or signs of severe cardio-respiratory failure. But it is well known that severe confusional states may be facilitated in elderly people by mild infective conditions such as those of the urinary tract, small areas of pneumonic consolidation, or thrombophlebitic patches in the legs. The possibility of a drug intoxication should always be remembered.

Management of Acute Confusional States

After ordering the appropriate initial treatment for any physical disorder present, adequate and speedy sedation should be aimed at in order to conserve the patient's strength. If the condition is not very severe, rapidly acting barbiturates may be given a trial; pentobarbitone sodium, 1½–3 gr. (0.1–0.2 g.), or quinalbarbitone sodium, up to 3 gr. (0.2 g.), are recommended. But inadequate repeated sedatives are often harmful by producing additional befuddlement, and as an initial hypnotic paraldehyde is to be preferred. Administration by mouth should be attempted at first with haustus paraldehydi *N.F.* in doses of 1½–3 fl. oz. (43–85 ml.). Only when the patient refuses the draught should intramuscular injection be resorted to, and for this injectio paraldehydi *N.F.* in a dose of 5–10 ml. is indicated. It is claimed by workers with extensive experience that abscesses are only very rarely produced if the injections are given deeply and into the vastus lateralis rather than into the gluteal region. With the patient sedated, a second physical examination may reveal the presence of disease which went undiscovered a few hours earlier, and this will lead to renewed efforts at securing the patient's admission to the medical or surgical wards of a general or geriatric hospital.

On the other hand, a regime of sedation may render the admission of patients with terminal confusional states to mental hospital or observation wards unnecessary. When admission to hospital is delayed, the practitioner, as well as treating any physical disease present, may consider giving intravenous glucose injections. It has been claimed that with this treatment, the rationale of which is not at all clear, a much higher recovery rate is achieved in the toxic delirious reactions of old age than with a regime of sedation. Infusions of 10% glucose in normal saline for the first few days, and later in sterile water, are recommended. One to two litres should be given daily during the first few days, later only 500 ml. a day, and the rate should never be more than 50 drops a minute.

Next article on Emergencies in General Practice.—“Gassing in the Home,” by Dr. A. Thelwall Jones.

Refresher Course Book.—Copies of the second volume of collected articles from the Refresher Course for General Practitioners are still available at 25s. (postage 1s.) each. The first volume is now sold out.

Clinical Pathology Book.—“Clinical Pathology in General Practice,” a collection of 39 articles on clinical pathology that appeared in the *Journal* as part of the Refresher Course for General Practitioners, is now available, price 21s. (postage 9d.).

Both these volumes are obtainable from the Publishing Manager, B.M.A. House, Tavistock Square, London, W.C.1, or through any bookseller.

The Victoria Cross awarded to Assistant Surgeon Thomas Egerton Hale, which was recently sold at Christie's for the record price of £420, was the first V.C. ever awarded to a member of the medical profession. The deed which earned it was performed on September 8, 1855; it was gazetted on May 5, 1857, being a retrospective award, as the V.C. was not instituted until January, 1856. Surgeon James Mouat was later awarded the V.C. for a deed performed on October 26, 1854 (see *Journal*, 1954, 2, 1045).

SOCIOLOGICAL IMPLICATIONS OF DIABETES*

BY

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Had I been asked ten years ago, “What are the sociological problems of diabetes?” I would have replied vaguely, “I do not know; are there any?” It was not until I worked with a group of diabetics in a clinic that my attention was drawn to some of their personal conditions, and the lack of means to redress their wrongs, which awoke in me a sense of their necessity and a need for a different approach.

This paper does not set out to be a complete survey of the sociology of diabetes—this was done admirably by Professor Tunbridge (1953) in his Banting Memorial Lecture at Leeds—but the substance of my personal experience. One of my earliest social problems is described in the following case record.

A Problem Case

Jane had become diabetic at the age of 13, in 1942. She lived in a very poor district and had no stability at home. She was labile and readily passed into ketosis and coma. An added misfortune was that she suffered continual dermal reactions to insulin, and as she was not very clean these lumps often became abscesses, which increased her insulin requirements. She did not like coming to the clinic: she thought our standards were too high.

In 1948 Jane was admitted to hospital with a pleural effusion which was concurrent with an early pregnancy, so she took her own discharge and got married. At about the 38th week of pregnancy she was admitted to another hospital in toxæmia. Induction of labour was performed by rupture of the membranes, and after a difficult forceps delivery the child, a boy, lived, and so far as I know is still alive. Jane, however, was transferred to the Isolation Hospital on account of septicaemia and rapidly spreading bilateral pulmonary tuberculosis. She required over 100 units of insulin a day and was treated with penicillin and streptomycin. I did not enjoy my weekly visit to her: she was ungrateful, discourteous, and uncooperative. In October, 1949, pneumoperitoneum and phrenic crush were performed, and in May, 1950, a tuberculomatous type of healing was seen on x-ray examination. Her general condition was now good; her insulin requirements were lower and she was taking a diet of over 2,500 calories. In October she discharged herself and did not attend the diabetic clinic as arranged. She began to go downhill. A year went by, with readmissions and self-discharge against advice. The pneumoperitoneum was discontinued. She lost weight, but, as often happens in these cases of deterioration, her insulin requirements diminished and she died at home in 1952 at the age of 23.

This case shows all the worst aspects of the problem. A bad home environment, with dirt and squalor, and no moral standards. The patient did not speak the truth and her language was abusive. She had no intellect with which to reason. Diabetes began during adolescence; pregnancy occurred at the age of 19 and coincided with a primary tuberculous infection. Matters were made worse by puerperal sepsis, and in spite of a remarkable initial recovery the course was fatal owing to her lack of co-operation.

Another Side to the Picture

As a contrast there is the small group of private patients, of whom the majority are men. Many of these are Freemasons, and are business or professional men filling every moment of their lives. They are middle-aged and have heavy responsibilities. They are intelligent, have good homes and families, and have a high moral code. They are good patients and mostly keep in good health; but the

*Based on a paper read at a meeting of the East Midlands Branch of the Medical Women's Federation on October 31, 1954.

nuisance of their disease lies in its social restrictions. Most of them drive cars and have to be keenly aware of the danger of hypoglycaemia. Such functions as lodge dinners cause an emotional disturbance unrecognized at first. Later they can eat their meal with minor adjustments in diet and insulin, also in alcohol, so that it becomes no worry, but the pleasure it was intended to be.

Life insurance presents a problem. Some companies refuse to accept diabetics; those which are more enlightened impose a considerable loading. Superannuation varies. In the Civil Service, promotion to higher grades is barred, possibly unjustly. The fighting Services are, of course, rightly barred to diabetics. In the case of women, I support the view that nursing should not be chosen as a career but need not necessarily be abandoned if training is complete.

Personal and public hazards of employment are of considerable importance, and one such case may be cited in illustration.

Fred had been a railway employee for 25 years, and was a guard on a goods train, which involved coupling and uncoupling trucks. He had retained this job without mishap for the nine years he had been diabetic. He required a large amount of insulin, and, owing to a period of poor control due to middle-ear infection, was off duty until he was quite steady again. The authorities now became aware of the situation and felt that they could not agree to his continuing in his former employment, although it had suited him so well, because of the element of risk to himself and others. He was no scholar, and the only job which could be found for him was in the parcels office. This entailed heavy lifting and sweeping the platforms. Besides the loss in prestige to a man recently married late in life, there was a loss of 17s. 6d. a week in pay. To lose a pension and come out of the railway is hard advice to offer, and until some decision can be reached the emotional stress will affect his diabetic state.

The Problem as a Whole

It is estimated that 3 per 1,000 of the population of Great Britain suffer from diabetes, and it is believed that a similar number have minor or latent forms. Under stress or infection or with over-indulgence these may become frank cases, although from time to time one comes across patients who, having had a transient glycosuria many years before, have by their natural abstemious living kept their disease latent and are unaware that they are diabetic.

Improved therapy has increased the diabetic population, and in therapy one includes not only insulin but modern dieting and antibiotics. The young diabetic no longer is expected to die within twelve months, but lives fully. Although he may not reach old age, he works, plays, marries, and produces children with or without the inherited character. Elderly diabetics go on living with vascular changes that are probably no worse than those of other old people, and, indeed, the gangrene of their feet may have a better prognosis than has non-diabetic senile gangrene. This is the state of affairs which has been realized by the Ministry of Health (1953) in the circular on "Regional Planning of Diabetic Services." There is no doubt that on this account recognition of the problem has become more general, and hospitals and local authorities have taken stock of the situation.

Apologia

If one has the collector's instinct, diabetes makes a very good subject for a collection. There is much sorting and classification that can profitably be done. To have under observation large numbers of similar cases and to recognize what is dissimilar increases knowledge of a particular condition and its variations and allows one's judgment to develop in a broader way than if only the occasional case is seen among the general mass of patients. Six frank diabetics in a practice of 2,000 is all one would expect, and with such a small number there is no yardstick for measurement. If these, as they may do, run an easy straight course the assumption is that the management of diabetes

is simple. On the other hand, they may be labile and complicated, swinging from hyperglycaemia to hypoglycaemia for no apparent reason. There is, of course, a reason, but it may be very difficult to find. If the doctor is too cautious or too casual the patient feels insecure and his diabetic control suffers.

We are dealing with a disease in which, because of its permanency, the doctor-patient relationship is most important. I suppose there is no disease in which the patient himself is expected to carry out more of his own treatment; and yet if he is to be well maintained there must always be a medical life-line strong enough to carry him through ketosis and coma at very short notice. I am therefore prepared to justify the setting up of special units in suitable centres where a trained team with proper facilities can advise and treat the patient and where the natural history of the disease may be studied. These two aspects should go hand in hand. I have stated elsewhere (Walker, 1953) what I consider to be the function of a clinic.

The Dietitian

Many of us are competent to advise and organize the plan of treatment, but many of us find that teaching a patient his diet is very tedious even when one is used to working out such a thing on paper. The patient usually has no basic knowledge, and our own is too specialized, so that this part of the work is very much better done by a trained dietitian than by a doctor. There are not enough dietitians to fill the vacant appointments on hospital establishments in Great Britain. The report of the Ministry of Health (1951) stated that there were then 440 members of the British Dietetic Association, from only three training schools. It was estimated that some 1,500 dietitians would be needed to staff the 2,600 hospitals and convalescent homes under the National Health Service. The position has not improved. There are very few dietitian catering officers. It is not possible to appoint enough therapy dietitians, and only a small number are capable of teaching. The U.S.A. do better than we do in this respect. On the other hand, the Scandinavian countries do not use dietitians at all: the medical and nursing staff take full responsibility. No attempt is made to cope with obesity, as the land flows too freely with milk, eggs, and butter.

The Health Visitor

I find that much of the dietetic teaching can be very well done by a specially trained health visitor. The health visitor has her S.R.N. and midwifery certificates; she then takes a course in sociology as applied to her work, which includes general nutrition and dietetics. Since 1950, in Leicester, the diabetic clinic has had the invaluable services of at first one and now two specialist health visitors seconded by the local authority. They are based on the clinic and see the patients there and in their own homes. They undertake the teaching of all new diabetic patients and follow up cases of special difficulty, such as the children, the blind, the old and bedridden, and the tuberculous. The health visitor has acted as liaison between the clinic, the general practitioner, the patient, and his school or work, and, through the almoner, for convalescence or national assistance when required. The secret of her success is that she is based on the clinic and knows the crucial problems in the management of the case, and the patient knows that she knows, so there are no doubts and no waste of time in getting treatment initiated. It is possible that prevention of delay in starting treatment prevents insulin resistance in some cases. It certainly reduces the number of admissions to hospital.

Children, unless they first come under observation in severe ketosis, are preferably treated at home from the beginning. One does not want a double set of values, and home treatment minimizes emotional disturbances of parent and child. The health visitor spends a little time at the

home talking to the mother to explain the essentials of adequate nutrition and carbohydrate equivalents. She can work out a regular routine and stress its importance, explaining the necessity for extra carbohydrate before games and swimming, also the advisability of giving sugar in cases of unexpected bad temper, as it may be associated with hypoglycaemia. She will visit the school and talk to the headmaster or headmistress, and also to the canteen supervisor, because it is often preferable for the child to have the school dinner with little or no modification.

In a similar way with adults, the health visitor calls at the home and sees his wife if, for example, the patient is a man who may be out at work. Unless the new patient is severely ill the initial stabilization is usually undertaken under working conditions. The health visitor has access to the personnel manager and canteen supervisor, and can often explain the situation so that a painter, say, can keep his job without climbing high ladders and scaffolding. Shift work can often be better sorted out by the health visitor on the spot. To come off shift work means a financial loss. Diabetes is no bar to hard labouring work provided it is regular and the diet adequate, but the change from sedentary clerical work to active gardening at the week-end may give rise to hypoglycaemia and require dietetic adjustments.

In a survey of the elderly diabetics in Leicestershire (1953), made in conjunction with the county health visitor, it was found that out of 113, 97 were living in their own homes, 12 were with relatives, and only 4 were in institutions. Roughly half (64) required insulin, and in only 16 of these was the district nurse administering it. In reviewing the complications, severe visual failure headed the list, and hypertensive cardiac failure, including coronary artery disease, came next. Severe peripheral vascular disease and diabetic neuropathy were significant in their relation to gangrene. As these patients get older and more infirm it is undesirable that they should be forced to attend the clinic, although many look forward to it as a social outing, but in certain cases the health visitor goes to the patient's home and makes her report to the patient's own doctor, merely keeping the clinic informed out of interest and giving follow-up details that are important. I know how much these visits help in the general management and hygiene of these elderly patients. Of 113 patients over 65 years old, 68 could bath themselves but 45 required help. The health visitor is delightfully persuasive about bathing. I am likely to offend if I probe too deeply. I now simply make a note—"More S and W"—and the health visitor sees that it is applied.

Convalescence and Rehabilitation

For the past few years the Leicester diabetic department has been blessed with the proximity of a convalescent hospital available for diabetics. Most convalescent homes will not admit diabetics, as they have a nuisance value: they require special food, and knowledgeable cooks are not easily found; they may also have hypoglycaemia, which is troublesome, and in certain homes there may not even be a trained night nurse capable of giving insulin. Burley-on-the-Hill is just an old and beautiful mansion set on a hill with a fine view and near a little market town. Here one may send difficult diabetics for a month, and they learn to live with their condition. The food is good, simple, and abundant, but correct in carbohydrate values, as it is supervised and served by the matron or her deputy. It is known when a patient cannot or will not help himself. Graded exercise is encouraged: at first, down the drive to the post office; then down to the town and a bus back; then both ways are walked. One notices the improvement in morale and the smartening in appearance. It is usual for the patients to leave at the end of their month, ready to return to work without delay; it may be, too, that the older ones return in better condition to their families, who have welcomed the rest from responsibility for a difficult member. Rehabilitation in diabetes is a special task that has not yet been fully tackled. It is quite distinct from passive convalescence.

The Diabetic Association

The British Diabetic Association is the first association of patients to be founded anywhere. In twenty-two years it has done much to help diabetics directly, both medically and socially, and an increasing amount of research is being undertaken through the scientific section. Branches are now being formed in the provinces, and at the inaugural meeting of the Leicester branch some 400 diabetics and interested persons attended. Only three of the twelve people on the platform were not diabetic, and I was told afterwards that it was the fact that these active and influential men stated that they were diabetic which had such a very fine effect on the other diabetic members of the audience. It was indeed a brotherly gesture.

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QUACKS IN FRANCE

[FROM A SPECIAL CORRESPONDENT]

France, with a population of about 43 million, has 38,000 practising doctors, but more than that number of so-called "healers." All the doctors, from the venerable *grands Patrons* to the young men and women who are starting on their careers, have strong feelings about these healers. Professional tradition has restricted collective comment, but now the doctors are expressing themselves vigorously and unitedly about recent developments of a flourishing racket.

A statement on the healers was recently made by the Seine county's section of the national *Ordre des Médecins*. The Seine county embraces Paris and its thick belt of suburbs, and has 9,300 doctors. President of their section of the *Ordre des Médecins* is Dr. Jacques Richier, a well-known ear, nose, and throat specialist.

Most of the healers in France, according to Dr. Richier, do their business round the large towns, and 75% of them make big money. At the home of one of them who was arrested for the illegal practice of medicine, gold ingots worth £12,000 were found. They had been bought, said the healer, with the proceeds of his last three months' work.

There are village healers to whose consulting-rooms regular motor-coach services run. One old man claims to have treated a million people. Thousands have stayed in his village for a few days, and have visited the "magical man" three times, paying 10s. a time. Refreshment rooms have been built for clients. Some of the sick people are accompanied by healthy members of their families who pay the healer for preventive treatment.

Though there are more healers than doctors in France, there are fewer now than there were eight years ago, and their number is still slowly decreasing. A Government decree of September 25, 1945, on the illegal practice of medicine, empowers the *Ordre des Médecins* to report offenders to magistrates' courts. This power is being exercised with increasing vigour. Last year the *Ordre des Médecins* for Paris and its suburbs was directly responsible for the prosecution of 88 healers. Fines ranging from £8 to £50 were imposed, and in some cases payment of damages, ranging from £10 to £30, was ordered. These damages are paid into a fund which assists aged, needy doctors.

The healers ask for an official statute, which would give them official recognition. "If they got this," says M. Georges Duhamel, a noted doctor and writer who is a member of the French Academy, it would be "a diploma of trickery."

Successful Anti-doctors

The big-business healers—those whose reputations grow as they are cited in one legal case after another, and to whom patients travel in special motor-coaches—are roughly