the ground upwards. As an experiment I suggest that such a person should visualize that he is supported from above his ears by a chain which lifts him so that his feet just touch the ground.—*Sunday Express*, Nov. 30, 1947.

Rabbit Pie

Dr. F. R. SELBIE has now succeeded in transmitting the Shope papilloma virus to its 9th passage in domestic rabbits. This has been done with the aid of contaminating micro-organisms; but just which ones are responsible has yet to be decided.—*Lancet*, 1947, 2, 835.

Wedding of the Year

MARRIAGES

JOHNSTON, Dr. C. L., with Lord Moran and Dr. Brooks, for a period of six months as from October 1, 1947.—*St. Mary's Hospital Gazette*, 1947, 53, 239.

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It is . . . for almoners and health visitors to multiply as fast as they can, since they are the eyes, ears, and tongues—the scouts, the field telephone, and the intelligence department—of the health service.—*Lancet*, 1947, 2, 875.

Tied Cottage ?

Some of the difficulties anticipated by the Committee will be met by enabling the Executive Council to buy the house for the incoming doctor.—Minister of Health's "Memorandum on the Statement of the Negotiating Committee's Views," para. 25.

Not So Recent

"Mr. Walter Whitehead, in proposing 'the Houses of Parliament,' stated that there was still much that the Legislature could do for the medical profession."—*British Medical Journal*, 1897, 2, 1865.

ORGANIZING A GERIATRIC DEPARTMENT

BY

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There can be no doubt that the aged sick and infirm need more skilled medical attention than is at present available; the provision of this would lead to improved classification and increased rehabilitation, and greatly reduce the number of old people who are bedfast.

To arrive at these results the available hospital accommodation will have to be reorganized to provide:

(1) *Acute geriatric wards*, where most patients will have their investigation and treatment completed in less than six months. (2) *Long-stay annexe wards for the permanently bedfast*. (These two types of wards will require a full nursing service.) (3) *Long-stay annexe wards for frail ambulant patients*. It is surprising how great a proportion of patients previously considered permanently bedfast can occupy this type of ward for a large part of their stay in hospital. Even patients with malignant disease are happier and feel better when they are able to do something for themselves, and are out of bed for part of the day. (4) *The "resident home" type of accommodation for the more robust patients*. Ultimately it is hoped that this type of patient will be moved out of the immediate hospital environment to a small hostel or resident home provided by voluntary bodies or the local authority. Considerable economies can be effected in nursing staff in these last two classes of patient.

The "Resident Home" Ward

With wards closed owing to the present nursing shortage it should be easy to provide one small unit for the resident home. As soon as a sufficient number (twelve to twenty) of ambulant patients are available the resident home ward could be pro-

vided with one part-time nurse to smooth out the administrative difficulties of the first six months. Later she could be transferred to the "long-stay annexe" ward for frail ambulant patients. One or two nursing orderlies would usually be needed to help the nurse in charge. I prefer no night supervision of the resident home ward except the routine three visits by the night superintendent, as such patients should be well able to look after themselves. If any nursing treatment, apart from minor dressings, is required patients should be moved back to the "active geriatric ward" for a short period. It is inadvisable to allow a period of more than a day or two in bed, as full nursing supervision should not be provided. Patients who have spent four to six weeks in the resident home ward under such a regime may be considered suitable for a resident home away from the hospital.

At the end of six months resident homes for both males and females should be filled, and another ward be taken over for this work, as probably no outside resident home would be available. By then the part-time nurse and orderlies would have settled down to their routine and the unsuitable patients have found their most suitable environment. No great amount of geriatric rehabilitation would have taken place, but a medical survey would have established the number of patients permanently bedfast, the number of patients who would most likely improve from a short course of physiotherapy and re-education in walking, and probably a larger number who would require more treatment and physiotherapy before recumbency could end.

Long-stay Annexes

The staffing of a long-stay annexe ward for the frail ambulant cases should not be difficult, for only one full-time nurse or sister-in-charge will be required for twenty to thirty patients, with one part-time nurse for off-duty periods. The rest of the staff would consist of male or female ward orderlies. One orderly for each six patients is the minimum required, while a night orderly service must be provided.

It should now be possible to provide one large ward, at first subdivided by curtain partitions, as the long-stay annexe for the permanently bedfast, and it is here that adequate staff must always be available. This ward should have a large number of senior part-time mature nurses, whose outside interests obviate the sapping of morale by their hospital duties and who are able to offer the best service to these most unfortunate people. We must keep our young nurses and trainees in the active geriatric wards, where progress towards recovery is the keynote of treatment and interest in the patients is not stultified because they are permanent.

Dr. Marjory Warren (1946) has drawn attention to the great advantage of segregating permanently incontinent patients; similar provision should be made for the mentally confused, many more of whom should be ambulant. The frequent use of cot-beds and narcotics in restraining the restlessness of old people kept recumbent for long periods is too common to be coincidental. Now cerebral vascular disease has several components, of which the cerebral oedema accompanying the subacute and acute periodic ischaemias is prominent. If to this composite picture we add the cerebral oedema of recumbency and the frequent presence of a high serum bromide, as well as the restlessness due to a disorientated old person trying to get out of bed to empty his bladder or bowels, we can picture what happens. How often have we seen a pitched battle fought in the ward between several nurses and an elderly man more aware of his bodily needs than are his attendants? On the few occasions when the patient wins he disgusts the staff by defaecating or micturating at the side of his bed. The picture of a distressed patient struggling to prevent the soiling of his bed while the nursing staff are struggling to keep the bed soiled would be amusing if it were not so often repeated.

Get these patients up into a suit of clothes; sit them up to the table at meals; take them to the lavatory at frequent intervals. It will then soon be found that those capable of walking to the lavatory unaided will do so and relearn the regular habits of childhood; others will need assistance from orderlies. In this way much of the incontinence of recumbency will be cured, for it is largely due to faecal retention with overflow. For other patients it may be found necessary to give an enema once or twice a week. By these means the regular bedpan

rounds, four-hourly linen changes, and routine "back" rounds are completely eliminated. The nocturnal quiet of a ward under such conditions must be seen to be appreciated.

The immediate difficulty of staff shortages will again be mooted; but here also male or female orderlies under the supervision of one or two part-time nurses will provide invaluable help.

I have described this clinical picture at length as an example of failure to accept the degree of *physical* disability as the indication for permanent bedfastness. It has been my experience that far too many mild cases of senile dementia and cerebral arteriosclerosis were left needlessly in bed, thereby throwing extra work on nurses.

The bathing of these patients can be organized on a team basis on one morning a week. By the use of two orderlies for bathing—one for drying, and one or two to run a shuttle service with wheel-chairs from ward to bath and back—some thirty patients can be dealt with in four hours. Further economy can be effected by a team of two following up and making the beds.

The medical profession has for too long cast its less pleasant responsibilities upon an uncomplaining nursing staff; we must now reconsider the part our depleted nursing services are to play if they are to be used efficiently. We must consider ways and means of saving nurses' time.

Medical Staff

Three factors that will control geriatric care in the next few years are the persistent shortage of nursing staff, the variable conditions prevailing in municipal hospitals, and the lack of doctors and physiotherapists trained in geriatrics. An immediate solution of this problem everywhere cannot, therefore, be contemplated, but it will be possible to organize a small number of efficient geriatric departments where aged patients can be properly treated and rehabilitated, so that nearly 50% can either be sent home or be given accommodation near the hospital and not require a full nursing service.

We may then concentrate our nursing and physiotherapy staff upon active geriatric wards, where rehabilitation may take up to one year but in most cases should not exceed six months. A geriatric department in a district hospital should comprise:

1. *A general physician*, who should be experienced in *geriatrics*, with available pathological, radiological, and electrocardiographic departments. I am making no plea for a new specialty or a new status. Geriatrics differs in no wise from general medicine, except that greater attention must be paid to the problem of multiple pathologies and their effect upon the vascular system as a whole. The medical aphorism that a man is as old as his arteries is the basic fact to which the geriatric general physician must always pay due attention.

2. *A physician experienced in physical medicine*. The organization of physiotherapy is the key to the whole problem of geriatric rehabilitation, for physiotherapy must be applied skilfully and with due regard to the patient's physical disability as the most important criterion of bedfastness.

3. *A psychiatrist*. The medical staff of the nearest mental hospital would be a very useful choice, because so many old people now sent to mental hospitals could be adequately cared for and improved physically and mentally in a more helpful environment where emphasis is laid upon the patient's recovery. These patients could then be sent to a long-stay annexe for the mentally confused, or to their own homes without any mention of mental hospitals. So many of these old people with mild senile dementias and cerebral arteriosclerosis need little or no mental treatment at all, but a well-organized kindly discipline with adequate nutrition, some supervision, and gentle occupations. Once again, with so many ambulant patients of this type there is little need for nurses. In view of the impending changes in lunacy certification, if a small proportion of beds were put aside in a geriatric department for this type of case another problem would be ameliorated, while the true senile dementias needing a mental hospital environment would go there after a most sympathetic general medical review of their condition.

4. *A good general surgical service*. This should not be difficult to organize in any area. It is not necessary to emphasize the importance of ophthalmology to the aged.

5. *A urological surgeon* skilled in primary prostatectomy and perurethral resection is essential to prevent the drain on hospital beds, nurses' time, and surgeons' time of over-prolonged or permanent suprapubic drainage.

6. *An orthopaedic surgeon* to deal specially with the problem of the fractured upper end of the femur. An active policy of rehabilitation will result in many more patients, whatever their physical or mental condition, being submitted to an operation which, in my experience, produces less shock than being bounced on and off a bedpan several times daily or submitting to frequent changes of bed-linen. Dr. A. J. Lee has shown us that even in the presence of electrocardiographic changes the "immediate" mortality is very small with a well-administered anaesthetic which prevents the possibility of anoxaemia. Incidentally a general anaesthetic given by an experienced anaesthetist is always preferable to a local anaesthetic, for there is less possibility of anoxaemia developing: the shallow respiratory excursion so common in old age may not be sufficient to prevent anoxaemia, especially where a basal anaesthetic is used to supplement the local.

I see no objection to the insertion of a Smith-Petersen pin or applying well-leg traction if by this means a patient's last days are eased and the nurses' work is lessened: sandbag "immobilization" cannot be considered as in any way satisfactory to patient, surgeon, or nursing staff. Another great waste of nurses' time and hospital beds is treatment of a fractured femur by prolonged traction or Whitman's plaster immobilization for many weeks.

It follows, therefore, that the use of the body as an immobilizing force providing countertraction, in old people at least, must be reconsidered from three points of view. First, there is no doubt that the work of the nursing staff is increased; secondly, the incidence of joint and muscle stiffness is raised, delaying the application of physiotherapy and thereby greatly prolonging its period of application and wasting the physiotherapist's time; thirdly, the method of immobilization increases the incidence of respiratory complications, including pulmonary embolism following phlebotrombosis of the calf and foot veins. Dock (1944) has pointed out that necropsies with complete leg dissections show that 30% of all hospital patients from the age of 17 to 90 have thrombi in the veins of the calf; in adults who have been in bed for two weeks or longer the incidence reaches 60%, while nearly all show necroses and inflammatory reaction in the calf muscles.

Nursing Staff

Geriatric patients need more nursing and medical attention during the period of active rehabilitation, while as soon as they are ready they can be transferred to a long-stay annexe ward without a nursing service or to a long-stay annexe for bedfast cases. Our depleted nursing service could then be concentrated upon 50 to 60% of the patients, which amounts to almost doubling the available nurses. The active geriatric wards could carry out their routine on a minimal basis of one nurse to four patients, while the 10% permanently bedfast cases would also need at least one to each four patients. It is becoming increasingly obvious that many more nursing orderlies, male and female, will therefore be required.

The correct psychological approach in the acute geriatric ward demands active group rehabilitation, and this is best carried out by the physiotherapist and her orderlies. I have found that the nursing staff cannot accurately assess when an old patient is fit to start rehabilitation or begin getting out of bed; thus the process is slowed. It is wiser, therefore, to hand over the rehabilitation of all physical lesions, either organic or postural, to the physiotherapist and her orderlies as soon as the physician finds no physical reason for further delaying rehabilitation. When more nursing staff trained in this branch of medicine are available this decision can be reviewed. The nursing shortage will be ameliorated by the future interchangeability of district hospital nursing staffs, but for the time being nursing orderlies (three to each ward) will have to be utilized. Indeed, they serve a very useful function in the routine of a ward, performing many non-nursing duties and leaving the nursing staff more time to carry out their work.

It is essential to provide a geriatric service, for a good medical, surgical, and nursing service alone will not help restore old people to activity; only the correct psychological and physiotherapeutic approach can effect this, by affording competitive group and individual rehabilitation, with each patient at a different stage of recovery. As soon as surgical, ophthalmic, orthopaedic, and urological problems have been dealt with the patients should be transferred to the helpful and less hurried atmosphere of the active geriatric ward; for elderly persons obtain no benefit in the noise and bustle of the acute surgical ward, while to see patients 40 to 50 years their junior improving rapidly and going home is to them often nothing but an irritation.

Premises

Having carried out a geriatric scheme as described in premises by no means ideal, I am satisfied that most public assistance institutions can be utilized *temporarily* for the provision of the desiderata previously mentioned: active geriatric wards; long-stay annexe wards for patients up part or all day; long-stay annexe wards for the residuum of geriatric bed-fast cases needing constant nursing; and resident homes, which can often be outside the hospital.

The size of the first unit will depend upon the nursing and physiotherapist staff available, but so long as 24 nurses and 12 orderlies, with one or two physiotherapists and four physiotherapist orderlies, can be obtained, it should be possible to run a unit of 100 beds.

We must clearly differentiate between a geriatric service as applied to newly admitted patients and the more difficult and painstaking work of gradually releasing hospital beds and nurses used up in nursing old people who require rehabilitation after years of neglect. It is imperative, however, that the first steps taken should be to solve the more difficult task, as in this way the effects of the nursing shortage can most rapidly be ameliorated. We must be sure that a gradually increasing part of the nurses' time is spent in the active geriatric wards, leaving part-time senior nurses to treat the relatively few permanently bedfast in their long-stay annexe wards. The more this policy is carried out the less will the nursing shortage be felt. It might be expected that an early result of the work of the geriatric departments would be a gradual decrease in the number of beds required. This cannot be the case for some years because of the rapidly increasing number of old people.

Summary

The view is expressed that improved care of the aged sick must depend upon the organization of a geriatric department in the hospital system.

The medical profession must change its attitude towards these patients from that of resignation to the inevitability of endless months in bed to active investigation, ensuring that each patient has the optimum chance of enjoying even limited activity and independence.

The need for reawakening the nursing staff's interest by the more optimistic approach of the medical profession is stressed.

The importance of physiotherapy in rehabilitating the aged is demonstrated.

Medical staff must consider therapeutic approaches which will economize nurses' time.

The insistence that nurses spend the maximum period of time actively nursing the sick in the active geriatric wards will decrease the unpopularity of this work.

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ROYAL MEDICAL FOUNDATION OF EPSOM COLLEGE

PENSION, SCHOLARSHIPS, GRANTS

The Council of Epsom College invites applications for a vacant "France" pension of £30 per annum for a necessitous medical man fully 55 years of age who has been registered for five years. Forms of application may be obtained from the Secretary's Office, Epsom College, Surrey.

There are also available: (a) Other pensions for medical practitioners or widows, when vacancies occur; (b) scholarships and grants for children of either sex, not necessarily orphans, but candidates must be of public-school age and in need of such help; (c) grants from the Eastes Trust for the relief of registered members of the profession of any age, their widows and orphans, and educational assistance for their daughters or sons.

STATEMENT BY THE COUNCIL OF THE BRITISH MEDICAL ASSOCIATION

December 18, 1947

The Negotiating Committee has now completed the work of presenting to the Minister of Health the views of the medical profession on the National Health Service Act, 1946. The Minister of Health has replied to the views of the Negotiating Committee. Every doctor should study carefully both documents, since, as the Minister himself has said:

"Every doctor will have to decide for himself when the proper time comes whether or not he should take part in the new Service, and the profession as a whole will be free to determine their views on the Service when they know what it is to be."

It is now the profession's duty to decide its collective attitude to the Act prior to the making of individual decisions by those doctors affected.

In his reply the Minister acknowledges that the medical profession has worked untiringly for a comprehensive health service to be available to all who need it. The medical profession itself has helped to formulate the plan, a contribution which has too often been ignored by opponents of the profession. The profession objects, not to the aim itself, but to the methods proposed, under the present Minister, to achieve it. It would be useless to disguise that on this subject the differences between the Minister and the profession are deep. On no single major issue has the Minister responded to the reasoned arguments of the profession.

Family doctors entering the Service will be the salaried employees of the State. There is no escaping this conclusion. That the public may not draw from this the deductions which are obvious to most medical men is the tragedy of the present situation. A man can be genuinely responsible only to one master. Until now that master, for the medical profession, has been its patients, to serve whom is its vocation. The need for single-minded devotion of the doctor to those under his care has been for centuries the first lesson to be taught to the young medical student by his teacher. Like other men, the doctor must gain a livelihood. For that livelihood he has been dependent until now on his own skill and his patients' recognition of this. Henceforward for those entering the Service there will be new loyalties and different paymasters—the all-powerful State, whose purposes are not necessarily those of medicine. To-day a doctor's advice is given without fear or favour, and is accepted—within the limits of ordinary human fallibility—as having but one sole object: to help his patient. To-morrow, when the doctor's attention—and loyalty—are divided between his patient and his paymasters in Whitehall (controlled, as these in turn will be, by extraneous considerations of national finance and other non-medical considerations), who knows what conflicts of duty and interest may not occur?

These are not imaginary bogies, conjured up by an alleged "reactionary" profession to impede the progress of "a great social reform." When the Negotiating Committee asked for the abolition of the "basic salary" idea it well knew what it was about.

It is significant that the Minister puts forward no arguments in favour of a universal basic salary. He stated in his letter of Jan. 6, 1947, that the question was still open and that he wished to discuss it with the profession. No such discussion has taken place. Now his arbitrary decision is that every general practitioner must be a salaried officer. The only argument ever used by a member of the Government in support of a universal basic salary is the one used by the Lord Chancellor in the House of Lords when he argued that the salary method was needed for the control of certification. If this is so, the public is vitally concerned. Public safety demands that the individual doctor shall be free to certify what he finds in his patient without fear of Government influence. At the outset the State salary is to be £300 a year. But this figure can be varied by the present Minister or a successor upwards or downwards by simple Regulation and at any time he chooses.

A further safeguard on the independence of medicine disappears with the abolition of goodwill in public general