THE CHALLENGE OF CHRONIC DISEASE IN OLD AGE

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A recent leading article in the British Medical Journal (1961) has stated that 'old age will provide the hospital service with its principal challenge in the next 20 years'. There is good reason for believing that this challenge is already in existence and furthermore that it concerns not only the hospital service, but the health and welfare services in the whole country.

Much has been said and written on this subject so that familiarity has given rise to an attitude of 'laissez faire'. Despite the work of Sheldon (1948) the amount of need among old people is still insufficiently appreciated by clinicians, administrators and politicians. Accommodation of hospital or residential home type remains inadequate in quantity and sometimes in quality, while the deficiencies increase progressively with the rising proportion of old people in the population. We are, in other words, being outstripped by population changes. The effect of this on individual lives of old people and their families, on the administration of the National Health Service, and the work of the Local Government Authorities, is grave. As a result Geriatric Hospital wards and Residential Homes have developed long waiting lists so that the patient's condition deteriorates before he can be admitted; meanwhile, wards of all types are blocked by aged people who no longer require a hospital bed. In the home, many nursing and welfare resources are wastefully used up in supporting people until hospital or residential accommodation is available. While the home care services are being uneconomically deployed, hospital beds are similarly used for the wrong purposes: 'acute' wards are not fully available for acute cases needing treatment or investigation and geriatric assessment wards can no longer pass on their long-term problems to the appropriate ward which alone may be able to carry out the slow process of social and medical rehabilitation. In consequence, bad feeling between departments and frustrations arise, both of which prejudice still further professional attitudes to aged patients.

It would be difficult to dispute the truth and fairness of the above statements; it is equally indisputable that the standard of work being done and the type of accommodation provided for old people wherever they may be, in their own homes, in statutory homes and in hospital wards, is often highly unsatisfactory. Sir Arthur Thomson (1946) in his Lumleian lectures, described the characteristic features of Public Assistance wards. As has recently been said, 'the buildings and the conditions were grim and deterrent and produced the desired effect on the poor for whom they were built'. After 17 years there are Hospital Groups which still tolerate such unsatisfactory conditions. Glyn Hughes (1960) describes the defective nature of many private nursing homes which cater for old people during terminal illness, while Peter Townsend (1962) has made a survey of residential accommodation for the homeless with conclusions which are equally disquieting. All this evidence, which many can match from personal experiences, suggests that the challenge of illness and social need in old age is not being properly met.

It is then indisputable that old age presents a challenge: our failure to take up the challenge is probably due, not to economic difficulties so much as to lack of basic thought at all levels, professional and administrative. Shortages of money and professional staff are too commonly blamed, whereas the underlying need may be for a constructive policy, based on understanding. At the root of inaction, prejudice is often at work: unfortunately, the care of long-term disease in the old has been subject to prejudice for decades.

Poor Law Medicine became what it was because of the bad conditions of unemployment which high-grade professional workers were generally loth to accept. Those who did so were liable to be despised by their colleagues, and this attitude has persisted in spite of the change in hospital conditions. To practise medicine and nursing under conditions of surgical asepsis, among 'interesting' patients who either die or rapidly recover has become 'respectable'; to minister to the neglected, the undernourished, those with long term conditions and the dying is no longer
considered an adequate role for workers with high standards of clinical experience. The value of professional work has thus been equated with its superficial interest.

Results of these defective attitudes are plain to see in every aspect of geriatric medicine. In hospitals, beds reserved for the elderly are generally too few, often falling considerably below the figures recommended by the Ministry of Health. The haphazard planning of geriatric departments not infrequently worsens the problem by placing either too many or too few (or none) of these beds at the acute hospital, so that either full initial assessment of the medical aspects is impossible, or else the patient has to remain too long in the assessment ward, thereby being deprived of the specific contribution to his cure which a well-run long-stay ward could provide. The progress of the patient from department to department, an essential feature of long-term rehabilitation, cannot therefore take place. In almost all geriatric wards, except those which have been purpose-built, ward design is a hindrance to efficiency and it is common experience that the usual arrangement of undivided wards of 30 or more beds with no opportunity for case-isolation is most unsuitable for work of this nature: the patient most apt to suffer is the recovering slow-stream patient. Furthermore, the type of patient being admitted into geriatric departments is changing, a higher incidence of acute disease (often terminal) presenting heavier nursing problems than was formerly the case. Adams and McIlwraith (1963) have recently found that 'nursing work in geriatric wards exceeded in quantity and equalled in quality, the work of the nurse in medical wards'. Such wards need a higher level of nursing than 'acute' wards catering for all age groups instead of the lower quota of nurses they normally receive.

Long-stay wards, still often designated 'chronic', are equally ill-designed, giving no opportunity for segregating patients into suitable groups: space for social, occupational and rehabilitation activities is often inadequate, while lifts, which are essential if garden facilities are to be used, may be non-existent. In all branches of geriatrics, medical staffing is apt to be deficient: it is thus not unusual to find that a consultant has ultimate clinical responsibility for 400 or more patients, with an overall medical staffing of one doctor to 100 hospital patients. Such a state might be tolerated in the absence of clinical activity: when, as usually occurs, a high level of clinical activity introduces a rapid turn-over and outpatient diagnostic and follow-up clinics and home-assessment visits are carried out, the burden of work becomes excessive. Howell (1962) has shown how the admission rate into a geriatric department is directly proportionate to the adequacy of medical staffing. With such pressure of work on both nurses and doctors, advances in technique are hindered as no-one has time to plan for the future. Much geriatric nursing is therefore old-fashioned, as the recent Geriatric Nursing Report by Exton-Smith, Norton and McLaren (1962) made plain. Apart from under-staffing, the nursing service is hampered by lack of labour-saving methods, from poor communications between nurses covering the 24-hour period, and a failure to adapt methods (originally devised for the bed-fast case) to the patient who now spends several hours a day in a chair.

Since it is underlying policy which actually determines our daily practice, it is worth while enquiring what that policy actually is. We can do this best by asking certain questions and seeing to what extent they can be answered.

**Under What Circumstances Should an Elderly Patient be Admitted to Hospital?**

Lowe and McKeown (1950) first brought evidence to show that many patients for whom hospital admission was requested had needs which could be met better by other means. Since then, careful preliminary assessment of cases referred for admission has become an accepted procedure. Apart from the necessity of exclusion from hospital of cases which do not need its special services, preliminary assessment is valuable in deciding priority of admission, the type of hospital to which the patient should be sent, and gaining the co-operation of the patient's family in future arrangements for the old person when the hospital's task is completed. Such screening is necessary if persons with severe psychiatric disturbances are to be diagnosed at an early stage and directed into a psychiatric hospital rather than into a general geriatric ward where they may not only lack skilled psychiatric care but also be a disturbing influence on those who are physically ill. This screening may either be carried out by a visit of both physician and social worker to the patient's home, or by an outpatient attendance coupled with a social enquiry. While most, if not all, geriatric departments conduct screening in accordance with one of these two procedures, many old people are admitted to acute wards without any adequate preliminary investigation. Their final discharge may therefore be prejudiced: the extension of 'screening' to this group might prove beneficial.
What is the True Function of a Geriatric Department?

More precisely, for what type of patient should it cater? This problem has been insufficiently considered, even by the geriatric movement itself. Geriatric departments cannot of course be responsible for the entire load of acute and long-term illness in the later age-groups. The old criteria for ‘geriatric care’ seem to have been chronicity irrespective of age, and ‘undesirability’ as seen by the acute wards. Neither of these attitudes is defensible. By definition, the Young Chronic Sick should be excluded from geriatric wards (though there is no reason why special departments for the younger age-groups should not be administered by the geriatric physician as an extra commitment) and geriatric physicians should take a firm stand against accepting such patients into their wards, in order to avoid the tragic misplacements of the ‘Young Chronic Sick’ patient described by Whitaker (1957) in the North-East Metropolitan Region.

The reason determining admission to a geriatric department should be a combination of age with a need for the special facilities with which the ward is equipped. Cases for whom a specific contribution can be made include those with residual disabilities requiring special techniques of mobilisation, slow-stream cases needing the special therapeutic atmosphere of the long-stay department, the case needing life-long nursing care and certain patients whose disposal is unusually complicated. The proper care and disposal of such patients may depend entirely on admission into the geriatric ward and they should therefore receive priority over the dying (whose care, although one of the most rewarding branches of nursing, can be equally well carried out in other wards), and the case with delayed recovery for whom the geriatric department can offer no particular advantage in care. The selection of patients to ensure the most effective use of geriatric beds is deserving of more study than it has hitherto received.

What Degree of Co-ordination of Services is Required?

The importance of treating the 'Right Patient in the Right Bed' was pointed out by the B.M.A. report of that name, published in 1948. In spite of this, many unsuitable placings still occur, instances of which have been recorded above. Misplacements between geriatric and psychiatric wards are exceedingly common and, as Kidd (1962) has shewn, reflect unfavourably on the misplaced patients as well as the wards in which they are cared for. Underlying this difficulty is, perhaps, lack of agreement as to what constitutes a geriatric and a psychiatric case, and a failure of liaison between the departments concerned. This needs considerably more thought than it has received: a first step towards co-operation might well be for geriatric physicians and psychiatrists to have reciprocal arrangements to visit each other's wards on a formal basis. A similar misplacement of patients between the hospital services and the Local Authority Residential Homes is commonly reported: once again, a study of methods of co-operation and goodwill on both sides should be able to overcome this difficulty. The role of the Consultant Physician to the Geriatric Department as co-ordinator has so far not been fully appreciated, nor has he generally been allotted sufficient time for this important task. A small co-ordination committee, representing the departments concerned, might be of value in overcoming placement difficulties and working out a policy of co-operation in the area.

What are the Requirements Sought in a Consultant Physician in Charge of Geriatric Services?

The variety of titles given by Hospital Boards to their geriatric consultants indicates the differing values set on their functions: at this point, it may be noted that some areas do not even consider such appointments are necessary. Bainbridge (1961) on the other hand considers that a geriatric department should be headed by a consultant experienced not only in his own speciality but also in general medicine and that he should possess, in addition, administrative ability and experience: if all these qualities are not available in a candidate, he recommends that the appointment should be postponed. The co-ordination of complicated services involving different types of hospitals and authorities can only be the outcome of tact and administrative skill, coupled with the outlay of much time. This should be allowed for when medical staffing of geriatric departments is considered. Furthermore, the seniority of the consultant-in-charge should be indicated by his official title, such nondescript names such as 'geriatrician' being abandoned.

How can Dangers of Hospital Admission be Minimized?

It is not generally appreciated that admitting an old person into hospital may have serious consequences, of which relatives may be unaware. The patient’s resentment at what he may consider
rejection by his family may lead him to give up his life-struggle and die from sheer apathy. Removal of familiar surroundings and landmarks easily lead, in a senile subject, to confusion and restlessness which may require sedation in the interest of the other ward-patients. Thus an added difficulty, that of undergoing the after-effects of hypnotics, is presented to the patient. Waiting for bed-pans and being unable to communicate their needs to nurses as easily as they could to their relatives both predispose to incontinence, the shame of which may prove an unsurmountable burden. Newman (1962) writing on 'Old Folk in Wet Beds' has graphically drawn attention to the plight of such patients and has pointed out the parallel between some ward policies and the personality destruction aimed at in brain-washing techniques (Sargant, 1957). These dangers are all very real, and require constant vigilance on the part of the whole medical and nursing staff, if elderly patients are to be benefited rather than harmed by admission to hospital, and if geriatric long-term wards are to be kept free of hospital-induced types of senile dementia. The destructive effects of a harsh or unimaginative ward organization are only just becoming appreciated: much more careful thought needs to be paid to the problem.

What Steps are we Taking to Provide 'Satisfactions' in Geriatric Nursing?

In considering nursing recruitment, undue stress is perhaps laid on shorter hours and increased pay with correspondingly less attention to providing 'satisfactions' which are necessary for the nurse's happiness and which alone may induce her to continue battling with the difficulties of geriatric nursing. Experience in long-term hospitals where nursing recruitment problems are minimal, suggests that the 'social health' of the hospital community, the psychological background in the wards, and the degree of activity in rehabilitation are more important factors than pay and length of working hours. In hospitals where there is little rehabilitation activity, poor ward amenities and decorations and faulty personal relations between the nursing staff themselves on the one hand, and other medical and administrative colleagues on the other, nursing recruitment and suitability of staff structure is likely to suffer. It would thus appear that the findings of Revans (1962) on nursing relations within acute hospitals would seem to be applicable to long term hospitals also. If this is so, it may well be pointless to endeavour to improve geriatric nursing recruitment until a beginning has been made by removing the appalling conditions under which many nurses are expected to work and by lightening the load of heavy nursing which is being thrust upon them.

The unsatisfactory position of home-care of the aged person is no doubt due to a similar state of ignorance to what the problems really are and a failure to enquire critically into the success of our efforts. Our preconceived ideas should be tested against experience under five headings:—

What are the Prevailing Attitudes of Families Towards the Care of their Old People?

Subsidiary to this, we need to know something of the social and cultural influence on which these attitudes are based, and to what extent they can be manipulated by public education. At present, our views are largely inferential, being based on the varied experience of individuals, some of whom may have a prejudiced approach. Undoubtedly, the 'family' as a responsible institution has had 'a bad press'. Sweeping allegations of carelessness and a defective sense of duty to the older generation are commonly made, though such views are seldom advanced by social workers with intimate knowledge of the difficulties of home care. A large proportion, say up to 30% of pensioners, have in fact no relations outside their own age-groups. Of the remainder, some have children who are neglectful and undutiful: there are, however, many instances where the sense of duty has broken down only under long strain, with no hope of relief in the future. In other words, the failure of the Home Care programme to render any useful assistance, and the inability of the hospital service to provide short-term admission at the time it is most needed, may have proved contributory or even major factors in breakdown. If this could be established, it might be made possible to support good family attitudes by giving them effective help immediately, instead of after a delay which may lead to a permanent breakdown in family relations. There is, furthermore, evidence that there is a variation in approach between different religious groups, Jewish and Roman Catholic families showing a greater degree of cohesion and a higher-than-average sense of family responsibility. Before drawing definite conclusions, we should need to know to what extent this favourable approach is correlated with size of family. In any event, it would appear that family attitudes are capable of manipulation by religious and social influences, and that methods of educating the public must be considered if we are to counteract the feeling that the Welfare State exists to relieve families of responsibilities for their dependants in any age group.
What is the Community Attitude to Home Care and What are the Influences Determining this Approach?

The community includes, of course, not only the family and the immediate neighbours but the elected members of the Local Authority, the various professionals associated with the case, doctor, district nurse, health visitor and all other representatives or workers of the Social Services. Informed opinion, with the backing of the Ministry of Health, favours management of old age in the home whenever possible. With this in view, extensive and expensive programmes for Home Care have been instituted by Local Authorities, including, as is well known, nursing and domestic help services, home meals, provision of nursing aids and aids to disablement, laundry and linen services, friendly visiting and many other services.

In spite, however, of the outlay of much time and expense, the conception of Home Care is commonly an unpopular one with general practitioners, nurses and families themselves. The reasons for this need further exploration. How much can be attributed to inertia on the part of the professional workers, to a sense of irresponsibility among younger members of the family and how much is due to the defective nature in the services rendered, both in the amount of help given and its timing in relation to need? Undoubtedly, the Home Care Services are extremely expensive: we have therefore an added right, as a nation, to know whether they are achieving their purpose and if the money spent could be used to better purpose. Such an enquiry might, for instance, reveal whether Meals on Wheels twice weekly make a real contribution to a severe nutritional problem or whether they are merely a ‘token’ of help. Similarly, home helps, provided infrequently, withdrawn over weekends and public holidays and not replaced immediately the worker is ill, are of little help in saving a hospital bed by maintaining a borderline case at home. The timing of help is a matter which needs more consideration. Patients who need nursing appliances and other welfare help, such as walking aids, stair rails and mechanical hoists often need these at short notice: the long delays which ensue before the help is finally given only lead to further deterioration in health. The contribution made by Old Peoples Welfare Committees needs further exploration: do they serve their agreed purpose of co-ordinating efforts to relieve distress in the older age-groups or do they dissipate their energies to a greater or lesser extent, in services of emotional appeal such as summer outings and Christmas parcels, which fail to contribute to daily needs of the house-bound? In this connection the work of Slack (1960) is highly relevant. There is at least ground for supposing that the optimum effort in home care is not yet being made, and that a reasonable increase in expenditure of money and personnel might well produce a surprisingly great improvement in the service rendered: furthermore it is possible that the full co-operation of the public will only be attained when we are able to offer real, effective and immediate help instead of our present incomplete and unorganised efforts.

A further question which demands attention is whether we are expending our efforts on the right type of person. It has long been recognised that home care is cheaper than institutional care, expressed in terms of money and personnel, only as long as the services required are few in number and are not demanded throughout the whole 24-hour period. If a patient needs the resources of the entire programme indefinitely, the effort is uneconomic and is generally better replaced by admission of the patient into hospital or a residential home. So long as our limited home facilities are deployed in such a way, so long will they be denied to persons to whose care they could offer an effective and economic contribution. Shortages of hospital beds and of places in residential accommodation thus have a double ill-effect: not only do they deny help to persons at the time of their greatest need, thus increasing their disabilities, but they also lead to a wrong deployment of the home care facilities. Mutual confidence between families and hospital departments is consequently at a low ebb. So long as the hospital can offer no project of relief to families in urgent difficulties, so long will families be reluctant to take the risk of receiving the patient home again. A rapid admission to hospital when such is necessary, and a confident feeling that re-admission would be equally rapid, might well go far in increasing the turnover in hospital wards.

The goodwill of the public is thus fundamental in maintaining home care; the factors which destroy mutual confidence must therefore be fully appreciated. It is possible that such a fault lies in the absence of any one person to whom the patient or family can turn for help in organizing their home care. In spite of the many persons who have access to the home, very few have the time to spend on this problem. General practitioner and district nurse are too busy with their set tasks to deal with the deficiencies in the patient’s home life and to ensure that their recommendations have been put into effect: consequently, Home Helps lapse, commodes are recommended but not received, the delivery of Welfare aids is long delayed and less spectacular services such as
invalid laundry and spare linen supplies are not invoked. This lack of organisation leads to an inefficient, haphazard service, which may either never work or break down under further strain. The task of co-ordination is one which might well be carried out by the Health Visitor whose future role in the Health Service is at present rather undecided. If the main energies of Health Visitors are to be directed towards old age, instead of the other end of the life scale, it will be necessary to recruit and train them with this object in view: it is doubtful if such a major reorientation of approach can be made without careful forethought.

To What Extent are Hospitals and Residential Homes 'Supporting' Families?

Little definite is known as to wastage which occurs through the delay in admitting suitable cases into hospital or residential accommodation. It is, however, a general experience that delay in providing admission to a welfare home often leads to the individual becoming a hospital case instead: similarly, patients requiring a short period of hospital treatment may become long-term cases if speedy admission is impossible. Both these situations prevent economic use of costly services. The need for facilities for short term admission into hospital and residential homes to cover illness or annual holidays in those who are normally undertaking the burden of care has recently been discussed by Rudd, Struthers and Waters (1962). Without an adequate supply of geriatric beds and places in hostels, this valuable support of the family cannot be offered.

Is the Standard of Residential Accommodation Generally Satisfactory?

Any person seeking admission into a residential home should be expected to make a reasonable adaptation to a community existence: whether he manages to do so, and how happy he is as a result, depends not only on the individual but the suitability of the community into which he is introduced. Grossly unsuitable conditions in statutory residential homes have recently been described by Townsend (1962) whose report is highly disquieting. Apart from the deficiencies in many of the premises still in use, the more modern types of residential home can be severely criticized on three points: (i) they are often sited in isolated areas, far away from centres of population, (ii) many are not purpose-built and having no lifts, cannot be fully used for the many patients who cannot climb stairs (iii) the homes are run with too few staff by day and none at night, so that even minor illness among the residents makes a severe strain on the administration of the home.

Conclusions

The preceding account describes only some of the basic problems met with in the care of long-term illness in old age, on which more information is required and to which further thought needs to be devoted. Problems not even mentioned include the training of nurses, medical students and practitioners in geriatric methods at all levels, especially in postgraduate years, without which experience they will be unable to fill executive and senior administrative posts. The many pilot schemes and investigations carried out in the field of old age have provided a mass of date, admittedly incomplete, but sufficient to form the basis of a wide-scale enquiry into our methods of care. Until the views of the many isolated workers are correlated and a firm national policy decided, no effective advance can be made: if such facilities are not forthcoming, the present service must inevitably be overwhelmed by the increasing demands being made upon it, with consequent loss of efficiency.

It is probable that there can be no solution to this national problem which does not include

1. An increase in beds for long-term illness in active, well-organised geriatric departments administered by experienced, well-trained clinicians of consultant status.

2. An increase in places in statutory Residential Homes, with a corresponding rise in standards of accommodation where appropriate.

3. Effective co-operation between all departments and agencies concerned with the care of the aged. This co-operation should take place not only between hospitals and Local Authorities, but also within the hospital and Local Authority services themselves: thus every effort should be made to ensure that the resources of each department are used in the most efficient way. In the Local Authority itself, the efforts of the Health, Welfare and Housing Departments should be co-ordinated instead of functioning, as they so often do, in water-tight compartments.

4. A critical review of the working of the Home Care Programme in each area, with a view to determining the value of the actual help available and recommending what extensions of services are required in order that the help available should be effective.

5. A national programme of education, aimed
at increasing family responsibility, overcoming prejudice against old age and stimulating local pride in the area services provided for the care of old people. While some of this programme would be directed towards lay persons and statutory bodies, the need for the professional education of medical and nursing students in geriatric methods would also be considered.

Only when this basic work has been carried out, will it be possible to decide how much money must be spent to provide a really effective service for the preservation of health of the whole community.

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