didn't it? You felt human—a person, not just a piece of the furniture—or, worse still, an embarrassment to everyone, like a bad smell in a clean ward. Last week he told me the story of the guide at Niagara Falls, who says, "I'll bet you have nothing like this where you come from," and the little man from Glasgow who replies "No, but I know a good plumber who might be able to fix it for you." I had heard it before, but I didn't have the heart to tell him so; he must have saved it up for the ward round, knowing I was a plumber. So that's the first thing you get on a good ward round. They treat you like a human being. And you begin to relax a little. And you feel less tense, more yourself.

BILL: What's the second thing?

GEORGE: The second thing is that they want to know all about your symptoms. The ones that matter most to you are the ones that matter most to them. So far as possible, they aim to do something about them. There's nothing half hearted about it. You can see they mean business. They have a quick look at you, check up on a few things in a professional, workmanlike sort of way—maybe explain some of your symptoms—and then tell you what they are going to do and what they are hoping for.

BILL: Perhaps in some wards they just don't have the time. It's like any other job. You have to pick and choose a bit when you are under pressure.

GEORGE: No. It's not that. Take this lot we are with now. Every week they have a dozen new acute cases—sometimes they hardly know if they are coming or going. At times like that they can't spend more than a minute or two with patients like you and me. Even when they are not so busy, they forget things, they make mistakes, they are not perfect . . . far from it. But they care. They try. They don't give up easily. When I came in I was in a terrible state, with pain and shortness of breath and God knows what else. I wanted to feel better quickly or die. And they saw this immediately. So they got to work. No messing about. No red tape. No waiting for scans or *x*-rays that weren't really needed. It took them less than two days to discover I needed four times the normal dose of morphine. That's quite common apparently. They asked me if I preferred tablets or liquid, and they explained that once the correct dose is found, then that's it—it doesn't usually lose its effect, and there's no need to increase the dose. Sometimes you can reduce it later on.

BILL: Maybe they think there's nothing they can do for some people and they'd just be wasting their time.

GEORGE: Well, if they think that, they have got it wrong, haven't they? Any doctor who thinks that is only half a doctor. If a patient is really suffering a good doctor can always do something. I've seen it. Many times. Just taking an interest and trying something—anything—will help. And anyway a doctor's got to be sure that there isn't something crying out to be done that he didn't spot at first. I know that from my own job. You can't tell until you've weighed up a situation—and that takes a bit of skill and experience. You learn from your mistakes. You never stop learning. You enjoy life more if you approach all your work in that way—not just some of it. I get a lot of satisfaction from installing new bathrooms—that's my special interest and that's how I spend most of my time. But I'd be ashamed if I couldn't also make a good job of patching up a leak or unblocking a waste pipe for some old person living alone in a house soon due for demolition. And doing it quickly—no fuss, no frills, no unnecessary disturbance. A good plumber takes a pride in both kinds of work. He knows that either can be done well or done badly. I thought of that when the ward sister here got *me* unblocked last month. I never thought of a woman as a plumber, but she'd make a good one. I told her so. She did it gently, too. And what a difference it made . . . you would never believe what a difference it made . . .

BILL: Maybe you should have been a doctor, not a plumber.

GEORGE (*smiling*): Maybe I should . . . maybe I should . . . but I'm not complaining, I've had a good life . . . anyway, you'll be glad to hear that's the end of my lecture for today . . . so let's see if there's anything worth listening to on the radio, shall we?

Role of the hospice in the care of the dying

W D REES

A hospice has three main roles and to these may be added various subsidiary roles. The three primary roles are to act as a catalyst, to provide a service to the community, and to serve as a centre for teaching. Of these, the catalytic action will be considered first.

Catalytic action

To place this role in perspective, you need to recall the general attitude to terminal care and bereavement 20 or even 15 years ago. Then the discussion of death and its wider implications was almost taboo. The terminal nature of an illness was rarely mentioned to the patient, and the usual practice of doctors and relatives was to hide from the patient the nature of any illness considered incurable. This applied especially to cancer. In the past 15 years the trend has been towards more open discussion about cancer and terminal illness. This trend is not complete but is developing rapidly. To assume that hospices are entirely or even mainly responsible for this change would be erroneous; but it is correct to claim that they played an important part in opening and enlarging the discussion on the subject. Theirs is the action of a catalyst, and this is a very potent factor. But catalysts work only when the other essential elements are present and do so by quickening a process that otherwise proceeds more slowly. The other needed factors are a readiness for people to change attitudes and accept open discussion on these important subjects. These factors are now present. People do feel an urgent need to give to death an interest and concern similar to that of birth. Hospices are an effective response and stimulus to that need.

Paper read at Leicester General Hospital on 26 March 1982.

St Mary's Hospice, Selly Park, Birmingham
W D REES, MD, FRCGP, medical director

Care of the dying

For the community it serves, the most obvious role of the hospice is the care of dying people. Some hospices provide inpatient care only, though increasingly other hospices provide both inpatient care and a home care service. The home care service is of increasing importance, but at present the inpatient care given by hospices makes more impact and receives the greater publicity. In discussing this aspect it is necessary to consider the various environments in which people die. In doing

this, I will confine the discussion to an examination of the terminal care of patients with cancer.

In Britain there are three main places in which such patients die—the hospital, the home, and the hospice. At present 59% of patients with cancer die in hospital, 33% at home, and 7% in hospices. With the rapid extension of hospices, it is logical to expect the proportion of people dying there to increase. It is generally accepted that hospital is not the best place for a patient with terminal cancer to die. In making this assertion it is necessary to remember that though hospitals are not usually the best places for a terminal illness, they do have an important role in terminal care, even though the patient is not responding to curative treatment. Anaesthetists help with nerve blocks, neurosurgeons with specialised operations, and radiotherapists with the judicious irradiation of metastatic lesions. But despite the great help hospitals provide, and to this we must add the readiness of hospitals to admit patients with terminal cancer when no other agency will accept them, the public ward of a hospital remains an inappropriate place in which to die. It is as inappropriate as giving birth to a baby in a public place. The great moments of birth and death merit privacy, and the presence of the chosen few.

When a person is dying, hospitals have a structural problem in facilitating good communications. In so many hospitals it is difficult for relatives to make reasonable contact at this unique time when much may need to be said, the emotions are taut, and there is a desire to strengthen those close bonds of affection and kinship that will soon be broken. One is too much aware of the presence of other people, of other patients. The absence of quietness is intrusive. Doctors and nurses, though sympathetic to ones needs and those of the dying relative, have more pressing and urgent demands on them. In these circumstances the need of a patient dying from incurable cancer must be superseded by the more urgent demands of a patient with coronary thrombosis in need of immediate resuscitation. It is also difficult with present hospital patterns for the type of drug regimen needed to maintain pain relief in terminal cancer to be given properly on hospital wards. In theory this should not be a problem. In practice one hears so often from doctors, patients, and nurses that though the intention to relieve suffering is great it becomes difficult to organise the regular four-hourly opiate routine that is so effectively used in hospices. Even though oral morphine is prescribed on a four-hourly basis it may be four and a half to five hours, or even longer, before the drug is actually given. The result is that the pain is not constantly relieved; it breaks through, and as the physical pain attacks the patient's body the recollection of impending pain dominates his mind. So hospitals have much to offer, but in their present structure are probably not the best places for the care of terminally ill patients.

Dying without distress

Thirty-three per cent of patients with terminal cancer die at home, and in many ways this is the ideal environment. There the patient remains a more dominant and central figure than he can ever be in a hospital or hospice. In the presence of a concerned family the desires and needs of a dying person are most readily noted and alleviated. Most people prefer familiar environments in times of stress, and given the chance most people prefer to die at home in their own beds. But this ideal situation is not always the most practical solution to the problem. An elderly person living alone will need more care in his terminal illness than can be given by the district nurse. In these instances admission to a unit becomes of paramount importance. It is for this type of case, when the family cannot cope and hospital is inappropriate, that the hospice has much to offer. It provides a half-way position between home and hospital. It endeavours to provide a relaxed atmosphere, time, sympathy, and an attentive ear. To this it adds the high degree of professional nursing skill and special expertise in pain relief by the use of strong analgesics that comes from constant usage. Simple but important things, such as providing the type of food a patient likes, are more easily dealt with in small units such as hospices than in large district hospitals. It is not uncommon for patients to say that they feel better after entering St Mary's Hospice simply because they can eat and enjoy the food we give.

In a hospice death is not a disaster. It is not a failure. It is not an enemy constantly to be fought against. It is accepted as a natural event in human life. Admittedly it is an event that occurs only once for each person; but this uniqueness increases its importance and consequently the anxiety associated with the thought of dying. Strangely enough, it is not the thought of being dead that disturbs most people, but the apprehension that dying will be unpleasant and painful and that they will lose control of the situation and perhaps behave badly. We can reassure them that dying will be easy; that their pain will be relieved and that the act of dying will not diminish them in the eyes of those who care for them. It would be wrong to claim that all or even most die with dignity, because the physical act of dying is usually not dignified. We can aim, however, and succeed in ensuring that they will die without distress and with serenity.

Teaching and role in the community

All hospices have a teaching role, especially those in university centres with established medical schools. One of the rewards of working in St Mary's Hospice is that we are visited regularly by students and can show them the courage, serenity, and ease with which people can die. We can teach them the importance in terminal care of looking to the need of relatives. We can and do remind them that bereavement has the characteristics of a disease with a substantial morbidity and, particularly in men, an appreciable mortality. As a result, terminal care includes not only the care of a single person but of the wider unit embraced by family and at times friends. In giving adequate support and help to these relatives we are reducing the subsequent risk of serious psychological and physical illness and of sudden death from coronary thrombosis. Looked at in this way the teaching of terminal care in hospices includes the teaching of preventive medicine.

Earlier on I said that hospices have three primary roles and a number of subsidiary roles. I will consider now three of the subsidiary roles. Firstly, hospices are centres of concern for the community. This role should not be underestimated. Most hospices have been established mainly from donations raised by local people living in the area served by the hospice. Also, most of the running costs of hospices have to be raised on a local basis. In St Mary's only 37% of our running costs are funded by the NHS. The rest comes from gifts and donations. In addition to their financial aid, some people wish to be involved in a more intimate way with the work of the hospice. At present, St Mary's has 200 volunteers who provide a wide variety of services within and outside the hospice. That the community is allowed and enabled to show its concern in this way is important.

Spiritual function

Let me state quite clearly that a hospice has a spiritual function. This I classify as a subsidiary role, though some may consider it a primary role, while others will regard it as of no importance. I shall introduce you to the idea in this way. I think all hospices should have a chapel. In St Mary's we are fortunate that the chapel has a central position in the hospice. It also happens that in St Mary's, and I assume in most other hospices, it is normal practice for nurses to say a simple short prayer with the patients on the wards each night and morning. These two things, the chapel and the prayers, point our patients to the spiritual dimensions of life. A dying patient will review his past and wonder about his future. The number of convinced

agnostics and atheists is small. In a final analysis most people have some concept of God and some concept of a life after death. This is such a widespread concept that at no time and in no civilisation throughout the history of man has any important race, nation, or culture existed without a real relief that death is not the end but the gateway to a new pattern of living. This is not based on the fear of death. I have already mentiond that most people are not frightened of being dead, they are frightened of the process of dying. It is not based on a wish for immortality, because most people would be quite happy to enter a long, uninterrupted sleep from which there is no awakening. For this reason it is important that we strengthen so far as we can the spiritual resources of dying people. In the Western world the spiritual basis on which they rely is Christianity. It follows that normally the spiritual support given in hospices is based on the teaching of the Christian church. It would, however, be quite wrong for people working in a hospice in any way to undermine the faith or absence of faith of those who hold alternative views. We consider it important that a dying person should receive all the spiritual succour that can be given by the heritage and tradition of his own group; whether this be Christian, Jewish, Moslem, Hindu, or any of the other "isms."

Research

Finally, a word about research. It is common practice when asked to define roles to add to the list—research. This is quite proper, but not always appropriate. Not all research programmes are worth while and most require considerable effort. This might best be expended in some other endeavour. But despite this caveat, hospices will undoubtedly become increasingly involved in scientific research and will add, thereby, to our knowledge of the great mystery of life we call death.

Functional diseases

MICHAEL R TRIMBLE

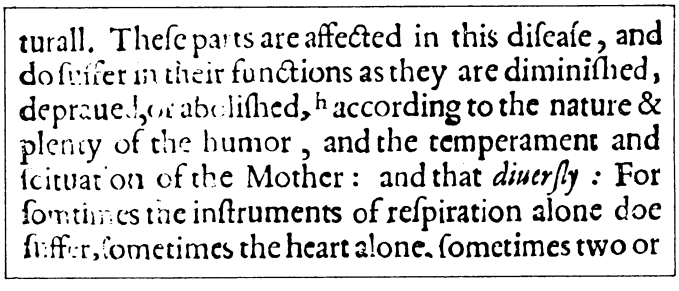
The word "function" has probably been in use in the English language for over 400 years, though its meaning as "a special kind of activity" is more recent. Originally, it had two uses: one physiological—that is, as the activity of an organ—and one psychological—that is, as the activity of the intellectual or emotional faculties. The word does not appear in either of these senses in the writings of, for example, Hobbs, Locke, Berkeley, or Hume, despite the fact that all wrote extensively on psychology and Locke had a medical training.[1] Its physiological sense was used by a sixteenth century physician called Edward Jorden in a book on hysteria, called *The Suffocation of the Mother*. Jorden argued against the theological demonic propositions of the times and suggested that hysteria was a natural disease within the scope of medical study. He wrote:

> "It is an affect of the mother or wombe wherein the principal parts of the bodie by consent do suffer ... [These] ... are the seates of the three faculties which do govern the whole bodie. The braine of the animal, the hart of the vitall, the liver of the naturall ... these parts are affected in this disease and do suffer in their functions as they are diminished, depraved or abolished, according to the nature and plenty of the humor and the temperament and situation of the mother."

Furthermore, Hartley in his *Observations on Man* used the word function 20 times, mainly in the physiological sense, when describing the structure and function of several bodily organs.

Andrew Combe[2] was the first to use the term functional in relation to nervous diseases. In about 1831 function had both the psychological and the physiological meaning. The first was particularly used by the phrenologists such as Gall and Spurzheim, who wrote extensively about the functions of the brain. Combe's use was physiological:

> "The exciting causes may be divided into two great classes of local and functional ... the functional causes ... are not only the most frequent and most important, but in the strictest sense functional ... the term functional has a reference to disorder in the action of the organs of the mind."


turall. Theſe parts are affected in this diſeaſe, and do ſuffer in their functions as they are diminiſhed, depraued, or abeliſhed, h according to the nature & plenty of the humor, and the temperament and ſcituation of the Mother: and that *diuerſly*: For ſometimes the inſtruments of reſpiration alone doe ſuffer, ſometimes the heart alone, ſometimes two or

From *The Suffocation of the Mother*, Edward Jorden (1569-1632). Reproduced by permission of the British Museum.

After this several neurologists classified diseases as organic and functional, the latter in its physiological sense. For example, Reynolds,[3] writing on the symptoms of disease, noted that they "resolve themselves into modifications of structure such as hypertrophy, variolus pustules, etc, and of function as for example paralysis, convulsions, flux and the like." Gowers[4] also classified neurological disorders as organic and functional. The last included "those diseases that consist only in a disturbance of function and many diseases which have this in common with true functional disease, ... they are transient and not permanent and they are not known to depend on organic changes." He did, however, consider their pathology when he said, "Molecular changes in nutrition, considered as such, must be colossal to be detected. Such alterations, not sufficient to be seen but still considerable, probably constitute the morbid process in many diseases that are commonly classed as functional." His "functional" disorders included chorea, paralysis agitans, tetanus, epilepsy, migraine, and hysteria.

Hughlings Jackson[5] also referred to the term functional: "It is sometimes used as a name for minute changes, or for those the existence of which we are obliged to discover at post mortem. For instance it is said that epilepsy and chorea are functional diseases, it being meant that the changes on which the symptoms

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