SECOND SESSION

The shrunk shank

WELCOME

Dr S. Cole, M.R.C.S., L.R.C.P., D.Obst.R.C.O.G., M.R.C.G.P. (*Provost, South-east England Faculty*)

Our Chairman for this session will need little introduction. Not only is Dr Ronald Gibson a general practitioner of great repute, but as many of you will know he was the first chairman of this faculty and is now chairman of the council of the British Medical Association.

OPENING REMARKS

Dr Ronald Gibson, *O.B.E.*, M.A., LL.D., F.R.C.S., F.R.C.G.P. (*general practitioner, Winchester, Chairman of BMA Council*)

I am grateful indeed for the privilege of being asked to chair this session. It is very much like coming home when I come back to the faculty. Yesterday we decided that the majority of people with cardiovascular complaints should, wherever possible, be treated at home, and they should be looked after by the general practitioner. We also discovered that lack of night care for these people is a major problem throughout the country.

Today we are to consider the rehabilitation of these patients, and as Dr Lindsay has said, this is restoration not just of body and mind but, particularly in this age group, of spirit or soul as well.

Medical aspects of geriatric rehabilitation

Dr R. E. Irvine, M.A., B.A., M.D., M.B., B.Chir., F.R.C.P. (*consultant physician*)

Most hospital specialists deal only with episodes in a patient's life, but geriatric physicians, like general practitioners, learn to see the problems on a more extended time-scale. We often need to think in terms of a programme of continuing care, which in one form or another is likely to go on for the rest of the patient's life. Also, like

general practitioners, we have to take a much greater interest than most other hospital specialists in the reaction of relatives to the patient's illness. We cannot practice geriatrics for one day in isolation from the needs of relatives. Four out of five chronically ill, bedridden old people are at home and only one out of five is in hospital, and this means that we have to take a broad view of the whole problem. My experience is centred on the hospital, but even so I hope you will feel that the attitudes of mind necessary for geriatrics are as appropriate at home as in hospital.

Medical assessment

Without a comprehensive medical assessment no kind of rehabilitation can be safely embarked upon. Four out of five people who come to a modern geriatric unit come with an acute illness or an acute exacerbation of a chronic illness and we much prefer to get our patients first hand. Rehabilitation is easier in patients who have come to the geriatric unit at the beginning of their illness. Multiple disorders are now a well-recognized feature of illness in old age and provide much of the interest in geriatric medicine. They imply the need for a complete medical assessment of every patient. The kind of things that are found are locomotor disorders arising from diseases of the joints, feet and nervous system. An accurate cardiac assessment is vital also. To limit an old person's efforts for fear of his heart is a commoner error than provoking heart failure or angina by pushing him too hard. Mental infirmity together with impaired balance, hearing and eye-sight are common additional problems which have to be taken into account.

One patient had for many years been in an old-fashioned chronic sick ward where she was regarded as mentally infirm and helpless. One day a new geriatrician discovered that the lady was in fact mentally normal and physically fit but happened to be both blind and deaf. When these facts were established and a proper assessment made, the patient was allowed out of bed and learned to do everything for herself. Eventually she was able to leave hospital and now lives in a welfare hostel.

Emotional factors

Emotion affects rehabilitation a great deal because no one can be rehabilitated against their will. If there was ever a situation when your college motto *Cum scientia caritas* was appropriate, it is in the efforts that we must make to understand the anxieties of an old person and to win his confidence, for without this rehabilitation will not be achieved. Social problems are closely interlinked with the medical ones, and it is as important to know what the patient's relatives and friends think about his illness as to know how the patient is reacting to it himself. In hospital this is the province of the medical social worker who is an indispensable member of the geriatric team. Perhaps the time will come when she is a key member of the general-practice team also.

What is rehabilitation?

Rehabilitation has many definitions, and Bernard Isaacs, in his excellent book *An introduction to geriatrics* describes it as "the orderly progression of the patient from dependence to independence". An old person who takes to bed with an acute illness which threatens his mobility, such as a stroke, becomes wholly dependent on others and if he stays in bed he is in danger of remaining there permanently. He is unlikely to get moving of his own accord and needs constant encouragement and assistance to exploit any improvement which can be achieved.

Rehabilitation is part of the treatment of the whole man. We are all inclined to think of treatment in terms of a prescription for drugs or a surgical operation; or we may think of rehabilitation as a mystique which is the exclusive province of physiotherapists and occupational therapists. This is quite wrong. These experts are indispensible, but rehabilitation also implies an attitude of mind which should affect every-

body. The whole team under the doctor's leadership should have a positive and constructive approach to the patient and his problems. Treatment will then be conducted in an atmosphere which helps the patient to regain the function he has lost. Some patients respond to a short, once and for all period of rehabilitation but for many it may need to be a continued process, lasting perhaps for life. One of the ways in which this type of rehabilitation can be provided is through the day hospital.

Aims of rehabilitation

The general aim should be to help the patient towards the greatest possible degree of independence. There are three areas of activity to be considered.

The first is mobility. The patient must be helped to walk and if he cannot walk he may learn to control a wheelchair. A patient who cannot walk and cannot move round is inevitably wholly dependent on others, but even a limited amount of walking—the ability to get from bed to chair, from chair to commode or to potter about the room with a walking aid—may make all the difference in the world to his future morale and self respect.

He also needs to become independent in the activities of daily living, particularly washing, dressing and toilet. Many patients benefit psychologically if they can practice some of the household skills which they exercised in the past. Confidence and morale are increased if there is an opportunity to resume such activities as cooking, food preparation and washing up.

A third need is to achieve social reliability, to be able to manage alone at home either continuously or for long periods of the day.

Home adaptations

These aims will not be achieved by everybody and it is important to be realistic as well as optimistic in trying to help the patient. To aim too high may only bring discouragement. It may become obvious in hospital that the patient cannot return to his home just as it was before. The environment may have to be adapted to his disability. This may simply involve fitting an appropriate handrail or a toilet aid or it may mean quite extensive alterations to the house. For these home adaptations we depend greatly on the advice and skill of the physiotherapist and occupational therapist. Nowadays both are undertaking an increasing amount of domiciliary visiting in collaboration with the welfare department, and we have found that great advantages arise from this system.

Alternatively, the patient may need to move to a new environment such as an old people's home and this kind of decision is a major responsibility of the medical social worker in consultation with the physician.

Getting up

The most important step in rehabilitation, whether at home or in hospital, is simply to get the patient out of bed. Bed rest not only convinces the patient that he is a hopeless invalid, it actually produces the physical conditions which make rehabilitation impossible —wasted muscles, foot drop, contractures. Moreover, bed rest predisposes to venous thrombosis, pulmonary embolism, faecal impaction and incontinence. To have the patient out of bed is to prove to him that he is not yet finished; it encourages him to relearn the activities which will enable him to regain his place in society.

To be up gives him confidence and the atmosphere in the ward becomes encouraging when he sees other patients up and making progress. A good geriatric ward should be a busy, active place.

Geriatric wards

Treatment and rehabilitation with the patient out of bed is difficult in hospital unless the environment is suitable. Few of our hospitals were designed with the up

patient in mind; few of them have enough lavatories, enough bathrooms, enough day space or suitable furniture. The situation is slowly changing but inadequate facilities are still the daily headaches of us all. However, much can be done if the wards are redecorated and supplied with the proper equipment.

Equipment for rehabilitation

In hospital the ordinary ward equipment provides the basic tools for rehabilitation. The first essential is a bed, which the patient can easily and safely get in and out of without being lifted by the nurses. This means that the bed must not be more than about 18 inches high from the floor, the same height as a chair, and the patient should be able to sit on the bed with her feet comfortably on the ground. A bed like this is, however, inconveniently low if the patient is ill enough to require bedside nursing. It is also rather too low for comfort in bedmaking. The answer is to have beds of adjustable height and there are now many different designs on the market. High-low beds obviate a great deal of lifting, encourage the patient in personal independence and reduce the need for hoists and other lifting equipment.

Good geriatric chairs are very important. The seat needs to be about 18 inches high. The back should be straight to encourage the patient to sit upright and there should be some additional support in the lumbar region. Padded arms are a great help, and for a frailer patient a tray to put in front is an advantage. Not everybody, however, should sit in a chair with a tray. Some people feel affronted if they have to do this and it is important to match the chair to the patient. The chair must be stable when it is standing and it must not be easily tipped up; it should have castors on which it can be moved, preferably with the patient in it.

If the patient is to be up and dressed, which is absolutely vital to the process of rehabilitation, there must be special lockers or cupboards for his clothes. Dressing has an enormous psychological effect on patients, staff, relatives and everyone who comes into the ward. A patient in nightclothes, is just a patient, but the same patient dressed in his day clothes looks and feels like someone who is going to resume his place in the community.

Bed tables are another important item. Many of the wards still have the traditional bridge type of bed table which goes over the bed. This is uncomfortable in use and makes washing in bed difficult. The cantilever type of table which can be used either by the bed or by the chair is much more convenient.

Finally, walking aids make an enormous difference. I cannot imagine how we managed before they were invented. The important thing about walking aids is to have them in profusion. No patient should have to share a walking aid, he should have one of his own and it should be regarded as his personal property for as long as he needs it.

Conclusion

Old people require treatment which takes account of the needs of the whole man. One must, therefore, bear in mind the patient's need to regain mobility, skill in the activities of daily living and social competence. Rehabilitation will often need to continue after the patient is discharged from hospital and can sometimes be offered without the patient coming into hospital at all. The entire team—the doctor, the nurse, the medical social worker, the physiotherapist, the occupational therapist—must believe that every gain, however slight, in the patient's struggle for independence is worthwhile. They must keep in close touch with each other so as to avoid giving the patient conflicting advice. All this must be done, not with a cold-blooded ruthless efficiency, but with kindness and respect for the patient's dignity as a human being. This is where the college motto *Cum scientia caritas* is very apt.