very valuable supporting part. The drive cog, however, must be somebody who can be easily contacted by the hospital, told of the patients discharged, and can visit the home and assess the problems and the needs of the patient and family without intrusion. A member of the caring team who has the necessary experience could well be the health visitor. In many areas she performs this task already for geriatric patients, and to extend it to the care of the dying seems logical.

For a domiciliary team to work effectively and efficiently they must be told in advance about the patient's need. A 'phone call from the ward sister, the general practitioner, or health visitor can start the drive wheel. Having assessed the needs by contact with the patient, the hospital, and the G.P.—by visiting the patient's home and by talking to the relatives—one is made aware of what is needed. Arrangements can be made for what is necessary from the local health authority—such things as day and night nursing services; perhaps help with cancer patients from the Marie Curie Foundation; a sitting service; a laundry service; Meals on Wheels—provided by the local health authority or the voluntary services; bathing services and disposable dressing service; loan of special beds or physical aids. From the social service department arrangements can be made for home helps and the valuable social workers' supportive help; any adaptation to the home that is necessary can be made before the patient's discharge.

Many of you may well be thinking that half these services are either non-existent or scanty in your area, and this is why I stress the importance of the 1974 reorganization. Area health authorities must be told that they are expected to provide a certain laid-down minimum for the care of the dying, and for the incapacitated. Incidentally, I find it very difficult to differentiate between the dying and the incapacitated. At what point do you die? If we do not think of the pre-terminal and the terminal phases together people are likely to fall through the net, and it is perhaps in the pre-terminal phase that they need the help so desperately—even more perhaps than in the terminal. The local authority should be told that their social services directorates must provide a certain laid-down minimum of services required by the area health authority. This is so essential now that home helps have been taken out of the health field.

It is somewhat sad that some of the services so essential to the needs of the dying have to compete with roads and libraries for finance from the rates. Having been the chairman of a health committee, I have had the experience of having to argue for what I considered were essential services against the cases put by my fellow chairman for perhaps libraries, or roads, or whatever it was. I found I never knew the strength of the cases they were putting up.

National Standard of Service

There must be a national standard of service. It must not be so patchy that if you live, for example, in one London borough you can get all the services I have mentioned, but if you live around the corner or across the road in another borough you can get hardly any of them. If the supportive services are available, the family will feel better able to cope with a dying relative at home and be more prepared to do so.

The voluntary services have a much greater part to play in care of the dying than perhaps many professionals think. All these organizations tend to work in isolation and with little communication with each other in some areas. Because of this and for the good of the community which they so ably serve, there is a need somewhere to tie the strings of communication. At the moment voluntary services are brought into the picture of the care of the dying or the incapacitated by their own bush telegraph—the G.P., the health visitor, the district nurse, or—as I have been told—even the milkman. Some hospitals now have voluntary service organizers, but I should far prefer to call that person a co-ordinator. The voluntary services co-ordinator has an invaluable part to play, and I hope that in 1974 she or he

will be acting as co-ordinator of the voluntary services that care for the dying in the community as well. It should be made obligatory on an area health authority to employ such a co-ordinator.

If the voluntary services co-ordinator knows the capabilities of the people involved, she or he can assure them that they will be usefully employed. There are many people in the community who have special qualities. Although they do not want to join any of the organizations such as I have mentioned, they would willingly apply to the voluntary services co-ordinator. It may be only calling in to see a dying patient once a week, perhaps giving encouragement in a particular interest or hobby that that patient has. The volunteers have got time: time to listen, time to sit with the knowledge that what they are doing is worthwhile. Sometimes in a less practical sense they have more to give the dying patient than perhaps the professional with many others to care for.

London Borough of Greenwich

MRS. W. MITCHELL, S.R.N., S.C.M., Former Chairman of Health Committee, Member of Central Health Services Council

Four Recurring Themes

K. R. O. PORTER

Four points have recurred throughout the whole course of today's discussion; let me identify them for you. The first is a new attitude. As a doctor, one is, I think, frequently thrown back on one's training as a medical student. And the way one was taught—certainly, in my day—there was no room for terminal care. It was the attitude of: "I am sorry, there is nothing more that I can do for you." It is of course true that we have got to try and cure as frequently as we can, but I think there are three aspects to medical care: to cure, sometimes; to alleviate, often; to support, always. If we can get that over to the people who are working with us in the care of terminal illness and to those under our care, then I believe something will be achieved.

One approach is the personal approach to care in hospitals—the setting aside of special beds and the establishment of special units for terminal care, and this is my second point—where people should die. I personally favour the wish of probably the bulk of people to die at home, among those whom they love, in familiar surroundings. But some will inevitably die in hospital, some will die in private nursing homes. I am a great believer in the pattern of a special unit where the real problems of the care of the dying can be handled. There may be centres of excellence, such as Cicely Saunders has described at St. Christopher's, but what we really need is to develop more small specialized units where the very tiny proportion of people who require special facilities can be cared for. Let us take, for example, the South-east, where my own regional board is. We have already started along this road: assuming we know for a fact that in the South-east we have 9,300 deaths a year from malignancy—that of course does not cover everything—and assuming that half of these cases will die at home under relatively tranquil well-supported circumstances, probably about 10% of those will require the care of special units. In our area for the population we have, for the number of deaths we have, something around 80 beds will be required. Clearly we have got to make sure that these units are not too big. We have got to make sure that the units are close to the patient's own homes, so that frequent visiting is possible and the beds can be used intermittently by patients who may be admitted and then returned back home again—perhaps several times. In national terms, somewhere around 12 beds per half-million population would be a good start towards meeting the need. These units cannot be built

immediately—that would cost an enormous amount of money. But there is something we can do now, and we are doing so in my area: we can use quite a number of existing nursing homes, some of them run by religious orders. We know of two or three, for example, with whom we could have contractual arrangements who are quite ready to develop this sort of service, and this is what we hope to pursue. This can be done at least within the next 12 months, using the yardstick I have quoted of roughly 12 beds per 500,000 population.

Staffing

The third point is personnel. It is a surprising thing, that when you develop these smaller specialized units the general public pep up; they suddenly become interested. But I want to turn now to the professional staff—G.P.s, the hospital consultant, nurses, and others. I want to return to the need for a new attitude, because this again is something that we can do immediately. We can go away and translate what we have heard at this symposium today into action, by holding conferences, seminars, and discussion groups of our own. In my region we are holding three seminars on terminal care—one in Brighton, one in Canterbury, and one in Lewisham, to try and bring home to everyone that this is an area of care which has been long neglected and which must be tackled realistically and with determination.

And then we need to make you think of how you can weave this pattern of care into vocational training for general practitioners. Between the South-east Metropolitan and the Wessex Regional Hospital Boards we cater for 75% of all vocational training for general practitioners in this country. We are trying to weave training in terminal care into the vocational training scheme for general practitioners.

My fourth point concerns organization. Clearly 1974 is going to make things easier in a sense, because the hospital will be the community and the community will be the hospital—a single identity. But we will need something further—some form of post-care team, whatever you call it, made up of the doctor, the nurse, the social worker, the minister of religion, with full representation for the voluntary services so that they can be informed of what is going on and make their own contribution. And let us have one organization to which people who want help in caring for the patient dying at home can turn for the expertise and the resources that they really need—whether these people be general practitioners or the family itself.

One final point: do not forget the spouse. I often think that when we send flowers and letters of condolence to those who are bereaved they must be overwhelmed. I often think that it would be much kinder to wait a month, or three months to send our flowers. The loneliness, the heartache, and feeling of isolation that overwhelm people so frequently comes a month, three months, four months, a year after the actual death of the husband or wife. This is the time when we need to support and help them. The research of Maddison and Parkes has shown all too clearly that the morbidity rate amongst widows is twice as high as it is in single women of a comparable age. Here is another area that needs investigation: the post-care, based as it is likely to be in the future district of the reorganized health service, must keep a record of every case, so that there can be a continuing follow-up, to ensure that all the resources of the welfare state and of the voluntary bodies are brought to bear where they are needed most—to help those in need.

South-east Metropolitan Regional Hospital Board

K. R. O. PORTER, F.R.C.P., D.P.H., Senior Administrative Medical Officer

Hospital Topics

Hyperthyroidism—a Disease of Old Age?

V. RØNNOV-JESSEN, C. KIRKEGAARD

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Summary

In a three-year project in which thyroid studies were undertaken for broad indications 49 cases of thyrotoxicosis were diagnosed; 28 of these patients were 60 years of age or older. Sixteen of these older patients had different forms of atypical thyrotoxicosis, and most were completely without the usual symptoms of the condition. It is concluded that thyrotoxicosis is more frequent in persons over 60 than in younger persons. Many older patients have various forms of masked thyrotoxicosis, and in many cases the correct diagnosis can be made only by undertaking thyroid studies on very wide indications.

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Introduction

At the beginning of the century thyrotoxicosis was thought to be rare among persons over 50 years of age.^{1,2} In 1939 it was shown for the first time that the disease in women was more common after the age of 40 than before.³ A decade later 12% and 10% of thyrotoxic patients were found to be over 60 years of age in two large study groups.^{4,5} Lamberg *et al.*⁶ found that among 366 cases of thyrotoxicosis 135 (37%) were in patients over the age of 60. The authors considered that these results were due to an improvement in diagnostic facilities, an increased awareness of the possibility of finding this disease in older people, prolongation of the length of life, and the fact that the patients studied came from an area endemic for goitre, particularly of the nodular type. In a Danish study from 1964 to 1968 33 out of 110 patients with thyrotoxicosis (30%) were 60 years of age or older.⁷

It is not rare for thyrotoxicosis to take an atypical course in older patients. Thyrotoxic symptoms are often less pronounced, and at times typical symptoms are almost totally absent.³⁻⁶ In these "masked" forms the course of the disease can be dominated by cardiac incompenation,^{8,9} gastrointestinal