nology and not enough service. The same thing goes not only for the elderly but the younger population as well. There could be many incentives to force them to lead healthier lives.

NS: Since you mentioned senility from a medical standpoint, what are the actual causes of senility?

KANE: Basically the problem with the term "senility" is that it is such a general term. What we are really talking about is that about 10 percent of people over 70 in this country would be, what I would call, demented. That means that they chronically have mental changes and they are chronically confused. There are two different kinds. One is a pathological change in the brain. We don't know what causes it. The second one is caused by small strokes. The problem and confusion with senility is that a large percentage of people who are confused are confused for another reason other than the brain changes. They may be confused because they are sick. They may be confused because they have something else going on in their life whether they're depressed, can't hear, can't see. Families and physicians' need to understand that if somebody's mental state changes, as in old people, that it's time to look for something else. As long as we believe that stereotypic appearance of the elderly being confused we are going to do a bad job of taking care of the reversible components.

NS: That is very interesting. From what I've read The Hartford Project is opposed to geriatric specialists directly treating the patients with the approach taken by the project. In addition to what could be an increase in costs to the elderly, if that approach were taken, there is some concern about fragmentation. I interviewed Dr. John Chissell who is also a family practitioner and he is also opposed to fragmentation. Is this the general philosophy of family practitioners to increase their medical knowledge on all levels so that people can be treated as whole entities?

KANE: I think the attitude of family physicians is exactly that. The issue of being opposed to specialization results from a real belief that what you will do is create an institutional specialty which will be very much located in our medical schools in which the elderly will have their care fragmented. It will also take away the pressures to educate all physicians about the problems of the elderly because you could create the specialty of geriatrics tomorrow and you'll only deal with a tiny bit of the population. What happens to the bulk of elderly people who are still in the community? Especially the rural elderly. What would happen if there were a large number of people not living near a medical center where their special problem would be taken care of? In family practice and internal medicine we have to create some people who do devote the majority of their professional careers to the care of the elderly. But that is different than saying its a practice specialty. These would be people, who in fact, would be in our educational institutions and would be teaching the doctors who are going out into the community. But I think it would be really a bad thing for the elderly if we create a specialty of geriatric medicine. It would become institutionally-based research oriented and would not help in the health care of the elderly people in this country.

NS: Often the elderly take multiple drugs, some of which may be prescribed, some may not be, over the counter. But they do this often unaware of the physical impact an improper mixture of medications can have on them. Is the Hartford Project doing anything to educate the elderly in this regard?

KANE: The Hartford Project is looking into the entire area of health education. I think you really hit upon what may be—if not the biggest—one of the two or three biggest problems in elderly health care, and that is medication. The problems are several. Over the counter medications are clearly there. The elderly, despite the popular myth, have a tendency to hide their problems. There is a myth in the medical profession that the elderly are multiple complainers and seek health care a lot. Whereas studies show that is not true. Most elderly stay home and doctor themselves and call the doctor as the last resort. So over the counters are second. The elderly have a tendency (especially in the cities) to have multiple providers of care. They wind up with doctors prescribing different medication. One doctor doesn't know what the other one did. The third problem we have is that 10% of elderly people are confused so they may not even, in fact, remember that they took the drug in the morning and take it again. All of that is a problem but it's not just health education of the elderly about drugs, it's an education about the medical profession and families that people can't be trusted to take drugs.

NS: You have stated that some mental disorders experienced by the elderly can be reversed if treated early enough.

KANE: Basically. We must recognize that mental disorders in the elderly are the most common symptom they are going to present. No matter what is wrong with them, if they have pneumonia, urinary tract infection, thyroid disease. Many things can present themselves as mental disturbances. The actual senility really can't be reversed. We don't know exactly what causes that and there needs to be a great deal more research to figure out how you prevent the chronic dementias of old age. But the thing that we could prevent and treat better is what I call "Acute Confusion"—confusion that only lasts days or weeks in the elderly. In other words, they were fine until a few weeks ago and then you noticed that they are not quite themselves. That kind of presentation, the majority of the time has a reversible cause. It can be treated, and you are not treating the confusion. You are treating the illness that caused it.

NS: Is there anything else you would like to add to this interview?

KANE: You can't just fix health care by looking at one aspect of it. Hospitals need to reorganize, at this point, to take care of the very old. They need to provide special kinds of surroundings and services just like we do for children. Not to say that the elderly are children, but they have special needs. If you go to hospitals now they are very concerned about children. They provide a lot of special services, the environment is different, the floor is different. We need to do some of that for the very old people. Hospitals are not very good places for old people. We need to be much more rehabilitation conscious. We need to be much more anxious to keep people active and not just put them in a nursing home and keep them there. Nursing homes need to, in fact, single out the elderly person with a good chance of going home and work hard to help them back home. And then we need to change our home health care so that we can provide more services for them when the patient is home. Finally, doctors themselves need to be better educated. If those four things were done, then we would probably have a rational system. That's what we're trying to do. ■

Fear in unsafe neighborhoods often make the elderly feel like captives in their own homes.