Papers and Originals

Approach to Disability and Breakdown

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"Where there is no vision, the people perish."
—Proverbs xxix, 18.

"Geriatrics" proves to be an accommodating word; it can be used to mean whatever people want it to mean. A clear definition seems too elusive for many. The result of this is evident in the sort of demands made on a geriatric unit. It is also evident in the assumption, encountered frequently, that there is a duty on the part of a geriatric unit to shoulder immediate and unending responsibility for the problems brought to its door, whatever the nature of these problems and regardless of their origin.

Thus geriatrics gives excellent opportunities to view the variety of ways in which problems of disability, incapacity, and breakdown are currently thought about and, as a result, handled.

I want, therefore, to describe a selection of common requests, and, in doing this, my main concern will be to consider the presuppositions that lie behind the ideas expressed in the requests.

Limited Approach

Mr. A. (Aged 75)

"It [geriatrics] has nothing to do with age"—we were told this by a general-practitioner hospital with full hospital facilities. "Any patient admitted for straightforward medical or surgical treatment who turns out to have social problems is geriatric." From this same hospital a wife was asked "to take her husband, Mr. A., home because he needed geriatric treatment which was not given at that hospital." Quite what treatment a patient should be given for social problems was not made clear. Mr. A. was intermittently confused and frequently incontinent of urine, with a fixed osteoarthritic right hip and an almost fixed right knee, a partial left hemiplegia, and Parkinson's disease. There had been, not unexpectedly, complete breakdown at home, where he lived alone with his wife of the same age.

It is very easy in a somewhat extreme example like this to appreciate the muddled thinking about treatment which gives rise to bewilderment, but such mistakes are very often made and go unnoticed, not only when the social and personal aspects of disability are considered, but also in relation to the work of physiotherapists and occupational therapists. The temporary passive acceptance which is all that is needed from the patient for the efficacy of intravenous therapy or radiotherapy, for example, is often not differentiated from the continuous participation with intent, purpose, and motive which is essential if physiotherapy and occupational therapy are to be effective. Efficacy is usually held to lie in the techniques themselves whenever the word therapy is mentioned, whatever mysteries this involves. These are only two of the many differences which lie within the words "therapy" and "treatment," but the general tendency

is to pressgang them all into the same limited model used by the applied natural scientist, smothering differences and causing immense trouble. The scientific model is not personal; it aims to be effective regardless of reason, motive, and intent of the recipient. Co-operation in acquiescence may be demanded, but scarcely participation. The idea that the hospital is there to do much more than just give technical "treatment," because it is there as part of the community to help people to live more successfully and effectively, takes us into a different range of country altogether and into other categories of "therapy."

Mrs. B. (Aged 86)

From a general hospital Mrs. B. was sent home because "the consultant physician who had been looking after her felt very strongly that she should not be blocking a medical bed." While staying with a married daughter Mrs. B. fell downstairs and fractured her right clavicle and was admitted to hospital through the casualty department. She had mild heart failure due to anaemia and hypertension and was treated for this, and with "a collar and cuff" for the fractured clavicle. She also had Parkinson's disease. She was in hospital three weeks and was sent back home 20 miles (32 km.) away, where she usually lived with another daughter who had a husband under psychiatric treatment. Mrs. B. was persistently confused and incontinent when she left hospital, and it was clearly stated that she was "really too senile to be left in the house on her own." After 12 days we had an urgent call for help; she was admitted comatose and dehydrated, and five days later she died from bronchopneumonia. It is difficult to see any stronger claim for a medical bed. Was such a patient blocking a medical bed?

Mrs. C. (Aged 77)

From another hospital Mrs. C. was "discharged home when all had been done that was possible for what she came in with." Ostensibly she went into hospital with thrombophlebitis, though this was somewhat doubtful, was treated with anticoagulants, and left for home bandaged from toes to thigh, after eight weeks. She also happened to go into hospital with Parkinson's disease, a residual left hemiplegia, an old fracture dislocation of the right shoulder, and, most important of all, she went in demoralized and with complete breakdown in relations between her and her daughter-in-law, with whom she lived, and there was no doubt at all about all these. We had a call to help with Mrs. C. two days after she had left hospital, and she died three months later, though not before she had regained full personal independence for a period. Had the original hospital done all that was possible for what she went in with?

Mr. D. (Aged 78)

From another hospital Mr. D., after a month, was "sent home when they could do no more for him." He had been

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admitted on a previously arranged date to give his single step-daughter with whom he lived a rest, so that she could have a holiday. A fortnight's stay in hospital had been intended. He had developed a partial left hemiplegia four days before the planned admission for custody. When he came out of hospital he was walking a little with help but not dressing, he had weakness on the left side, was incontinent of urine, and had a pressure sore on his left heel. His morale was exceedingly low and had been deteriorating slowly for three years. He had always been "neurasthenic" and had retired at the age of 54 because of vague ill-health. We had a call for help with Mr. D. 10 days after he left hospital. He died seven weeks later. The real trouble was breakdown in practical living at home, and complete disaster had been brought about by a cerebral thrombosis. Would a rest or a holiday for the stepdaughter have solved anything even without the cerebral thrombosis? Could the original hospital have done no more for him? The nature of the problem had not even been recognized.

Comment

It was clear from the structural changes present, the amount of disability and incapacity, and the logic of the situations in which these patients were placed that they were still in need of hospital support when they were discharged from hospital. The need for hospital support when present does not disappear when a patient is sent out of hospital, it almost certainly increases. It is not something which turns on arbitrary opinion, availability, or convenience. Likewise, the responsibility for providing hospital support in the face of established need does not disappear as the result of arbitrary claims concerning the use to which a particular type of bed should be put. A "chronic" patient in an "acute" bed is too often described as "no longer a responsibility of this hospital."

Imperative Relegation

This describes a method of approach which assumes that certain people must be consigned to a somewhat less important sphere. It also assumes that the person consigned will naturally accept this and that those to whom the person is consigned will naturally be there to accept total responsibility without question.

Mrs. E. (Aged 84)

"We do feel that we have carried the burden of Mrs. E. in our acute wards for a very considerable period now, and I wonder if you would be kind enough to consider moving her to a geriatric hospital." This was the request about an overweight woman, facile and unrealistic, with some intellectual impairment, who in hospital could be kept just independent for her personal needs with supervision. Out of hospital in a private residential home she had immediately broken down and become incontinent and inert and had had to come into hospital again. In further correspondence about the same patient with the same hospital the following appeared: "I am at present also treating a 92-year-old who lives alone and who may become a disposal problem, as are numerous of our elderly patients, but I will not worry you about her yet."

Mr. F. (Aged 68)

"I am sure you will agree that it has now become imperative for Mr. F. to be looked after as a long-term geriatric patient for both his own and his wife's sake, and I should be glad if you would take the necessary steps" was the request from a teaching hospital. With this request the patient's general practitioner

was "in complete agreement," and his request to the hospital geriatric department was, somewhat inappropriately, to "kindly admit him into a suitable home as soon as possible." This failure to appreciate the distinction between homes and hospitals is common. Mr. F. was a stocky, plethoric, chesty man with Parkinson's disease. He had been under one teaching hospital for 10 years and for the past four years under another such hospital. There was a story of an injury in the past, a prolapsed disc, a period of depression with E.C.T., and, more recently, talk of cortical atrophy, though at necropsy 15 months later there was no evidence of this. He was continent and needed a little help with dressing. His main trouble was frequent falls at home. He was prevented by his wife from doing anything himself for fear of the consequences.

It was clear when a domiciliary visit was made that he was extremely frustrated, anxious to be independent, and terrified of being admitted to hospital or being put into a home. He was only too well aware of the situation. The breakdown at home and the resulting fear and insecurity were with little doubt responsible to a large extent for the falls, but this aspect had never been considered. The social report from the teaching hospital stated somewhat paradoxically that "he has very little insight and gets very distressed when the question of going away anywhere is discussed." He was caught in a trap and knew it.

Situations like this one are common producers of mental confusion as well as falls, and this unfortunately is all too common a way of managing them. It involves giving such undue emphasis to the nature of the incurable, and assumed progressive, structural disease that this produces demoralization and further reduction of function in people like Mr. F. Not surprisingly, breakdown and rejection in the domestic setting are frequently the outcome. Tacit acceptance of this situation, acquiescence in distress, is enforced with all the misery that this involves, since no better basis for management is offered by those whose work it is to help. In the wake of breakdown there follows insistence that someone else accepts residual custody immediately and without question and carries the burden of the mess that has been created, the tangled mess on all sides of guilt, resentment, hostility, and conspiracy. There is little that is fundamentally more stupid and immoral than this, but this way of seeing things is not appreciated. It is the personal affront to the human dignity not only of the patient but of those on whom the custodial demands are made that causes so much of the trouble. The common assumption of inevitable deterioration of structure, and therefore of function, because of the lack of any technical cure does not help either. To be on the receiving end of all this often puts one in an impossible position.

There are more intelligent ways of managing these disabilities, which without an atmosphere of support and understanding often produce demoralization. This support can be found in properly organized outpatient departments, in day centres, and workrooms, where the emphasis will be on the remaining physical function and personal response rather than on the extent of structural disease. Function and personality can then be related to the nature of the environment in which they must work, but success can never be guaranteed. The model on which they are based is not the scientific but the historical and personal one (Carr, 1964). The altering of a situation by the way it has been managed makes it well nigh impossible often to unscramble things once rejection and breakdown have occurred and residual custody been forced.

Miss G. (Aged 63)

From another teaching hospital came the following: "She is an extremely difficult patient, needs suitable nursing care in a long-stay chronic hospital, and is a most unsuitable patient in the type of ward in which she is at present accommodated."

... The situation is now becoming so serious that I must ask you to make immediate arrangements for Miss G.'s transfer to more suitable accommodation." It is difficult to believe that this comes not from the nineteenth century but from a teaching hospital in the second part of the twentieth century. Here again we have, as in other examples, the assault on human dignity. This very well staffed hospital, part of a group with 600 beds taking no serious territorial responsibility, could not adjust to accommodate this patient, who was without question in need of hospital support. She had committed no offence except the one of being where she was not wanted, and those who did not want her were those who were primarily responsible for the state she was in. The fact that she was rejected by those whose work it was to help her was reflected in the condition she was in. She was demoralized, demanding, bored, and bedfast, with pressure sores and an indwelling catheter, with Parkinson's disease, and with an obscure extension rigidity and apparent paralysis of all four limbs.

Aggressive Irresponsibility

This takes matters a stage beyond imperative relegation to where critical situations are manufactured to force someone else to act. It usually takes the form of sending someone out of hospital to a situation known to be untenable and refusing to help when disaster occurs. It is as ugly as blackmail. One example has already been described—Mrs. B.

Mr. H. (Aged 68)

"Patient went into X hospital for two weeks in the first instance to give his wife a rest. While there he developed retention of urine, and consequently his stay has been so far for four weeks. X hospital are wanting to send him home and are going to do so despite the bedsores he has developed while being in there, and the general practitioner is asking that we take the patient into our unit to heal these before he returns to his own home. Wife willing to take him back home."

This patient was sent home seven days later, as intended by X hospital, and on that day the following message came from the general practitioner: "I had to send the patient home today. I am very unpopular because originally he went in for only two weeks. Son is flaming mad about this, as his mother is unable to cope." The general practitioner here was also the doctor who was responsible for the patient in hospital, and the hospital concerned had full hospital facilities, no staff shortages, and an average bed occupancy of 65%. Mr. H. became an immediate call on another hospital and was admitted four days later. This second hospital had a persistent staff shortage, in part related to being too often on the receiving end of this and similar sorts of behaviour. Mr. H. had a severe residual right hemiplegia with contracture of the leg and dysphasia from a cerebral thrombosis two years previously, and was incontinent of faeces. He had an indwelling catheter. It needed two people to get him in and out of bed and into a chair, and two people to take him to the lavatory and to help him walk a few steps. Apart from the small pressure sores this was his condition and function before he was sent into hospital to give his wife a rest. It was quite clear that the situation and the whole business of practical living at home had broken down, and for very good reasons, some going back much more than two years. Two weeks in hospital on the basis of custody, however well intentioned, was most unlikely to help his wife or Mr. H., and, as so often happens when sentimentality takes precedence over realism, it led to further trouble, both physical and with personal relationships. Then, to make things worse, an attempt was made to force the whole mess on to a geriatric service.

Mr. H. had a clear call on any hospital for help to enable him to try to live more satisfactorily, and if the right thing had been done for the right reason Mrs. H. would have had the

opportunity to try to start living more successfully herself, not just wait a fortnight for it to start all over again. Did her husband's stay in hospital give her a rest, if this term is to mean anything at all, except a very temporary respite from certain forms of physical exertion? If Mr. H. had eventually reached the stage when hospital support was not needed, then the question of return home would have been a practical possibility, and only then would there have been a likelihood of it working.

Mrs. I. (Aged 83)

Mrs. I. had chronic bronchitis and asthma and had been admitted many times to a teaching hospital. During her last admission there we received the following request and information: "Her present illness dates back some weeks, at which time she had a gastrointestinal upset and became steroid-depleted with symptoms of hypoadrenalism. This has now been corrected, but I am afraid the old lady is now almost bedridden, incontinent, and totally confused. . . . I am now writing to ask whether you would consider her for transfer to a full geriatric unit. I am afraid the family could not possibly manage her at home any longer, and I do not think we are likely to see any further improvement in her condition."

Despite a reply explaining our position, that we were indeed a full geriatric unit and could not help, Mrs. I. was sent home in the condition already described. Within a week we had an urgent call for help, but it was another 10 days before we could find even an extra bed in an already inadequately staffed ward for the confused, doubly incontinent, and bedfast woman who had by then developed pressure sores, and she died 10 days later from hypostatic pneumonia. An attempt to get the teaching hospital to readmit her had failed.

Public Responsibility

The legal obligations which were imposed on local authorities in the past, and which underpinned the methods of approach to the problems of Mrs. B., Miss G., Mr. H., and Mrs. I., disappeared nearly 20 years ago. The responsibilities placed on local public health and public assistance committees before 1948 were indirectly responsible for what amounted to a statutory division between the historical accidents of "acute" and "chronic," between technical medicine and custody, between the "elite" and the "under labourer." With the coming of the Health Service the dividing lines were redrawn and came to lie not between "acute" and "chronic" but between those who needed a home and those who needed a hospital. The significance of all this even now is not generally recognized. It is not primarily the techniques that can be applied to people that matter, but what they need for support to enable them to live as effectively as possible.

People who have a continuing need of hospital support in a hospital bed are not "blocking a hospital bed" if they happen to find themselves in a so-called "acute" or "chronic" bed. In relation to established need the categories "acute" and "chronic" appear for what they are—an artificially created internal division. Beds are blocked in two ways: firstly, by those patients who, though not actually in need of inpatient treatment, receive it directly as the result of their acceptability and spontaneity; secondly, by those who have to remain in hospital beyond their need because they have no home in which to live.

Day Centres and Workrooms

These have already been mentioned in relation to Mr. F., yet even now we get the following, which came from a local-authority description of the intended function of a day centre, "day accommodation and care thereby enabling the members of the family who would normally provide this care to follow

their occupation free of the anxiety arising from leaving aged relatives to fend for themselves during long periods of the day." Surely the purpose of a day centre is not to provide a custodial service for the benefit of relatives, a service which relatives by implication really should be providing. What politician is going to press readily for the expenditure of public funds on this basis? The purpose of day centres and work-rooms is to help provide a reason for living for the elderly people themselves, which relatives alone could not give anyway.

If we do the right thing for the right reason other things have a tendency to fall into place: "Truth has always a certain clarity of line" (Galbraith, 1966). Far too often elderly people are automatically deemed to have no place and no purpose in life. They are there to be looked after, objects of care, all desperately well-intentioned. Herein lies so much of the trouble. The term "old people" often carries this pejorative sense and its patronizing loss of human dignity. This is Kant's "paternalism is the greatest despotism imaginable." The custodial idea spreads to holidays and homes too, very commonly, and very few people seem to think there is anything wrong with it. We get the same old wretched negative underlay in the term "community care," which is so often conceived as the transference of custody from institutions to people's homes and the dishing out of chunks of welfare. The word "support" is much better in this context and is much more likely to contain the idea of the minimum support for the maximum degree of personal independence and fulfilment, and also the idea of more effective living and probably consequent on this less disability, though structural disease may remain the same or even increase.

Present Situation

These situations have arisen in a very prosperous residential area with a population of 750,000 and just over 4,000 hospital beds, excluding mental hospital beds and voluntary hospital beds, there being 350 of the latter, all "acute." On the latest figures (Ministry of Health, 1966) 2,500 acute beds should be needed and 770 geriatric beds to satisfy the needs of the resident population. In reality there are 500 geriatric beds, 250 maternity beds, and the other 3,250 beds all classed as acute, and certainly none chronic or geriatric. A new hospital is now being built in this area with 300 beds in the first phase. All will be "acute" or "research" beds except for 25, which are to be geriatric assessment beds. A situation with an excess of 750 acute beds and a deficiency of 270 geriatric beds is being changed to one with an excess of 1,025 acute beds and a deficiency of 245 geriatric beds.

In my part of this area, almost two-thirds of it, the Poor Law area of 1895, with a population of 450,000—51,000 aged 65 and over—there are only 245 geriatric beds. My own hospital group has only sufficient "acute" beds for the needs of the "acute area" imposed on it, which is considerably smaller than the imposed geriatric and maternity areas. These 245 geriatric beds are widely scattered in nine different hospitals, all except one of them small, all at best makeshift, and all overcrowded, with an average of 27 beds in each, and only 38 beds have full hospital facilities. The management and staffing of this set-up is a nightmare. There is a shortage of sheltered housing and of welfare places in the area, and 210 of the welfare home places are still in what was a nineteenth-century work-house. Historically the main hospital set-up is based on previously well-developed local authority and voluntary hospitals. Development in this context over the first part of this century has meant development particularly along the lines of medical science and technology. It exemplifies what much of modern medicine is built on, and is closely connected with a cluster of related presuppositions centred on science and social relations. Shortages approaching these in other areas often have the same explanation, no overall shortage of beds, but an artificially produced shortage historically determined. Re-

deployment of resources and reshaping of ideas according to need has not come about.

The first responsibility of any hospital or group of hospitals is to serve completely the area in which they are placed. The area must be commensurate with the size of the hospital or the hospital with the area. Teaching does not exempt anyone from this, it only makes the acceptance of this responsibility even more necessary.

Presuppositions

It is assumed that the more one presses the methods of natural science the more likely one is to find the answers to the problems of disease and therefore disability. There is, moreover, the belief that if only we accumulate enough facts, enough knowledge, the answers will emerge of themselves, that the facts, solution. It is also assumed that, because natural science produced such remarkable results over the first part of this century, especially with the help of computers, will provide their own particularly with infectious and some deficiency diseases, further intensive measures along these lines on the basis of extrapolation will produce more and better results in the future with other diseases and so with disability. These are some of our contemporary delusions.

Many of our hospitals are institutes of medical science and technology, producing whatever service is thought to be appropriate by those giving it. The needs of people must fit into this, and everything technically possible must be done for the patient in the name of medical science. "The hospital has evolved into a highly specialized medical factory, or 'disease plant'—a veritable power-house of scientific skills—which functions in terms of an uncomplicated philosophy of 'cure'" (Hunter, 1967). Questions of relevance and desirability lose meaning. Nothing must be missed except, not infrequently, the main point. Commitment is primarily to pure science, for after all only in this way, *ex hypothesi*, can progress and the well-being of mankind be achieved.

It is always possible, if not imperative, on this basis to find reasons for investigating and doing things to more and more people, and the system more and more makes the reason for its own existence. What is possible becomes desirable solely because it is technically possible, runaway medicine. Beds can be filled conveniently and legitimately in this way, and the non-technical, the incurable, and the unwanted—particularly the elderly—kept out as social problems. The reverse of this coin is custody for those for whom science can do nothing, residual custody for those for whom, or perhaps more correctly to whom, nothing can be done, and from this it follows that very little is required to do nothing. With increasing numbers of older people who represent science's largest "failure" rate in the population this call for residual custody increases too, but this system cannot be managed in a society with full employment, a decreasing number of single women, and greater varieties of opportunity for women generally. These are the limiting factors which now make the traditional solutions of residual custody unworkable.

The situation in the area described is an excellent example of what happens in practice, but there are further implications not usually appreciated. Despite the very large number of "acute" beds the constant plea is that "acute" beds are being blocked, and this comes even from hospitals where the average bed occupancy is 70% and where there are no staff shortages. The average bed occupancy in the geriatric hospitals and wards is 97% and there are chronic staff shortages. If "acute" makes a greatly excessive demand on limited available resources there will be even less left for "geriatrics." If with this goes the "acute" hospital's depreciatory attitude for "geriatrics," so commonly found, what is already unfavourable for "geriatrics" will become worse still, especially from the point of view of staffing.

At one time, in an attempt to overcome the shortage of geriatric beds produced in my area, the length of stay in hospital was in effect rationed, and as many people as possible were given a period in hospital with "intensive treatment" applied to them for about six weeks. This resulted in a waiting-list of 350 because of the high relapse rate and because a promise of readmission had to be given to relatives in many instances, as might be expected when the people returning home were still in need of hospital support. The system defeated itself, because after a time nothing could be honoured.

In all examples given in this paper the patients were still in need of inpatient hospital support, and there was nothing but the attitudes in the original hospitals' failure to see the problem, and their lack of acceptance and commitment, which prevented those hospitals from giving the continued support that was needed. They all had far better facilities and staffing than the geriatric unit, which was being expected to take over very difficult problems that had been made even more difficult by the way things had been managed and then passed on. The longer people have to stay in hospital the better should be the conditions under which they are expected to live, because only in favourable conditions are they likely to live as effectively as possible and be less disabled. Moreover, doing things twice over—sending people out of one hospital only to go into another, and start all over again—is not economic.

Social Questions

We are often led to believe that most of our troubles are due to some dramatic social change as a result of which families no longer look after their old people. The implication is that if families did as they used to, and are still supposed to do in less developed societies, the State would not be called on to look after so many old people in homes and hospitals. "Relatives tend to lean too heavily on the State" is a phrase used and commonly believed in my area despite the great underprovision of services for the elderly and the great excess of technical services. We are asked to look back to a golden age which in fact never existed. The evidence from primitive and peasant societies suggests no golden age (Tunstall, 1966). Even in the seventeenth century in England there were very few elderly people alive, and in that period a widowed mother could not always rely on her children to give her a home, and our ancestors had the same rule as we have, or would like to have—no two married couples in one family home (Laslett, 1965). Today there are nearly three times as many people aged 65 and over alive as in the middle of the nineteenth century, and at any one time 94% of all these are living in private households (Tunstall, 1966). This, with early marriage and smaller and more widely scattered families and less domestic help, is not bad going. There is, moreover, no evidence that families today are irresponsible; quite the reverse (Townsend, 1957; Young and Willmott, 1957; Willmott and Young, 1960; Laslett, 1965; Lowther and Williamson, 1966; Tunstall, 1966). What is not often recognized is that, while families can fairly often provide the board and lodging of custody, they cannot as a rule, and practically never unaided, provide the reason for living for an elderly relative. In a subsistence society these tend to much the same thing. A more appropriate approach would be to recognize that our present situation is unlike anything that has gone before and needs new answers.

We are still bedevilled with the ideas of social Darwinism, where failures and rejects must fail because how else, *ex hypothesi*, can the fittest survive? Embedded too are ideas of less eligibility, the deserving, and the undeserving, all rocks on which the Poor Law foundered. The trouble is now that we cannot under present social and economic conditions find enough people to look after our society's rejects on the basis of custody and of less eligibility, and it is this that is the practical limiting factor (Norton, 1966, 1967).

Conclusion

It is not my business to be antiscientific; I am concerned with the extra-scientific pretensions and effects of medical science. Scientific rejection in its brashness and vanity—*ὕβρις*; is the appropriate word—makes untold difficulty for others because it fails to distinguish, firstly, between disability which is personal and experienced and structural disease which is observed, and, secondly, between explanation and prediction. While explanation and prediction may have the same logical structure in natural science, they are quite distinct in structure where human action is concerned.

Many of the assessments I have been concerned with in this paper do not turn on structural disease and custody, on the external approach, on detachment, on "spectatorism," but on those concerned with function, explanatory force, and the logic of situations. These problems have to be seen from the point of view of a participant, one who acts, from the "inside." It is not a matter of trying to show how something could only have happened as it did and in no other way, but of the need to achieve an understanding of particular human action at particular times and places under particular conditions. A story has to be followed. Explanation is not prediction reversed (Collingwood, 1946; Dray, 1957; Hart and Honoré, 1959; Hart, 1961, Gallie, 1964). "Historical explanation is not the application of generalizations and theories to particular instances; it is the tracing of internal relations. It is like applying one's knowledge of a language in order to understand a conversation rather than like applying one's knowledge of the laws of mechanics to understand the workings of a watch" (Winch, 1958). It is not possible to enlarge here on these fundamental ideas without taking much more space. Others, moreover, have done this far more effectively than I could ever do, and here the bibliography will help. Strangely enough, no discussion of these very important subjects is found in textbooks of medicine.

The issues facing us are neither scientific nor custodial but the existential ones of practical living. The trouble is that men will misconstrue the issues as if they were scientific problems. The appraisal of the relevance or appropriateness of what is attempted or achieved in different circumstances has affinities with moral inquiry rather than physical discovery (Louch, 1966). It is a matter of trying to enable many people, some not very well equipped, to live effective and fulfilling lives as independently as possible for a normal life's span of some 70 to 80 years and more, with all the difficulties this involves. This has never had to be done before to the extent now demanded of us. The technical treatment of disease processes alone is quite inadequate, and there is no answer in the conspiracy which surrounds residual custody and relegation. It is not the offence of destitution which must concern us, nor the offence of occupying an "acute" bed when one has become "chronic sick" or "geriatric," but the breakdown (Society for Promotion of Christian Knowledge, 1966) in effective and independent living and the place the hospital has in trying to rectify this, bearing in mind the fact that the greatest difficulties centre around those who for one reason or another lack the reserves or the response to reach personal independence. We have, moreover, to work within the framework of an affluent and not a subsistence society, where the prevention and relief of breakdown need much more than just board and lodging arranged for sweeping up the destitute and those without adequate support.

Our present battles are not going to be won by using the last war's weapons, tactics, and strategy.

Summary

A selection of common requests to a geriatric unit are examined under the limited approach, imperative relegation, and aggressive irresponsibility, with definitions of these terms. Public responsibility and the approach to day centres and work-rooms are also considered.

The situation in which these requests have been arising is analysed and related to the presuppositions which lay behind the ideas expressed in the requests.

There is no evidence in this country that families are irresponsible, but plenty to indicate that shortage of hospital services for the elderly in the area under review are artificially produced, there being, overall, on accepted criteria, a great excess of hospital beds in relation to the resident population.

The main cause for this was the obsession with medical science and technology giving a producer-orientated service, the source and generator of runaway medicine.

The old historical accidents of "acute" and "chronic," given indirect statutory sanction in the past, have been perpetuated despite the disappearance 20 years ago of the legal obligations which determined their perpetuation.

The alternative to the scientific approach is the rejection and conspiracy of residual custody, with their assault on human dignity, for those for whom or to whom science could do nothing. This traditional approach cannot be contained in an affluent society with full employment and a decreasing number of single women.

The answers lie in the historian's method of approach, which is more inclusive than the scientific, the concept of breakdown in practical and effective living, and the place a hospital has in providing sufficient support for the maximum of personal independence.

Disability is not the same as disease and explanation is not prediction reversed.

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Mitral Valvotomy in Elderly Patients

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Most patients with untreated mitral stenosis die before the age of 50 (DeGraff and Lingg, 1935; Olesen, 1955; Wood, 1956). Those who survive are liable to have atrial fibrillation, rigid and calcified valves, cardiac enlargement, and chronic heart failure over and above the other conditions to which elderly people are prone (hypertension, atherosclerosis, diabetes, chronic airways obstruction). On account of these factors there are differences of opinion among cardiologists on the advisability of mitral valvotomy in those aged 50 or over, where the operative risks and the proportion of poor results have often been reported to be higher (Goodwin *et al.*, 1955; Ellis *et al.*, 1959; Lowther and Turner, 1962; Reid *et al.*, 1966).

Surgical experience of closed mitral valvotomy at the Royal Postgraduate Medical School now includes 75 patients aged 50 or over. The results of surgery are examined critically in the light of preoperative findings, and the various potentially adverse factors are analysed for their effect on operative mortality and long-term results.

Patients

The present study is concerned with 77 mitral valvotomies carried out on 75 patients aged 50 years or over. The operations were performed by Mr. W. P. Cleland, Professor H. H. Bentall, and their surgical colleagues. The period under review extends from 1954 to July 1966. Of the 75 patients 65 were female. Their ages ranged from 50 to 67 years: 38 were 50

to 54 years, 27 were 55 to 59, and 12 were 60 or over at the time of each valvotomy. A history of rheumatic fever was obtained in 38 (51%). Eight patients had had a previous valvotomy; for two of them the current operation was the third.

Preoperative and Operative Findings

Symptoms.—Dyspnoea was present in all but one patient. From careful consideration of the history and observation of the patients' effort tolerance while in hospital the degree of dyspnoea was estimated as grade 1 in 2 cases, grade 2a in 20, grade 2b in 45, and grade 3-4 in 7 (using the criteria of Goodwin *et al.*, 1955). Preoperative systemic embolism occurred in 20 patients (27%); repetitively in eight. The commonest sites were the femoral (15 episodes) and cerebral arteries (14 episodes). Two patients had a history of coronary embolism or thrombosis. Fifteen patients (20%) suffered from chronic obstructive airways disease, which was severe in nine. One had asbestosis, another bronchiectasis. Pain suggestive of angina of effort was a feature in 12 (16%). One had Stokes-Adams attacks. Twelve had had previous episodes of cardiac failure. A history of haemoptysis was obtained in five.

Physical Findings.—The incidence of atrial fibrillation was extremely high (56 patients; 75%) and increased with age, as shown in Table I (Obeyesekere *et al.*, 1965; Reid *et al.*, 1966). Twenty-seven patients (36%) had clinical evidence of associated valve disease. In 17 cases some degree of aortic valve disease was diagnosed; it was regarded as mild in 10 instances (six with aortic regurgitation, three with aortic stenosis, and one with mixed aortic valve disease) and as

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