CONTINUING NURSING CARE FOR THE SMALL INFANT DISCHARGED FROM HOSPITAL

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Discharge home of an infant from hospital necessarily involves a break in the continuity of professional supervision. The break applies less to medical than to nursing supervision. Established custom ensures that the family doctor is advised concerning babies who are being returned from hospital to his care. Continuing medical care is thus favoured. In contrast, arrangements for securing continuing nursing supervision where it is required are less simple. This is true of infants leaving any hospital. The situation arises particularly in the case of the newborn infant discharged from a maternity hospital in certain circumstances. Two examples will suffice: (1) the case of the baby returning home before feeding has been established or before the mother is certain of her desire to feed her baby or confident of her ability to do so; and (2) the problem suddenly presented to the mother by the arrival home of her baby, who has been retained in hospital on account of illness or prematurity.

Discharge of babies in such circumstances involves transfer of considerable responsibility from trained nursing staff to a mother who, however willing, may be understandably anxious. Anxiety not to separate mother from child may on rare occasions contribute to the undesirably early discharge home of a baby. On the other hand, the desire not to impose too great a nursing problem on a mother may result in a baby being detained for an unduly long period in hospital. These and similar difficulties are less likely to arise if the households to which babies are being returned are assured of nursing assistance and guidance. The assistance required, for a temporary period at least, calls for more time and personal attention than the district midwife or health visitor can readily give in the course of her normal routine duties. Nor is this of a nature which every busy family doctor can reasonably be expected to give with the frequency or in the detail desirable.

The problem resolves itself into the provision for selected infants and for a limited period of the services of a nurse who is skilled in the care of infants and who, at the same time as helping the family doctor, will serve as a link between the hospital and domiciliary services.

This article is intended to describe a year's experience of a limited experiment designed to deal with the problem described above. Those taking part in the experiment include members of the staff of the infant-welfare departments of the City of Leeds and of the West Riding County Council, and the Leeds Maternity Hospital.

Arrangements with the City of Leeds

The first phase of the experiment took the form of arrangements which were agreed between the City of Leeds Health Department and the Leeds Maternity Hospital after previous consultation with the senior obstetrical staff and matron of the hospital, and which had particular reference to premature babies. In accordance with these arrangements, the hospital informs the health department concerning babies who are due for early discharge and who are considered to need continuing nursing supervision. This advance information is telephoned by the resident paediatric registrar to the supervisor of midwives. Selection of infants for special follow-up nursing care is made by the visiting paediatrician to the hospital. On receipt of a telephone request from the registrar, the supervisor of midwives then allocates responsibility for the baby in question to one of her staff. Nearly all the cases are allocated to one of a team of special nurses who are also trained midwives employed whole-time on follow-up care of infants included in the scheme and who have had special experience in the domiciliary care of premature and ailing newborn infants.

When informed of a new case the nurse visits the maternity hospital. There she is introduced to the mother of the baby by the lying-in ward sister, and has explained to her by the paediatric registrar and ward sister the clinical or other circumstances which have prompted a request for the baby to be specially followed up. In the event of the mother having been discharged before the baby, arrangements are made for the mother to revisit the hospital at the same time as the special nurse.

At an early date the nurse visits the home to which the baby will be soon returning. There she satisfies herself that all is in readiness and that no essentials are lacking. The special nurse knows in advance the day on which the baby will be discharged from hospital and makes a point of visiting the household a few hours after the baby's arrival home. After she has seen the baby and given the mother any necessary help the nurse telephones the family doctor, advising him concerning the baby's return home and general condition. The doctor receives additional information from the paediatric registrar, who as a routine in all such cases sends a letter summarizing clinical events during the time the baby was in hospital and explaining the reasons why the help of the health department has been enlisted.

The frequency with which the special nurse pays further visits depends upon the baby's progress, upon the needs of the mother for guidance, and upon the wishes of the family medical attendant. Arrangements are invariably made to meet a family doctor's request to see him by appointment. On an average, visits have continued for a period of three to four weeks. At first the visits are daily, or if necessary several times daily. Later they are made at intervals of several days. Exceptionally, visits have continued for longer than four weeks where the baby's progress has been slow, where the mother has had trouble with her breasts, or where for various reasons she has been slow to show ability to look after her infant. Visits cease when the demands on the nurse's time are not in excess of those with which a health visitor can cope. The last visit is made in company with the health visitor, to whom the facts concerning the baby's progress are explained.

Field workers are always in danger of losing contact with their colleagues at the centre. To forestall any such risks periodic meetings are arranged which are attended by the nurses undertaking the follow-up care and by those on the paediatric staff of the maternity hospital. The meetings enable the results of the follow-up care to be assessed, and provide opportunities for the joint discussions of clinical and other problems met with in hospital and on the field.

Arrangements in the West Riding

Initially, selection of babies was limited to those whose homes were in the City of Leeds. Early results suggested that arrangements might be extended to selected babies born in the Leeds Maternity Hospital and returning to homes outside the city boundary. Not unexpectedly, a county area presented problems of its own. Although relatively small in number, the children involved have returned to homes dispersed over an extensive geographical area. The distances separating the homes from one another and from the maternity hospital have been considerable. It is not often possible for a district midwife or health visitor from outlying districts to visit the maternity hospital. The employment whole-time, on a county basis, of special nurses on follow-up services of the type described in connexion with the county borough of Leeds is seldom practicable. Nor has the practising midwife the time to supervise the nursing care of babies returned from hospital. To meet the county situation the special follow-up visits are undertaken by health visitors.

The resident paediatric registrar at the maternity hospital, having previously telephoned the family doctor, communicates with the county superintendent of health visitors, who is in charge of organized arrangements for the aftercare of children discharged from hospital. This nurse then visits the maternity hospital, sees the mother, and is given first-hand information about the baby by the registrar and ward sister. Subsequently she arranges (through the divisional medical officer) for follow-up care to be undertaken by the appropriate health visitor, to whom she passes on the facts previously obtained from the hospital. In cases of special difficulty the superintendent of health visitors herself visits the home. In all other respects the procedure followed by the county authority resembles that described in connexion with the City of Leeds.

A further although very limited extension of the original experiment developed in rather more fortuitous fashion. At different times two babies were transferred from the maternity hospital to general hospitals in the city for necessary treatment. In both instances, when the time for final discharge arrived, and after consultation with the family doctor, the local health authority was asked to implement nursing follow-up arrangements. This in turn has led to similar approaches being made in the case of a few babies leaving the children's wards of general hospitals after surgical, medical, or dietetic treatment.

Selection of Babies

To date 225 babies have been provided with follow-up nursing care. Selection is not subject to any rigid rules, but takes account of the physical well-being of the infant, doubts concerning the establishment of appropriate feeding, and home circumstances. Assessment of the baby's condition is based upon daily observations of the developing clinical pattern, and on the findings of

repeated complete physical examination. Account is taken of the bearing of such anomalies as cleft-palate or congenital heart on care of the infant during the early weeks after discharge home.

An infant who has survived a clinically violent neonatal course is regarded as suited to a follow-up; so also is a baby with evidence of some localized superficial infection which may be slow to heal if the infant is detained in hospital, but which may be expected to disappear rapidly with removal from a hospital environment. The random examples quoted are not met with often, but illustrate the variety of factors which may influence selection. The two factors of greatest importance in influencing selection are prematurity and incompletely solved feeding problems. Final selection takes place at the cot-side, takes account of the wishes of the mother and the observations of the paediatric registrar and ward sister, and aims at anticipating situations in which the family doctor would appreciate skilled nursing assistance.

What Are the Advantages of the Arrangements?

Experience over the past year justifies the view that the arrangements are beneficial not only to mother and child but also to those responsible for the professional care of the newborn infant. Some of these immediate benefits may be conveniently summarized as follows:

1. The informal procedure whereby the domiciliary nurse is introduced to the mother by the hospital staff gives to continuity of supervision a live personal touch of infinite value.
2. The hospital midwife finds satisfaction and stimulus in the personal interest shown in her work by her colleagues on district.
3. The nurse working on district is brought in contact with and reminded of the difficulties of nursing the neonate under institutional conditions, and finds a verbal exchange of information given before assuming responsibility for a baby more stimulating and more helpful than facts recorded on prescribed forms.
4. Breast-feeding is often successfully established and maintained in circumstances (delayed lactation, temporary decline of secretion, malformed nipples, etc.) which in the absence of adequate follow-up measures often contribute to natural feeding being wholly discontinued after discharge from hospital and without any professional advice (medical or nursing) being sought.
5. A number of babies who might otherwise be retained in hospital for precautionary observation or minor treatment can be confidently returned home with their mothers.
6. Infants who on account of prematurity, frailty, or illness are detained in hospital after the discharge of their mothers are enabled to return home sooner than would otherwise be the case.
7. The demands on hospital nursing staff are lessened and the pressure on maternity nursery cots is relieved.
8. The attention of mothers is focused on the desirability of continuing medical supervision by the family doctor as a preventive measure.

Other Considerations

Any arrangements which involve team-work and the linking of hitherto separate or partially separate interests are apt to give rise to misgivings. The local experiment described has been no exception, but so far as we can assess the doubts have been few in number. If they are more numerous than we believe, it is because they have not been brought to our notice. Certainly there have been no complaints from any households. On the

contrary, there have been many unsolicited expressions of appreciation, by mothers and relatives, of the nursing care given in the homes. Lying-in ward sisters have, without exception, welcomed the contact with their colleagues working in the field and are enthusiastic in their encouragement of follow-up care. The enthusiasm of those undertaking the follow-up nursing care is no less than that of the ward sisters.

While it has been relatively easy to gauge the reactions of the nurses, it has been less easy to gauge those of the family doctor. Two instances have occurred of general practitioners objecting to the special visits of the nurse or health visitor. A number have spoken of the value of her help, and, as was to be anticipated, there have been isolated occasions when the nurse's advice has been modified or reversed at the time of the doctor's visit. It need hardly be stated that the medical attendant is looked to for decisions relating alike to treatment of the child or mother. There have been other occasions when the visiting nurse has been instrumental in securing for a baby timely medical advice not thought to be necessary by the parents. On a number of occasions the nurse has been able to secure urgent help necessary to offset in part at least the indirect effects of poverty and slum conditions.

The few misgivings of which we have heard appear to have arisen from suspicions concerning motives rather than from doubts about the working practicability of the arrangements. The arrangements have only one motive—the discharge home, with the minimum of delay, of small babies who are in hospital as a result of illness or of the circumstances of birth. It is implicit in the arrangements that when the family doctor assumes clinical responsibility for these babies he should be enabled to share in the indispensable benefits, known to his hospital colleagues, of having the assistance of a nurse skilled in the observation and in the general management of the small or ailing infant aged only a few weeks. Success is dependent upon careful selection of infants; the skill, knowledge, and personality of those providing the infant-nursing care; and co-operation between the family doctor, the local health services, and maternity hospitals. If this co-operation can be firmly secured the task of hospitals will be lightened, the place of child care in the home will be emphasized, and a further contribution—no matter how small—will have been made to improved prospects of total health in infancy and childhood.

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At a meeting of the North of England Section of the Society of Public Analysts in April, Mr. J. G. Sherratt compared the methylene-blue grading test and the plate counts of ice-cream. He said that comparison of the results of the methylene-blue grading test for 1,400 samples of ice-cream from various sources was made with the results of plate counts at 37° C. and 20° C. and the coliform population of the samples. It was concluded that a Grade 1 indication may be accepted with confidence, that about 80% of samples falling into Grade 2 were bacteriologically satisfactory, and that the presumption that samples falling into Grades 3 and 4 are unsatisfactory must be adopted only with considerable reserve.

CARCINOMA OF THE PROSTATE

A COMPARISON OF METHODS OF DIAGNOSIS

BY

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The difficulty of making a conclusive differential diagnosis between malignant involvement and inflammatory changes in the prostate gland raises the question of the reliability of the various methods of investigation. The importance of this differential diagnosis becomes all the more evident when it is realized that cancer of the prostate is said to be the commonest carcinoma in the male over the age of 60 years (Hey, 1948). In 1921 the death rate from this disease was 4.18 per 100,000 of the male population, and it had risen in 1930 to 7.55 (Hoffman, 1934). The Registrar-General's Review for 1948 records double the number of deaths from this disease in 1948 than in 1928 (Registrar-General, 1948).

There is a wide divergence of opinion regarding the effect on the expectation of life from the introduction of hormone therapy in a patient with cancer of the prostate; nevertheless it is generally agreed that, whether conservative or radical surgical treatment is to be undertaken, only by early diagnosis can the best results be obtained.

In order to review the reliability of the commoner methods of diagnosis a series of 62 cases (see Table) in

Cases (62) Suspected of Cancer of Prostate on Rectal Examination

	Non-malignant (28)			Malignant (34)		
	No. Examined	Normal	Inconclusive Evidence	No. Examined	Definite Evidence of Malignancy	Inconclusive Evidence
Cystoscopy	28*	15	9	30	14	16
Radiological examination	28	28	Osteitis deformans 2	34	Secondaries of bone 15	19
Serum acid phosphatase	28	25	3	34	9	25
Test for malignant cells in prostatic secretion or in urine	28	28	0	32	19	13
Needle biopsy	19	19	0	21	17	4
Perurethral biopsy	19	19	0	21	17	4

* Four of these patients had carcinoma of the bladder.

which there were strong clinical grounds for suspecting malignant changes in the prostate were investigated and the results compared. Of these cases only 34 had cancer of the prostate.

Rectal Examination

This had elicited one or more of the following alterations in the gland suggestive of malignant change: (1) increased induration in a part or the whole of the gland; (2) irregularity in the contour of one or both lobes; (3) obliteration of the notch between the seminal vesicles; (4) induration along the lateral ligaments and lymphatics of the gland, especially at the upper pole and the seminal vesicles; (5) loss of the lateral sulcus; (6) increased fixation of the gland on bimanual palpation; (7) the membranous urethra broadened, indurated, ill-defined, and more fixed.

Of the 62 cases 34 were proved to be carcinomatous; of these latter, induration of a part or the whole of the