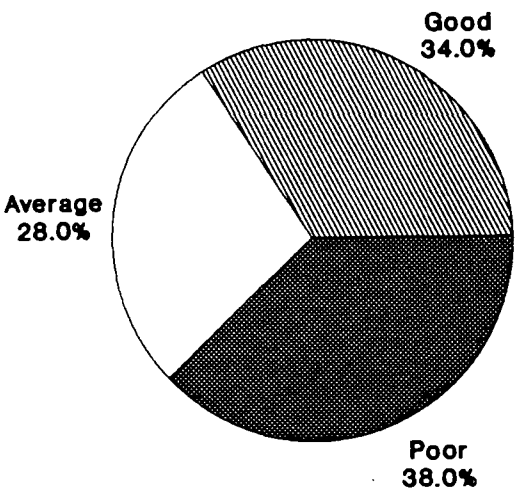
5.3.1.1 Knowledge and understanding of the way to take medicines on a regular basis

Ignorance about medication practices, adverse effects of medicines, personal health problems, and the reasons for taking sleeping tablets, raises, in some cases, serious questions about "the intent of curing or exploiting the patient" (Illich 1976a: 41). The emphasis in this study is on establishing whether old-age home residents are defenceless or not. As mentioned in chapter 4, section 4.3.1, every old-age home included in this study was equipped with a frailcare unit (medical care services), as well as a professional medical staff available on a twenty-four hour basis.

Knowledge and understanding of the way to take medicines on a regular basis are analysed in terms of the following three groups of responses, namely *good, average and poor*. Percentage distributions according to these three groups of responses is graphically presented in figure 5.2.

FIGURE 5.2

RESPONSES WHICH REFLECT LEVELS OF KNOWLEDGE AND UNDERSTANDING OF THE WAY TO TAKE MEDICINES ON A REGULAR BASIS



Questions formulated to elicit information in this regard are the following:

- Tell me about the medicines you use on a regular basis.
- What is each one for?
- How is it supposed to help you?
- For how long have you been taking it?
- Do you take any medicines that are not specifically prescribed by the doctor?
- What are they for?
- Does the doctor know about these?

Subsequently, a presentation of the three groups of responses identified according to respondents' knowledge and understanding of the way to take medicines on a regular basis.

(1) *Good* knowledge and understanding of medication practices

Thirty-four per cent (17 respondents) of the sample of 50 subjects gave indications of a good knowledge and understanding of their medication practices. [*Henceforth in this discussion, reference will be made to percentages and not to numbers of respondents.*] This group of respondents revealed the following characteristics which were used as criteria:

- They were able to explain exactly which medication they took.
- They had a proper knowledge of the type of medicines they used.
- They had a good understanding of the reasons for which they were taking the medicines.
- They could explain what the correct dosages were.

Those respondents who had a background in health care professions, such as nurses, revealed an exceptional knowledge and understanding of their health matters and medication practices. *Excluding* this group of people, some responses in this regard were as follows:

- Respondent 18 who suffers from high blood pressure, explains that he has "'n bietjie bloeddruk wat op is waarvoor ek Capoten drink."

- Respondent 37 describes the medicines she uses on a regular basis as follows: "Jong, wat is die goed se naam ... Lasix? En dan drink ek ook Warfarin. Ek drink elke dag 'n halwe, en Sondae drink ek een hele ... op die oomblik, maar hulle verander van maand tot maand. [She has her blood taken every month for the prothrombin index. This result determines the dosage of Sodium Warfarin.] Ek drink ook Lanoxin, 'n hartpilletjie, 'n halwe op 'n dag behalwe naweke. En dan drink ek ook Slow K."

- Respondent 6 explains, "Ek het 'n bietjie hoë bloeddruk. Nou gebruik ek net elke dag 'n halwe Moduretic - net 'n waterpil - maar dit is al."

- Respondent 12 explains as follows: "Dis die twee soutpille en dan is dit Moduretic vir bloeddruk. Ek het eenmaal hoë bloeddruk gehad. Toe sê hulle ek moet dit permanent drink. Dan drink ek Premarin [female hormones] - ek het 'n histerektomie ook gehad. Dit herhaal elke maand. En ek drink dit baie stiptelik." She also takes antidepressants: "Ludiomil - ek gebruik twee van 25 mg in die aand en Serepax van 15 mg."

(2) *Average* knowledge and understanding of medication practices

Twenty-eight per cent of the sample revealed an average knowledge and understanding regarding their medication practices. These respondents had a basic idea of whatever medication they took on a regular basis, as well as a basic idea of what it was for, but *they generally did not know the names of the medicines and/or the dosages*. Superficial knowledge of medication practices served as a specific criterion for average knowledge, for example, "I take eight tablets a day. The green one is for arthritis, the white one for my heart, and the two yellow ones are for my blood pressure, I think."

The following is a number of responses specific to the group revealing an average knowledge and understanding of the proper way to take medicines on a regular basis:

- Respondent 41 replies as follows to the question of which medicines she uses on a regular basis: "Nie medisyne nie ... dis pille. Ek drink hartpille, ek drink rumatiekpille, ek drink 'n kalmeerpil om te slaap. Ek weet nie hoe lank nie."

- Respondent 19 describes the medication he uses on a regular basis in the following words: "'n Hoë bloeddrukpilletjie en 'n pilletjie om my te laat slaap. ... En dan gee hulle vir my 'n pilletjie vir my knieë as hy baie seer is, jy weet."

- Respondent 17 explains her medical routine in the following words: "Ek persoonlik gebruik net drie basiese pilletjies. Dis 'n hartpilletjie en 'n bloeddrukpilletjie. ... En dan gee hulle vir my 'n ontwateringspilletjie, omdat ek die blaas- en nierprobleem ook het."

(3) *Poor* knowledge and understanding of medication practices

This group of responses is based on the following criterion: respondents were *not* able to explain what medication they use on a regular basis. Thirty-eight per cent of the sample gave indications of poor knowledge and understanding of their medication practices. Specific responses in this regard were the following:

- Respondent 24 replies: "I take two pink ones. I don't know what they're for. I think they were for my shoulder. I don't know the way they work now."

- Respondent 23 describes the medication he takes on a regular basis as follows: "Twee pynpille 'n dag, dan kry ek nog so 'n ou kleintjie. Dan kry ek nog drie ander. ... Ek vra vir die suster waarvoor dit is, maar hulle maak grappe met jou."

- Respondent 21 describes his daily medical routine in the following words: "Dit is vir die bloeddruk ... die bloeddrukpilletjie ... en die ander weet ek nie waarvoor ek dit drink nie. In die oggend drink ek twee en in die aand ook twee."

- Respondent 38 explains that he has "no health problems at all ... nothing". However, he states that he takes tablets on a daily basis. In response to the question of what the medicine is for, he replies: "Oh, I don't know. ... Some I take after breakfast, then after lunch and then after dinner."

- Respondent 48 explains that she uses "allerhande pille ... bloeddrukpille ... en die pille wat ek moet vat ... wat die dokter my voorskrywe". In response to the question which inquires as to whether she knows what the tablets are for, she replies: "Nee, ek weet nie. Ek kan dit nie sê nie."

5.3.1.2 Knowledge about the adverse effects of medicines used by respondents

Respondents' knowledge about the adverse effects of the medicines they use was established through their responses to the following question:

- Are you sometimes afraid that the medicine might harm you?

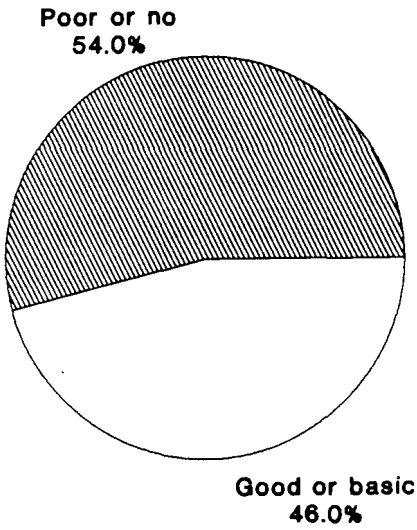
The two groups of responses to this question are the following:

- respondents revealing *poor or no* knowledge
- respondents revealing *good or basic* knowledge

The percentage distribution of these responses can be presented graphically as follows:

FIGURE 5.3

RESPONSES WHICH REFLECT LEVELS OF KNOWLEDGE ABOUT THE ADVERSE EFFECTS OF MEDICINES USED BY RESPONDENTS



(1) *Poor or no* knowledge about the adverse effects of medicines

Fifty-four per cent of the sample reported that they were either *not afraid to take any medicines or they did not mind taking any medication* prescribed by the doctor (see figure 5.3). For the purposes of this investigation, these respondents were regarded as having poor or no knowledge about the adverse effects of medicines. Specific indicators for interpreting information in this group were the following:

- no fear of taking medicines
- carelessness with regard to taking medicines
- ignorance about the effects of medicines

What follows are some of the responses given by respondents revealing poor or no knowledge about the adverse effects of medicines:

- In reply to the question about how she feels about taking medicine, respondent 12 answers: "Ek glo baie aan my medisyne, want ... ek weet nie. ... Ek glo aan my dokter soos ek aan my Bybel glo."

- In response to the question of whether she is sometimes afraid that the medicine might harm her, respondent 17 replies: "Ag nee ... nie dit wat die dokters vir my voorgeskryf het nie."

- Respondent 32 states: "It doesn't worry me at all." He continues by saying that he is never afraid that medicine could harm him.

- In response to the question of how he feels about taking medicine, respondent 38 replies: "I just take what is given to me. ... I don't complain. I get my tablets in the morning, afternoon and evening ..." He states that he is never afraid that the medicine might harm him.

- Respondent 41 replies that she does not mind taking medicine: "Dit maak aan my niks. Solank as wat ek leef."

(2) *Good or basic* knowledge about the adverse effects of medicines

The remaining forty-six per cent of the sample who were regarded as having good or basic knowledge with regard to the adverse effects of their medicines expressed the following ideas which were used as criteria for this group:

- some or other form of caution or wariness when taking medicines and/or
- some form of action or planned action in this regard

Some of the responses from this group are as follows:

- Respondent 4 replies: "Ek is versigtig, hoor. Ek hou nie daarvan om sommer te drink omdat drink drink is nie."

- In response to the question of how she feels about taking medicine, respondent 5 replies: "Ek drink nie graag medisyne nie. Ek drink net wanneer dit absoluut nodig is. Wanneer my bene met rukke heeltemal skaflik is, dan sê ek vir die suster 'Nee, moenie vir my

'n pilletjie gee nie.' Nee, ek is nie 'n pilledrinker nie."

- According to respondent 8, she is "nie 'n liefhebber om pille te drink nie, want dit affekteer later jou niere, sê hulle".

- Respondent 11 states that she is not fond of the idea of taking medicine: "Ek wil soveel moontlik sonder dit klaarkom, jy weet."

- According to respondent 14, she does not take any painkillers for her painful neck: "Ek wil nie nou 'n klomp pille drink nie ... ek meen as ek nog oor die weg kan kom nie. Ek is op heeltemal anti-medisyne. Daar is mense wat my al baie keer hier wil slaappilletjies gee en pynpilletjies en watse pilletjies. Dan sê ek 'Wag net so 'n bietjie. ... Ek gaan lê eers op die bed en kyk of my hoofpyn nie oorgaan nie.' En dan gaan hy oor ... waar die ander lankal twee pille sou gesluk het."

- Respondent 15 explains: "Ek het op 'n stadium meer pille gedrink en toe het ek begin dronk word. Dis 'n ander ding wat my pla nou nog. Ek het gedink die pille is te veel. Toe het ek die dokter gevra om dit minder te maak."

Only 4% (two respondents) of the total sample did not take any medicine on a regular basis:

- In response to the question of whether she takes any medicines on a daily basis, respondent 46 replies: "Gladnie. Niks. Ek gebruik bietjie 'n vitamine-aanvulling, hierdie kalsiumtablette."

- According to respondent 14, she does not take any medication on a regular basis: "Al wat ek op die oomblik drink, is hierdie Berocca Calcium. Vriende het vir my gesê hulle gebruik dit. Hulle sê op ons ouderdom behoort ons dit te gebruik."

Although many respondents are taking medication without which their health would be in danger, such as blood pressure tablets and heart

tablets, the analysis in this subsection did not attempt to shed light on the actual or possible dangers of medicines, but on respondents' knowledge about potential adverse effects of medicines.

5.3.1.3 Reasons for taking sleeping tablets

This subsection represents an application of the previous subsection to an actual situation. Since the pilot study revealed that many elderly people do not regard sleeping tablets as "medicine", it was decided to phrase a specific question for the purposes of gaining this information, namely "Do you take sleeping tablets?" If the answer was "yes", the respondent was asked to explain the reason for this practice.

Since the actual taking of medication constitutes part of clinical iatrogenesis, this subsection revealing reasons for taking sleeping tablets was included in this category. Illich (1976a: 41) views the "defenceless patient" as a victim in terms of clinical iatrogenesis. Some of the reasons provided by respondents for taking sleeping tablets underline the "defencelessness" of old-age home residents.

(1) *Regular* use of sleeping tablets

Sixty per cent of the total sample stated that they take sleeping tablets on a regular basis. Reasons provided for this practice were diverse, such as the following:

- Respondent 2 explains: "Ek het my dokter gaan vra om vir my slaappille te gee deur my kamermaat so vreeslik snork en ek slaap lig."

- According to respondent 30, he is taking sleeping tablets since he has been admitted to the old-age home: "I told the doctor I don't sleep at all here. ... You know, your brain works a lot of overtime at night time."

- Respondent 35 states that she has been taking half a sleeping

tablet every night for many years - a long time before she moved to the old-age home.

- Respondent 1 explains how she started taking sleeping tablets: "My eie dokter wou nooit vir my gegee het nie. Hy't altyd gesê, 'Nee jy kry niks nie.' Hy wou nooit, so ek het nooit my bekommer oor 'n slaappil nie. Ek het maar so aangegaan tot ek nou hier gekom het, toe't ek by die dokter hier gekry. ..." She states that the old-age home is not at all noisy at night: "Nee ... nee ... nee ... dis doodse stilte."

- Since respondent 33 has been in the old-age home, she has been taking a sleeping tablet every night. She could not remember whether she requested it or not and explains in this regard: "Most people here take a sleeping tablet, you know. I think when one gets older, you need something to relax yourself."

- Respondent 5 explains that she has started taking sleeping tablets since being in the old-age home: "Daar is baie steurings partykeer in die gange. Maar dis 'n baie flou enetjie wat ek kry, jy weet. Ek het op 'n tyd maar net 'n halwe enetjie gedrink."

- Respondent 19 has been taking sleeping tablets for many years before he moved to an old-age home: "Die dokter het my gesê ek sal nie kan slaap sonder 'n slaappil nie."

- Respondent 22 explains the reason why she requested sleeping tablets: "Ek moet jou sê, toe ek jonger was, dan werk jy en jy slaap. ... Maar as jy nou so sit ... jy weet, jy't nie oefening nie ... ek slaap sleg."

- According to respondent 38, he did not request sleeping tablets: "Well, they examined me and said that I must take a sleeping tablet. I've been taking sleeping tablets since I've been here."

- Respondent 42 remarks that he has been using sleeping tablets since

he has been in the old-age home: "Ons gebruik almal slaappille. Ja, ek weet nie of hier een is wat nie slaappille gebruik nie."

(2) *No* use of sleeping tablets

The following are some of the responses given by 40% of the sample taking no sleeping tablets:

- Respondent 49 states that she never takes sleeping tablets: "Ek hou nie daarvan nie, om die waarheid te sê. Ek drink nooit pille om my te kalmeer of so nie. Ek weet nie hoekom nie, maar ek glo nie daaraan nie."

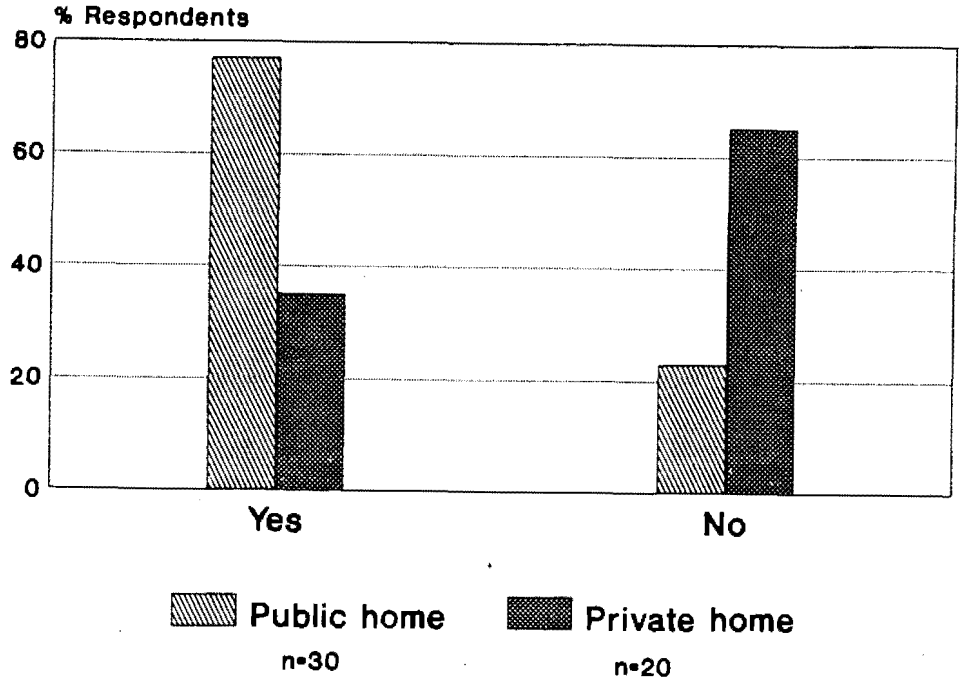
- Respondent 50 remarks as follows: "Ek hou nie daarvan om medisyne te drink nie en ek hou nie daarvan om pille te drink nie. Ek hou ook nie daarvan om slaappille te drink nie. Ek moet self aan die slaap raak."

The analysis of reasons for taking sleeping tablets was also done in terms of the type of old-age home. When distinguishing between sleeping tablet practices of respondents from *public and private old-age homes*, a clear tendency is revealed in both groups of responses, namely that 77% of those staying in public old-age homes take sleeping tablets on a regular basis, while 65% of those respondents staying in private old-age homes do not take any sleeping tablets at all.

The following histogram provides a percentage distribution of respondents' sleeping tablet practices in terms of type of old-age home:

FIGURE 5.4

RESPONDENTS IN PUBLIC AND PRIVATE OLD-AGE HOMES WHO REGULARLY CONSUME SLEEPING TABLETS AS OPPOSED TO THOSE WHO DO NOT TAKE SLEEPING TABLETS



From the above histogram it is evident that a definite difference exists between the practice of taking sleeping tablets in private and public old-age homes. Reasons for this difference are discussed in section 5.3.3.1 of this chapter.

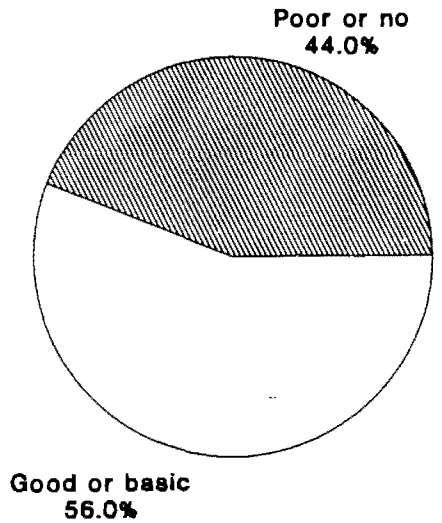
Although the doctor has probably prescribed sleeping tablets for other reasons than those stated by the respondent, this subsection focuses on *the respondent's* interpretation of this practice as an example of knowledge about the adverse effects of the medicines used by respondents. The different adverse effects of taking sleeping tablets on a regular basis, are discussed in section 5.4.1 of this chapter where an interpretation of results is provided.

5.3.1.4 Knowledge about the respondent's personal health problems

Respondents' knowledge about their own health problems was divided into two groups of responses which can be presented graphically as follows:

FIGURE 5.5

RESPONSES WHICH REFLECT LEVELS OF KNOWLEDGE ABOUT RESPONDENTS' PERSONAL HEALTH PROBLEMS



Questions formulated to elicit information in this regard are the following:

- Do you have any health problems?
- How would you describe your health today?
- Are you able to move around freely and independently or do you need some form of assistance?

(1) *Poor or no* knowledge about the respondent's personal health problems

Forty-four per cent of the sample revealed some degree of ignorance regarding their own health problems. Specific criteria for ignorance in

this regard were the following:

- The respondent was not interested in his or her personal health matters.
- The respondent was ill-informed about his or her personal health matters.

Some of the responses revealing poor or no knowledge regarding own health matters were the following:

- Respondent 2 takes three heart tablets a day. To the question of what the problem with her heart is, she replies: "Jong, dis maar net ... ek weet nie ... hulle het maar vir my die hartpille gegee, want ek het dinges ... ek dink ook maar dit was die skok met my man se dood, jy weet."

- Respondent 12 describes her health status in the following words: "Wel, dat ek só sê, vir my ouderdom [76 years] is ek baie gesond, maar ek drink my pille baie stiptelik. Ek drink in die môre ses. Twee van hulle is soutpille, wat ek nou sommer vir jare aan van dokter na dokter vir hulle sê hulle moet dit vir my voorskryf."

- Respondent 22 explains with regard to her health problems: "My hart pla partykeer. ... Die grootaar wat deur die hart loop, daar is 'n knop, en dit is 'n verkalking ... en daardie ding druk teen my sluk. Dis dié dat ek so hees word. Baie lankal as ek sluk, dan moet ek water drink."

- Respondent 48 explains that she has problems with her legs: "Hierdie linkerknie van my is nie reg nie, sien ... dan gaan ek maar altyd buitepasiënte toe. Dit pyn baie. Ek het ook net 'n bietjie hartmoeilikheid, maar dit is nie om van te praat nie, sien."

(2) *Good or basic* knowledge about the respondent's personal health problems

This group of responses was analysed in terms of the following criteria:

- Respondents revealed a *basic* knowledge of their own health problems.
- Respondents were *well-informed* with regard to their own health matters.

Fifty-six per cent of the sample were divided into this group on the basis of their responses such as the following:

- According to respondent 31, she does not really have any health problems: "I've got arthritis in the knees and I've got a little bit of heart trouble, you know ... high blood pressure, but otherwise I'm very healthy."

- Respondent 7 explains that she suffers from Brown Siquard syndrome which she describes as "'n rugmurgontsteking as gevolg van spanning. My linkerbeen is heeltemal verlam. Dis amper soos sklerose wat hy naderhand veroorsaak in die rugmurg."

- According to respondent 37, she has "'n baie moeilike ou hart. Ek het rumatiekkoors gehad toe ek so omtrent dertig jaar oud was en daarvan het ek natuurlik 'n lekklep oorgehou."

Although this group of responses could have been subdivided into two different groups, namely

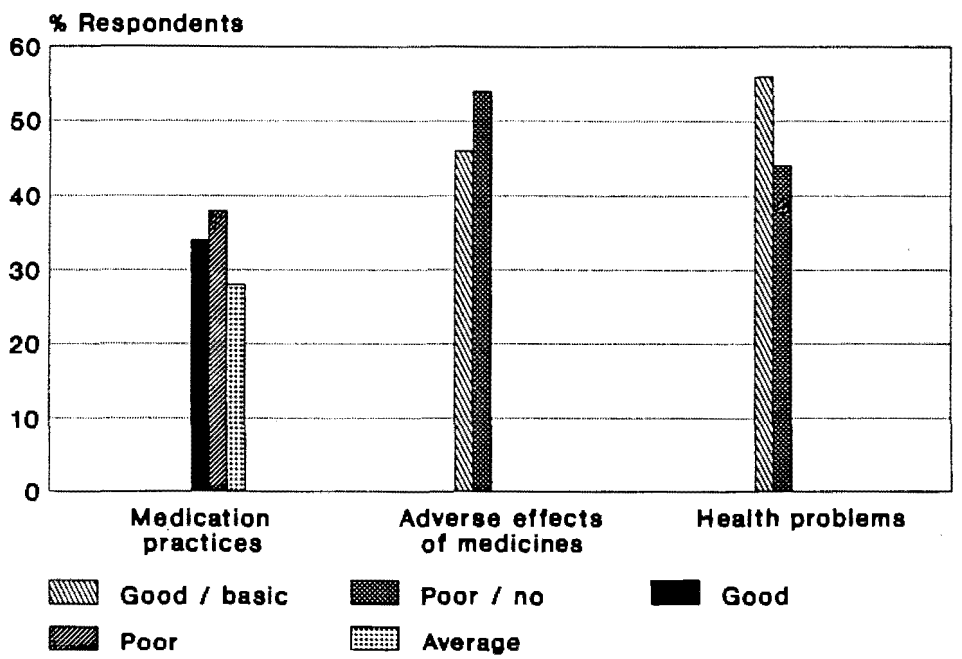
- *good* knowledge about own health problems and
- *basic* knowledge about own health problems,

it was felt that any relevant knowledge, whether good or basic, fitted the criteria set for this group of responses.

In summary, a histogram is provided with results for establishing the occurrence of clinical iatrogenesis under elderly people in old-age homes. These results are an indication of the extent to which old-age home residents are defenceless.

FIGURE 5.6

RESULTS INDICATING THE OCCURRENCE OF CLINICAL IATROGENESIS AMONG OLD-AGE HOME RESIDENTS



With reference to the above percentages, it could be argued that a substantial proportion (more than half of the total sample) is ignorant about important aspects concerning the medicines they take on a regular basis. In this explorative study, it was found that residents of old-age homes do suffer from clinical iatrogenesis to a greater or lesser extent. Although 56% of the sample revealed a good or basic knowledge regarding their own health problems, the 44% (almost half of the total sample) who

revealed poor or no knowledge is disturbing. As only one aspect of clinical iatrogenesis was investigated in this study, it is not possible to comment on the exact extent to which old-age home residents suffer from clinical iatrogenesis. However, since clinical iatrogenesis involves a dimension of physical harm, it could be argued that even the finding revealing the lowest percentage (38% poor/no knowledge and understanding of the proper way to take medicines on a regular basis) could in extreme cases lead to death. Poor or no knowledge with regard to respondents' medication practices, the adverse effects of their medicines, as well as their own health problems reflect negligence and professional apathy on the part of the doctor. To Illich (1976a: 38), this is an indication of clinical iatrogenesis.

5.3.2 Social iatrogenesis

Social iatrogenesis, as explained in chapter 2, section 2.2.3 of this study, can be defined as the medicalisation of life which is caused by the power of the medical bureaucracy. This condition leads to a particular state of mind which influences people's interpretations and behaviour. Social iatrogenesis leads to a dependence on society's provision of medical care and this dependence refers to an addictive *state of mind* which is described by Illich (1976a: 87) as life being "turned into a pilgrimage through check-ups and clinics." As outlined in chapter 2, section 2.2.3, Illich (1976a: 49) describes several forms of social iatrogenesis, namely the following:

- increased stress levels
- *increased medical dependency*
- abrogation of the right to self-care
- awakening of new, painful needs

For the purposes of this study, the category of social iatrogenesis is investigated in terms of interpretations which provide an indication of *increased medical dependency*. In other words, emphasis is on the occurrence of increased medical dependence as one form of social iatrogenesis described by Illich. The aim is thus to establish whether

or not social iatrogenesis occurs in the lives of elderly people staying in old-age homes. Whether or not a respondent is regarded as medically dependent is decided by means of the analysis of responses to questions which pertain to the following:

- the use of medicines
- health improvement and prevention of disease
- reliance on the doctor
- aging

Sections B and C of the questionnaire deal with certain interpretations revealed by respondents with regard to their own health status, medication practices, and the way in which they experience aging and life satisfaction. Questions specifically designed to shed light on interpretations of medicalised life are the following:

- How do you feel about taking medicine?

- What do you actively do on a regular basis to improve your health and prevent disease? Do you take any vitamins? Does the old-age home provide physical exercise programmes? Do you participate in these?

- Do you always go to the same doctor? How often and why do you visit the doctor? How do you experience your relationship with the doctor? Do you have confidence in the doctor's judgements? Do you trust the doctor? Do you feel that the doctor should take responsibility for your health matters?

- How do you feel about your age? Did you look forward to retirement? Are you afraid to die?

Responses to the above-mentioned questions were respectively analysed according to the above questions in terms of certain approaches revealed by respondents.

Subsequently, an analysis and interpretation of the collected data in this regard is presented.

5.3.2.1 Approaches towards taking medicines

Approaches to taking medicines were established by analysing responses to the question "How do you feel about taking medicines?" Whether or not respondents really needed to take certain medicines was not taken into account in this regard. However, their *approaches* to their medication practices were important. For example, a person may have to take heart tablets on a daily basis in order to stay alive, and yet, this person will still have a personal opinion revealed by a particular approach about having to take medicine on a regular basis. These approaches were divided into the following two groups:

- a *critical approach* where the respondent is explicit about not wanting to take medication when not necessary

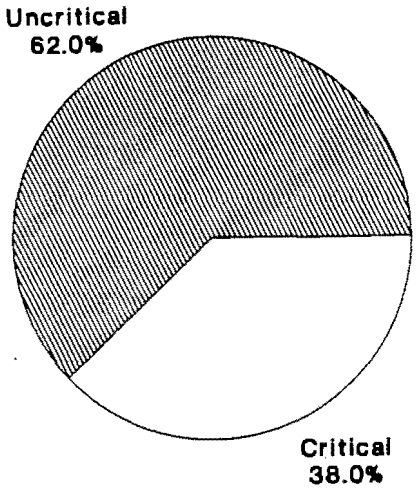
- an *uncritical approach* where the respondent is apathetic and uninterested concerning his or her medication practices

The above-mentioned distinction is not derived from descriptions in literature regarding this theme. However, it is based on the personal judgement of the researcher about respondents' general feelings regarding the use of medicines.

The following graph provides the percentage distribution in terms of the following two approaches revealed towards taking medicines:

FIGURE 5.7

RESPONSES WHICH REFLECT RESPONDENTS' APPROACHES TO TAKING MEDICINES



(1) *Critical* approach

Thirty-eight percent of the sample were to some or other degree outspoken about the fact that they do not like taking medicines unnecessarily and they therefore expressed a concern about taking medicines. In Illich's terms, this group would not be classified as suffering from social iatrogenesis since their approach towards taking medicines might rather be described as being opposed to medicalisation. For example:

- Respondent 27 states that she does not like taking medicine and replied: "If I can stay off it, I would."

- According to respondent 4, she is careful with regard to taking medicines: "Ek hou nie daarvan om sommer te drink nie."

- Respondent 11 explains that she is not comfortable with the idea of taking medicine: "Ek wil soveel moontlik sonder dit klaarkom."

- Respondent 13 states that she does not like taking medicine: "Ek is nie lief vir medisyne nie. ... Ek is so maklik allergies."

- Regarding his approach towards taking medicine, respondent 18 states: "Ek het 'n renons in pille."

- Regarding the use of medicines, respondent 26 replies: "No, I don't like taking it at all. No ... I trust in the Lord."

(2) *Uncritical* approach

Sixty-two per cent of the sample gave indications of apathy and indifference towards their medicine taking routines. Since this group seemed to ask no questions about their medicine, they could be regarded as suffering from social iatrogenesis. These were some of their expressions in this regard:

- With regard to taking medicines, respondent 38 explains as follows: "I just take what's given to me."

- Respondent 41 has an indifferent attitude to taking medicines: "Ek drink dit maar ... ek kan nie worry nie. Ek is nie bang vir 'n pil nie."

- On the question of how he feels about taking medicines, respondent 42 replies: "Ag, wat sal jy nou maak? Jy weet, een dag gaan dit só en die ander dag gaan dit so. Kyk, hulle bring die pille ... hierdie is nou die aand s'n. Dis nou 'n roete van elke dag tot dokter dit nou weer miskien verander. Ek kan nie vir jou sê waarvoor is hierdie pille nie. ... Dit het maar alles met die bors te doen ... ek weet nie."

No explicit and outspoken approach such as "I love taking pills" or "I hate taking pills" was found in the uncritical group. An uncritical approach could be regarded as revealing signs of an increased medical dependency and therefore of an addictive state of mind which characterises social iatrogenesis.

5.3.2.2 Approaches to health improvement and prevention of disease

After analysing the data, it was found that approaches to health improvement and prevention of disease could be divided into the following two groups of responses:

- a *positive* approach to health improvement and prevention of disease
- a *negative or indifferent* approach to health improvement and prevention of disease

A positive approach refers to the respondent being physically active by, for instance, participating in the physical exercise programme provided by the old-age home or by doing other forms of exercises in order to stay fit and healthy. A positive approach also refers to other aspects of healthy living such as healthy eating habits. In the second group, a negative or indifferent approach refers to physical inactivity, as well as a general unconcern about taking any deliberate steps to prevent disease and improve health. A respondent could be inactive as a result of disease or a physical condition that does not allow for exercise. In this case, the person does not necessarily have a negative approach towards participating in exercise programmes, but has no other option than to be inactive. An inactive person could thus be positive with regard to health improvement and prevention of disease.

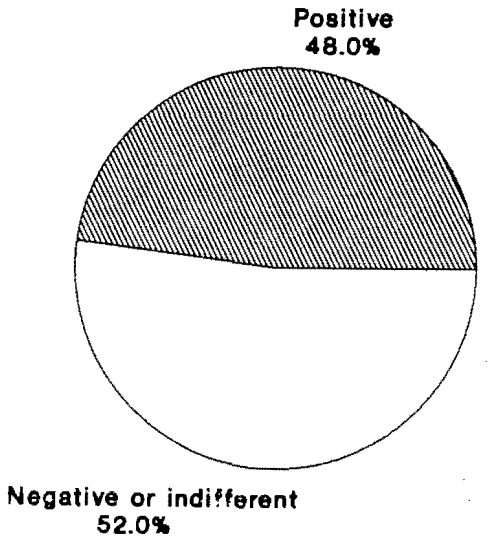
The following questions were formulated to shed light on these approaches:

- What do you actively do on a regular basis to improve your health and prevent disease?
- Do you take any vitamins?
- Does the old-age home provide physical exercise programmes?
- Do you participate in these?

The following diagram provides a percentage distribution of the two main groups of responses to the above-mentioned questions.

FIGURE 5.8

RESPONSES TO HEALTH IMPROVEMENT AND PREVENTION OF DISEASE



(1) *Positive* approach

Forty-eight per cent of the sample expressed a positive approach towards health improvement and prevention of disease. The following are examples of responses received which fit well into this group:

- Respondent 30 states that he walks a lot and partakes in the exercise programme provided by the old-age home every morning. He remarks: "If you look after yourself and you eat plenty fruit then you're OK."

- Respondent 16 describes her approach towards health improvement and prevention of disease in the following words: "Ek is grootgemaak deur 'n moeder wat ontsettend gesondheidsbewus was ... en ek het dit maar net voortgesit in my familie. Ekself ... nou nog is my grootste kos groente en vrugte. Nou nog is ek geweldig gesteld op hoe ek eet. Ek is ook baie aktief en ek stap vinnig."

- Regarding her approach towards health improvement and prevention of disease, respondent 25 explains: "I've got exercises that I do in my flat here. I have to look after myself, you know, and I don't do things that I know I shouldn't do."

- According to respondent 9, she goes for walks every day "en ek doen oefeninge tweemaal 'n week. En ek speel elke Donderdag matrolbal [carpet bowls] in die tehuis. Ons het nie tuine nie, maar ons stap in die straat."

- In response to the question of what he actively does on a regular basis to improve his health and prevent disease, respondent 32 explains as follows: "I go into town, come back ... do a bit of shopping. I walk a lot." He also participates in the physical exercise programme provided by the old-age home. Furthermore, he explains: "I eat a lot of fruit. I normally make myself a fruit salad which I'm very fond of."

It was found that respondents who participate in exercise programmes were generally health conscious with regard to their eating habits as well. They revealed a responsibility regarding health improvement and prevention of disease which excluded them from being medicalised and therefore from suffering from social iatrogenesis.

(2) *Negative or indifferent* approach

Fifty-two per cent of the sample revealed a negative or indifferent approach with regard to health improvement and prevention of disease. What follows are some of the responses which are characteristic of this group:

- In response to the question of what she actively does on a regular basis to prevent disease and to promote her health, respondent 5 replies: "Niks." She never walks around outside for the sake of exercise.

- In response to the question of what she actively does on a regular basis to improve her health and to prevent disease, respondent 17 replies: "Eet en slaap!" She continues by explaining: "Ag, hier is 'n gimtrim ook, maar ek neem nie daaraan deel nie. Eintlik moet ek gaan ... maar ek is 'n huishen."

- Respondent 41 states that she does nothing to improve her health or prevent disease: "Nee ... ek is te sleg."

- In response to the question of what she actively does on a regular basis to prevent disease and to improve her health, respondent 48 replies that she does nothing: "Ek beweeg maar hierso." [referring to her room].

In this group, it was often found that respondents were handicapped as a result of illness. Some respondents divided into this group were thus inactive, not as a matter of personal choice but rather as a result of necessity. Indifferent respondents generally ackowledged the fact that they should be more active. However, they provided some form of excuse for their indifferent approaches.

5.3.2.3 Reliance on the doctor

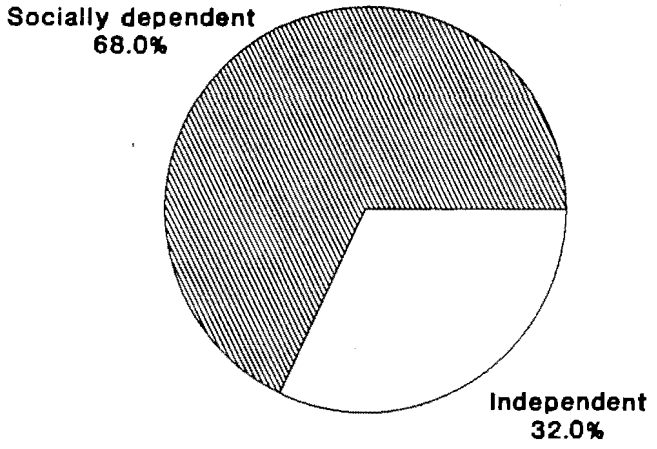
Respondents' reliance on their doctors varies from what seems to be a social dependence to independence, or indifference and apathy. For the purposes of this study, two broad groups of responses were identified, namely the following:

- Respondents revealing a *social dependence* on their doctors
- Respondents *not revealing any form of social dependence or reliance* on their doctors (*independence*)

These two groups of responses can be presented graphically as follows:

FIGURE 5.9

RESPONSES WHICH REFLECT RESPONDENTS' RELIANCE ON THEIR DOCTORS



Questions specifically formulated to gather information in this regard were the following:

- Do you always go to the same doctor?
- How often and why do you visit the doctor?
- How do you experience your relationship with the doctor? Do you have confidence in the doctor's judgements? Do you trust the doctor?
- Do you feel that the doctor should take responsibility for your health matters?

(1) Respondents revealing a *social dependence* on their doctors

In this group, respondents revealed the following characteristics:

- They often had more than one doctor.
- They visited the doctor(s) on a regular basis even if it did not seem necessary.
- They trusted the doctor unconditionally and uncritically.

Sixty-eight per cent of the sample gave indications of a very strong reliance on their doctors. Here follows a summary of some of the responses received in this group:

- According to respondent 36, her son, who is a medical doctor, referred her to a psychiatrist because she trembled severely as a result of medication prescribed by her family doctor. However, she still continues to visit the family doctor every three months: "Hy gee vir my 'n voorskrif vir drie maande, en as daardie drie maande om is, dan gaan ek weer terug na hom toe sodat hy my weer 'n nuwe voorskrif gee."

- According to respondent 12, she sees four doctors on a regular basis for different health problems. Some of these doctors are not aware of the fact that she is already under medical supervision. Regarding her relationship with these doctors, she states: "Ek doen álles wat 'n dokter vir my sê ... en sover het ek nog altyd goeie dokters gehad." In response to the question as to whether she ever visits the medical unit of the old-age home for medical attention, respondent 12 replies: "Ek het so 'n goeie mediese skema. Hulle betaal honderd persent. Laat ek eerder dokter toe gaan as wat ek na die siekeboeg toe gaan. Die siekeboeg ken my eintlik nie, maar die susters daar het nou al af en toe vir my 'n pilletjie gegee as ek probleme het in die nag, jy weet." In this regard she is referring to problems with her knee as a result of a fall some time ago, as well as sinusitis. She states that her relationship with her doctors "gee my regtig al die vertroue. ... Ek glo aan my dokter soos ek aan my Bybel glo."

- According to respondent 49, she does not see the visiting doctor of the old-age home: "Ek het 'n baie goeie dokter. Hy's baie slim. Ek het hom elke maand gaan sien, partymaal tweemaal in 'n maand." On the question of why she went to see the doctor, she replies: "Ag, dan gaan ek ... toe kyk hy na my en dan gee hy vir my medisynetjies vir die maand ... maar ... en 'n inspuiting as hy dink ek moet een kry en al so aan ..."

Since increased medical dependence is regarded as a form of social iatrogenesis, this group of respondents seems to have fallen victim in this regard.

(2) Respondents *not revealing any form of social dependence or reliance* on their doctors (*independence*)

Responses given by this group were characterised by the following behavioural patterns:

- Respondents did not visit their doctors when not necessary.
- Respondents did not give indications of relying on the doctor for their physical, psychological and social well-being.

Thirty-two per cent of the sample could be placed in this group on the basis of their responses. These are some of the responses received in this regard:

- Respondent 16 is a healthy and very health conscious person. She eats lots of fruit and vegetables and is physically very active. She is eighty five years old and does not see any doctor on a regular basis: "Soos 'n dokter eendag gesê het, hulle sal my moet verongeluk eendag, want anders sal hulle my nie doodkry nie!"

- Respondent 25 who used to be a trained nurse states: "I just know I need this or I need that. Then I go for it. But I don't hang around the doctors' rooms all the time or ring them up and all that sort of thing."

- For the past 23 years, respondent 14 has been visiting the same doctor. She suffers from backaches and states that she is happy with his treatment. On the question of how often she sees her doctor, she replies: "Ek weet nie ... eenkeer 'n jaar ... of minder." She never visits the medical unit of the old-age home.

- According to respondent 19, he always sees the same doctor, who is

also the visiting doctor of the old-age home: "Ek kan hom elke Dinsdag sien as ek wil, maar ek wil hom nie sien nie."

In this category, the researcher attempted to distinguish between respondents who revealed a healthy sense of responsibility towards their personal health matters (such as visiting a doctor when necessary or for regular check-ups), and respondents who gave indications of abuse of medicines and unhealthy dependence. The latter could be said to fit Illich's description of being medicalised and they could therefore be regarded as suffering from social iatrogenesis.

It could be argued that membership of a medical fund could have an influence on the respondent's relationship with his or her doctor in the sense that people belonging to a medical fund might not think twice before visiting a doctor, or they might even visit doctors for the mere sake of "using" their medical funds. However, no specific pattern was established in this regard. Fifty-six per cent of the total sample of residents in old-age homes belonged to medical funds.

5.3.2.4 Approaches towards aging

In order to uncover different approaches revealed by elderly people to aging, the following questions were included in the interview guide:

- How do you feel about your age?
- Did you look forward to retirement?
- Are you afraid to die?

Three groups of responses were identified in this subsection, namely:

- a *positive approach* which led respondents to express their feelings with regard to their age in terms such as "It's fun" or "I like it"

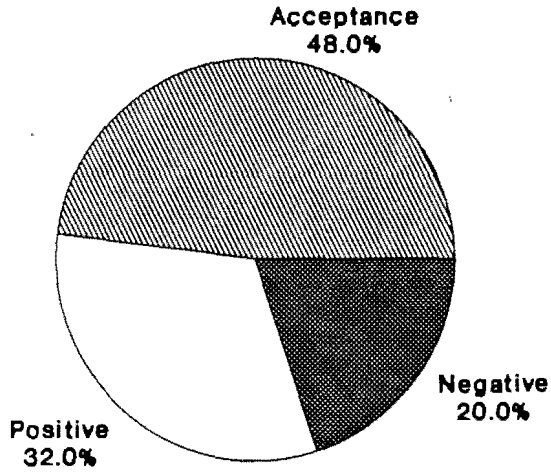
- a *negative approach* which led respondents to explicitly state that they experience aging as an unpleasant period in their lives

- an *approach of acceptance* which led respondents to express an attitude of acquiescence

The percentage distribution of responses in this regard can be presented graphically as follows:

FIGURE 5.10

RESPONSES WHICH REFLECT RESPONDENTS' APPROACHES TOWARDS AGING



(1) A *positive* approach towards aging

Thirty-two per cent of the sample revealed a positive approach towards aging. The following are some of their expressions in this regard:

- Respondent 2 feels happy and contented about life. If she had to choose again, she would choose the same husband and type of life. She states that she is not afraid to die: "As jy glo van Bo, dan het jy nie nodig om bang te wees nie."

- Respondent 16 explains how she feels about her age: "Elke ouderdom het sy eie kompensasies. Daar is nie een ouderdom wat onaangenaam is nie. Die Here neem baie dinge weg, maar Hy sit weer baie dinge

in die plek daarvan." The same respondent is not afraid to die, "maar as ek sien hoe die mense op die vierde vloer [in the senile unit] daarso sit, en hoe hulle nie kan doodgaan nie, en die onmenswaardige toestand waarin hulle is... Ek is nie bang vir doodgaan nie, maar ek is bang vir die wyse waarop ek kan doodgaan. Daar is party wat al agt jaar daar sit en daar kom nie 'n einde aan nie. ... Dit maak my bang ... die wyse waarop ek doodgaan, maar nie om dood te gaan nie. ..."

- In response to the question of how she feels about her age, respondent 35 replies: "Dis 'n seën van Bo." She is not afraid to die: "Kyk, ek sal nie sê 'n mens is nie bang nie, maar of jy op daardie moment reg is om dood te gaan ... jy moet tog darem eers met jou Heer praat. Jy wil tog darem graag 'n afskeid hê. Jy wil nie 'n skielike dood hê nie. ..."

- Respondent 1 remarks: "Ek het 'n gelukkige oudag. Dit was my wens. En dit het ek werklik vandag." In response to the question of whether she is afraid to die, she replies: "Ja ... ek is. Ek moet eerlik erken ek is bang. Ek behoort nie bang te wees nie, maar ek is bang ... . Jy moet altyd reg wees, want jy weet nooit of jy in so 'n toestand sal wees om reg te maak wat verkeerd was nie, né?"

- In response to the question of how she feels about her age, respondent 5 states: "Die lewe is vir my nou nog lekker." She says that she is not afraid to die.

(2) A *negative* approach towards aging

Twenty per cent of the sample were negative about aging. Some of them expressed their negativity as follows:

- According to respondent 24, "The age might be getting on, but the body is getting older. Some people have a saying 'mooi bly', but I don't know how we can 'mooi bly' if we get older and uglier by the day." He states that he is not afraid to die, but did not give

any reason for his answer.

- Respondent 15 describes his feelings about his age in the following words: "As 'n mens in hierdie toestand kom wat ek ook nou is - my verstand is nie meer goed nie, my gehoor is nie goed nie, my sig is nie goed nie, my oë is nie goed nie - dan voel jy jy kom by die einde, en dan begin jy dink of dit nie beter sal wees as jy maar gaan nie. Ek is nie bang daarvoor nie. Al wat ek bang voor is, is hóé jy daar kom. Dit is die periode wat ek nou in is."

- Respondent 31 regards aging as a struggle: "I'm still healthy. Sometimes I'm a bit tired. You know, you ... you wonder why ... you know ... you're carrying on and carrying on ... you wonder why you get old. ... Some days you feel very tired, but you ... struggle along, you know." She is not afraid to die: "I'm waiting. Sometimes you think you've come to the end, you know. You're tired. You don't want to be a nuisance to anybody. I'm not looking forward to die, but I'm not afraid to die."

- According to respondent 46, she is not afraid to die: "Ek kan maar gaan rus, want ek sê as 'n mens oud is, dan beteken jy ook maar niks meer hierso nie. Jy is maar hier."

- According to respondent 50, she has never thought of getting older: "Ek het nooit in my lewe oor die ouderdom gedink nie. Sowaar as vet nie! Dis nie lekker nie. Dit is gladnie 'n goeie ding om oud te word nie. Jy moet 'n stop daaraan sit, hoor!" She is not afraid to die and states that she knows the Lord.

(3) An approach of *acceptance* towards aging

Forty-eight per cent of the sample revealed an approach of acceptance with regard to aging. For example:

- Respondent 30 states that his age does not "worry" him. He is not afraid to die and replies: "Why should I be? Beyond the blue

there's a mansion for me."

- On the question of how she feels about her age, respondent 7 replies: "Ag, dit pla my niks. Ek wens ek was ouer dat ek gouer kon doodgaan!" She explains that she is really looking forward to die: "Mens het natuurlik 'n doel. My doel weet ek is om te bid vir my kinders, veral my kleinkinders."

- Regarding his feelings about his age, respondent 29 remarks: "Well, its got to come to us all at some stage or the other. Personally it doesn't worry me in fact." He states that he is not afraid to die.

- According to respondent 3, she does not feel anything about her age: "Dit help nie om jou daaroor te bekommer nie. Dit gaan maar aan, die lewe." She is not afraid to die.

- According to respondent 11, her age does not bother her: "Jy aanvaar dit. Jy weet jy word ouer en jy weet jou kragte is nie meer wat dit moet wees nie. Jy kan nie meer wees soos wat jy was nie ... en jy berus daarin, want die Here sê dit vir jou in Prediker. Dit móét gebeur." She is not afraid to die.

- Regarding her feelings about her age, respondent 22 replies: "Ek is tevrede. Ek sê altyd die Here het vir my die goeie gegee en ek moet nou met hierdie ook tevrede wees." She explains how she feels about death: "Dis seker maar vir ons almal 'n stryd as jy daaroor dink."

- On the question of how she feels about her age, respondent 37 replies: "Mens is maar naderhand so, jy aanvaar maar net alles eenvoudig." She is not at all afraid to die: "Ek sien partykeer nogal daarna uit. Dit is seker 'n bietjie snaaks om dit te sê, maar dit is absoluut so."

- Respondent 44 describes how she feels about her age: "Ag eintlik,

hoe sal 'n mens nou sê? Jy moet dit maar net aanvaar. Ek aanvaar dit maar net." She states that she is not afraid to die: "Nee, ek sien daarna uit."

Although responses revealing an approach of *acceptance* sound positive in nature and not negative, responses grouped under a *positive* approach are identified by explicit positive expressions used to describe feelings towards old age, retirement and death. With regard to feelings about dying, no explicit pattern is revealed, except in the case of respondents who accepted old age as part of life: they were generally not afraid to die. These approaches towards aging served to provide an introduction to the section on cultural iatrogenesis which deals with, inter alia, elderly people's experiences and interpretations of life in an old-age home.

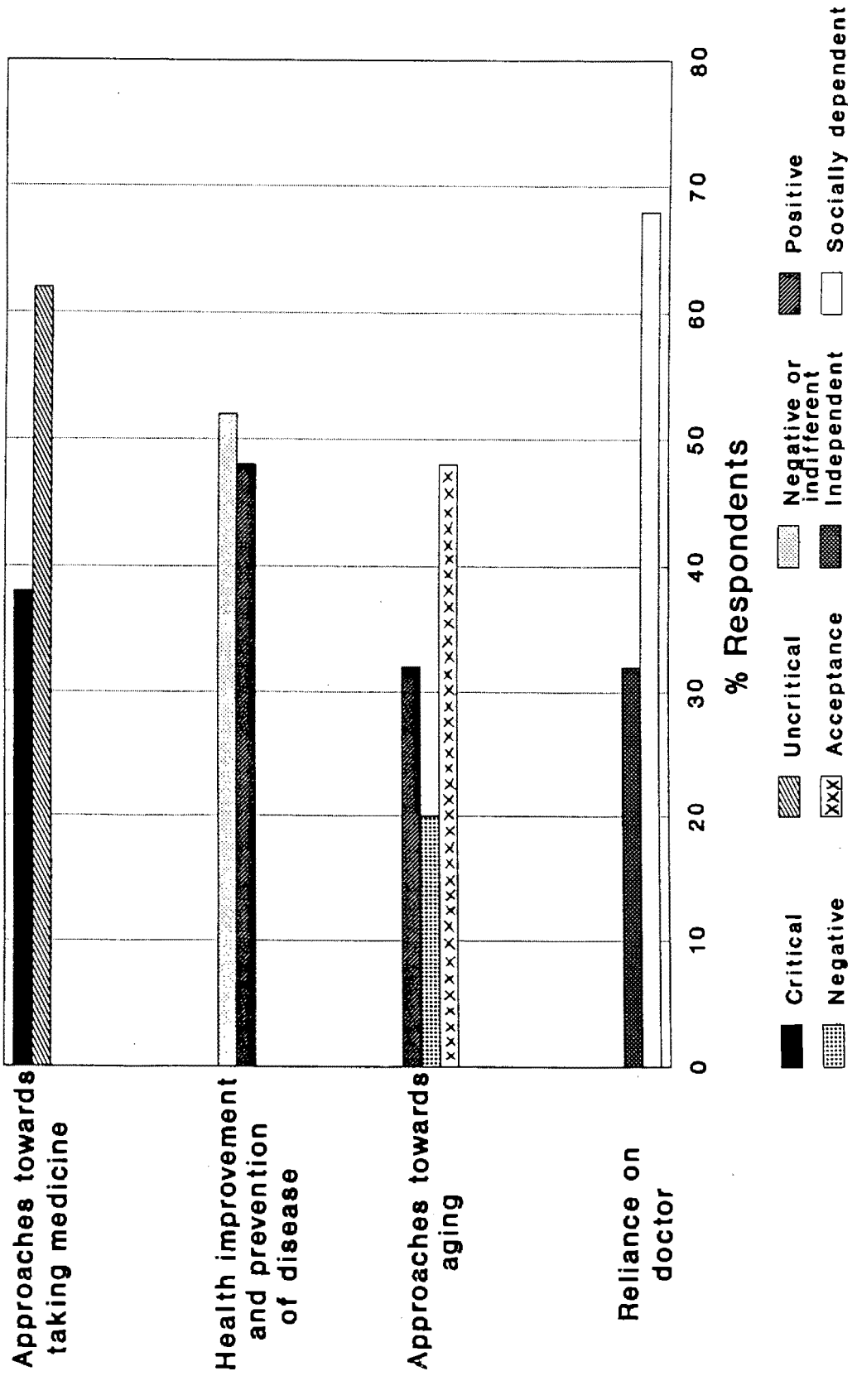
Different manifestations of social iatrogenesis, as revealed in this study, namely

- approaches towards taking medicine
- approaches to health improvement and prevention of disease
- approaches towards aging
- reliance on doctor

are summarised in the following histogram which provides a comparison between all the responses received in this category:

FIGURE 5.11

A SUMMARY OF RESPONSES WHICH REFLECT APPROACHES REVEALED IN THE CATEGORY SOCIAL IATROGENESIS



From the above histogram, it is evident that the elderly people included in this sample (n = 50) suffer from social iatrogenesis. For the purposes of this study, the focus was on social iatrogenesis occurring in the form of increased medical dependency. In three of the four subsections used to analyse this category, namely approaches towards taking medicine, approaches towards health improvement and prevention of disease, as well as reliance on the doctor, more than half of the total sample (an average of 61%) showed signs of increased medical dependency. The high percentage (68%) of respondents revealing a social dependence on their doctors is particularly disturbing. The fact that an increased medical dependency involves depending on the medical profession for solving problems which are not always medical in nature, is confirmed by the high percentage (62%) of the sample revealing an uncritical approach towards taking medicine. In addition to this uncritical approach, 52% of the sample is negative or indifferent about ways to improve their own health and to prevent disease. This attitude speaks of ignorance which may lead to incorrect lifestyle practices. Since doctors seem to form a popular point of contact for elderly people in old-age homes, and since medicine prescriptions are usually written by doctors, the responsibility rests on their shoulders to educate their patients about taking medicines, improving their health and preventing disease.

Even though Illich describes social iatorogenesis as it occurs under different circumstances (see chapter 2, section 2.2.3), the general condition of medicalisation of life becomes evident in each circumstance as an attitude of overreliance on the medical profession. Disturbing in this regard is the fact that the medicalisation of life does not remain a negative phenomenon which only pertains to the medical profession, but it influences thinking patterns in general such as, for instance, approaches towards aging.

It could therefore be argued that a condition of social iatrogenesis is evident in each of the four subsections used to analyse this category.

5.3.3 Cultural iatrogenesis

To Illich (1976a: 133), cultural iatrogenesis represents "a third dimension of health-denial". He describes the onset of this dimension as follows: "It sets in when the medical enterprise saps the will of people to suffer their reality" (Illich 1976a: 133). Illich views cultural iatrogenesis as a *symbolic dimension* rooted in the culture of people. This symbolic dimension is characterised by sets of meanings, values and interpretations assigned to the following conditions:

- the *destruction of personal autonomy*
- the *deprivation of personal responsibility* for one's own health matters

This third dimension of so-called pathology or harm done by modern medicine, is investigated in terms of the way in which residents of old-age homes regard themselves as being stripped of their personal autonomy, responsibility and control as a result of institutionalisation. For the purposes of this study, institutionalisation in old-age homes is regarded as a potential cause of cultural iatrogenesis.

Sections C, D and E of the questionnaire deal with the category of cultural iatrogenesis. These questions, which were formulated to reveal attitudes towards life in an old-age home, as well as the experience of institutionalisation, are the following:

- Since you've been here, have you had to change your medical routine at all? Are you taking more or less medicines? Do you ever visit the medical unit of the old-age home or call for the nurse? If yes, what was the reason for the last visit? Do you regard the services rendered in this old-age home as mainly medical in nature?

- Did you get most of the things you wanted and expected out of life? Have you ever thought of something that could make the aging experience easier? Does the old-age home arrange for any social activities? Do you attend these?

- Tell me how you feel about being in an old-age home. How do you generally pass the day here? How does this routine differ from a usual day in your previous home? Do you ever feel lonely or bored? What do you do to overcome this feeling? What were your hobbies before you moved to the old-age home? Are you still doing these things? How does the system work here? What do you like about being in an old-age home? Is there something you particularly dislike about being in an old-age home? What did you find most difficult to get used to in the old-age home? How do you feel about having meals at strictly set times? Would you prefer to be living elsewhere?

- Do you miss the privacy you had in your own home? Have you lost your independence since being in the old-age home? If so, in what way? Is your opinion valued with regard to decisions affecting yourself in the old-age home? Tell me whether you feel as in control of your own life in the old-age home as you were before you moved here. Do you have any specific needs which, to your mind, are not catered for in the old-age home? Do you have any ideas about how to make life easier in an old-age home?

The above-mentioned questions regarding cultural iatrogenesis were respectively operationalised and analysed in order to draw the following information from the collected data:

- the influence of institutionalisation on medical routines
- approaches to life and life satisfaction
- approaches to life in an old-age home
- feelings of loss of privacy, independence and/or control

Since the pilot study revealed certain differences between the functioning of public and private old-age homes, data collected for analysing the dimension of cultural iatrogenesis was interpreted in conjunction with certain aspects of biographical information, such as type of old-age home, length of stay in old-age home, as well as the respondent's living arrangements before admission to the old-age home.

Since it was believed that this information could shed more light on specific approaches revealed towards, for instance, life in an old-age home, this biographical information was taken into consideration in analysing the dimension of cultural iatrogenesis, but not in clinical and social iatrogenesis.

What follows is an interpretation of data in terms of the following subsections:

5.3.3.1 Influence of institutionalisation on medical routine

This theme was analysed in terms of the following questions:

- Since you've been here, have you had to change your medical routine at all?
- Are you taking more or less medicines?
- Do you ever visit the medical unit of the old-age home or call for the nurse?
- If "yes", what was the reason for the last visit?
- Do you regard the services rendered in this old-age home as mainly medical in nature?

Since the type of old-age home proved to have an influence on this issue, data regarding this subsection was interpreted in terms of the biographical information which indicated whether a respondent stayed in a public or private old-age home. Where applicable, examples will be given of personal opinions regarding this matter.

Fifty-eight per cent of the total sample are taking more medicines since being in an old-age home. The following figure provides a percentage distribution of this result in terms of the type of old-age home:

TABLE 5.1

PERCENTAGE DISTRIBUTION OF RESPONDENTS TAKING MORE MEDICINES SINCE BEING IN A PRIVATE OR PUBLIC OLD-AGE HOME

PUBLIC HOME	67% (20)
PRIVATE HOME	45% (9)

From the above percentage distribution it is evident that 67% of those respondents staying in public old-age homes, take more medicines since being there, while this is also the case for 45% of respondents staying in private homes. This difference in percentages could be attributed to the fact that public and private old-age homes are managed in terms of different sets of functions. As was mentioned in chapter 3, section 3.3.5, the institutionalisation of elderly people in old-age homes may lead to the problem of medicalisation, depending on the way in which the old-age home views its functions. For example, it seems that public old-age homes tend to be more medically orientated than private homes. Even though people who are getting older often need to take more medicines, it could still be argued that the 67% of respondents in public old-age homes have indeed become more medicalised than what they used to be.

Some of the responses received to the question of whether they are taking more or less medicines since being in an old-age home are summarised in terms of the two types of homes. Where applicable the researcher attempted to find the reason for the changes in medical routine, reasons such as a deteriorating physical condition.

(1) Respondents in *public old-age homes* taking more medicines since being there

The following are some of the responses received from the 67% of residents from public old-age homes taking more medicines since being there:

- In response to the question of whether he is taking more or less

medicines since being in an old-age home, respondent 24 replies that he is taking more: "They give me a sleeping tablet now."

- Since she has been in the old-age home, respondent 1 is taking more medicine: "Al wat ek nou nog het, is die slaappil wat ek nooit gedrink het voordat ek hier was nie."

- According to respondent 33, there were no changes in her medical routine since being in the old-age home, except for the sleeping tablet: "Most people here take a sleeping tablet, you know."

- According to respondent 21, he never took any medicine before he moved to the old-age home. He does not know why he has to take four tablets a day: "Ek weet nie ... nee, ek weet regtig nie ... dit slaan ons almal dronk!"

- In response to the question as to whether she is taking more or less medicines since being in the old-age home, respondent 22 replies: "Meer pille, want ek het altyd net 'n paar gedrink, maar nou's dit daardie waterpil en hoë bloedpil wat ek bykry ... by die slaappille."

- According to respondent 23, he started taking tablets since he first arrived in the old-age home: "Ek het nie pille gedrink voor ek hier gekom het nie." He takes six tablets a day and remarks: "Ek het nie geweet jy kan soveel drink nie!"

- According to respondent 38, he gets a sleeping tablet every night which he never requested: "They examined me and said that I must take a sleeping tablet. I've been taking sleeping tablets since I've been here. I think I started taking them [all his medication] when I came here."

- Regarding the medicine he takes on a regular basis, respondent 40 replies: "Die pille het ek maar eers hier kom gebruik."

- Respondent 41 states that she never requested sleeping tablets: "Dit is maar vir my voorgeskryf vandat ek hier is. Ek het dit maar hier beginne gebruik. Ek weet nie hoe lank nie ... lankal al."

- According to respondent 50, she is taking more medicines since being in the old-age home: "Ek sal jou sê, ek het nooit dit gedrink nie. Ek het net byvoorbeeld vitamine E gedrink vir kraggies en so."

- Respondent 39 states that he is taking more medicine since being in the old-age home. He is very unhappy and argues that being in an old-age home is the cause of his problems: "Ek het by die huis byna nooit medisyne gedrink nie."

It seems clear that what contributes to a higher consumption of medicines after entry into an old-age home, is mainly the consumption of sleeping tablets.

(2) Respondents in *private old-age homes* taking more medicines since being there

Forty-five per cent of the group of respondents staying in private old-age homes, were taking more medicines since being in the old-age home. What follows is an extract of their responses concerning this matter:

- According to respondent 15, there is no relationship between his moving to the old-age home and the changes in his medical routine. He is taking more medicines as a result of a deterioration in his physical condition.

- Respondent 10 is taking more medicines since she had an operation and they started giving her sleeping tablets in hospital: "Ek vind party aande dan drink ek dit nie. Ek is nie verslaaf daaraan nie."

- Respondent 17 is a diabetic and she suffers from osteoporosis. She has been taking more medicines since being in the old-age home as

a result of her physical condition which is gradually deteriorating.

From these results and responses, it seems that respondents in public old-age homes have less personal autonomy as regards the taking of medicines than respondents from private old-age homes. Generally, the group of respondents from public old-age homes revealed less knowledge about the medication they take or the reasons for taking it than the group from private old-age homes. It also seemed that those respondents in public old-age homes who started taking sleeping tablets in the old-age home, did not actually request any sleeping tablet. From some of their responses, it seems that they have little control over the fact that they receive sleeping tablets. Or rather, this is how they experience and interpret their taking sleeping tablets. In the light of this, it could be argued that public old-age homes tend to deprive people of their personal responsibility for self-care.

As mentioned in chapter 3, section 3.3.5, it can be stated that institutionalisation enhances the process of medicalisation, because the behaviour of elderly people (especially at night) is sometimes controlled by, for instance, the handing out of sleeping tablets. In agreement with Binney et al. (1990: 762), one could argue that public old-age homes are more clearly medically orientated with regard to their policies and services than private old-age homes. However, the investigation of different reasons for this as a cause for cultural iatrogenesis could be a topic for study on its own.

5.3.3.2 Approaches to life and life satisfaction

Approaches to life and life satisfaction were divided into three groups, namely *positive*, *negative* and *indifferent*. These approaches involve past influences, as well as present feelings. Questions that were designed to shed light on approaches towards life and life satisfaction are, inter alia, the following:

- Did you get most of the things you wanted and expected out of life?

- Have you ever thought of something that could make the aging experience easier?
- Does the old-age home arrange for any social activities? Do you attend these?

In this subsection, attention is mainly focused on whether respondents got most of the things they wanted and expected out of life. In section 5.3.2.4 on social iatrogenesis, respondents' approaches towards aging were investigated. These approaches were also divided into positive, negative and indifferent groups. In spite of the fact that different questions were asked to establish these approaches, an exact correspondence exists between the percentage distributions in these two subsections. This correspondence reveals a consistency in approaches, be it towards aging or towards life and life satisfaction. From this analysis it became apparent that when a person had a positive attitude towards aging, that person also revealed a positive attitude towards life. However, even though the percentages for negative and indifferent approaches also correspond directly, it was found that the latter two groups partly coincided.

TABLE 5.2

A COMPARISON BETWEEN APPROACHES TO AGING AND APPROACHES TO LIFE AND LIFE SATISFACTION

APPROACHES	POSITIVE	NEGATIVE	INDIFFERENT	TOTAL
To aging	32%	20%	48%	100%
To life and life satis-faction	32%	20%	48%	100%

(1) *Positive* approach

In this group, 32% of the respondents gave indications of satisfaction and they expressed happiness in and contentment with their lives. The following is a number of responses received in this regard:

- Respondent 35 replies: "Ek het 'n baie, baie goeie lewe gehad. Ek is gelukkig. ..." Responding to the question of what could make

the aging experience easier, she replies: "Berusting. Kyk, jy't jou goeie gehad, jy't jou swaar en jou moeilike dae ook gehad."

- According to respondent 5, she had a very happy life: "Ja, o ja. Ek is baie tevrede en gelukkig ... baie dankbaar. Ek het 'n goeie man en ek het goeie kinders." In response to the question of whether she has ever thought of something that could make the aging experience easier, she comments: "As jy klaar oud is en jy't maklik oud geword, dan wat moet ek nou antwoord? Ek het oud geword sonder dat dit vir my swaar was om oud te word. En ek is oud ... en ek wil graag nog lewe, want ek is nog 'n redelik gesonde mens."

- Responding to the question of whether she got most of the things she wanted and expected from life, respondent 6 replies: "O ja! Meer as wat ek verwag het. Ek was verskriklik gelukkig ... baie gelukkig." She has never thought of anything that could make the aging experience easier.

- According to respondent 38, he got most of the things he wanted and expected out of life: "Very much indeed. I think I'm awfully lucky." He states that he enjoyed his life. He feels that keeping the brain active could make the aging experience easier: "Well, I do a lot of reading. I've still got common sense. You find a lot of people at my age [90 years] that haven't got the sense. You must keep the brain active."

- Respondent 47 feels that he got most of the things he wanted and expected from life: "Die Here was goed vir ons gewees." He has the following ideas on how the aging experience could be made easier: "Mens moet natuurlik 'n positiewe uitkyk behou. Jy moet 'n humorsin behou en jy moet die Here ken."

(2) *Negative* approach

Twenty per cent of the sample expressed unhappiness about their lives. They gave explicit indications of negativity towards life and life

satisfaction, for example:

- According to respondent 15, he had a very unhappy working career: "Eintlik het ek 'n baie ongelukkige lewe gehad in die staatsdiens. Ek het 'n hele reeks probleme gehad. Hulle het my bevordering ook teruggehou. Hulle het my departementeel aangekla in 'n saak wat hulle glad geen klagte teen my gehad het nie. Ek kon nie wag om af te tree nie." He could not think of anything that could make the aging experience easier.

- Respondent 10 expresses unhappiness regarding her life: "Ek sal jou sê, my egskeiding was 'n verskriklike slag ... want as jy darem 25 jaar getroud was... . Kyk, die dood is finaal, maar 'n egskeiding nie. Dis nie iets wat jy ooit oorkom nie." She does not know of anything that could make the aging experience easier.

- According to respondent 14, she did not get the things that she wanted and expected from life: "Nee, as ek nou eerlik moet wees ... nee. Ek weet nie ... ek het heelwat verwagtinge gehad wat ek nie by uitgekom het nie. Jy weet, dis natuurlik omstandighede. Die eerste ding is omdat my man 'n staatsdiensamptenaar was. Jy weet, toe het ons so baie rondgetrek en dit is 'n groot ontwrigting vir 'n mens." In response to the question of whether she has ever thought of something that could make the aging experience easier, she replies: "Al wat ek gedink het ... 'n mens moet vir jouself aanvaar ... Dit sal dit vir jou makliker maak. Jy moet aanvaar jy word ouer."

(3) *Indifferent* approach

Forty-eight per cent of the sample revealed an indifferent approach towards life and life satisfaction. This became evident in, inter alia, the following responses received in this regard:

- Respondent 25 replies that she cannot complain about her life. She has no ideas about how to make the aging experience easier and

replies: "We've all got to get old; we've all got to go that way; ... we've all got to die and I only hope that I just wake up one morning and find I'm dead."

- Respondent 33 states that she does not know whether she got all the things she wanted and expected out of life: "You know, one can't say all these things. You know you don't expect to lose all your children... . Those are the things we don't know. We don't know what's in store for us in life and it's just as well, isn't it? They often say there's a purpose in everything, but we don't see that purpose, do we? We don't, you know. ..." In response to the question of whether she has ever thought of something that could make the aging experience easier, she replies: "Oh yes, I think your faith is everything." She states that she knows she will one day be re-united with her whole family.

- Respondent 44 states that she did not expect anything from life: "Ek het eintlik niks verwag van die lewe nie. Ek het net geestelike rykheid en rypheid begeer." She thinks that knowing the Lord is the only thing that could make the aging experience easier.

Forty-eight per cent of the sample have never thought of anything that could make the aging experience easier. These respondents did not necessarily reveal a negative attitude towards life and life satisfaction. It is evident that those who have never thought of anything that could make the aging experience easier are divided into all three groups, namely positive, negative and indifferent. In other words, no explicit relationship exists between life satisfaction and knowledge about what could make the aging experience easier.

5.3.3.3 Approaches to life in an old-age home

Approaches revealed by respondents to life in an old-age home varied from happy to indifferent to unhappy. In order to analyse and interpret this subsection of cultural iatrogenesis, three groups of responses were identified, namely *positive*, *negative* and *indifferent*. Responses were

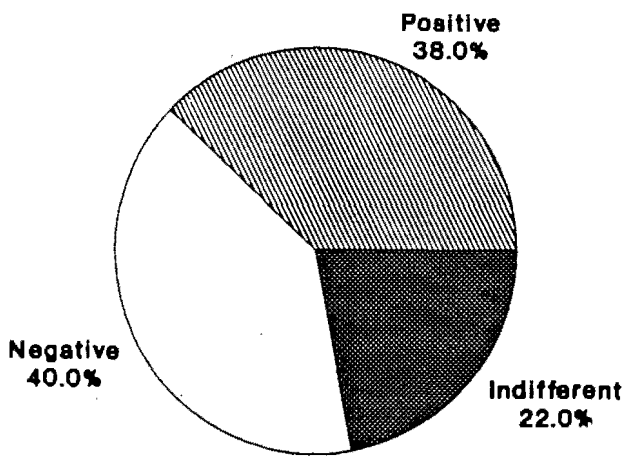
received in reply to the following questions:

- How do you feel about being in an old-age home?
- How do you generally pass the day here?
- How does this routine differ from a usual day in your previous home?
- Do you ever feel lonely or bored?
- What do you do to overcome this feeling?
- What were your hobbies before you moved to the old-age home?
- Are you still doing these things?
- How does the system work here?
- What do you like about being in an old-age home?
- Is there something you particularly dislike about being in an old-age home?
- What did you find most difficult to get used to in the old-age home?
- How do you feel about having meals at strictly set times?
- Would you prefer to be living elsewhere?

The following graph provides the percentage distribution of the three groups of responses received in this regard:

FIGURE 5.12

RESPONSES WHICH REFLECT RESPONDENTS' APPROACHES TO LIFE IN AN OLD-AGE HOME

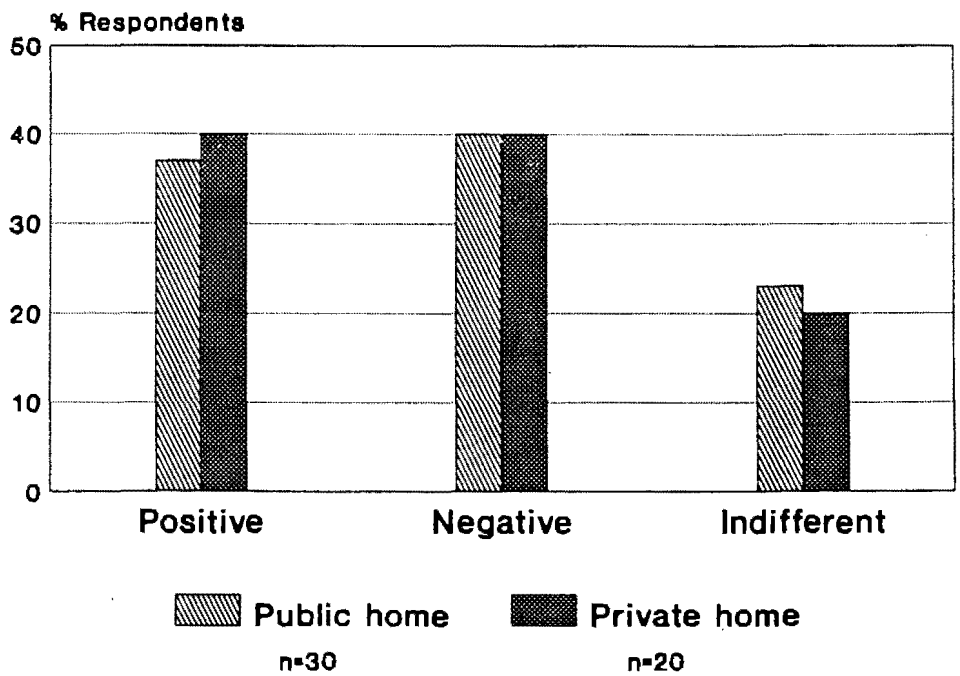


The distribution of approaches to life in an old-age home in terms of the type of old-age home reveals no significant difference. One could argue that the mere idea of *being in an old-age home* is the crucial factor in this regard.

What follows is a histogram which shows the distribution of approaches to life in an old-age home in terms of the type of old-age home.

FIGURE 5.13

A COMPARISON BETWEEN APPROACHES TOWARDS LIFE IN AN OLD-AGE HOME IN TERMS OF THE TWO TYPES OF OLD-AGE HOMES



From the above histogram, it is evident that no substantial difference occurs between approaches of respondents in public old-age homes and those of respondents in private old-age homes. It seems that, in the mind of the elderly person, the experience and interpretation of life in an old-age home is influenced more significantly by cultural meanings assigned to institutionalisation than by any distinction between public and private old-age homes.

Respondents' approaches to life in an old-age home were also interpreted in terms of their living arrangements before admission to the old-age home, as well as the type of old-age home. It was found that the largest group (54% of the sample) stayed in houses before they moved to an old-age home. Of the three groups of responses, most of the respondents (40%) revealed a negative approach to life in an old-age home, while 38% were positive in this regard. It was thought that any form of communal living before moving to an old-age home could have served as preparation for life in an old-age home. On the other hand, if a respondent had stayed in a flat, adaptation could be easier in terms of, for instance, having less space and not having a garden. However, no explicit pattern was revealed between living arrangements and attitude to life in an old-age home.

The following outline of the three groups of responses does not provide any distinction between responses from public and private old-age homes.

(1) *Positive* approach

In the first group, namely a positive approach towards life in an old-age home, 38% of the total sample explicitly stated that they enjoy life in an old-age home and that they do not prefer to be living elsewhere. Some of the responses in this regard were as follows:

- According to respondent 15, he is very happy in the old-age home. What he finds particularly pleasant is the interest residents have in one another. "Jy kan nie anders nie. 'n Mens moet gelukkig en tevrede voel. Dit gee vir jou satisfaksie, dit gee vir jou plesier, dit gee vir jou moed, dit gee vir jou krag." He would not prefer to be living elsewhere.

- In response to the question of how she feels about being in an old-age home, respondent 28 replies: "Well, I'm very thankful to be here. It is one of the nicest places there is, I think. I've got my little balcony. I get lovely sun on the balcony. And then, I've got no garden, so I don't garden ... but that's alright. I'm

quite happy. I've got a few plants on the balcony." She would not prefer to be living elsewhere.

- Respondent 1 states that she is very happy in the old-age home and that the treatment is exceptional: "Die atmosfeer hier ... die behandeling is honderd persent. Hier het ons 'n huislike lewe." She would not prefer to be living elsewhere.

- Respondent 8 enjoys life in the old-age home: "Dit is vir my lekker om hier te wees. Dis lekker om maats te maak en om mense te leer ken. So, ek kan nie sê ek mis my huis nie." She would not prefer to be living elsewhere.

(2) *Negative* approach

Forty per cent of the total sample revealed a negative approach towards life in an old-age home. This approach was generally characterised by unhappiness and an inability to adapt to life in an old-age home. Some repondents expressed a longing for their own homes. Loneliness seemed to be one major reason for a negative approach. It was found that those respondents who do not see their family on a regular basis, felt more isolated than respondents who described their contact with family members as "often", "regularly" or "heelwat". The following responses revealing a negative approach towards life in an old-age home were received:

- According to respondent 2, she has problems with her roommate: "Ek het so 'n paar maal vies geword vir haar, dan gee ek haar nie antwoord nie, en ek praat nie en ek gaan sit hier in die sitkamer of ek sit buite op die stoep. ... Dit is moeilik as jy jou eie lewe gewoond is, jy weet, jou eie dinge doen, is dit moeilik. En, ek moet vir jou sê, die kas waarin ek my klere ophang, is baie klein. Jou klere word so vasgedruk." One of the things she found most difficult to get used to in the old-age home was the food: "Jy weet, ons kry vreeslik baie stysel hier in die ouetehuis ... en min groente. Hier is nie 'n dieetkundige nie. Die pap word ook vreeslik dun gemaak. ... Ons koop maar ons eie vrugte." She says

that she would rather be living with her one daughter than in an old-age home.

- Regarding her feelings about being in an old-age home, respondent 34 comments: "It's not what I would have chosen. First of all, its only this one room to live in. ... I had a beautiful flat and, you know, you miss being able to go from room to room. And ... I sometimes kick against the routine of breakfast at eight, lunch at twelve. ... A bird flies, you know. ..."

- Respondent 13 states that she feels very lonely in the old-age home: "Jy weet, tussen baie mense, maar tog eensaam. ... Ek sou my huis verkies het as ek nog alleen kon bly, maar 'n vrou kan nie meer alleen in 'n huis bly soos vroeër dae nie."

- Regarding her feelings about being in an old-age home, respondent 41 replies: "Kyk, ek voel my lewe is eensaam ... baie eensaam. Jy weet, in so 'n plek is die oumense baie lief om te skinder ... en daarvan hou ek nie. Ek bly in my kamer en hier sit ek." She would not prefer to be living elsewhere.

- Respondent 50 remarks that she feels very lonely in the old-age home: "Die soort van geselskap ... dat hulle altyd hulle siektes bespreek ... dit sit my af. Dit is vir my irriterend. Ek vermy mense as hulle begin kla. ... Dan staan ek op en dan loop ek. En jy voel gefrustreerd hier tussen die vier mure. Dis nou nie weg te prate nie." However, she states that she would prefer to stay there, "want ek voel veilig".

(3) *Indifferent* approach

Twenty-two per cent of the total sample revealed what can be referred to as an indifferent approach towards life in an old-age home. Generally, these respondents expressed a "don't care" attitude and some of them felt they have no other option but to accept their circumstances.

What follows are some of the responses which were received in this regard:

- In response to the question of how he feels about being in an old-age home, respondent 24 replies: "Well, to put it this way, you've got a bed to sleep in, you've got a roof over your head and you get three meals a day. What more can you ask for? It might be a bit expensive, but what else can you do?" He would prefer to be living elsewhere.

- Responding to the question of how she feels about being in an old-age home, respondent 4 explains: "Ek sal vir jou sê, 'n mens het eintlik nie 'n opsie nie. Dis nie hoe jy voel nie. Jy's verplig ... dis 'n verpligting. ... Op my ere woord, as 'n mens die dag op die ouderdom is wat ek is, dan is daar geen ander keuse nie." She would not prefer to be living elsewhere.

- Regarding his feelings about being in an old-age home, respondent 19 says: "Kyk, ek vat dit só: dis 'n dak oor my kop, en ek het 'n plek om te gaan slaap saans en ek het 'n plek waar ek kan gaan sit en eet." He remarks that he would have liked to be closer to his sister, "maar dit kon nou nie so gebeur het nie."

- In response to the question of how he feels about being in an old-age home, respondent 40 replies: "Ag, ek voel dis maar die regte plek vir 'n oumens." He would not prefer to be living elsewhere.

Generally, respondents who revealed a positive approach towards life in an old-age home stated that they would not prefer to be living elsewhere. However, in the response groups of negative and indifferent approaches, no clear pattern was found. Specific reasons for unhappiness varied from, inter alia, a lack of space to loneliness. Excluding the 38% revealing a positive approach, it seems that, although they complained and expressed unhappiness, respondents generally felt they had no other option but to be in an old-age home.

5.3.3.4 Feelings of loss of privacy, independence and/or control

Cultural iatrogenesis refers, inter alia, to the destruction of personal autonomy which was, for the purposes of this study, operationalised in terms of a loss of privacy and/or control and/or independence.

Therefore, this subsection deals with feelings of:

- loss of privacy and/or
- loss of independence and/or
- loss of control

It was found that respondents have different definitions for the concepts "independence" and "control". Since this study focuses on the approaches, interpretations and experiences of elderly people in old-age homes, these diverse definitions are not taken into account in the interpretation of the data. For example, a respondent may regard loss of control in a financial, personal, physical or social sense. Whatever constitutes "loss of control" for a respondent, is recorded in the way it is expressed. What is important in this regard is whether or not the respondent experienced a feeling of "loss of control". By implication, a "feeling" is a subjective personal experience. Therefore, depending on the individual, different responses refer to different aspects of respondents' lives.

Feelings of loss of privacy and/or independence and/or control were analysed in terms of responses to the following questions:

- Do you miss the privacy you had in your own home?
- Have you lost your independence since being in the old-age home? If so, in what way?
- Is your opinion valued with regard to decisions affecting yourself in the old-age home?
- Do you feel as in control of your own life in the old-age home as you were before you moved here?
- Do you have any specific needs which, to your mind, are not catered

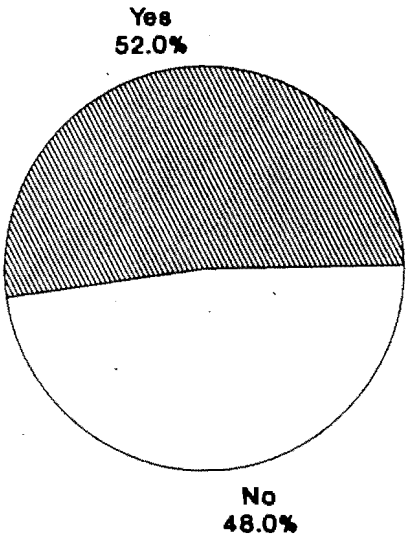
for in the old-age home?

- Do you have any ideas about how to make life easier in an old-age home?

Two major responses regarding feelings of loss of privacy and/or independence and/or control were distinguished, namely *yes* and *no*. The results can be presented graphically as follows:

FIGURE 5.14

RESPONSES REFLECTING FEELINGS OF LOSS OF PRIVACY AND/OR INDEPENDENCE AND/OR CONTROL



From the above figures, it is evident that more than half of the total sample (52% of respondents in old-age homes) felt they have in some or other way lost their privacy and/or independence and/or control of certain aspects of their lives as a result of being in an old-age home.

(1) The "*yes*" group who indicated that they suffer from feelings of loss of privacy and/or independence and/or control

In this group, responses varied, inter alia, from problems with roommates to the sharing of bathrooms and transport problems. Subsequently, some

of the responses received in this regard will be provided:

- Respondent 2 feels that she has lost some of the privacy she used to have in her own home: "Ek deel nou. En met die bad... nou-die-aand het iemand gaan bad en nooit die bad skoongemaak nie... die bad het so 'n vuil rif gehad. ... Dit lyk of iemand net die prop uitgetrek het en nooit die bad skoongemaak het nie."

- According to respondent 30, his routine in the old-age home differs significantly from what he was used to: "I haven't got that freedom I had." He felt that he has lost some of his independence: "Fifty per cent indeed. ... It is in my movements, you know, I am like an object to them."

- Regarding privacy in the old-age home, respondent 16 replies: "Jy boet jou privaatheid in. Dis nie altemit nie, want dis 'n kwessie van instap en uitstap wanneer hulle wil."

- Respondent 5 states that they (she and her husband) miss having their own car: "Ons sou vreeslik graag nog self wou ry. ..." She states that they have lost some of their independence "ook omdat alles nou vir jou gedoen word." With regard to their privacy, she replies: "Ons maak maar ons deur toe. Maar my prentjie verskil heelwat van die mense wat moet kamers deel. Ek weet nie as daardie dag aanbreek en jy kom my weer ondervra ... dit gaan hééltemal anders wees! Ek weet nie ... ek weet nie ... of ek dán hier sal bly nie. Ek weet nie. ... Dit is te veel geverwag."

- According to respondent 21, he definitely misses the privacy he used to have in his own home: "Ek sal dit só stel: 'n mens voel nie so vry in 'n ouetehuis as wat jy in jou eie huis gewees het nie. Die mense, ... jou medemens in so 'n plek is ... ek sal dit só sê ... hulle is gebind. Hulle is nie vry nie. Hulle is gebind ... of so iets omtrent. Jy's definitief nie meer heeltemal onafhanklik nie." He states that one loses control of one's life in an old-age home.

- In response to the question of whether he misses the privacy he used to have, respondent 23 replies that he finds it particularly difficult to share a room with someone: "Ek hou nogal daarvan om alleen te wees." He feels that he has lost some control over his life, as well as his independence since being in an old-age home: "Ja, o ja. Jy weet ... nou sit ek net. ... Ons lewens ... baie van ons ... bestaan uit sit. Wat anders kan jy doen? As jy hier opstaan en jy gaan daar onder, dan gaan sit jy maar. As jy daar opstaan, dan kom sit jy. Jou lewe bestaan uit sit. As jy nou hier opstaan en jy gaan onder toe ... tafels ... eet. Daar staan jy op ... dan sit jy weer. Middagete ... dan staan jy op, dan sit jy weer. ..."

- Regarding her privacy, respondent 37 replies: "Man, partymaal voel ek so half 'n bietjie omgekrap as ek nou na 'n spesifieke program op die radio wil luister en hier kom nou ene in of iets van die aard." She does feel that she has lost some of her independence since being in an old-age home: "Ja, ek dink 'n mens voel maar 'n bietjie so. In 'n mate voel 'n mens soos 'n oumens ... want jy word soos een behandel."

- Respondent 38 does not miss the privacy he used to have in his own home: "I miss my car. ... If I had my own car, then you'd find me going out every day." He states that he feels restricted and that he has lost some of his independence since being in the old-age home.

- On the question of whether he still feels as in control of his life as before he moved to the old-age home, respondent 42 replies: "Ek het ongelukkig my motor verkoop voor ek hiernatoe gekom het. Ek het gehoor hulle steel die karre hier en hier is nie staanplek nie. Toe is ek bang. Toe gaan ek liewerster en ek verkoop my kar ... en dis die grootste fout wat ek gemaak het." He states that he has definitely lost his independence since being in the old-age home. "Ek is baie jammer dat ek my motor weggemaak het, want toe ek hier kom, toe sien ek hier staan die motors. ... Toe is ek nou baie

omgekrap!" He does not miss the privacy he used to have in his own home: "Jy raak dit gewoond."

(2) The "*no*" group who declared that they do not suffer from feelings of loss of privacy and/or independence and/or control

Forty-eight per cent of the sample replied that they do not suffer from feelings of loss of privacy and/or independence and/or control. These respondents are grouped under the "no" response. In some instances, people stated that they were particularly fortunate to have got a single room or to still have their own car, and they regard these as the reasons for not having lost their privacy and/or independence and/or control. On the contrary, regarding the "yes" group, it seems that transport problems can to a great extent be blamed for feelings of loss of independence and control, while communal living and sharing a room seem to be the main causes for feelings of loss of privacy. The following responses were received in this regard:

- Respondent 28 is still driving her own car. "We have our independence. You can go when and where you like. I'm out quite often."

- Respondent 17 does not miss the privacy she had in her own home: "Nee, ek maak my deur toe. ... En my bure respekteer my privaatheid." She states that she does not feel less in control of her life than before she moved to the old-age home.

- In response to the question of whether she misses the privacy she used to have in her own home, respondent 22 replies: "Nie meer nie. In die begin voel 'n mens dit, maar nie meer nie."

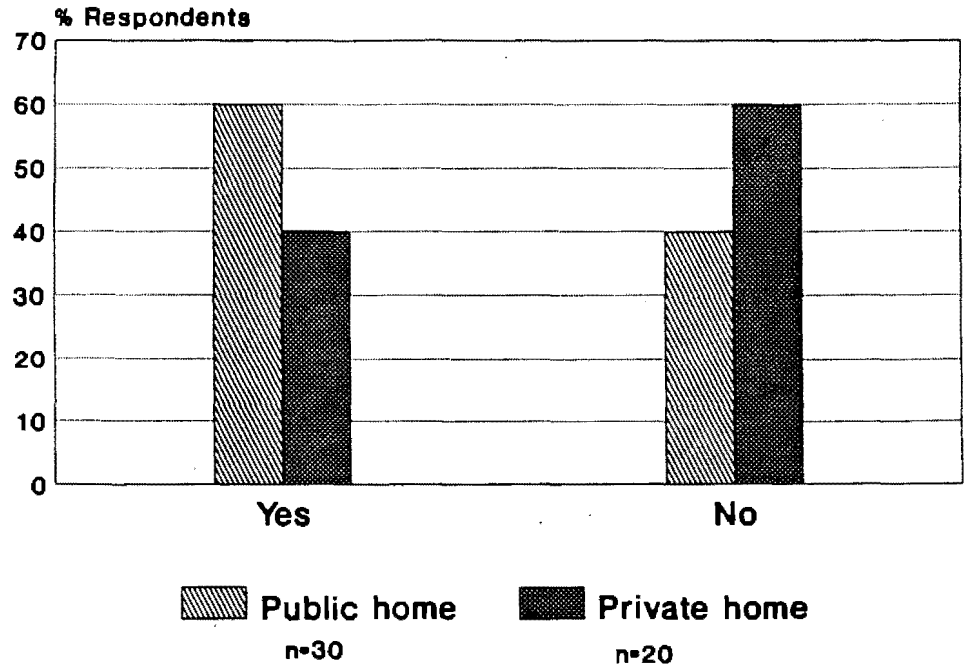
- Respondent 26 does not feel that she has lost the privacy she had in her own home. Due to the fact that she still drives her own car and goes wherever she wants to, she does not feel as though she has lost some of her independence.

- With regard to his privacy and independence, respondent 32 remarks: "You've got all the privacy you want, you've got the freedom you want, you know ... as long as you just obey the rules. You must be in at half past eight." He does not think that he has lost any of his independence since being in an old-age home.

Feelings of loss of privacy, independence and/or control were interpreted in terms of the type of old-age home, as well as the length of stay in the home. The following histogram summarises the percentage distribution in this category in terms of the two types of old-age homes:

FIGURE 5.15

RESPONSES TO QUESTIONS ABOUT FEELINGS OF LOSS OF PRIVACY AND/OR INDEPENDENCE AND/OR CONTROL IN TERMS OF TYPE OF OLD-AGE HOME



From the above historgram, it is evident that the largest group of respondents who complain about feelings of loss of privacy, independence and/or control, stays in public old-age homes. It seems that this finding serves as confirmation for previous findings in section 5.3.3.1

of this chapter, namely that respondents in public old-age homes suffer from a destruction of their personal autonomy to a greater extent than do respondents in private old-age homes.

Concerning length of stay in an old-age home, the following pattern was revealed: respondents who have been staying in public old-age homes for a period of up to three years, seemed most dissatisfied with regard to feelings of loss of privacy, control and/or independence. As the length of stay in public old-age homes increases, so, it seems, do the levels of dissatisfaction decrease. This finding is confirmed by the 8% of the sample who do not experience any feelings of loss of privacy, independence and/or control, but who have been staying in public old-age homes for longer than seven years. Could it be argued that, the longer a person is institutionalised in a public old-age home, the more likely that person becomes to "surrender" to life in an old-age home? Or do they finally come to terms with the fact that they have no other option but to stay there, because "their place in the community has been permitted to close in behind them" (Tibbit 1983: 241)? It seems that a similar pattern (although to a lesser extent) appears in private old-age homes. This could indicate that, after a certain length of time, an old-age home is but an old-age home in the mind of the elderly person.

With reference to the above findings, which reveal certain influences which old-age homes exert (both directly and indirectly) on the lives, attitudes and feelings of residents, it could be argued that elderly people in old-age homes do suffer from cultural iatrogenesis as a result of institutionalisation. In Illich's terms, institutionalisation could be regarded as a particular system of meanings which - in an industrialised society - is often highly informed and controlled by the medical profession. It could thus be argued that cultural iatrogenesis results from certain symbols and values for action which are planned and organised in such a way in old-age homes that elderly people suffer from the destruction of personal autonomy, as well as the deprivation of their personal responsibility for their own health matters.

Finally, a summary of the research findings will be provided in terms of

the three levels of iatrogenesis, namely clinical, social and cultural iatrogenesis.

5.4 SUMMARY OF RESEARCH FINDINGS

The purpose of this study was to establish whether elderly people in old-age homes suffer from the three levels of iatrogenesis as described by Illich, namely clinical, social and cultural/structural iatrogenesis. Although this study is not able to provide empirical evidence of the degree to which people are suffering, it can indeed say that elderly people in old-age homes do suffer from harm done by the medical profession, on a clinical, social, and cultural level.

In order to investigate people's approaches and interpretations, it was necessary to evaluate their views and experiences of different aspects of life in an old-age home.

Results will subsequently be summarised in terms of clinical iatrogenesis.

5.4.1 Clinical iatrogenesis

According to Illich (1976a: 36), clinical iatrogenic disease comprises "all clinical conditions for which remedies, physicians, or hospitals are the pathogens, or 'sickening' agents". Since this study is explorative in nature, no fixed explanations are given. All findings should rather be regarded as relative.

With reference to clinical iatrogenesis, the present research findings indicate that sleeping tablets are widely used among elderly people living in old-age homes. From the perspective of the respondent, it seems quite a common practice in some old-age homes (especially public homes) to take a sleeping tablet every night. In many instances, these were not specifically requested by respondents. It should be noted that sleeping tablets are generally not available over the counter without a doctor's prescription.

This study revealed that sleeping tablets are taken for various reasons, among which were the following:

- a snoring or noisy roommate
- noises in the passages
- previous use of sleeping tablets
- the most common explanation: "Everyone here uses it."

According to the Monthly Index of Medical Specialities (hereafter referred to as MIMS) (1991: 3), sleeping tablets are categorised as sedatives which are sold under different trade-names such as Mogadon, Arem, Dormicum, Dalmadorm and many more. The use of sedatives could lead to various side-effects as summarised in MIMS (1991: 4):

- drowsiness
- lightheadedness
- confusion
- oversedation, especially in elderly people
- dose dependency
- dizziness
- morning headaches
- depression
- disorientation (especially upon waking)
- kidney and liver diseases
- lethargy (morbid drowsiness due to prolonged and unnatural sleep)
- ataxia (failure of muscle co-ordination)
- headaches
- paradoxical reactions (when the two lungs are not working in unison)
- impaired acuity (sharpness)
- skin rashes

In the light of the above-mentioned possible side-effects of sleeping tablets, it could be argued that at least 60% of this sample of elderly people in old-age homes are at risk of physical damage due to the prolonged use of sedatives. In addition to the possibility of this cause

of clinical iatrogenesis, 44% of the sample were ill-informed concerning their health problems, 54% gave indications of ignorance regarding the adverse effects of medicines, and 38% of the sample revealed ignorance with regard to their medication practices. In terms of the above-mentioned themes, it could be argued that almost half of the respondents (45% of the total sample) suffer from a degree of clinical iatrogenesis.

According to Illich's (1976a: 41) description of clinical iatrogenesis in terms of, among others, defenceless patients, it can be argued that elderly people staying in old-age homes are in danger of suffering from definite side effects as a result of the common and in many instances routine practice of prescribing sleeping tablets. Illich (1976a: 36) remarks that "medicines have always been potentially poisonous, but their unwanted side effects have increased with their power and widespread use". Some of the side effects of sedatives are subtle and thus not easily and instantly recognisable.

The critical question to be asked in this regard is: Had elderly people known of the side effects of sleeping tablets, would they have taken these merely because they were prescribed and "everybody else is taking them"? This question is inclusive of the different research expectations covered in the section on clinical iatrogenesis, namely:

- Elderly people in old-age homes suffer from clinical iatrogenesis as a result of *ignorance* about their medication practices.

- Elderly people in old-age homes suffer from clinical iatrogenesis as a result of *ignorance* about the adverse effects of medicines.

- Elderly people in old-age homes suffer from clinical iatrogenesis as a result of *ignorance* about their own health problems.

According to Illich, the revelation of this condition of ignorance which could lead to damage on a clinical level, should be regarded as an exposure of the ways in which the self-understandings of a group of people are false. The argument in this regard is not that sleeping

tablets should never be prescribed, but that they should be prescribed with more caution and with consideration of possible side effects and of alternative ways of treating sleeplessness, such as encouragement to take more exercise and to drink less coffee. Furthermore, it seems that the onus rests very much on doctors and nurses to provide their patients with the necessary information when potentially harmful actions are carried out.

5.4.2 Social iatrogenesis

The second level of damage, namely social iatrogenesis, focuses the attention on a particular frame of mind which originated as a result of a dependence on society's provision of medical care. This condition is revealed by people in industrialised societies characterised by bureaucracies such as the medical bureaucracy. Although Illich provides a number of ways which could give rise to social iatrogenesis, the focus in this study is on increased medical dependency which represents his main thrust, namely the medicalisation of life.

Sixty-two per cent of the total sample of 50 respondents gave indications of an uncritical approach towards having to take medicines. This group was uncritical in the sense that they were either indifferent or they liked taking medicines or they believed in their medicines regardless of any side effects - "Medisyne is vir my so goed soos kos." For the purposes of this study, the fact that they are taking medicines is not so much the issue as the fact that they are ill-informed about these medicines and therefore do not mind taking them.

A total of 52% of the sample revealed an indifferent and/or negative approach towards health improvement and prevention of disease. In Illich's terms, this could be interpreted as a passive condition created by the medical profession in the sense that the doctor fulfils the active role of taking all the decisions. Sixty-eight per cent of the sample gave indications of a degree of social dependence concerning their relationship with their doctors - another sign of passivity or being at the receiving end. One could argue that a substantial number of

residents in old-age homes have handed their responsibility for health improvement and disease prevention over to their doctors, like the respondent who replies: "Ek glo aan my dokter soos ek aan my Bybel glo."

From the above summary of research findings pertaining to social iatrogenesis, it could be argued that this study arrived at the following conclusions which confirm the research expectations spelled out in this regard (see chapter 1, section 1.2)

- Elderly people in old-age homes suffer from social iatrogenesis as a result of *uncritical approaches* towards their medication practices

- Elderly people in old-age homes suffer from social iatrogenesis as a result of *indifferent approaches* towards their health improvement and prevention of disease

- Elderly people in old-age homes suffer from social iatrogenesis as a result of *social dependence* on their doctors

Illich implicitly pleads for practical steps to be taken towards socially transformative behaviour. Critical questions in this regard are: Is it possible to activate an already "addicted" and socially paralysed society? Is this medicalised behaviour not the result of certain ideas used by the medical profession and imposed on people in the process of treating them? The three concepts, *enlightenment*, *empowerment* and *emancipation* constitute the essence of what Illich terms de-industrialisation and de-professionalisation. The process of recovery is meant to start in the mind of the individual from where it will lead to a release from bondages imposed on people by the medical profession. Once people have managed to break loose from medicalisation, the power of the medical profession will automatically be broken.

The review of some approaches towards taking medicines, as well as towards health improvement and prevention of disease, inevitably reminds one of what Illich (1976a: 87) is saying about elderly people and the

medicalisation of life:

> At each stage of their lives people are age-specifically disabled. The old are the most obvious example: they are victims of treatments meted out for an incurable condition. Relatively more old people are around, and they are increasingly prone to be ill, out of place, and helpless.

Signs of increased medical dependency were evident in more than half of the responses.

5.4.3 Cultural iatrogenesis

The dimension of cultural iatrogenesis is characterised by the destruction of personal autonomy, as well as the deprivation of personal responsibility for self-care as a result of cultural symbols and values which distort a person's reality to such an extent that the person falls victim to certain debilitating patterns in society. Particular approaches and interpretations revealed by respondents were investigated in terms of the following expectations which were confirmed in this study for the category of cultural iatrogenesis (see chapter 1, section 1.2):

- Elderly people in old-age homes suffer from cultural iatrogenesis in terms of *loss of control* as a result of staying in an old-age home.

- Elderly people in old-age homes suffer from cultural iatrogenesis in terms of *loss of privacy* as a result of staying in an old-age home.

- Elderly people in old-age homes suffer from cultural iatrogenesis in terms of *loss of independence* as a result of staying in an old-age home.

Although individual respondents provided different reasons for their loss of privacy, independence and control, and even though the concepts of

"independence" and "control" meant different things to different respondents, the existence of a problem cannot be denied. People feel unhappy in terms of their frame of reference which, in this case, is shaped by a society which places a great emphasis on economic performance and functionality.

The fact that elderly people end up in old-age homes where they become exposed to the danger of cultural iatrogenesis, is a serious problem. Fifty-two per cent of the total sample reported a loss of privacy, independence and/or control, while 58% of the total number of respondents were taking more medicines since being in an old-age home. This indicates the need for political and emancipatory change. The important question in this regard is: Who should initiate this change? Should the government take responsibility for the education and emancipation of the members of its society or does the responsibility rest on the shoulders of the individual to free himself or herself from this three-dimensional trap which Illich calls iatrogenesis? Although Illich provides no practical ideas for solving the problem, his argument could be regarded as leading the individual into a process of self-reflection which may pave the way to self-knowledge and eventually to the emancipation of the individual. This emancipation will eventually become part of the received wisdom of society in general. With regard to this particular study, virtually every respondent thanked the researcher after the interview and mentioned something about "having learned a lot". Perhaps this indicates the beginning of an emancipatory process.

With regard to old-age homes, it seems that the longer one stays in an old-age home - be it private or public - the more likely it will become that one will accept one's circumstances. Regarding institutionalisation of elderly people, Illich (1976a: 92) states the following (based on research done by Markson): "Some old people seek institutionalization with the intention of shortening their lives." Here Illich is referring to the way in which some elderly people in old-age homes reach a point where they surrender their entire lives to the control of the old-age home. This control is more than likely to be medical control. To Illich (1976a: 92), "dependence is always painful, and more so for the old".

In spite of very real problems experienced by elderly people in old-age homes, such as loss of privacy, recommendations proposed by respondents do not refer to solutions. (These recommendations will be discussed in chapter 6.) Could one regard this as a confirmation of the condition of alienation experienced by these people?

Critical theory pleads for the education of the audience as a basis for political emancipation. According to Fay (1987: 151), such education is bent on "raising their consciousness", that is to say, getting them to adopt a new concept of who they are and what they are doing. Helping them to form a new understanding of themselves is thought to be the means by which these people's very identities can be altered. This new understanding can become the basis of the process by which they begin to be freed from the forces which have oppressed them and caused them to live less than optimal lives.

It should be clearly stated that critical theory evokes reflection. It does not, however, prescribe solutions. The crucial element in critical theory is to provide methods which allow people to see themselves in a radically different way from their current self-perceptions. Critical theorists do this by offering a theory which explains why these people are frustrated and dissatisfied and also why they are doomed to continue in this condition.

5.5 CONCLUSION

The following statement by Illich (1976a: 49) probably provides the most concise summary of his three-level theory of iatrogenesis:

> The medical bureaucracy creates ill-health ... by multiplying disabling dependence ... and by abolishing even the right to self-care.

From the results, it is evident that white elderly people in old-age homes in and around Pretoria appear to be victims of iatrogenesis on the three levels described by Illich (1976a). Evidence derived from

qualitative data collected for this investigation appears to be supportive of the research expectations. However, this evidence was exclusively based on the views, approaches and interpretations of elderly respondents staying in old-age homes.

CHAPTER SIX:

CONCLUDING REMARKS AND RECOMMENDATIONS

6.1 INTRODUCTION

In this general conclusion, certain recommendations pertaining to the levels of iatrogenesis will be discussed. For a more holistic approach to health care, general recommendations will also be made for future studies/investigations regarding the aged in general.

First, it is necessary, however, to provide an overview of the various theoretical and empirical issues dealt with in each of the preceding chapters.

6.2 GENERAL CONCLUSIONS

In this thesis, Illich's three-level theory of iatrogenesis was applied to a sample of elderly people in old-age homes. Although Illich is widely criticised for his radical critique of the medical bureaucracy, his ideas on medicalisation still prove to be relevant. In chapter 1, the problem was stated and the purpose of and need for the study was outlined in terms of the assumptions underlying the investigation. A description of key concepts and an exposition of the investigation were also provided.

Chapter 2 dealt with the theoretical aspect of the study, which involves a critical evaluation of Illich's theory of iatrogenesis. The three levels of iatrogenesis, namely the clinical, social and cultural levels of iatrogenesis were discussed. Following this discussion, an outline was provided of Illich's view of society. Since Illich's theory makes use of certain Marxist ideas, as well as ideas belonging to critical theory, an attempt was made to locate the theoretical underpinnings of Illich's theory. This discussion was followed by an evaluation of

Illich's theory in terms of positive and negative critiques. Finally, an exposition was provided of the usefulness of Illich's theory for this study.

In chapter 3, the phenomenon of medicalisation among elderly people was discussed and particular emphasis was placed on certain aspects of aging and the elderly, namely: life satisfaction and the attitudes of the elderly (in this section, brief attention was paid to three theories of aging); medicines and elderly people; drug-induced iatrogenesis together with the hazard of multiple drug therapy; the role of the doctor in the health care of the elderly; and the role of old-age homes in the institutionalisation of elderly people.

Chapter 4 dealt with the research methodology underlying this study. This discussion included the following topics: techniques and collection of data which involve the sample, the pilot study, the sampling procedure, the interview guide, and the interview.

In chapter 5, an analysis, interpretation and presentation of the collected data was provided in terms of the three levels of iatrogenesis respectively. Following the interpretation of the findings, certain general conclusions can be reached, and, in the light of these, some recommendations can be made. These conclusions pertain to the research expectations underlying this study. See chapter 1, section 1.2 in this regard.

Significant findings in terms of the three levels of iatrogenesis resulting from this study are, inter alia, the following:

- *clinical iatrogenesis*: 54% poor or no knowledge about the adverse effects of medicines used by respondents
- *social iatrogenesis*: 68% social dependence on doctors
- *cultural iatrogenesis*: 52% feelings of loss of privacy, independence and/or control

Although only one indicator was researched for clinical and social

iatrogenesis respectively, it can be said that more than half of the total sample can be regarded as victims of iatrogenesis. Furthermore, although certain subsections used in this study imply an indirect or implicit reference to the medical bureaucracy as causing iatrogenesis (such as approaches towards aging, and approaches to life and life satisfaction), the author is of the opinion that sufficient explicit evidence was obtained in this study to support Illich's theory.

6.2.1 General conclusions and recommendations with regard to clinical iatrogenesis

Illich's theory of iatrogenesis was investigated in terms of his use of the theme *defenceless patients*. As indicated in the previous section, sufficient evidence was obtained from the study to draw the following general conclusions with regard to clinical iatrogenesis. More than half of the total sample revealed poor or no knowledge about the adverse effects of the medicines they use. A number of residents of old-age homes take sleeping tablets on a regular basis simply because they are in an old-age home and are given sleeping tablets every night whether they have requested them or not.

It was found that clinical iatrogenesis is indeed present in the lives of elderly residents of old-age homes. In this regard, Mr Chris van Niekerk, Registrar of the Pharmaceutical Council in South Africa (Beeld, 19 May 1994: 12) indicated

> dat 55 persent van alle medikasie in Suid-Afrika verkeerd gebruik word en dat dit regstreeks lei tot 10 persent van die pasiënte wat in hospitale beland. Indien hierdie bewering waar is, is 'n diepte-ondersoek dringend nodig. So 'n situasie is onhoudbaar en 'n ernstige vingerwysing na die mediese beroep en na die publiek wat om welke rede ook al medisyne verkeerd gebruik. Daar rus 'n groot verantwoordelikheid op dokters met die voorskryf en verskaffing van medisyne. Dit geld ook aptekers. Dit is hierdie mense se taak om die publiek in te lig oor die regte gebruik van

medisyne en oor die gevare wat die verkeerde gebruik of misbruik inhou.

In the light of these findings, it is necessary to spell out recommendations which can be drawn from the findings of this study. These recommendations are necessary so that doctors, pharmacists, as well as health care professionals working in old-age homes become aware of the problem of clinical iatrogenesis. This group of professionals should receive the sensitisation and training needed to deal with the problem in practical ways such as providing health education from a holistic approach according to specific individual needs encountered by elderly residents in old-age homes. This corresponds with Illich's (1976a: 44) statement that medical nemesis "can be reversed only through a recovery of the will to self-care ... which imposes limits upon the professional monopoly of physicians." It is recommended that health care professionals develop education campaigns to promote an awareness of the hazards of drug use and misuse among the elderly themselves.

6.2.2 General conclusions and recommendations with regard to social iatrogenesis

The most evident finding in this category was that more than two-thirds of the total sample revealed a reliance on doctors which could be described as social dependence. This social dependence refers to a general condition of the medicalisation of life. Since doctors then seem to be the point of focus in social iatrogenesis, it is recommended that they use the ample time spent with elderly people (during consultations) as opportunities to educate them about health improvement and the prevention of disease after having done an individual lifestyle analysis. This holistic approach is proposed instead of the orthodox way of treating symptoms rather than treating a person as a physical, psychological, social and spiritual being.

As indicated by respondents' comments after their individual interviews, it seems that insight into themselves and their situation is the key through which personal change is affected - this key is necessary for

social transformation and it also underpins emancipation. After years of following a particular pattern of living it is unlikely that an elderly person will arrive at new insights without any external input. It could therefore be argued that new insights depend on some or other form of communication. Since people in the medical profession have the necessary knowledge, as well as firsthand and individual contact with elderly people, it is suggested that initiation for the emancipation of the individual should come from the medical profession.

6.2.3 General conclusions and recommendations with regard to cultural iatrogenesis

As indicated in this study, cultural iatrogenesis implies a symbolic dimension and it has to do with the destruction of personal autonomy and the deprivation of personal responsibility for one's own health matters. As mentioned earlier, this was indicated most evidently in the lives of elderly residents of old-age homes in terms of the finding that more than half of the number of respondents experienced feelings of loss of privacy, independence and/or control as a result of being in an old-age home.

In the light of these findings, it is recommended that old-age home policies be revised in order to allow for ways to increase respondents' feelings of independence. For example, since many respondents complained about transport, an accessible transport system such as a regular minibus is suggested as a necessity. According to Dooghe et al. (1980: 164),

> the elderly are aware of their own weakness and of the need for ... assistance. This process of becoming dependent causes uncertainty, forebodings, and feelings of guilt. The self-image and self-esteem are damaged.

Therefore, policies should focus on uplifting the morale of elderly people in old-age homes by, for instance, organising social events which they would find interesting. The matron or superintendent of the old-age home should arrange health education sessions which are specifically

focused on problems relating to geriatric health. These sessions could be combined with a physical exercise programme. According to Illich (1976a: 260), people are generally "more the product of their environment than of their genetic endowment", and since this "environment is being rapidly distorted by industrialization", liberating information and knowledge will lead to emancipation and understanding.

On the basis of the above general conclusions, it could be argued that iatrogenesis, whether on clinical, social or cultural level, is a real danger in the lives of a significant number of elderly people in old-age homes. Unless the causes of these problems are addressed, these processes will continue distorting the life-world, as well as the lives of human beings.

In the following section a number of specific suggestions for further research will be made.

6.3 RECOMMENDATIONS FOR FUTURE RESEARCH

The first recommendation for future research stems from the unforseen problem of some residents *moving to an old-age home too soon*. Particular points of focus in this regard are the ways in which elderly people view themselves as old-age home residents, as well as the meaning of "buite lekker kon geleef het" in the perception of the elderly person. This phenomenon needs to be researched.

Second, it is recommended that feelings of loss of independence loss of control, loss of privacy, as well as feelings of loneliness, misery and deprivation could be improved by researching and instituting a number of practical changes such as the following:

- better transport facilities
- health education programmes
- a dietician on the staff of old-age homes
- constructive entertainment
- orientation programmes

- contact with family and friends
- techniques to increase the self-esteem of the elderly such as a polite mode of address, as well as involving old-age home residents in compiling programmes to improve certain conditions in old-age homes.

Since the last section of the interview guide inquired about proposed recommendations, these could be regarded as attempts by old-age home residents to reflect upon their situation and to propose suggestions for improvement. Forty-six per cent of the sample have never thought of anything that could make life easier in an old-age home. The reason for this could be that they never realised that they could contribute towards improvement. This situation can be seen as a sign of their apathy.

In a contrary vein, fifty-four per cent of the sample verbalised one or other recommendation on how to make life easier in an old-age home. The following responses received in this regard serve to illustrate the above-mentioned recommendations:

- As already mentioned, *transport* seems to be quite a general problem encountered by old-age home residents. Respondent 34 explains that she does not have her own car any longer: "You have to get rid of that. Transport is a terrible problem. There's no transport from here unless you get on the bus. But the bus is for people who can use it. I never go out." Practical problems encountered by elderly people in this regard are that the steps into the bus are too high; often the bus is full and the person has to stand - which is not only inconvenient, but sometimes even physically impossible. For these reasons, a minibus service was suggested in section 6.2.3.

- *Adaptation* to life in an old-age home is another problem expressed by some respondents: "You just have to learn to live with it." An extensive orientation programme (e.g. a video show, a sightseeing tour of the place, a personal meeting with staff and other residents) provided by the old-age home before the person moves

there might serve to prepare people psychologically for life in an old-age home.

- A number of respondents complained about the nutritional value of the *food* in the old-age home. Respondent 39 complains: "Ek moet sê, ons kos is nie hier só dat jy kan sê daar's baie vitamine in nie. Hulle gaan nie in vir 'n dieet of so iets nie. ... Nie baie groente nie ... hulle is pap gekook en so aan. Nou koop ek maar vitamine. Die laaste drie of vier weke het ons geen vars vrugte gekry nie. Daar's onopgeleide mense daar onder in die kombuis, want hulle wil geld spaar op die kos."

- Many old-age home residents feel bored and miss some form of *entertainment*: "They can have sing-songs and those that can, do a little bit of acting or clowning or things like that to make you laugh. ... I miss that a lot."

- With regard to *contact with family members and friends* respondent 37 replies: "Jy kan miskien oral waar jy gaan as jy met jongmense in verbinding tree, vir hulle aanmoedig om hulle ouers te kom besoek in die ouetehuise, want ek weet van baie wat min besoekers kry ... of 'n bietjie uitgeneem word, want 'n mens word regtig moeg om in hierdie kamer te sit. ... Jy hoor dieselfde geselskap oor en oor. ..."

- *Sharing rooms and bathrooms* seem to be problems to some respondents: "I was just lucky to get a single room ..." or "Sharing a bathroom poses a problem in terms of privacy". Respondent 50 explains: "Vantevore was ons twee in die kamer. Jong, en sy staan vieruur vanmôre op dan begin sy raas. Dan's daar ook 'n kassie wat ons moes deel, maar sy sluit hom toe met my goed ook daar binne-in. ..." It is suggested that people are carefully screened before being placed in rooms together, since interests, lifestyles and temperaments may differ and cause problems.

- Some respondents complained about all the *misery* in an old-age

home, as well as the fact that it sometimes "feels like a hospital". "Jy weet, baie is verlam, party is van hulle brein af ... deurmekaar ... maar hulle is algar onpadvaardig. Ons is almal maar in dieselfde bootjie" and "Jy's so omring met die ellende. Dis 'n hospitaal in die kleine hierdie ... werklik."

- Respondent 5 complained about the *mode of address*: "hulle 'oupa en ouma' ons almal en dit was vir my vreeslik swaar gewees aan die begin. Jy's so van alles gestroop ... jy's so uitgelewer. Geheel en al uitgelewer ... In besigheid sê hulle 'die kliënt is altyd reg'. Nou hier reken ek dat ons wat uitgelewer is en so aan ... ons moet ook krediet kry vir wat agter die rug is ... vir ons wysheid ... ons moet daarvoor erkenning kry."

These recommendations proposed by respondents on how to make life easier in an old-age home are regarded as a reflection on existing problems experienced by old-age home residents and they could be of use in devising programmes to transform old-age homes into havens where elderly people retain their personal autonomy. Since elderly people in old-age homes need to be conscientised towards critical and creative thinking and living, it is suggested that this plan be compiled by old-age home residents themselves.

Finally, further research is needed for a better understanding of (1) medicalisation on the organisational level in the context of the medical professions, and (2) the processes involved in furthering the dominance of the orthodox medical model such as the following:

- researching and then implementing the kinds of activities and lifestyles that can provide the elderly with positive alternatives to an overreliance on the medical profession

- researching the relationship between drug-taking behaviours in the elderly and other health behaviours and lifestyle factors such as exercise and nutrition

Binney et al. (1990: 770) remark:

> In this light, the processes of medicalisation can be viewed as contributing to the rationalising and bureaucratising strategies that effectively bring aspects of aging under the logic of a biomedical model in a way that is compatible with a corporate/managerial/market model.

In Illich's mode of arguing, it seems that the problems encountered in old-age homes are directly linked to the structure of our society and are not solely attributed to lifestyle within an old-age home. In this sense, the old-age home is seen as one of the range of services available to elderly people. However, the essential task of the old-age home is not to solve major social problems, but to provide services to elderly people in a way that offers the opportunity for an individual to be in control of his or her own life.

Since a holistic approach implies an evaluation of lifestyle factors in treating a person, this approach is put forward as an alternative way of dealing with problems pertaining to elderly people.

What follows is a brief outline of the basic principles of a holistic approach.

6.4 HOLISTIC APPROACH: PLEA FOR A LIFESTYLE EVALUATION

According to Capra (1982: 119),

> health and the phenomenon of healing have meant different things in different ages. The concept of health, like the concept of life, cannot be defined precisely, and in fact, the two are closely related. What is meant by health depends on one's view of the living organism.

As a result of the biomedical definition of disease as caused by bacteria, medical treatment has become directed exclusively at biological

abnormality. For instance, sleeplessness is often caused by some or other lifestyle practice which results in sleeplessness, such as too little exercise, too much coffee or coffee at bedtime, or perhaps too much sleep during the day. The prescription of sleeping tablets will treat the symptom but the real cause will not be addressed.

Therefore, a holistic approach as an alternative to the orthodox approach to health care implies an examination of the person's lifestyle. Holism aims at treating the whole person and not only a particular symptom.

Pretorius (1993: 14) states that

> practitioners of holistic health care differ from orthodox practitioners by virtue of their adherence to the concept of health rather than a narrow concern with disease, as well as their focus on the patient as the subject of treatment rather than the object.

Prevention of disease and promotion of health (rather than the treatment of disease) are the main goals of the holistic health care approach.

The aim of a holistic approach is for people to have autonomous control over their physical bodies. According to Pretorius (1993: 16), "the development of alternative therapies [such as a holistic approach] in South Africa could take a ... direction ... of demedicalisation."

6.5 LIMITATIONS OF THIS STUDY

First, this study was limited to the views of elderly people and it did not include views of medical professionals such as doctors and nurses. Together, these views of both elderly people and medical people would reveal a more comprehensive view of the phenomenon of medicalisation.

Second, although Illich's theory involves a diversity of aspects on each of the three levels of iatrogenesis, this study only researched particular aspects of clinical and social iatrogenesis. It would

therefore take a much wider study to provide a more extensive understanding and measurement of these iatrogeneses.

Third, the measuring of medicalisation seems to be rather relative and difficult to prove. Different researchers will probably focus on different aspects and dimensions of medicalisation as described by Illich. For example, more studies with different indicators could be used to operationalise Illich's concepts.

Finally, this application of Illich's theory should be regarded as merely a starting point in establishing the occurrence of iatrogenesis in an industrialised society. Pretorius (1984), in a study on the medicalisation of society, focused mainly on theoretical aspects of the concept "medicalisation", and especially on medicine as a means of social control. The application excercised in this research should be viewed as pioneer work in the field of medical sociology. Due to the limitations of this study the researcher supports Illich's plea for further extensive research in order to expose the dehumanising and debilitating effects of the medical monopoly in society.

6.6 CONCLUSION

This study viewed medicalisation as an addictive approach - an approach revealed by the consumer (in this case the elderly person in an old-age home) towards medicine, medication practices, as well as ways of health improvement and personal measures to prevent disease. In other words, much responsibility is assigned to the consumer in the process of medicalisation. If people are not to become helpless victims, a plan of action needs to be devised. The definition of medicalisation as an addictive approach leaves room for enlightenment and liberation which should recognise limitations set by the medical bureaucracy.

In conclusion the words of Capra (1982: 365):

> If acceptance of individual responsibility will be crucial to a future system of holistic health care, it will be

equally crucial to recognize that this responsibility is subject to severe constraints. Individuals can be held responsible only to the extent that they have the freedom to look after themselves, and this freedom is often curtailed by heavy social and cultural conditioning. Moreover, many health problems arise from economic and political factors that can be modified only by collective action. Individual responsibility has to be accompanied by social responsibility, and individual health care by social actions and policies.

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APPENDIX 1

INTERVIEW GUIDE

A. BIOGRAPHICAL INFORMATION

1. Interview schedule number .....

2. Date of interview .....

3. Name of interviewee .....

4. Name and address of old-age home .....
.....

5. Type of home: public or private .....

6. Gender .....

7. Age .....

8. Marital status

9. Occupation for most of life .....

10. Occupation of spouse .....

11. Number of children still alive

12. Number of grandchildren

13. How often do you see your family?

14. Living arrangements before admission to old-age home

15. Date of admission to old-age home

16. Most important reason for moving to old-age home

17. Who took the decision that you should go to an old-age home?

18. Are you a member of a medical aid fund?

B. PERCEIVED HEALTH STATUS AND APPROACH TOWARDS MEDICATION PRACTICES

1. Do you have any health problems? (Probe to test knowledge.)

2. Would you describe your health today as excellent/good/average/poor/very poor?

3. Are you able to move around freely and independently; independently but with difficulty; only with assistance?

4. Tell me about the medicines you use on a regular basis. What is each one for? How is it supposed to help you? For how long have you been taking it?

5. Do you take sleeping tablets? If yes, why?

6. Do you take any medicines that are not specifically prescribed by the doctor? What are they for? Does the doctor know about these? Do you take any vitamins?

7. How do you feel about taking medicine? Are you sometimes afraid that the medicine might harm you?

8. What do you actively do on a regular basis to improve your health and prevent disease?

9. Since you've been here, have you had to change your medical routine at all? Are you taking more or less medicines?

10. Do you always go to the same doctor?

11. How often and why do you visit the doctor?

12. Do you ever visit the medical unit of the old-age home or call for the nurse? If yes, what was the reason for the last visit?

13. How do you experience your relationship with the doctor? Do you have confidence in the doctor's judgements? Do you trust the doctor?

14. Do you feel that the doctor should take responsibility for your health matters?

C. THE AGING EXPERIENCE AND LIFE SATISFACTION

1. Did you get most of the things you wanted and expected out of life?

2. Tell me how you feel about your age.

3. Did you look forward to retirement?

4. Are you afraid to die?

5. Have you ever thought of something that could make the aging experience easier?

D. APPROACH TOWARDS LIFE IN AN OLD-AGE HOME

1. How do you generally pass the day here?

2. How does this routine differ from a usual day in your previous home?

3. Do you ever feel lonely or bored? What do you do to overcome this feeling?

4. What were your hobbies before you moved to the old-age home? Are you

still doing these things?

5. Tell me how you feel about being in an old-age home.

6. How does the system work here?

7. What do you like about being in an old-age home?

8. Is there something you particularly dislike about being in an old-age home?

9. What did you find most difficult to get used to in the old-age home?

10. Does the old-age home arrange for any social activities? Do you attend these?

11. Does the old-age home provide physical exercise programmes? Do you participate in these?

12. Do you regard the services rendered in this old-age home as mainly medical in nature?

13. Do you have any specific needs which, to your mind, are not catered for in the old-age home?

14. How do you feel about having meals at strictly set times?

15. Do you miss the privacy you had in your own home?

16. Have you lost your independence since being in the old-age home? If so, in what way?

17. Is your opinion valued with regard to decisions affecting yourself in the old-age home?

18. Tell me whether you feel as in control of your own life in the old-

age home as you were before you moved here.

19. Would you prefer to be living elsewhere?

E. RECOMMENDATIONS

1. Do you have any ideas about how to make life easier in an old-age home?

APPENDIX 2

QUESTIONS TO MEDICAL STAFF

Interview number .....
Date of interview .....
Category of health worker .....
Work address .....
.....

1. Do you think elderly people abuse medicine?
2. If yes, what would you say is the most important reason?
   .....
   .....
3. Do you think the medical profession contributes to medicalising elderly people?
4. If yes, how?
   .....
   .....
   .....
   .....
5. Do you think the medical profession regards elderliness as a disease?
6. Do you think doctors prescribe medicine to elderly people without considering alternative methods of treating the problem? (Probe, for example, the use of sleeping tablets.)
7. Do you think doctors sometimes prescribe unnecessary medicine only to please the patient?
8. Do you think the doctor provides the patient with sufficient information concerning the medicine s/he prescribes?
9. If not, what would you say is the reason for this?
   .....
   .....
   .....
10. Do you think elderly people sometimes buy medicine only because they belong to medical aid funds?

11. Do you think elderly people generally have a positive outlook on life?

12. Do you find that many elderly people take sleeping tablets?
13. If yes, what would you say is the most important reason?

.....

.....

.....

.....

14. Do you think elderly people take medicine because they feel lonely?
15. Do you think the old-age home contributes to medicalising elderly people?
16. If yes, how?

.....

.....

17. Do you think the old-age home deprives elderly people of their autonomy regarding health matters?

18. If yes, how?

.....

.....

19. Do you regard the old-age home as mainly rendering medical services?

APPENDIX 3

A SELECTION OF TRANSCRIBED INTERVIEWS

In this Appendix, detailed transcriptions of a selection of eight of the fifty interviews conducted, are provided. As already mentioned in chapter 5, section 5.1, these interviews were purposively selected as being representative of different characteristics revealed by the sample, namely the following:

- both male and female respondents
- both English- and Afrikaans-speaking respondents
- positive, negative and indifferent attitudes
- respondents from both public and private old-age homes.

Interview 4

A. Biographical information

Respondent 4 is an Afrikaans-speaking widow who is eighty years of age and has been staying in a public old-age home for the past two and a half years. Her husband passed away less than a year ago. She used to be a housewife.

Respondent 4 had three children but one passed away. She has eleven grandchildren and fourteen great-grandchildren. Her children live in Pretoria and she sees them on a regular basis.

Before she moved to the old-age home, they lived in a house in Pretoria. She explains their most important reason for moving to an old-age home as follows: "Omrede ons altwee bejaard geword het en ... later was ons in 'n woonstel en die woonstel het trappe gehad en my ou man het eintlik koue voete gekry. ... Hy het seker maar gedink, wel, ons kan nou nie meer alles hanteer nie. 'n Huis kon ons nie meer hanteer nie, want daar's 'n 'yard' om na te sien, en toe gaan ons woonstel toe, maar ons is toe nie

te lank in die woonstel nie, toe het ons maar besluit om ouetehuis toe te kom. ... Toe het sy gesondheid begin agteruitgaan. ... Toe het ons gedink dis maar die beste."

Respondent 4 does not belong to a medical fund.

B. Perceived health status and attitude towards medication practices

Respondent 4 suffers from high blood pressure and arthritis, "maar verder het ek nie klagtes nie". At the time of the interview, she states that she feels good.

She is able to move around freely and independently without a walking-stick.

According to respondent 4, the only medication she takes on a regular basis is a blood pressure tablet: "Ek drink in die môre twee en in die aand een." She has been taking this medication for almost four years. She does not take a sleeping tablet.

In response to the question as to whether she takes any medicine that is not specifically prescribed by the doctor, she replies: "Ja, miskien soos 'n pynpil so af en toe, en ... ek is eintlik 'n migrainelyer. As dit my pak dan gebruik ek maar pynpille. Enkele kere wanneer mens nou voel jou maag is nie so lekker nie, dan drink jy nou maar iets, maar dis nie 'n gereelde ding nie." Respondent 4 takes vitamin C as a supplement.

In response to the question as to how she feels about taking medicine, she replies: "Ek is versigtig, hoor. Ek hou nie daarvan om sommer te drink omdat drink drink is nie."

With regard to her activities to prevent disease and promote her health, respondent 4 states: "Ag wat jong, hier doen 'n mens nou eintlik mos maar niks nie. Ek is versigtig wat ek eet omrede ek 'n migrainelyer is. Somtyds bring verkeerd eet hom aan, jy weet. Ek eet nie vetterige kos nie; ek eet nie baie botter nie; ek is nie vreeslik lief vir 'n eier nie;

ek is versigtig om nie in die aand kaas te eet nie. So deur al die jare het ek myself bietjie geleer van dinge wat myself benadeel."

Respondent 4 does participate in the physical exercise programme provided by the old-age home.

Since being in the old-age home, her medical routine has not changed. She visits her doctor every three months for a medical check-up. She feels that her doctor should take responsibility for her health matters.

C. The aging experience and life satisfaction

In response to the question as to whether she got most of the things she wanted and expected from life, respondent 4 replies: "Ek sal vir jou dit só stel: ek het 'n goeie lewe gehad. In die jare toe ek en my man begin het ... dit was in die jare van die depressie, was ons verskriklik arm. Ek en my ou man was sestig jaar getroud, en die Hoër Hand het vir ons drie kinders gegee - 'n dogter en twee seuns. En ons het altwee baie hard gewerk. My ou man was 'n vreeslike opgeruimde mens ... en baie hardwerkend gewees ... en soos die tye beter geword het, het dit met ons altyd beter en beter gegaan. ..."

In response to the question as to how she feels about her age, respondent 4 explains: "Hoe sal ek sê? Mens mis natuurlik ... die jeug mis jy baie, maar daar's altyd gelukkig mooi herinnerings wat jou aan die gang hou. ... Dis swaar om oud te word. Jou hart is somtyds nog bietjie jonk en dan voel jy die kragte is nie meer daar nie. Jy kan nie meer doen wat jy gedoen het nie al wil jy ook. Jy kan dit nie meer doen nie. Maar die ding is seker mens moet dit maar seker só aanvaar. ... Jy weet, as mens als in die lewe aanvaar wat jou pad langs kom, dan is jy 'n gelukkige mens. Nou dit is al manier om gelukkig te wees: om die dinge wat jy niks aan kan doen nie - want ons kan daar tog niks aan doen nie - net te aanvaar. En dis nie net ek wat oud word nie. Ons algar word oud. ... Ons kan maak wat ons wil."

Respondent 4 states that she is not afraid to die: "Dit bring vir mens

heimwee om te dink jy gaan van als wat vir jou lief en dierbaar is vir ewig weg, né, maar bang is ek nie. Ek het net een begeerte en dis dat die Hoër Hand vir my so goed sal wees om nie vir my jare van lyding te gee soos dit hier met party mense gaan nie. ... Dít ... dit maak my bang."

Respondent 4 has never thought of anything that could make the aging experience easier: "Dit is maar 'n deel van die lewe."

D. Attitude towards life in an old-age home

Respondent 4 is on the house committee: "Kyk, elke gang het 'n paar persone wat op die komitee is. Hierdie persone het 'n verantwoordelikheid om te kyk dat dit goed gaan met elkeen. As daar dinge nie reg is nie, om dit te rapporteer en al die soorte van dinge. Jy hou gedurig jou oog daaroor. En dan brei ek maar. Ek is verantwoordelik vir die snoepie eenmaal 'n week. Ek kyk daarna en ek sien daarna om. So gaan dit maar van dag tot dag ... dit gaan maar dieselfde. ..." She also does sewing.

In response to the question as to whether this routine differs a lot from what she was used to, respondent 4 replies: "Jy weet, as mens nog in jou eie plek is, dan leef jy mos 'n heeltemal anderster lewe. Dit kom en gaan en dit kook en bak."

Respondent 4 states that she never had specific hobbies: "Ek het baie graag naaldwerk gedoen en baie in die tuin gewerk en al die dinge. Die dae was toe eintlik te kort waar dit nou te lank is."

She does feel lonely and states that she sometimes does nothing: "Jy sit maar ... heeldag. Soos vandag. ... Ek voel eintlik skuldig, want ek het vandag minder as niks gedoen nie. Daar kom mos sulke dae in 'n mens se lewe, né, dat als vir 'n mens te veel is."

In response to the question as to how she feels to be in an old-age home, respondent 4 explains: "Hoe sal ek vir jou sê? 'n Mens het eintlik nie

'n opsie nie. Dis nie hoe jy voel nie. Jy's verplig. ... Dis 'n verpligting. ... Op my ere woord, as 'n mens die dag op die ouderdom is wat ek is, dan is daar geen ander keuse nie. ... Daar's geen ander beter plek as 'n ouetehuis nie."

Respondent 4 cannot think of anything she particularly likes about life in an old-age home: "Ag, ek weet nie. ... Ek kan nie my vinger op iets druk nie." What she found very difficult to adapt to when she first got there, was the food: "Kyk, die groot storie is die voorbereiding daarvan. Jy kry nooit werklik mense wat dit ordentlik doen nie." In response to the question as to how she feels about having meals at strictly set times every day, she replies: "Man, mens raak dit eintlik gewoond. As jy voel jy wil nie gaan eet nie, dan los jy dit."

This old-age home arranges regular meetings between the management and residents. They also arrange social activities. Respondent 4 states that she attends these activities. She does not have any particular needs which, to her mind, are not catered for.

In response to the question as to whether she misses the privacy she had in her own home, respondent 4 says: "Dit is al wat eintlik bietjie swaar is. Soos ek nou, na my ou man se heengaan... toe het hulle iemand anders by my in die kamer gesit, en dit is eintlik bietjie swaar. ... Dit is nie lekker nie. Hoor hier, dit is regtig nie lekker nie. Vir my is dit baie, baie swaar."

In response to the question as to whether she feels that she has lost her independence since being in the old-age home, respondent 4 replies: "Ja, ek dink so ... oor als vir jou gedoen word." She still drives her own car. Respondent 4 would not prefer to be living elsewhere.

E. Recommendations

Respondent 4 has no ideas about how to make life easier in an old-age home: "Ek weet nie wat dit kan makliker maak nie. ..."

Interview 11

A. Biographical information

Respondent 11 is a seventy-one-year-old widow who has been living in a private old-age home for the past three years. She states that she bought her unit in the old-age home and that it has become her private possession.

She had been a shorthand typist, but, after her marriage, she became a housewife. Her husband used to be a school teacher and later on became a shool principle and inspector. He passed away in 1989.

Respondent 11 has two children and five grandchildren. Both her children live close to her and she sees them on a weekly basis.

Since her husband passed away, she stayed alternatively with either of the two children. Before that, she and her husband lived in a house in Pretoria. She describes her most important reason for moving to the old-age home in the following words: "Wel, om dit nou so uit te druk ... mens kan nie alleen bly vandag nie. In die tweede instansie, ek het gehoorprobleme. ... My kinders het gevoel dis die beste vir my om hier na ... so 'n plek toe te kom. ... Die kinders het die besluit eintlik meer geneem as wat ek dit geneem het."

Respondent 11 does belong to a medical fund.

B. Perceived health status and attitude towards medication practices

In response to the question as to whether she has any other health problems apart from the hearing problem, she replies: "Nee wat." She has had this problem ever since her children were born: "'n Gehoorbeentjie het verkalk. Ek het al vier operasies gehad. Ek dra die apparaatjie." She also states that she suffers a bit from low blood pressure.

At the time of the interview, she states that she feels well. Respondent

11 is able to move around freely and independently.

In reply to the question of which medication she takes on a regular basis, respondent 11 answers: "Net die bloeddrukpille ... tweetjies op 'n dag ... Effortil." [According to MIMS (1991: 25), this medication is prescribed for hypertension (high blood pressure)]. Respondent 11 does not know when she first began to take these tablets, or how long she has been taking them.

In response to the question as to whether she takes sleeping tablets or something for stress, respondent 11 replies: "Man, ek moet vir jou sê, dis op en af. ... Dokter het my 'n ontspanningspilletjie gegee, maar dit hang af hoe ek voel om dit te gebruik. Hy het dit uit sy eie gegee. ... Dis maar van my man se dood af." Furthermore, she states that she occasionally takes "'n Panado miskien of so".

According to respondent 11, she is not fond of the idea of taking medicine: "Ek wil soveel moontlik sonder dit klaarkom, jy weet."

Since she has been in the old-age home, respondent 11 has not had to change her medical routine at all.

In response to the question as to what she actively does on a regular basis to improve her health and prevent disease, respondent 11 replies: "Ag, ek stap 'n bietjie maar hier rond en so aan. ..." She does not participate in the physical exercise programme provided by the old-age home: "Dis vir my 'n bietjie moeilik met die apparaat ... die beweging en so ... dat dit sal afval ... dis wat dit moeilik maak."

The doctor whom she used visit left his practice to specialise. The last time she saw her doctor was a year ago for a general check-up, "maar ek is van plan om vir my 'n ander dokter aan te skaf." She trusted her doctor and was very happy with his treatment.

C. The aging experience and life satisfaction

In response to the question as to whether she got most of the things she wanted and expected from life, respondent 11 replies: "Hoe meen u nou? Ek verstaan nou nie. ..." The question was then rephrased in the following way: "As u terugdink oor u lewe - voel u gelukkig en tevrede?" to which she replies: "Jaaa ... jy word oud en jy is nie die mens wat jy altyd nog was nie. Die Here het dit so vir jou beskryf ook ... en jy maak die beste daarvan." However, she states that she has had a good life.

According to respondent 11, her age does not bother her: "Jy aanvaar dit. Jy weet jy word oud en jy weet jou kragte is nie meer wat dit moet wees nie. Jy kan nie meer wees soos wat jy was nie ... en jy berus daarin, want die Here sê dit vir jou in Prediker. ... Dit móét gebeur."

Respondent 11 is not afraid to die.

She has never thought of something that could make the aging experience easier: "Ag, ek het nog nooit só ver gedink nie."

D. Attitude towards life in an old-age home

Respondent 11 generally passes her day in the following way: "Ek behoort aan verskillende paar dingetjies. Ek brei, lees, doen my eie wasgoed, maak my woonstel aan die kant, kuier tussen mense en so aan."

According to respondent 11, this routine differs from an average day at her previous home: "Ja nogal. Kyk, jy't jou huis gehad en jy't jou huishouding gehad en jy't jou vriendekring gehad en ... jy's uit jou omgewing uitgeneem ... en dis 'n aanpassing wat jy hier moet maak."

Respondent 11 states that she does feel lonely: "Ja ... eensaamheid kom maar ... veral as jy jou man verloor het. Jou kinders gaan hulle gang en hulle het hulle lewens en jy kan nie verwag hulle moet altyd aandag aan jou gee nie. Daar kom die dae van eensaamheid ... en daar kom die

dae van tevredenheid. Dit is doodnatuurlik." When she feels lonely she explains: "Ek gaan kuier vir een of ek berus maar daarin ... werp my tot my Skepper. ..."

In response to the question as to how she feels about being in an old-age home, respondent 11 replies: "Dis 'n baie moeilike vraag ... want ... ek weet nie hoe ek sou gevoel het as ek op 'n ander plek was. ..."

Respondent 11 explains the working of the system in the old-age home in the following words: "Kyk, die vergaderings is meestal oor die huishoudelike dinge ... dis 'n baie aangename dame wat ons het ... en hulle meng met jou. Jy kan na haar met alles gaan in die lewe. Sy sal vir jou mooi uithelp met alles."

In response to the question as to whether there is something she particularly likes in the old-age home, respondent 11 replies: "Wat vir my lekker is hierso is dat jy meng met jou mense." She states that there is nothing in particular that she does not like. She describes her difficult adaptation process in the following words: "Kyk, jy kom hier in 'n vreemde plek in, né. ... Die lewe is heeltemal anders as wat jy gewoond was. Dis 'n roetine wat jy moet volg. Jy moet jou aanpas by harde roetine, waar jy by jou huis gemaak het soos wat jy wil. Dis wat ek bedoel by aanpassing ... jy's tussen mense, waar by jou huis was jy met jou gesin en jou man." However, having meals at strictly set times, does not bother her.

Respondent 11 participates selectively in social activities arranged by the old-age home: "Ek gaan nie vir uitstappies eintlik nie oor my gehoorprobleem. ... Dis bietjie moeilik vir my."

She states that she has no specific needs which, to her mind, are not catered for by the old-age home.

In response to the question as to whether she misses the privacy she had in her own home, respondent 11 explains: "Kyk, laat ek dit vir jou so stel ... ek voel ... ek is hier ... en ek het gawe bure. Ek is in my eie

plekkie ... ek is doodtevrede hierso." She does, however, state that she would have liked to stay closer to her son. "Wat vir my moeilik was, is hulle het my uit my omgewing uitgevat, jy weet. ..."

Respondent 11 has a car, but it is with her son.

In response to the question as to whether she has lost some of her independence and control over her own life, respondent 11 replies: "Ag, ek weet nie. ... Mens gee maar prys ... jy gee prys. Jy besef nou maar as jy na só 'n plek toe gaan, gee jy dit prys. ... Jy kan nie anders nie. ... Jou huis gee jy op ... jy gee alles af. Jy mis daardie omgewing waar jy was ... daardie mense mis jy, maar dis doodnatuurlik. ... Maar 'n mens raak als gewoond."

E. Recommendations

Respondent 11 has no ideas about how to make life easier in an old-age home: "Nee ... hoe sal jy dit makliker maak? Nee ... dis maar net dat jy is hier ... en al gaan jy ook na 'n ander plek of waar ... jy mis jou kinders. ... Jy mis jou man. ... Jy mis jou huis. Jy kan nie by jou kinders gaan bly nie. Hulle het hulle eie lewe. ... Alleen kan jy ook nie gaan bly nie. Hier is jy darem veilig. ..."

Interview 18

A. Biographical information

Respondent 18 is sixty-eight years of age, married and has been living with his wife in a private old-age home for the past year. They are the youngest residents of this old-age home. He explains the following about the old-age home: "Jy koop die verblyfreg hier solank as jy lewe en daarna verkoop hulle dit ... en die bedrag wat jy betaal het, minus agt persent val terug in die boedel. So, jy koop die reg vir daardie X-bedrag en dan as die waarde opgaan, kry die trust die waardevermeerdering daarvan."

Respondent 18 used to work as a journalist as well as in the advertising business. His wife was a school teacher. They have four children and eleven grandchildren whom they see on a regular basis.

Before they moved to the old-age home, respondent 18 and his wife lived in their own house in Johannesburg for many years. He describes the main reason for their moving to the old-age home as being the need for care and specifically medical care.

Respondent 18 does belong to a medical fund.

B. Perceived health status and attitude towards medication practices

In response to the question as to whether he has any health problems, respondent 18 explains: "Nie veel nie. Ag, 'n bietjie bloeddruk wat op is. ... Nee, nee, eintlik is daar nie veel probleme nie." He says that his blood pressure problem started four years ago, but that it is well controlled.

At the time of the interview, he states that he feels "honderd persent". Respondent 18 is able to move around freely and independently.

The only medication he takes on a regular basis is Capoten, a

hypotensive. He does not take sleeping tablets or any other medication that is not specifically prescribed by a doctor and explains: "Ek het 'n renons in pille."

Respondent 18 takes vitamin supplements: "Ek het nou begin ... iemand het vir my die raad gegee om hierdie knoffelpilletjies te drink. Ek gaan dit probeer."

On the question of what he actively does on a regular basis to improve his health and prevent disease, respondent 18 replies: "Ek stap taamlik. Ons doen nou bietjie gimtrim. Verder loop ons baie. ... Ek skat ek stap so ses kilometer 'n dag. In die winter is dit lekker. Dan lê ek maar bietjie. Dis goeie oefening om te lê!"

Since being in Pretoria, respondent 18 has a new doctor. They do not know him very well: "Ons het hom miskien maar vyfkeer gesien ... as dit so baie is."

Respondent 18 states that he regularly visits the medical unit of the old-age home to have his blood pressure checked.

C. <u>The aging experience and life satisfaction</u>

In response to the question as to whether he got most of the things he wanted and expected from life, respondent 18 replies: "Ek is baie gelukkig getroud. Dit is een van die groot goed wat ek wou hê. Ek wou baie ryk gewees het. Ek is dit nie. Ek is baie tevrede met my lewe. Ek is baie dankbaar. ... Ek sê elke dag honderd maal dankie. Ons is baie gelukkig, maar daar's baie dinge wat ons wou gedoen het, of wat ons miskien nog wil doen."

Respondent 18 describes how he feels about his age: "Nogal half in my skik. Dis nie vir ons 'n bedreiging nie. Ek het 'n goeie ou vriend wat eendag gesê het: 'This old age is a very much overrated state of life'. Ons is bang natuurlik vir ... almal is bang vir die dood. Wat jy voor bang is, is om hulpeloos te word, om afhanklik te word en ... 'n

bespotting te word vir menswees."

Respondent 18 did not look forward to his retirement: "Dit was maar 'n normale ding vir ons. Hy't maar gekom. Ons het besluit ons tree 'n bietjie vroeg af."

Respondent 18 has never thought of something that could make the aging experience easier: "Nee, oud word is vir ons nie 'n probleem nie. Ons word saam oud. Kyk, ek dink dis een van die groot genadegawes wat ons saam kan belewe ... Vir ons is dit nie 'n oorgang nie. Dis vir ons 'n normale deel van die lewe. Ons soek nie iets om die ouderdom makliker te maak nie. Ons hoop net dat dit sal vinning gaan op die end."

D. Attitude towards life in an old-age home

Respondent 18 describes a normal day in the old-age home in the following words: "Ons is besig met verskeie goedjies. Ons stap en ons gaan eet in die oggend en in die middag. Daar is die gimtrim. Ek help 'n bietjie met tydskrifwerkies wat my besig hou miskien so paar uur 'n week. Ons gaan af en toe na die kleinkinders ... kuier. Ons maak vir hulle biltong en sulke goed. Ons ry graag rond. Dis vir ons vreeslik lekker. Ons lees taamlik. Ouma brei dat jy dit nie kan glo nie ... vir die kleinkinders."

According to respondent 18, this routine in the old-age home differs a lot from how they used to live: "Ons het geëet wanneer dit ons pas. Nou eet jy agtuur op 'n gesette tyd. ... Ons het geleef soos dit ons gepas het. Nou moet jy daardie twee tye akkommodeer in die dag. Dis nie 'n probleem nie, maar dit is anders as wat ons gewoond is." His wife adds: "Ek sal jou sê, ek mis my kombuis baie. Ja, ek het baie graag gekook. As die ding my vang dan ry ons na een van die kinders toe of een van die susters toe dan kook ek daar."

Respondent 18 never feels lonely or bored: "Daar's eintlik 'n bietjie te min tyd daarvoor!"

On the question of how he feels about being in an old-age home, respondent 18 replies: "Dis nogal 'n bietjie ... 'n probleem dat dit nie vir jou lekker is om te sê 'Ek bly in 'n ouetehuis' nie, want jou pêls lag vir jou. Maar ek is baie gelukkig dat ek hier is. Dit moet ek reguit sê, maar ek voel partykeer ergerlik as 'n ou nou sê ... ek bly in 'n ouetehuis. Dit is nogal 'n gevoeletjie dat ... jy is nou op die laaste skof. Dit is nie lekker om dit vir vreemde mense te sê nie. Dit hinder my nie vreeslik nie, maar ... dit laat jou tog wonder. ... Het jy nie dalk te vroeg gegaan nie? Sê-nou die goeie Vader gee vir jou nog twintig jaar, dan sit jy twintig jaar waar jy buite lekker kon geleef het nog ... dan sit jy hier. Dit is net daardie effense gedagtetjie wat daar nog aan is ... die ouetehuis-idee is nog 'n bietjie lastig."

Respondent 18 describes the functioning of the system as follows: "Ag, dis maar 'n doodgewone kopverkiesing wat jy eenkeer 'n jaar het, dan kies jy die huiskomitee. Ons het die vloere ingedeel dat jy kry vir elke vloer 'n Primarius en 'n Secundus. Dan kies die mans 'n paar lede en dan word daar 'n dagbestuur gekies uit hulle geledere uit wat bestaan uit die voorsitter, ondervoorsitter, sekretaris en twee lede wat dan moet kyk na die daaglikse loop van die ding in samewerking met die bestuurder en onderbestuurder van die dienssentrum en die sosiale werker."

Respondent 18 is particularly happy with the idea of care in the old-age home: "Kyk, dis 'n gemaklike plek. Die etes is heel goed ... daar's nie fout daarmee nie. Ek mis my vrou se kos. Ek dink sy mis die kombuis, het sy gesê ook. So, dit is dinge wat ons mis, maar dis 'n gemaklike plek. Daar's nie probleme nie. Jy kan doodgemaklik aangaan."

In response to the question as to whether there is something he particularly dislikes about being in an old-age home, respondent 18 replies: "Nee, dit het niks met die ouetehuis te doen nie. Ek hou nie van mense wat te veel negatief praat nie ... en daar is van die oumense wat tog kan kla oor alles ... die kos is te warm of dis te koud of dis te veel of dis te min. Dis nooit 'Dankie, Here, vir hierdie wat ek het. Ek is so dankbaar ek kan dit geniet.' Daar word altyd gekerm, maar dit is 'n ou man se manier om so te reageer. Dit is 'n ding wat my nie aanstaan nie."

Respondent 18 does feel that they have lost some of the privacy they had in their own home: "Ruimte ingeboet. ... En kyk, as jy hier oor die foon praat, dan hoor die hele gang wat jy sê. Dit is 'n ding wat effens lol... die privaatheid daar in gesprekke. ... As jy gewoond is om normaal te praat, dan moet jy dit aanvaar dat mense in die gange hoor jou. Dis 'n lastigheid."

On the question of whether they have any specific needs which, to their minds, are not catered for by the old-age home, respondent 18 replies: "Ag, een dingetjie wat ons van gepraat het, is 'n ding soos 'n braaivleisplek hier buite. Dit mis jy. Daar is 'n ding van 'n bietjie wyn aan tafel geniet. Dit is 'n ding wat by ons 'n instelling was al die jare. Dit word nie hier verwelkom nie. Dis 'n ding wat ons mis."

Respondent 18 regards the services rendered in the old-age hame as mainly medical in nature: "Ja, tot 'n groot mate. Kyk, tot hierdie oefeninge wat hulle het, is ook eintlik gemik op gesondheid. Ja-nee, hoofsaaklik. Ek sou so dink."

In response to the question as to whether he would prefer to be living elsewhere, respondent 18 remarks: "Ek het nog nooit daaraan gedink nie. Nee, ek dink nie dit kom in berekening nie. ... Hierdie pas ons nou goed vanweë die omstandighede van ons lewens. As een van ons iets moet oorkom, dan wil ons versorg wees. En ek dink dit is die belangrikste ding."

E. Recommendations

Respondent 18 has no ideas about how to make life easier in an old-age home: "Ek dink nie jy moet te veel vir die mense 'organise' nie. Hulle bly hierso. Ek dink nie hulle moet te veel karring nie ... dat die mense nog hulle onafhanklikheid behou. Wat 'n probleem is ... hulle het probleme om by die winkels te kom. Laat dit miskien makliker gemaak word veral as hulle baie oud begin word."

Interview 24

A. Biographical information

Respondent 24 is a widower (he was married four times and all his wives are deceased), Englishspeaking, 79 years old and has been staying in a public old-age home for the past eleven months. He used to be a blacksmith on the railways, has two children of his own, three grandchildren and seven great-grandchildren. He sees his granddaughter on a weekly basis.

Before he came to the old-age home, he had his "own property" which he gave to his children. The most important reason for his moving to the home is because he had a stroke. "They sent me to hospital and from hospital they sent me straight here." According to respondent 24, the doctor took the decision to send him to an old-age home. He does belong to a medical fund. He also has his own private doctor and is not seen by the visiting doctor of the old-age home.

B. Perceived health status and attitude towards medication practices

Two years ago, respondent 24 had a stroke. He has been in a wheelchair ever since. "I can't walk now. ... My hip is out. ... Healthwise I feel hundred percent, but as I say, I'm handicapped: I can't walk." Before his hip problem he was "very active. I used to play soccer, hockey and tennis".

For the past year, he has been taking blood pressure tablets twice a day and at night pain tablets for his hip. "And I take two pink ones. I don't know what they're for. I think they were for my shoulder. I don't know the way they work now." He is taking more tablets since he has been in the old-age home. "They give me a sleeping tablet now." He does not take any vitamin supplements. On the question of how he feels about taking medicines, he replies: "I don't mind taking medicine as long as I know what its for." He sees his doctor once a month, "you know, for a check-up". Respondent 24 feels that the doctor should take

responsibility for his health.

C. The aging experience and life satisfaction

Respondent 24 states that he had a "full life. I'm quite contented". In response to the question as to how he feels about his age, he replies as follows: "The age might be getting on, but the body is getting older. Some people have a saying 'mooi bly', but I don't know how we can 'mooi bly' if we get older and uglier by the day."

Respondent 24 had to retire from his job, but he had to find another job "to help [him] out for a couple of years".

He is not afraid to die, but did not give any reason for his answer. In response to the question as to whether he has ever thought of something to make the aging experience easier, he replies: "That is a hard question to answer. You know, you get plenty of daydreams now. They're all like flying bubbles... flying into the air and, like my dreams, they fly to die."

D. Attitude towards life in an old-age home

He passes the day in the old-age home by sitting outside most of the time. "There you do see a bit of life." His main hobby before he moved to the old-age home, was "mostly fishing". He does not feel too lonely and bored, because he gets on well with his roommate. As a result of poor eyesight he cannot read much, but he listens to the radio. "We have got friends but I do not visit them."

In response to the question as to how he feels about being in an old-age home, respondent 24 replies as follows: "Well, to put it this way, you've got a bed to sleep in, you've got a roof over your head and you get three meals a day. What more can you ask for? It might be a bit expensive but what else can you do? You've got no worries at all actually."

In response to the question as to what he particularly likes about being

in an old-age home, respondent 24 replies: "Well, I don't know. All I can think of is my old wireless here. I like listening to the wireless." He does not particularly dislike anything in the old-age home: "As I say, I put it to you the right way: a bed in your room, and three meals ... you can't expect anything else." What he found most difficult to adapt to is living with many people: "You know, I mean ... I'd say at least forty five per cent of my life I was alone. ... You know, I mean, you could do just what you wanted to do."

Respondent 24 does sometimes attend the social activities arranged by the old-age home, "but not always". In response to the question as to whether he regards the services rendered in the old-age home as mainly medical in nature, he replies: "Well, if you add it up, I would say it would be." He doesn't feel that his opinion is valued with regard to decisions affecting him in the old-age home: "I wouldn't say I bear any influence on anybody ... but I do think you are free to complain if you want to." He regards having meals at strictly set times every day as a good idea.

He would prefer to be living elsewhere: "I never pictured myself in an old-age home. You see, I mean, when my youngster got into trouble I thought the best thing to do was to give them the house, sign the house over to them, then they can give me a room ... a bed, you know and look after me until I kick the bucket ... and they can have the house. But it didn't work out that way. My granddaughter made sure I came here."

E. Recommendations

In response to the question of whether he had any ideas about how to make life easier in an old-age home, respondent 24 replies: "That is a corrupt question. I mean, many thoughts go through your mind, but they don't ever work. You're bound to just go anyway. ..."

Interview 31

A. Biographical information

Respondent 31 is an eighty six year old widow who, for the past six years, has been renting a room in a public old-age home.

She used to be a housewife and her husband, who passed away eight years ago, used to be a moulder.

She has 4 children, 8 grandchildren and 13 great-grandchildren. She sees some of her children on a weekly basis.

Before she moved to the old-age home, she lived in their house in Pretoria. She describes the most important reason for moving to an old-age home in the following words: "Well, I was alone. I couldn't stay in the house by myself. I was only getting an old-age pension. And ... I couldn't keep the house on the old-age pension. And ... I didn't want to go and stay with the children, because they're wanting you to go here and they're wanting you to go there and ... perhaps you're not feeling up to it. ... Also it all depends on company. You know, they have younger company and ... so, you like to mix with older people." Respondent 31 herself took the decision to move to an old-age home.

Respondent 31 does belong to a medical fund.

B. Perceived health status and attitude towards medication practices

Respondent 31 states that she does not really have any health problems: "I've got arthritis in the knees and I've got a little bit of heart trouble, you know ... high blood pressure, but otherwise I'm very healthy."

At the time of the interview she described her health as very good.

Respondent 31 is able to move around comfortably with a walking-stick.

The medicines she uses on a regular basis she describes as follows: "I have a heart tablet and a blood pressure tablet every day." Now and again she takes a Panado for the pain in her knees, "but otherwise I don't take anything". She states that she started taking these tablets quite a while before she went to the old-age home. Respondent 31 does not take sleeping tablets. In response to the question as to whether she takes any medicines that are not specifically prescribed by the doctor, she replies: "Well, at the moment I've been trying this oil of celery seeds for the arthritis, but otherwise I don't take anything else." Respondent 31 explains that her medicine is being handed out to her, except for the oil of celery seeds. She is not allowed to keep her prescription medicines with her. With regard to vitamin supplements, she takes Berocca calcium and vitamin C.

In response to the question as to how she feels about taking medicine, respondent 31 replies: "No, I'm not a medicine fan."

On the question of what she actively does on a regular basis to improve her health and prevent disease, respondent 31 explains: "I'm only walking a bit." She states that she does take part in the exercise programme that is provided by the old-age home.

Respondent 31 states that her medical routine has not changed in any way since she has been in the old-age home. She always sees the same doctor: "He is the private doctor for the Haven." She sees him once in three months, "just for my medication, unless I have to see him." She states that she is free to visit the medical unit of the old-age home if she feels that she needs medical attention.

Respondent 31 is happy with her doctor and feels that he is taking responsibility for her health matters.

C. <u>The aging experience and life satisfaction</u>

In response to the question as to whether she got most of the things she wanted and expected out of life, respondent 31 replies: "Well, I've

always been very happy."

In response to the question as to how she feels about her age, respondent 31 explains: "I'm still healthy. ... Sometimes I'm a bit tired. ... You know, you ... you wonder why. ... You know ... you're carrying on and carrying on ... you wonder why you get old. ... Some days you feel very tired, but you ... struggle along, you know."

Respondent 31 is not afraid to die: "I'm waiting. Sometimes you think you've come to the end, you know ... you're tired. You don't want to be a nuisance to anybody. I'm not looking forward to dying, but I'm not afraid to die."

Respondent 31 has never thought of anything that could make the aging experience easier.

D. Attitude towards life in an old-age home

Respondent 31 describes how she generally passes the day in the old-age home: "Well, you're busy in your room until you go for breakfast. And then I come back here until tea time, and I usually knit or crochet or do any little mending job ... and I read and sew."

Respondent 31 never feels lonely or bored. In response to the question as to whether this routine differs a lot from what she was used to doing in her own house, she replies: "Well, of course you haven't got your housekeeping. It takes time to ... adjust, you know ... but I've been very happy right from the day I came in to the home. My daughter cried when they brought me in. ..."

In response to the question as to what her hobbies used to be before she moved to the old-age home, respondent 31 replies: "Oh, everything in the home line ... sewing, knitting, gardening, preserving ... everything." She states that she does not have the physical strength to do these things any longer.

According to respondent 31, she is very happy in the old-age home. She does not miss the privacy she used to have in her own home: "Of course, I'm very blessed at the moment, you know ... It's when you have to share with somebody. ... Of course it all depends on whether you can settle in together ... with some you can, you know ... with others you can't." She explains that she was just lucky to get a single room: "If they see that I can't carry on any longer ... that I need the help of a nurse, you know ... for bathing and things like that ... then they move you to a double room ... or to the frailcare unit."

Respondent 31 explains the working of the system in the following way: "Well, they used to have meetings to discuss the menu and things in the Haven ... like security meetings, and it all depends which panel you're on, you know. ... But you can go to matron anytime."

In response to the question as to whether there is something she particularly likes about being in an old-age home, respondent 31 replies: "Well, I like the company, you know, being together. Another thing that I like ... or that I did like when I first came here, was to learn something from somebody else that I couldn't do myself ... or to help somebody that needed help ... say with knitting."

There is nothing that she particularly dislikes or found very difficult to adapt to: "I can take the good with the bad."

According to respondent 31, one gets used to having meals at strictly set times every day. She does not have a kettle in her room, but in the passage they have an urn where they can get boiling water.

This old-age home does arrange for social activities: "We had a bingo evening last night and I believe the Police Band is coming here next month. They don't have much in the cold months." Respondent 31 states that she enjoys attending these activities.

She does regard the services provided in the old-age home as mainly medical in nature: "Yes, well, I suppose everything that's done for you

is done for your interest ... for your health."

Respondent 31 has no specific needs which are not catered for by the old-age home: "No, I haven't, because if I need anything my family takes care of it." She states that transport is a problem, but her family takes her wherever she wants to go.

Residents of this old-age home do not have telephones in their rooms: "We're not allowed to keep telephones here. You know, a telephone can run into problems. ... You get other people who use your phone and when you get your account at the end of the month, you have trouble."

Respondent 31 is free to come and go as she wishes. On the question of whether she has lost some of the independence she used to have in her own home, she replies: "That's hard to answer, because at this stage now I wouldn't be able to do what I could do when I was in my own home. ... It would be silly to grumble about this." Respondent 31 states that she still feels as in control as she used to feel in her own home. It does not bother her not to have her medicine with her.

She would not prefer to be living elsewhere.

E. Recommendations

In response to the question as to whether she has any ideas about how to make life easier in an old-age home, respondent 31 replies: "Well, I don't know. I'm a very happy person. ... I tag along with everything. ... I always make the best of everything. I'm outgoing." She does mention that sharing a bathroom poses a problem in terms of privacy.

Interview 33

A. Biographical information

Respondent 33 is an English speaking widow, 82 years of age, who has been renting a room in a public old-age home for the past two and a half years. Her husband passed away in 1984.

Respondent 33 had 3 children: 1 son and 2 daughters. The younger daughter passed away in 1964 at age 25. The older daughter passed away in 1977 at age 43. She has 8 grandchildren and 5 great-grandchildren. She sees her son and his family "quite often". She used to stay with her son and his family before she moved to the old-age home. She herself took this decision.

Respondent 33 explains her most important reason for having moved to an old-age home in the following words: "You know, the thing is, your children have their home and I just felt ... you feel sort of in the way. So, I put my name down."

Respondent 33 does not belong to a medical fund.

B. Perceived health status and attitude towards medication practices

Respondent 33 describes her health as good. She suffers from "a bit of a high blood pressure". She takes half a water pill and half a blood pressure pill every day. Since she has been in the old-age home, she has been taking a sleeping tablet every night. She could not remember whether she requested one and said: "Most people here take a sleeping tablet, you know. I think, when one gets older, you need something to relax yourself. We have a doctor that comes here ... We've got two doctors, you know, one for the old age pensioners and one for those on medical."

In response to the question about whether she takes vitamin supplements, respondent 33 replies: "I used to take a few vitamins but I stopped with

that." She does not know how she feels about taking medicines: "I asked the sister one night ... she said no, she doesn't think at our age medicine can harm us. The sleeping pill I take is very good, because it has no hangover. I don't know what its called... wonderful pill."

Respondent 33 participates in the physical exercise programme provided by the old-age home every morning. Furthermore, she does a lot of knitting and she walks "around the place".

Except for the sleeping tablet, respondent 33 has not had to change her medical routine since being in the old-age home.

Since being in the old-age home, respondent 33 does not see her private doctor whom she used to see for many years. She is now seen by the visiting doctor of the old-age home: "They make it compulsory that we see him every three months for a check-up, you know. And that's a good thing really, isn't it?" Respondent 33 never visits the frailcare unit for medical attention: "We have a sister here every night and we have one in the day all the time ... if we need them." She states that she has a very good relationship with the doctor.

C. <u>The aging experience and life satisfaction</u>

On the question of whether respondent 33 feels that she got most of the things she wanted and expected from life, she replies: "I don't know, you know one can't say all these things. You know, you don't expect to lose all your children ... Those are the things we don't know ... we don't know what's in store for us in life and just as well, isn't it? They often say there's a purpose in everything, but we don't see that purpose, do we? We don't, you know. ..."

Respondent 33 states that she feels "fine" about her age. "I just feel lazy sometimes." She explains that she is not afraid to die: "I believe in the Lord and I know when my time comes, I'll go. I can't stop anything, isn't it so? I'll be re-united with my whole family."

In reply to the question as to whether she has ever thought of something that could make the aging experience easier, she replies: "Oh yes, I think your faith is everything."

D. Attitude towards life in an old-age home

Respondent 33 generally passes the day in the old-age home by knitting, reading and having tea. She does not want a television set. She states that her life is different in the old-age home. At home she used to help with the cooking. Knitting has always been her favourite hobby. According to respondent 33, she never feels lonely or bored.

About being in an old-age home, respondent 33 explains: "There comes a time, I think, when a person has to go into one. I don't think anything about it. From the very beginning I've said I'm going to be happy, and I have. I think it depends on yourself, you know. In the summertime we sometimes play canasta, you know. Last night we had bingo. ... They do sometimes take us to parks and different places." This old-age home has a library service, as well as a hairdresser.

In response to the question about whether residents are free to raise their complaints, respondent 33 replies: "Oh yes, I think if we want to, we could. But there's nothing to complain about. It's really such a wonderful place. It really is, you know."

Respondent 33 states that she really likes the company in the old-age home: "It's something that goes a long way, you know." She continues by explaining: "I suppose at first you feel a bit funny, you know, but you overcome that. I made up my mind I was going to be happy here."

In response to the question as to whether she regards the services rendered in the old-age home as mainly medical in nature, respondent 33 replies: "Oh yes, the nursing system is very good. They're always there to help you."

Respondent 33 has no needs that to her mind are not catered for. "I'm

just contented with what I've got. I think we all get our cross to bear in life. We do, you know ... we do."

She does not mind having her meals at strictly set times every day. On the question of whether she has lost some of her independence since being in an old-age home, she replies: "Not really. You see, I've lived with my children. It's no different really."

Repsondent 33 would not prefer to be living elsewhere.

E. Recommendations

Respondent 33 has no ideas about how to make life easier in an old-age home: "You know, a contented mind, I think, that's the main thing. It really is, you know."

Interview 34

A. Biographical information

Respondent 34 is seventy two years of age, female and has been divorced since 1966. She has been staying in a public old-age home for the past four years: "A lot of us here get an old-age pension. Then ninety percent of that pension is taken for your board and lodging. ... You don't really get everything. They take ninety percent ... but you've got to supply your own soap, toothpaste, face cloth. ..."

Respondent 34 used to be a bookkeeper. She worked for auditors until 1985 when she had a heart attack: "I was in hospital for three weeks, and when I came back, my job had been taken by somebody else. They said that they needed younger people there."

She has one son and three grandchildren whom she sees "maybe once every three months, maybe four months. But he phones me twice a week." She states that she is not very keen on going out for weekends: "I much prefer to be here in my own little room."

Before she moved to the old-age home, she lived in a flat in Germiston and then she moved to live with a niece. She asked her son to find her a place in an old-age home.

Respondent 34 states that her most important reason for moving to an old-age home had to do with her health and finances. She does not belong to a medical fund.

B. Perceived health status and attitude towards medication practices

Respondent 34 had a mastectomy five years ago: "They removed, I think, twenty six glands ... but now ... I had been in remission for quite a long time ... but now I believe it's in the spine." She received chemotherapy at one time, but now she is taking tablets: "I was on cortisone and chemotherapy tablets, and this is where I've put the weight

on. I just spread like ice-cream in summer!" Respondent 34 is not taking cortisone any longer. She is now only taking chemotherapy tablets: "I think there's a possibility that the nodules on the spine have a ... I think the ones on the spine are disappearing." Respondent 34 has also been taking three morphine tablets (Wellconal) daily "for a couple of years".

Regarding the medicines she takes on a regular basis, respondent 34 explains as follows: "I take two in the morning for the ... the cancer tablet. What they are, I don't know. Then I take a thyroid tablet. I don't know what it is. Then in the morning I take Serepax... It's actually a tranquiliser. ... Doctor put me on a tranquiliser. She said my nerves were in a shocking state. Sometimes I take three a day ... most times I don't. And then I have vitamin B tablets and ... the water pill [Lasix] with the Slow K. And then I have a sleeping pill at night. I don't know what it is." On the question of whether she requested sleeping tablets, she replies: "I was taking three Serepax at night and they weren't helping. So doctor gave me the sleeping pill." She has been taking sleeping tablets for "about three four months now".

Respondent 34 states that she does not take any medicines that are not specifically prescribed by the doctor. She does, however, take Citro Soda for bladder infections.

In response to the question as to how she feels about taking medicines, respondent 34 replies: "Not too happy. You know, if I didn't actually have to take them, I wouldn't. I'm so terrified of becoming addicted. So my son said to me, 'So ma, at seventy two, if you become addicted, so what. And when I told her [the doctor] that, she said 'I agree with him - so what?'." Respondent 34 states that "the government is now cutting down on medicines. Whatever it is, you're only allowed four a day." Regarding the Vitamin B tablets, respondent 34 remarks: "I don't count them as tablets - I can do without them. But my lips started cracking here ... ."

Respondent 34 describes her relationship with her doctor as "marvellous".

Apart from the treatment she gets on a regular basis at the hospital, she also sees the visiting doctor of the old-age home: "That's compulsory, you know."

Another health problem respondent 34 suffers from is arthritis. She explains: "Of course I have arthritis, but I think everybody has that." She moves around freely and independently without a walking-stick.

At the time of the interview, respondent 34 describes her health as "fine".

C. The aging experience and life satisfaction

In response to the question as to whether she got most of the things she wanted and expected out of life, respondent 34 replies: "Really I didn't have any great expectations. I was very fortunate to be able to do the job I did."

She explains that her age "doesn't really worry" her, and continues by saying: "In fact, I don't feel seventy two. I think age is in the mind. Being here ... this can have a ... I chose to be here, but some of them ... their children put them here ... and then of course they get old. ..."

Respondent 34 states that she would rather have liked not to retire when she had to: "You know, even now ... I keep bluffing myself that I can still work, but I tire very quickly."

Respondent 34 states that she is "not at all afraid to die", but she does not give any reason for her statement. She has never thought of anything that could make the aging experience easier.

D. Attitude towards life in an old-age home

Respondent 34 replies that she does not take part in the social activities that are arranged by the old-age home: "I can't ... I never

have been able to ... what do you call it ... you know, when you're forced to go and sit down and listen to somebody singing. ... Sometimes matron picks me out about this. I think if I explained to her she would understand, but I never get around to sort of talking to her." Respondent 34 states that she prefers to be in her room rather than to partake in social activities: "I don't encourage visitors and I don't visit."

According to respondent 34, she never feels lonely or bored. Her hobbies are knitting, reading and crosswords.

Respondent 34 does "quite a bit of walking". She was not allowed to take her own furniture to the old-age home: "The only thing that's here, that's mine, is my TV and my chair. They wouldn't let me have my things ... but I see that lots of people do bring their things and, you know, I'm sorry then, because I would have liked my bed. But she told me that I wasn't allowed to. ..."

Every room has an intercom which could be used to call the sister.

Every Monday morning, respondent 34 helps in the library at the old-age home.

With regard to her routine in the old-age home, respondent 34 explains: "First of all, it's only this one room to live in. ... I had a beautiful flat and, you know, you miss being able to go from room to room. And ... I sometimes kick against the routine of breakfast at eight, lunch at twelve. ... A bird flies, you know ... ."

She states that she does not feel "unhappy" about being in an old-age home, "but its not what I would have chosen". In response to the question as to whether she would prefer to be living elsewhere, she replies: "Oh yes ... oh yes, any day. ... But that now is impossible ... mainly its because of my finances."

Regarding the working of the system, respondent 34 explains: "If you have

anything that you're unhappy about, then you speak to the matron's secretary, then she makes an appointment for you to see the matron."

Respondent 34 states that she is "very contented" in the old-age home, "but, you know, its not what I would have chosen if I had the option ... but I have no other option". She particularly dislikes the routine in the old-age home: "I think I came here too soon, you know. ..." She does not have any needs that are not catered for, neither does she feel that her privacy is invaded. She does not have her own car: "You have to get rid of that. Transport is a terrible problem. There's no transport from here unless you get on the bus. But the bus is for people who can use it. ... I never go out."

In response to the question as to whether she still feels in control of her own life, she replies: "Not really, but you sort of adapt to that. ... You know, you know that you've got to follow the rules of the house and you've got to do everything that you're told to do. You know, you're back to boarding school."

E. Recommendations

Respondent 34 has no ideas about how to make life easier in an old-age home: "You know, you've got to adapt ... like old Uys says 'adapt or die'. Sometimes I really feel rotten and then I take a walk up to the frailcare and then I say 'thank you, God, for what I haven't got.' In a place like this you have to adapt ... ."

Interview 39

A. Biographical information

Respondent 39 is 75 years of age, a widower and has been staying in a public old-age home for the past year and a half: "Kyk, ons kry die kamer ongemeubileerd, dan moet ons self ons eie meubels inbring en dan betaal ons 'n fooi. ... Ek dink myne is R969 'n maand met etes. Dan betaal ons verder R15 vir 'n dienskaart. Dit behels dan haresny ... maar ons moet dan nog daarvoor betaal ... vir die haresny, maar dan kry ons dit goedkoper."

Respondent 39 used to be a civil engineer. His wife, who passed away 6 years ago, was a beautician. He has 3 children and 5 grandchildren. He states that he does not see them very often: "Hulle is so ver van my af, jy weet. My jongste seun kom haal my so nou en dan ... so eenmaal 'n maand of so, dan vat hy my na Roodepoort na hulle toe, dan eet ek daar en dan bly ek vir die dag daar, en dan kom ek terug. Maar dan het ek ander vriende wat my nou naweke uitvat, dan slaap ek daar, dan kom ek weer terug."

Before he moved to the old-age home he stayed in a townhouse in Faerie Glen. He describes the main reason for his moving to an old-age home in the following words: "Ek wat net een been het ... dit het begin moeilik word vir my en die bediendes het my in die steek gelaat ... dan kom hulle, dan is dit stay-away. ... Toe is dit te moeilik vir my om aan te gaan. En ek was baie eensaam ... alleengeid ... en ek kon nie self vir my sorg nie. Eensaamheid ... baie eensaam."

Respondent 39 does belong to a medical fund.

B. Perceived health status and attitude towards medication practices

Respondent 39 describes his health status as follows: "Ek het lang ure moes werk ... sonder verlof vir 6 jaar. Met die gevolg is dat ek 'n 'bloedstol' in my linkerbeen gekry het. Ek het te lank gestaan en te

lang ure. Dit het 27 jaar gelede gebeur, 1965. Sewe-en-twintig jaar het ek pyn."

At the time of the interview, respondent 39 stated that his health is very good: "Ek voel nie of ek nou 75 is nie. Ek voel nou regtigwaar of ek nou 56 is."

Respondent 39 moves around comfortably using crutches. He has an artificial limb but he does not use it: "Ek kan nie, want ek het 'n ongeluk gehad. Die kruk het onder my gebreek, toe val ek bo-op die kruk met my stuitjiebeen en ek kraak hom. Dit het 16 maande gelede gebeur en dis nog steeds onder behandeling. Ek kry nou nog fisioterapie tweekeer 'n week vir 'n longontsteking wat ek drie jaar gelede gekry het."

Respondent 39 gives the following explanation about the medicines he uses on a regular basis: "Ek drink nou op 'n gereelde basis byna net pynpille en daardie Mucaine vir 'n sooibrand. Ek het nou stress gekry, jy weet, hoe sal ek sê, nie senuwee-aanval nie, maar ... ek het vreeslik verlang na iets wat ek nie kan kry nie. Ek het begin moeg word hierso. Ek verlang weer na my vryheid, jy weet ... en ek kon dit nie kry nie. En nou gebruik ek nou hierso ... neem een tablet viermaal per dag ... hierdie ene is nou vir die stress. Dan een tablet tweemaal per dag ... dis om my 'n bietjie te kalmeer." Respondent 39 knows exactly what medication he is taking and for what reasons: Celestamine for hayfever, Lexotan for stress, Dolorol for pain and Mucaine for heartburn: "Suster-hulle help my nie met my pille nie. Ek doen dit myself. Die normale praktyk is dat die pille by die eettafel uitgedeel word." He continues about his health status: "Dis nou al moeilikheid wat ek het, ek het verskriklike stress, jy weet. Ek kan nie ontspan nie. Ek is baie gespanne ... maar dis al."

According to respondent 39, this old-age home does not arrange for any social activities or physical exercises.

Respondent 39 continues explaining about his stress and loneliness: "Kyk, hier is elkeen vir homself. Nie een maak vriende met iemand nie. Ons

is net omtrent sewe mans hierso teen omtrent amper honderd vrouens. Jy weet, en dan sê die mans, 'Ag, ek gaan nou maar huis toe'. Die huis is die kamer. Dan staan hulle op en dan loop hulle almal, want hulle is almal oud, jy weet. Dan kom ek ook maar huistoe en dan lees ek, en dan ... as ek nou moeg gelees is, dan probeer ek ontspan 'n bietjie. So gaan dit maar net. ..."

Respondent 39 states that he does not mind taking the medicine, because it helps for him. He takes various vitamin supplements: "Ek moet sê, ons kos is nie hierso dat jy kan sê daar's baie vitamine in nie. Hulle gaan nie in vir 'n dieet of so iets nie ... nie baie groente nie ... hulle is papgekook en so aan. Ek wil nou reguit praat: die kos is baie sleg. Daar is nou niks wat jou vitamine laat kry nie. Nou koop ek maar vitamine. Baie van ons koop ons eie vitamine. My kinders bring vir my vars vrugte. Ons kry by die tafel so nou en dan 'n banana. Die laaste drie weke of vier weke het ons niks gekry nie. Daar's onopgeleide mense daar onder in die kombuis, want hulle wil geld spaar op die kos ... kyk of hulle nie 'n wins kan maak nie, jy sien, en nou moet ons natuurlik daaronder ly."

Respondent 39 states that he takes more medicine (as a direct result of being in an old-age home) than what he used to take at home: "Ek het by die huis byna nooit medisyne gedrink nie."

Respondent 39 had to get rid of his dog when he moved to the old-age home: "O, en ek is verskriklik lief vir diere. Toe gee ek haar [the dog] vir iemand wat ek ken. Hulle het belowe hulle sal haar goed oppas. Dan't ek 'n kat ook gehad. Die kat was altyd op my skoot en so aan. Weet jy, ek kan sê ek het met diere grootgeword en ek het oud geword met diere ... en dit was vir my baie moeilik om aan te pas sonder diere. Om als op te som: dis 'n eensame lewe ... jy weet."

Respondent 39 always sees the same private doctor. However, he explains that he has previously been treated by a lung specialist, an urologist and a general practitioner. He states that he sees them very rarely: "Ek is nie so sieklik dat ek dokters toe moet gaan nie." According to

respondent 39, he trusts his doctors and is happy with their treatment. He states that he takes responsibility for his own health matters.

Respondent 39 explains that he is not free to visit the medical unit if he needs medical attention: "Kyk, jy moet oorgeplaas word soontoe en daar is dit nou net vir die baie siek mense. Maar die susters hier is baie gaaf. Hulle is altyd daar om jou te help en raad te gee, ek moet sê ... baie gaaf."

C. The aging experience

On the question of whether he got most of the things he wanted and expected out of life, respondent 39 replies: "Ek het dit nie gekry nie. Kyk, ek is 'n man wat graag tuin wil maak, ek wil loop. Nou hier is obstruksies. Ek kan nie met die krukke loop nie. Soos daar by die huis het ons pragtige grasperke gehad. Ek het geloop. Ons was baie gelukkig. Ek wil vreeslik graag vry wees, maar ek moet sê in my omstandighede kan ek nou nie anders nie. Ek moet nou hier bly ... maar het ek twee bene gehad, dan was ek nog in Faerie Glen."

Respondent 39 explains how he feels about his age: "Ek voel baie gelukkig, want ek voel nie 75 nie. Ons kan dit net omdraai - 57."

He did not look forward to his retirement: "Ek wou nog langer werk. Ek was al daar oor die 60. Jy't nie eintlik 'n keuse nie. Ek wou nog langer aangegaan het."

Respondent 39 is not afraid to die: "As ek net nie gaan lê en sterwe nie ... lang tyd siek word en so aan."

In reply to the question about whether there might be something that could make the aging experience easier, respondent 39 replies: "Meer sport, meer geselskap ... dat ons geïnteresseerd wees in iets."

D. Attitude towards life in an old-age home

Respondent 39 describes a "normal" day in the old-age home: "Elkeen gaan sy eie weg. Agtuur gaan jy eet. Dan kom ons terug kamer toe, dan probeer ons ontspan 'n bietjie. Ek het my draadloos en ek het my TV en dan luister ek na die musiek. My draadloos is altyd aan ... en dan gaan elkeen sy eie koers. Party gaan dan of onder toe, party bly in die kamer. Hier's baie mense wat baie lees. Hulle bly in hulle kamers. Almal is vry om te gaan waar hulle wil. Dan gaan eet ons middagete twaalfuur ... dis vroeg ... en dan weer vieruur in die middag ... aandete. Ek slaap party aande twaalfuur, twee-uur ... ek kyk maar TV. Dan gesels ek met iemand op die telefoon. Hulle bel my en ek bel hulle en so gaan dit aan. Ek kry my dag om, maar verskriklik eentonig en eensaam."

According to respondent 39, this routine differs radically from the routine at his previous home: "Ek het daar 'n snoekertafeltjie gehad, jy weet. Of ek vat my hondjie vir 'n loop. Daar's pragtige tuine gewees. Daar's grasperke. Ek het altyd op my patio gesit en na die voëltjies gekyk en so aan. Daar's baie aantreklike dinge gewees, maar hier waar jy kyk, kyk jy net teen 'concrete' vas. Ek het baie aan my motor gewerk. Ek het motor gedryf tot ek hier ingekom het, maar toe kan ek nie parkeerplek kry nie, toe moet ek hom verkoop."

Respondent 39 describes his feelings about life in an old-age home: "Kyk, die ouetehuis is nie 'n antwoord vir mense nie. Kyk, daar's baie plekke wat sulke klein eenhede op die grond het, wat 'n tuintjie daar het en so aan ... waar jy kan geïnteresseerd raak in 'n blom en so aan ... maar nie hier waar hulle vier, vyf, sewe vloere het nie. Jy weet, dan is die hysbak stukkend. Ek sê nog, 'n oumens moet op die grond wees. Hy moet hom besig hou."

In response to the question about what he particularly dislikes about being in an old-age home, respondent 39 replies: "Nee, ek stel dit nie voor nie. Definitief nie."

In response to the question about whether there is something he likes about being in an old-age home, respondent 39 replies: "Jy weet, die susters en die verpleegsters is baie goed vir my. Daarvan hou ek baie. Maar in die algemeen ... ek hou nie van 'n ouetehuis nie ... nie op hierdie manier nie."

In response to the question about what he found particularly difficult to get used to when he first came there, respondent 39 says: "Ek sal nooit in my lewe hier aanpas nie. Kyk, ek is nog jonk hierso. Dit sal my seker nog vyftien jaar vat om aan te pas."

Respondent 39 does not regard the services rendered in the old-age home as mainly medical in nature: "Jy weet, die dienste wat ons hier kry, is hulle maak die kamers skoon en die gebou word skoongemaak. Hier bad ons tweemaal 'n week. My badtyd is Woensdae en Saterdae. Elkeen het sy tyd."

On the question of whether he has any specific needs which are not catered for by the old-age home, respondent 39 replies: "Soos baie sport en so aan, jy weet ... bietjie oefeninge en so aan."

Respondent 39 is not very happy about having his meals at strictly set times every day: "By die huis het ek geëet wanneer ek wil." He really misses the privacy he had in his own home: "As ek gesond is en ek kan môre teruggaan, sal ek nie wag nie. Nou is ek heeltemal afhanklik van die ouetehuis. Ek kan nie meer buitekant gaan nie. Ek het my motor ook verkoop. Nou het ek niks meer nie, jy sien. Nou moet ek maar hier aanpas ... of ek dit nou graag wil doen of nie."

In response to the question about whether his opinion is valued with regard to decisions affecting him in the old-age home, respondent 39 replies: "Nee. Ons het hier 'n vrou wat ons verteenwoordig by die bestuur. Sy is ook 'n inwoner hier. As ons klagtes het, dan gaan ons na haar toe, jy weet ... en dan ... baie min word na haar geluister natuurlik, jy weet. As dit kom dat daar geld moet uitgegee word, dan luister hulle niks. Onse TV is nou vir drie weke al so dat ons nie kan

kyk nie. Ons het 'n petisie opgetrek om dit reg te kry, maar dit kom nog nie reg nie."

E. Recommendations

Respondent 39 has no ideas about how to make life easier in an old-age home: "Soos ek jou sê ... ek hou nie van ouetehuise nie."