Correspondence

To the Editors:

Tobacco, alcohol and doctors

While delighted to see that the prestigious *Ceylon Medical Journal* has published an article on the important topic of tobacco, alcohol and doctors [1], and fully agreeing with much of what Carlo Fonseka has written, I am concerned about the potential misinterpretation of his passage about “Famous soft drug addicts”. He mentions the case of some famous people who used tobacco and later died “in the fullness of years and honours”. While he explains the reason for their ignorance of the likely consequences of their behaviour, the fact that they went on to enjoy a long life could suggest that tobacco is not as harmful as claimed.

There is of course a simple explanation for this apparent contradiction: using tobacco involves a gamble. While it kills about half of its long-term users, the other half survives. This leads to only one small problem: individuals do not know into which half they belong. By the time one is diagnosed with a deadly or debilitating disease, it is too late to revise one’s decision. The problem is further magnified by the highly addictive nature of tobacco. At the time of taking the first puff, it would be wise to remember the high chance of an early death. Few opportunities in life offer such good odds as 50-50, and where the odds are likely to mean suffering and death, the gamble is best avoided.

References


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Elder abuse and carer abuse: two sides of the same coin

We read the leading article “Elder abuse – a wake up call” [1] in the March 2009 issue of the *CMJ* with great interest, and commend the authors for highlighting this neglected health issue. While agreeing with the authors that elder abuse is under-reported and under-recognized, we would like to highlight an even more latent aspect: the problems faced by carers of the elderly. The issue is particularly important in developing countries where services for the elderly are poorly developed. Societal norms may also dictate that the elderly be cared for primarily by their offspring. The burden of care is then placed on the family, and in many countries, including Sri Lanka, it is the female family members who traditionally care for the elderly. However, with rapid socio-economic change, more and more women are required to seek employment, and may therefore be required to play a dual role – wage earner and carer. The resulting physical and psychological stress may, by some definitions, even meet criteria for carer abuse.

The physical burden of caring for an elderly person, especially with impaired mobility or when bedridden, is very demanding. This results in the carer often neglecting his or her own health. Elderly persons with dementia, delirium and other psychiatric conditions have disturbed behavior, and tend to become aggressive and develop paranoid ideation. This commonly leads to carers being physically assaulted or verbally abused. Care givers of demented persons often experience ever-increasing demands for care by these patients that may lead to financial difficulties, social isolation, emotional difficulties such as anxiety and depression, and impaired autonomy with increased functional disability [2]. Having to neglect the carer’s own children may lead to ideas of guilt and distress. To add to these problems, elderly persons with cognitive deficits are often unable to recognise their carers, and this may be extremely demoralising.

Distressed and psychologically disturbed carers eventually tend to neglect the needs of their elderly as
well as their nuclear family. This can lead to exacerbations of existing abuse, both emotional and physical. If elder abuse and neglect are to be minimized, issues relating to carers must also be addressed. Carers, particularly of disabled elderly persons, may need more psycho-social support and access to counseling than is presently considered necessary.

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References
