outline of the principles of diminishing these unfavourable emotions as much as possible. The patient who initially has no idea of his malignancy but who nevertheless is going to require surgery for its treatment must, I believe, be told the cause of his symptoms and the justification for his treatment, but it is very important for him to have a period of acclimatization in which to adjust to the fact that he has cancer. It follows that if at the first encounter the doctor thinks his patient has cancer, then when the problem of diagnosis is discussed the doctor should imply that malignancy is a possible diagnosis. The patient then has some diagnostic tests and when he returns for the results he should be asked to come with his wife so that if the final blow has to be coped with they are together at the interview. I believe the latter to be important because the key to excessive suffering in this situation comes from suspicion, fear, loneliness, and self pity. If the patient is aware that his doctor is saying one thing to him and something else to his wife the obvious inference is that his wife is being told the truth which is too unpleasant for him to hear. The surgeon must see the patient with his wife alone and not surrounded by a formidable entourage of white coats and serious faces. The surgeon must have time enough to answer questions and be gentle enough to feel some sympathy for the man and his family.

The key to management therefore is gentle understanding, time, and honesty; it is not a long face and "I am so sorry for you." The patient's specific fears are dealt with one by one in discussion and positive things are stressed rather than negative. For example, ways of relieving pain are outlined if the patient

starts to worry about pain. Above all the care of the patient with cancer must be combined with understanding the thoughts passing through his mind and discussing them frankly with him and his family.

The patient must not feel that the surgeon or physician to whom he turned for treatment when his disease appeared curable has now abandoned him, "There is nothing more I can do for you, go back to your family doctor." There is a great deal that the specialist can do in the way of emotional support and this may be very valuable. Abandonment of the incurable patient by the specialist has far-reaching effects: not only does the patient and his family feel disappointed, even betrayed, but also the junior staff in training from interns to nurses learn that the "great man" abandons an incurable patient and may put this into practice in their own working life.

Kindly understanding by a team which includes the specialist, the family doctor, nurses, and the patient and his family, will not eliminate the suffering of the cancer patient but will diminish it—a modest achievement but one worth obtaining.

References

- ¹ Milton, G. W., *Medical Journal of Australia*, 1972, 2, 177.
- ² Solzhenitzyn, Alexander, *Cancer Ward*. Harmondsworth, Penguin Books, 1972.
- ³ Johnson, Samuel, *Rasselas*, in *Poems and Selected Prose*, ed. B. H. Bronson, p. 180. New York, Holt, Rinehart and Winston Inc., 1958.
- ⁴ Maddison, D., *Archives of the Foundation of Thanatology*, 1970, 2, 000.

Medicine in Old Age

Role of Day Hospital Care

J. C. BROCKLEHURST

British Medical Journal, 1973, 4, 223–225

Geriatric medicine initiated an early form of progressive patient care in hospital—through acute admission ward, to rehabilitation ward, and continuing care ward. The geriatric day hospital is a logical extension of this system and forms a bridge between the hospital and the community. The ever-increasing numbers and proportion of elderly people, particularly the very old, in our society inevitably increase the incidence of disabling disease. The provision of day care for the treatment and support of elderly disabled people has been an attempt, attended with a good deal of success, to prevent the admission to hospital of more and more of these old people.

Social Day Care

Day care for the elderly includes a wide variety of social and hospital provisions which must be clearly distinguished. Social

day care is provided either by local authorities or by voluntary organizations (for example, old peoples welfare committees)—or occasionally by thoughtful employers. Social day care itself offers a whole spectrum of facilities.¹ Anderson's definition of social day care is as follows: "Clubs and social centres exist for all old people, to increase social contact and to give scope and facilities for new pursuits in retirement".

Several main types of day care are now available. Day care centres, most usually instituted by local authorities, provide a substantial amount of personal care to at least a small proportion of clients. Referral is usually through general practitioners or social workers. There are a wide range of services, including bathing, chiropody, meals, and provision of low priced foods. Psychogeriatric day care centres are similar to day care centres but require a greater degree of supervision. Their purpose is more that of a crèche than a club. Since it is now the Department of Health and Social Security's policy to support old people suffering from dementia, who are neither physically handicapped nor pose behavioural problems, in the community the importance of psychogeriatric day care centres is likely to increase.²

Both these types of social day centres may be provided by local authorities under the 1968 Health Services and Public Health Act and both require transport to bring the clients to them.

Social centres or social clubs come in many varieties; some are open seven days a week, others only one half day a fortnight.

Department of Geriatric Medicine, University Hospital of South Manchester, M20 8LR

J. C. BROCKLEHURST, M.D., F.R.C.P., Professor

They usually have a regular membership and are often organized by the retired people themselves. Shelters (rest centre or drop-in) may be provided by local communities or employers and serve simply as a communal meeting place which elderly people may use as they wish.

Communal rooms in sheltered housing and other housing schemes clearly offer a great opportunity for day care, in which both residents in the sheltered housing and other people living in the area may join together. A most important development for the future will be the provision of a restaurant so that residents in sheltered housing may have at least one communal cooked meal a day, where they may be joined by elderly people from the local community.

Lunch clubs are an important and desirable alternative to meals on wheels. Work centres may be provided either by the local authority, commercial organizations, or voluntary bodies. Essentially, retired people come here to engage in productive work for which they are paid. This has, of course, very important social and emotional advantages.

These various types of social day care available at present must be clearly distinguished from the geriatric day hospital.

Day Hospitals

Day hospitals are part of the hospital service and are generally situated within a district general hospital in close relationship to the geriatric rehabilitation department. In many cases, day hospital and geriatric rehabilitation department share the same premises and facilities. This is a particularly desirable concept, which allows patients who have been undergoing rehabilitation to return to their homes and yet have the security of a continuing contact with the hospital and so with their therapists, until they are firmly settled back at home. Though day hospitals have many uses other than this, this is one of the most important, and one which guards against waste of hospital resources.

The concept of a geriatric day hospital must now be extended to include the psychogeriatric day hospital. Though not many are so far available it is part of the clearly defined policy of the Department of Health and Social Security to provide two places per 1,000 people over 65 for geriatric day hospital care and an additional two places per 1,000 people over 65 for psychogeriatric day hospital care. The psychogeriatric day hospital may be established adjoining the geriatric day hospital and share several facilities. Alternatively, and hitherto more commonly, it may be set up within a psychiatric hospital, though in future, of course, these will be replaced. A further possibility is that the psychogeriatric day hospital may be situated within the community hospital or general-practitioner hospital, particularly in rural areas.

DEVELOPMENT

Geriatric day hospitals first developed from occupational therapy departments. The first purpose-built geriatric day hospital was opened in Oxford at Cowley Road Hospital, and this has served as the model for subsequent development. The day hospital at Oxford was opened in 1958 and by the end of 1970 there were 120 geriatric day hospitals in the U.K. Now most geriatric departments include a day hospital, and increasingly purpose-built day hospitals are superseding adaptations of various other hospital premises.

WORK

Elderly patients come to a day hospital for one of four main reasons: rehabilitation; maintenance treatment; medical or nursing investigation; or social care.

Rehabilitation is an important part of geriatric practice since so often the problem is one of physical disability: there is

prospect of improvement, though often not of recovery. It is helpful to see rehabilitation as a finite process to which there is usually an end—reached when the patient achieves his maximum degree of independence.

Maintenance treatment is important in old age since having once achieved maximum independence many elderly people will deteriorate slowly (and sometimes quite rapidly) once they are cut off from the stimulus of the geriatric rehabilitation department. Much important and laborious work can thereby be undone, particularly if relatives are over-protective or the old person poorly motivated. Once-weekly day hospital attendance perhaps for an indefinite period often ensures that the state of independence achieved is maintained.

Medical and nursing procedures in the day hospital form a very variable part of current geriatric practice. In a few departments great stress is laid on these;³ in most some use is made of the day hospital for procedures such as sternal marrow punctures, the supervision and treatment of faecal incontinence, glucose tolerance tests, etc. On the other hand, obviously it is not appropriate to bring elderly people up to a day hospital simply to carry out procedures which might equally well be done by the district nurse or the family doctor in the patients' home.

The distinction between social day care and the geriatric day hospital has already been emphasized, but a few elderly people are so physically disabled as to be unsuitable for social day centres and yet have needs for companionship and relief of their isolation. Its nursing care makes the geriatric day hospital the appropriate place for such patients. In some day hospitals severely disabled younger patients are brought for this purpose. Another, if uncommon, aspect of social care is when a disabled elderly patient may be discharged home from hospital and looked after at night and at the weekend, but when the relative on whom he depends has to work. Discharge may then be possible only if day hospital attendance can be arranged.

PATIENTS

In a national survey of day hospitals Brocklehurst⁴ found that consultant geriatricians placed most importance on physical rehabilitation and physical maintenance (89% and 78%, respectively of respondents). Half laid stress on the social care of physically disabled people as important, 36% on medical or nursing procedures, and 21% on the social care of mentally confused old people. In a more detailed survey of five day hospitals the numbers of patients actually attending for these various purposes were as follows: rehabilitation 27%, physical maintenance 42%, social reason 26%, and other 5%.

This survey also noted the source of referral of 465 day hospital patients as follows: in-patient geriatric ward 32%, medical ward 7%, other wards 2%, geriatric outpatient consultative clinic 29%, domiciliary or assessment visit 13%, and by direct negotiation with the general practitioner 17%. Most people attending the day hospitals surveyed were aged between 75 and 84 and the major diagnostic categories were stroke (30%) and arthritis (26%).

STAFF

The day hospital should be regarded as a ward within the hospital—in fact, Andrews has suggested that it should be called a day ward rather than a day hospital. This emphasizes that staffing should be on similar levels of that of an inpatient ward and that management should be along similar lines. The day hospital is generally in charge of the consultant geriatrician and consists of three main departments—nursing, physiotherapy, and occupational therapy—with a smaller involvement of speech therapists, social workers, volunteers, and administrators. A doctor must attend daily to maintain records and to initiate investigation and treatment of patients. There should also be a case conference of the whole medical, social, and therapeutic

team at least once weekly to review the patients' progress. To be dynamic a day hospital must be continually discharging and accepting new patients and there should never be a waiting list. It is a great advantage if there are clear pathways between the day hospital and the various social day care facilities so that those who no longer need the therapeutic aspect of day care may continue to enjoy its social benefit.

ADVANTAGES

The advantages of the geriatric day hospital lie first in allowing the treatment of many elderly people without hospital admission, particularly when outpatient attendance at a physiotherapy department would be unsuitable. The need is for a continuing therapeutic environment where the pace is slower but activity continues throughout most of the day. The day hospital also allows the earlier discharge of patients and their subsequent supervision until they are safely settled at home. Another advantage is that the hours are attractive to staff and recruitment of suitable staff is often easier than to the inpatient wards.

PROBLEMS

Day hospitals are not without their problems. Probably the greatest of these lies in the provision of ambulance transport. It is exceptional for any patient needing day hospital treatment to be able to come independently. A few can be brought by relatives in cars, and in the occasional area taxis are hired for this purpose, but generally day hospitals must depend on the ambulance service for the delivery and returning home of their patients. This requires special and appropriate transport—for example, a vehicle with eight to ten seats with a hydraulic or other lift, good visibility for the passengers, safe seating, and good heating. Such a vehicle is likely to take between an hour and an hour and a half to collect its complement of patients and so those collected first may well spend upwards of an hour in the vehicle. For most of them this is of no hardship provided that the vehicle is appropriate, since it is likely to be the only time that they get out of their own homes.

It is essential that ambulances should bring patients to the day hospital and take them home according to a pre-arranged timetable and that vehicles are not used which are apt to be diverted for other purposes. The whole professional team in the day hospital awaits the arrival of the patients and if ambulance services are erratic there is an enormous waste of these professional resources. It is equally frustrating for the old person sitting for two or three hours awaiting the ambulance's arrival. Furthermore, patients coming to day hospitals are often relying on this as their only source of food that day, and perhaps of heating and other care. If the ambulance does not collect them they may suffer great hardship, as was shown in a survey of the effect of industrial action by the ambulance service on day hospital patients.⁵

Finally, what of the future? The day hospital is now firmly established and in due course every geriatric department will have one as an essential part of its service. There may be an increase of specialization within day hospitals, some developing more as day wards for medical and nursing treatment, others becoming the local stroke rehabilitation unit or orthopaedic rehabilitation unit for elderly people. Possibly some smaller day hospitals may be set up in association with community hospitals, where the emphasis will be on maintenance and social treatment. The day hospital serves as an excellent focus bringing together community medical care (the general-practitioner team) and the geriatric hospital team. The day hospital is in many ways a shop window for the geriatric service and undoubtedly a good one adds immeasurably to the morale of the whole geriatric department.

References

- ¹ Anderson, D. C., *Report on Leisure and Day Care Facilities for the Old*. London, Age Concern, 1972.
- ² Davidge, J. L., in *The Elderly Mind*, [London, British Hospital Journal/Hospital International, 1972]
- ³ Andrews, J., Fairley, A., Hyland, M., *Journal of the American Geriatrics Society*, 1970, **18**, 378.
- ⁴ Brocklehurst, J. C., *The Geriatric Day Hospital*, London, King Edward's Hospital Fund for London, 1970.
- ⁵ Prinsley, D. N., *British Medical Journal*, 1971, **3**, 170.

Occasional Survey

Trade Names or Proper Names?—A Problem For the Prescriber

E. C. HUSKISSON

British Medical Journal, 1973, **4**, 225–228

Prescribers in Britain have a choice; they may prescribe medicine by an approved name, which has been given to the active ingredient of the medicine by the British Pharmacopoeia Commission; or they may prescribe using a trade name which identifies the product of a particular manufacturer. For some

commonly used drugs such as aspirin and digoxin there are many brands containing the same quantity of the same active ingredient.

Most doctors will have been taught to use approved names for drugs. In the past this has been recommended by the Department of Health and has been standard teaching for medical students. The first prescribing experience of doctors is in National Health Service Hospitals, whose pharmacists are often authorized to substitute an alternative brand of any drug prescribed; this cuts down the work of the pharmacy as well as that of the nurses administering the drugs by reducing the number of available brands of any drug. Considerable savings are also made by hospitals deciding to buy a single brand of a

St. Bartholomew's Hospital, London E.C.1

E. C. HUSKISSON, M.B., M.R.C.P., Senior Medical Registrar