

# Geriatric Psychiatry and Elder Law: Speaking a Common Language

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## *Geriatric Psychiatry and Elder Law: Speaking a Common Language*

Dr. Finlayson looks at issues involving the elderly, such as competency and informed consent, from a medical perspective, helping to illuminate the intersection of the legal and medical professions.

**By Richard E. Finlayson, M.D.**

I find it interesting and a challenge to have a part in the start-up of a new enterprise. The only hesitation I had in accepting the offer to write a column for this journal was my lack of formal training in law. Once assured that that was not necessary, I accepted. The charge to me from Jane Mulcahy, executive editor of *Elder's Advisor: Journal of Elder Law*, is to serve as a conduit, providing the legal profession with information about the mental health problems of elders that is largely free of medical jargon. I interpret my charge to include the selection of topics that are of interest to elder law attorneys in their day-to-day encounters with their clients.

Please allow me a few lines to introduce myself. I am a senior consultant in the Division of Adult Psychiatry at the Mayo Clinic. The views expressed in this column, however, are mine and do not necessarily represent the institutional views of the Mayo Clinic. My particular interest in geriatric practice began about 15 years ago and involved the area of substance

abuse, which was already a subspecialty interest of mine. Later I became involved, in a more general way, with geriatric psychiatry. This was actually before the American Board of Psychiatry and Neurology established credentials in geriatrics, later to be identified as "Added Qualifications in Geriatric Psychiatry." Subsequently, the board developed "Added Qualifications in Addiction Psychiatry." These subspecialty certifications are available only to those who were already board certified and have clinical experience. I, like hundreds of others, have obtained these added qualifications, but the number of psychiatrists as well as other medical specialists certified to practice in the field of geriatric medicine is, according to the best estimates, far short of what is needed.

Demographic trends help to explain why we are lagging in providing specially trained professionals to serve this population. You probably have many of the numbers in hand with respect to our senior population, but let me restate some of them. About 12 percent of the general

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population is over age 65 years. Gerontologists do not agree on how being *elderly* or *aged* should be defined. It is my impression from the literature that many experts think we should redefine this period of life as beginning later than the usual retirement age of 65, for example, the mid to late seventies. The arbitrary selection of 65 years for retirement and drawing on one's Social Security actually had its origins in Germany and was later adopted by our Social Security Administration. In the meantime, life expectancy has been increasing. The fastest growing segment of the population now is those over age 85. Fewer than 5 percent of persons over age 65 are receiving custodial care, for example, in a nursing home. Many persons are seeking second careers following retirement or at least live very active lives supported by their pensions and savings. Those unfortunate enough to require nursing home care typically have multiple general medical and psychiatric problems. Nursing homes have become something akin to mental hospitals, with the proportion of persons with identified mental disorders, such as dementia, depression, and alcoholism being 75 percent or more. Yet few nursing homes have the luxury of on-site psychiatric services.

Why has the medical profession singled out the aging population as an area for specialization? Are they really that different? The answer is yes and no. In order to make geriatric psychiatry a specialty area, proponents had to establish that there was a body of knowledge that would

set the elderly apart. The easiest to demonstrate is the biology of aging. There is a general slowing of biological functions with aging. Changes in the body's composition (more fat and less muscle), for example, alter how drugs and alcohol are broken down and eliminated from the body. In general, the elderly in the United States are taking one-quarter to one-third more prescription drugs than are the nonelderly, making this one area in which special physician knowledge is needed. Intellectual functions generally do not decline with age, except in the presence of diseases such as Alzheimer's, but mental processes are usually slowed. Complaints of memory difficulty may merely reflect a slowing of recall rather than actual loss of ability to retain and retrieve information. The term *senility* has fallen out of favor because it is stigmatizing, suggesting that older people are intellectually impaired on the basis of age alone. The medical complexity of old age requires not only a knowledge of individual diseases, but a working knowledge of how these disorders and the medications used to treat them interact in the older person.

Some mental disorders typically have their onset in late life. Alzheimer's type dementia is perhaps the best example. The risk increases with age, with onset occurring in mid-life only when there is a positive family history for Alzheimer's. Late onset depression (occurring for the first time in advanced age) has been shown to be related to degenerative changes in the brain due to disease of small

blood vessels, which increase with age in many persons. Alcoholism that begins in late life is different than the types that start earlier, in that it is less likely to be associated with a positive family history for alcoholism. It also seems to be a less severe disorder and can clearly benefit by addiction treatment in the majority of cases. These are but a few examples of patterns of mental illness that differ in the elderly compared to the nonelderly.

The social changes of late life also make this group different. Work years have typically passed. A spouse and other loved ones may have died. Social isolation is common, especially in the very old. Many elderly have serious financial problems. Hearing and sight difficulties place an extra demand upon those who must communicate with these seniors. There are many other differences we can cite of course.

Counterpoint to the above remarks is one of the most important observations about aging, *interindividual variability*. Having made the points I have, I must now enlarge briefly upon this dynamic of aging. For reasons of heredity, lifestyle, and other factors, people seem to age at different rates. To make matters even more complicated, one part of an individual's physical and/or mental existence may age at a different rate compared to another part of that individual. The progression of disease also contributes to this phenomenon. You may have heard it said, "What a shame it is for someone so healthy to die of a heart attack, there was nothing else

wrong with him.” The lesson to be learned is that there are some generalities that apply to aging, but we should always keep in mind the principle of interindividual variability. Thus, generalizations about aging and the aged must be examined critically. Robert Butler, M.D., coined the term *ageism* to refer to a societal stereotype that attempts to explain many of the shortcomings of the elderly on the fact of age itself, rather than consider the disorders and illnesses that compromise the intellectual, emotional expression, and functioning of the older person.

Our readers will, of course, be familiar with many of the issues of law that intersect with the mental health of the elderly. As a starter, I will share some general observations that have come out of my practice. In later columns, these and other topics will be explored in more detail. Competency, in its various

forms, has been the most common issue raised by my referral sources. This is not surprising given that the most common disturbance of mental function in older persons is intellectual impairment with its implications for errors in comprehension, judgment, and behavior. A common problem for me, as a psychiatrist, has been to know in which type of competence the referral source is interested, that is, “competent to do what?” Additionally, the very elderly especially often lack family members who can provide information as to the elderly person’s actual wealth, natural heirs, etc. Competence to participate meaningfully in their medical care is usually an easier thing to evaluate than competence to manage financial affairs or make a will, because much of the baseline information needed is in the medical record.

Issues of informed consent are often difficult to resolve in

geriatric practice. It may surprise some of our readers, but ECT (electroconvulsive therapy) is still widely used, even in older people and even in the demented older person. Depressive states accompany Alzheimer’s dementia in about one third of cases, and ECT may be very helpful. It does not reverse the intellectual decline, but can reverse or modify the adverse mood changes. I recall one case, the wife of a physician, who had advanced Alzheimer’s. She was very depressed, losing weight, and not sleeping. A course of ECT produced a gratifying change that was very appreciated by the family, leaving the woman more comfortable during the last few months of her life. Issues of informed consent often arise within this context.

I would be pleased to hear from the readership as to what specific areas of mental health in the elderly would be of most interest to them.