CARE OF CHRONIC SICK

A CASE FOR TREATING CHRONIC SICK IN BLOCKS IN A GENERAL HOSPITAL*

BY

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This contribution to the problem of the chronic sick is an effort to make a case for their treatment in a special block in a general hospital. My reasons for advocating such an arrangement are fourfold: (1) that geriatrics is an important subject for the teaching of medical students and should form part of their curriculum; (2) that the care of the chronic sick should comprise an essential part of the training of student nurses; (3) that for the proper care of the chronic sick the full facilities of a general hospital are necessary, both for the establishment of a correct diagnosis and for treatment; (4) to encourage research work on the diseases of old age which can only be undertaken with the full facilities of a general hospital. These statements will be amplified in support of my arguments.

Although the term "chronic sick" includes patients of all ages, I understand that this discussion applies principally to the problem of the elderly sick, and I therefore intend to eliminate the younger age group. Before passing on to the main subject, however, I will make one or two cursory remarks on the care of these younger patients. First, I think that they should be nursed and treated with ample accommodation in small units, and *separate* from elderly patients. Secondly, there should be adequate opportunities for medical research into the chronic conditions affecting the young and those in the prime of life. Lastly, no pains should be spared in affording these patients all the possible amenities by which their cramped and restricted lives may be made pleasanter, seeing that many of them live for several years. I have in mind particularly mobile libraries and visiting librarians, forms of occupational therapy, and concerts for those fit to attend.

To return to the main subject—the elderly and aged chronic sick—first, it must be appreciated that the number of men and women over 60 years of age has increased and is still increasing, as shown by the Ministry of Health census figures:

Population Aged 60 and over in England and Wales

1901 Census figures:
Males, 1,071,519
Females, 1,336,907 } 2,408,426

1939, July estimate; unquoted, unpublished:
Males, 2,511,200
Females, 3,197,400 } 5,708,600

This statistical fact means not only an increase in the absolute numbers of elderly people living but also a relative increase in the proportion of elderly to middle-aged and young people. At the present time, in my own experience—and this I have confirmed so far as is possible from other sources—women outnumber men in all institutions and hospitals where the chronic sick are catered for. Two factors, I think, contribute to this state of affairs: that the average duration of life in a woman is longer than in a man; and that it more frequently happens that a man can be cared for at home by his womenfolk than vice versa. The increase in the number of elderly people has resulted from the steady practice of preventive and industrial medicine during the present century, and is therefore a problem which has been brought about in part, at least, by the medical profession and which can no longer be ignored by them.

Specialization in Geriatrics

Although I do not claim to be a specialist in geriatrics I have for several years been much interested in the problem, and in my opinion until the subject is recognized as a special branch of medicine in this country it will not receive the sympathy and attention it deserves. Only in comparatively recent times has paediatrics really been fully appreciated as a specialty—and certainly in my student days children were too often nursed in adult wards (there being no special wards set apart for them), and too often junior medical and nursing staff were considered all that was necessary for their care. To-day much the same attitude is shown towards the care of the chronic sick—a class which includes the majority of elderly folk—and very frequently they receive but scant attention. The proper care of the aged chronic sick requires knowledge of the elderly and sympathy with their particular requirements—and most classes of these patients should be treated in blocks as part of a general hospital. It is quite as unsuitable to treat these patients in wards for acute cases as it is to relegate them, often unsegregated, to institutions for the chronic, where facilities for diagnosis, research, and treatment are unobtainable. In the former case these worthy people, whose lives have been every whit as useful as we should like to believe our own, are ill-housed with younger folk who are irritated by them and in turn annoy them, and usually the staff has neither time nor facility for treatment. In the latter case there is usually a lack of attention and of facilities should an acute condition supervene—and, moreover, the "chronic" institution tends to attract a less good medical and nursing staff. With these points in mind, and appreciating that the problem shows no signs of diminishing in the years to come, I cannot too strongly advocate the inclusion of geriatrics in the medical student's curriculum. A comparison of the numbers of chronic sick treated in the voluntary hospitals, where hitherto most of the teaching of medical students has taken place, with the numbers treated in the municipal hospitals and other institutions bears ample testimony to the attitude of the profession as a whole to this subject.

Classification of the Chronic Sick

In 1935, by the appropriation of the Poor Law institution, the West Middlesex County Hospital inherited overnight several hundreds of chronic sick patients, unclassified and ill-assorted. Early in 1936, still overwhelmed by the problem of the proper care and treatment of these patients, I interested myself in a scheme of classification, and am much indebted to my chief, Dr. Cook, for allowing me to carry out this experiment, which has been working more or less satisfactorily ever since. The classification adopted was as follows:

1. Chronic up-patients—that is, patients who get up part or whole days and can get about with some help, but who cannot manage stairs.
2. Chronic continent bed-ridden patients.
3. Chronic incontinent patients—such wards are allocated only on the female side.
4. Senile, quietly restless and mentally confused or childish patients requiring cot beds for their own safety, but not noisy or annoying to others.
5. Senile dements—requiring segregation from other patients.

I am certain that wards for such patients should be small and that day-rooms, verandahs, and occupational therapeutic facilities should be amply provided. Elderly people are essentially individualists, and provision should be made for grouping together those congenial to each other—e.g., I have more than once had patients over 70 years of age complain of being warded with "old people," and invariably such patients have been considerably more alert, although no younger, than others present, and as such should be nursed with those of equal mental capacity. With such classification the special requirements for each group can be ascertained, and in addition to the comfort of patients there is the convenience to staff, regard to exercise, and experience in nursing care. These requirements include:

Diet.—Where large numbers of edentulous patients are nursed meat should always be minced and vegetables puréed.

Linen.—Additional stocks should be provided for incontinent wards.

Staff.—Nursing staff and attendants should be arranged for, to give additional help to patients in dressing and in getting up and about the ward.

Equipment.—This should include tables for games, additional easy-chairs, wheel-chairs, crutches, and sticks with rubber ferrules.

Blocks thus equipped should be—and I think this very important—easy of access to all special departments, including *x*-ray department, pathological laboratory (plus post-mortem room), gymnasium, ophthalmic surgeon, dental surgeon, chiropodist.

* Read to the London and Home Counties Branch of the Medical Superintendents' Society.

Advantages of the Block System

With these facilities such blocks should provide excellent experience for teaching both medical students and student nurses, and I claim that these blocks should not be relegated to the sole charge of the newly qualified or very junior medical staff, nor be used by the matron as punishment wards for nurses. Certainly all students should be taught to recognize geriatrics as an essential and interesting part of their work.

The more time spent in such wards with full hospital facilities the greater the number of patients that can be correctly diagnosed, treated, and discharged home to the care of relatives and friends. Often education to a slower tenure of life during senescence and readjustment to a slightly more dependent existence are what is needed, and relatives are most grateful for such treatment of their elderly folk and for advice given as to their future care at home. The number of patients able to leave such wards varies, I think, immensely with the time available and the work done. Many of the so-called "incurable" cases only need the patience, tact, and quiet energy of a staff trained to work with this type of patient to show a considerable measure of improvement. Without easy access to special departments, however, there is a strong disinclination to undertake the necessary investigations in these cases, and in the absence of a correct and complete diagnosis treatment must perforce be less efficient.

It is unlikely that facilities on the scale that I advocate would be available at a hospital for chronic sick only. Nor is it likely at the present time that sufficient medical and nursing staff of the right type would be attracted to such hospitals.

Conclusion

The urgent need for research work on senile diseases cannot be overstressed, and should be organized in connexion with wards such as I have described. With the experience obtained during the last seven years, and for the reasons stated, I do very strongly advocate treating the chronic sick in blocks allocated, equipped, and suitably staffed for the purpose in a general hospital.

It is noteworthy that geriatrics has received more attention in America than in this country, and much of the literature on the subject has emanated from American writers, notably Thewlis.

TWENTY-ONE YEARS OF THE B.P.A.

The late Dr. J. F. Gordon Dill and his friends who founded the British Provident Association, which has just completed its twenty-first year, probably had no thought in mind save to help people of moderate means, whose resources were straitened after the last war, when faced with the financial burden of a serious illness. At that time there appeared no real threat to the principle of unrestricted choice of doctor and institution, and although voluntary hospitals were in jeopardy as a result of falling income and rising demands, a State Medical Service was a subject only for academic discussion. The Hospital Saving Association, proceeding by different methods and providing for a different class of the community, came into existence at almost the same time and as a result of the same solicitude. In the narrowest sense both these movements were forms of insurance; to become a subscriber or contributor was as much a matter of business as taking out an endowment policy, yet the H.S.A. has created a great co-operative movement for the fortification of the voluntary hospital, and the B.P.A. has greatly strengthened the regard for what may be called unregimented medicine. Both these movements have to be reckoned with in the future shaping of hospital and health policy.

The British Provident Association had its forerunner in a local effort in 1920, known as the Sussex Provident Scheme for Hospital and Additional Medical Services, in which a number of Sussex hospitals co-operated. In the light of that successful experiment Dr. Dill, together with Lord Dawson of Penn, the late Sir Napier Burnett, Mr. W. McAdam Eccles, Sir Arthur Stanley, Sir Alan Anderson, and others, conceived a provident scheme on national lines, to be applied first to the Metropolitan area. After discussions with hospitals, friendly societies, and the medical profession, a scheme was launched, with three large London hospitals co-operating. It provided benefits for its subscribers—people with incomes in excess of those who came under the contributory scheme of the Hospital Saving Association—and began by making grants towards the cost of hospital maintenance and of consultations, expenses of home nursing, and the like. In 1925 it instituted a new form of benefit—assistance towards the fees of operating surgeons—and this was later extended to include the fees of consulting physicians. Additional privileges have been accorded from time to time, including the provision of family doctor benefit. Surpluses have been used for providing additional benefits for subscribers who have been registered for three years or longer. These benefits include payments towards the cost of manipulative orthopaedic operations and various special diagnostic and therapeutic services.

In the course of its history the association has distributed benefits amounting to some £134,000, one-tenth of this sum during the last year. But there is much more behind these figures than the reward of thrift or foresight for certain people. A great deterrent to recovery after a serious operation is the thought of the financial adjustments looming ahead, and the reflection that the surgeon's fee will be met in whole or in great part by the association's contribution, and that a large percentage of the hospital or nursing-home charges will be similarly met, contributes greatly to recovery. We cannot here recapitulate the various benefits and the conditions under which they are made; they occupy an entire booklet, which can be obtained from the office of the Association at 30, Lancaster Gate, W.2.

A BIOLOGICAL CRITICISM OF EDUCATION

In a recent address to the Leeds Medical School Sir JOHN GRAHAM KERR, F.R.S., M.P. for the Scottish Combined Universities, made some criticisms as a biologist of the Governmental scheme of education. He recalled his own early experience of living for a time among a primitive race of the Gran Chaco in South America and observing the system of education practised among them. In their communal evolution these people had not reached even the stage of cultivating plants or of keeping flocks and herds, but the system of education among them, to sum it up in modern phraseology, consisted simply of training in good citizenship—training to be an efficient, and therefore a happy, member of the community. It relied upon training in observation of natural phenomena, the interpretation of such observation, and the development of the habit of constant mental alertness.

The fact that education to-day in civilized communities had departed so widely from this original type was due, paradoxically, to one of the most beneficent events in the whole history of civilization—the invention of the printed book. It was the printed book which brought with it the possibility of mass education. In the age of manuscript education was centred in the religious houses, and spread beyond them only into the circles of the well-to-do. With printing it could be extended to the common people, but the teaching so given was the teaching of authority—namely, pronouncements on subjects of an abstract kind, such as theology, philosophy, mathematics, and history—and an inevitable result of the domination of the printed book was the reduction to a position of relative unimportance of training in observation, judgment, and mental alertness, which had formed so important a part of education in the earlier phases of communal evolution. While he would not speak disrespectfully of superficial culture, he was reminded of a remark about an old Clyde steamer, that she was "held together by the paint." Did we not rely in these days too much upon the paint of culture to hold civilization together?

He believed that there was an urgent call for a far more thorough overhaul of the system of elementary education than was contemplated by those whose interest was centred in improving its administrative machinery. Imprisoned in the schoolroom, the young boy occupied himself no longer with observing and puzzling out the meaning of what he observed, but rather with an uncritical absorption of snippets of information. The memorizing of masses of detail of a multiplicity of subjects, such as geography, history, and the vocabularies of foreign languages, was relatively trivial as a means of general