STUDENT PRIZE ESSAY

MOTHER AND DAUGHTER

NIELS E. JENSEN
Carshalton

I was taken to see two patients, Mrs H, aged 84, and Miss H, her unmarried daughter, aged 52. Their general practitioner introduced me to them at my first visit on 16 March, 1960. Since then, I have seen them on two further occasions. Both mother and daughter were voluble, and only too glad to discuss their many ailments and to undergo physical examination.

Clinical Presentation

Mrs H married in 1897, aged 21. Of the four children of the marriage, a daughter succumbed to meningitis in infancy, another daughter died at the age of 40 of rheumatic heart disease and the son, born in 1910, is now a cardiac invalid. Mr H died in 1934, from rheumatic cardiac disease.

Mrs H herself is said to have had acute rheumatism at the age of 17, and again subsequently, but there is reason, as shall be seen, to doubt this. Aged 26, she had the first attack of ' acute rheumatoid arthritis ', which reduced her to hobbling with crutches. This became quiescent after the first exacerbation. When aged 50, she suffered from peptic ulceration, and at 68 she had an unsuccessful operation for a cataract in the left eye, and she is now almost totally blind. At the age of 78, she developed sudden retrosternal pain. A coronary thrombosis was diagnosed and she was six months in hospital, receiving anti-coagulants, digoxin and mersalyl. Her main complaints now are dyspnoea and angina on slight effort, and pain in, and swelling of the ankles, especially late in the day.

The only surviving daughter, Miss H, is also said to have had several bouts of acute rheumatism in childhood. When she was 26, after a long history of bronchitis and coughs, open pulmonary tuberculosis was diagnosed on the strength of a single positive sputum, and she spent a year at a sanatorium. She has never had another positive sputum. Since then she has been homebound, living with her mother, only venturing out for short periods on fine days, and now suffers, she maintains, from bronchitis and dyspnoea as a result

of her tuberculosis. Her health has otherwise been good. She is seen at six monthly intervals at a chest clinic and is on digoxin, gr. ½ daily.

Examination

Mrs H is rather shrunken with age, and spends most of the day in her chair by the fire, but is able to hobble around. Her hands and knees show rheumatoid deformities of moderate severity, but she is able to knit. Both pupils are opaque. She is dyspnoeic on slight exertion, and her ankles and sacral region exhibited pronounced pitting oedema. The neck veins were raised two inches. Her pulse was regular and collapsing in nature, the artery wall being thickened and easily palpable, although not 'pipe-stem' in quality. The blood pressure was 190/90. No thrills were palpable. On auscultation, in the mitral area, there was a whistling, bird-like systolic murmur, loud second sound, loud third sound, and a late diastolic murmur. An aortic pan-systolic murmur was present, and a loud second sound. Although she was not fibrillating when examined, she has done so in the past, certainly just following the infarct. I feel that the murmur and Corrigan's pulse were probably due to atherosclerosis and a failing heart, and not of rheumatic origin. Most probably the joint condition has always been rheumatoid in type. Her doctor is of the same opinion.

Miss H is a very facile woman, with an inadequate personality. She lies on her bed, prostrate, at the slightest suggestion of coughing. She moves about the room, in a struggling, listless way, doing only the lightest housework. She exhibits a curious malar flush—possibly from sitting in front of the fire for long periods. On examination, her heart was completely normal, with no evidence of cardiac disease. There was, however, reduced movement of the left lung, with rhonchi, increased tactile vocal fremitus, and whispering pectoriloquy at the left apex, together with dullness on percussion. Her doctor states these findings too have remained unchanged for at least six years. Coupled with the history of occasional febrile episodes, with infected sputum, dyspnoea and cough, clearing on antibiotic therapy, this suggests some degree of bronchiectasis, probably resulting from previous tuberculous infection. Hospital x rays are reported as showing 'fibrosis'. No other abnormalities were found.

Social Aspects

These two patients present a joint social and medical problem, and are best dealt with together. Both are invalids, one genuine, one self-convinced, and both represent almost total burdens on the community. Neither see anything strange or wrong in their way of life, and as far as I could determine, would have no compunction in

seeking further aid on any pretext. The daughter is certainly capable of a sedentary occupation in addition to her admittedly useful task of tending Mrs H, who would otherwise have to be maintained in a geriatric hospital, the cost of which would be at least £15 a week.

They avail themselves of an impressive list of public services. The health visitor calls every four months, but only to keep an eye on their living standards. The district nurse visits every Thursday to administer mersalyl to Mrs H; she has been coming for six years. A home help, supplied by the borough council, has arrived for two hours every weekday for eight years, and does all the shopping, carrying, and heavy cleaning. Mid-day meals are delivered at no cost on four days of the week from the invalid kitchen service, and they get occasional visits from a visitor to the blind, who also supplies knitting wool, and from the old age visitor from the welfare clinic. In addition, they receive annual gifts of coal and food parcels from the parish, and also the services of the chiropodist.

Their weekly income can be tabuled as follows:

Daughter—National Insurance	£2 10 0	
Assistance Board	£1 14 0	
Mother—Old age pension	£2 10 0	
Rent from upstairs flats	£1 18 0	
Total	£8 12 0	less rates

Mr H bought the house before his death, and they let two floors to lodgers. Thus, two people without rent liabilities are able to live in moderate comfort as complete recluses from society.

Loneliness does not seem to be an important factor to these people They have been given a television and a radio, which are used a great deal. They are on good terms with their lodgers, although they never meet them socially, nor have they any local friends. Relatives are quite frequent visitors, and also some acquaintances from the sanatorium, and these appear to satisfy their need for social contact.

The General Practitioner's Role

The family doctor has been in the practice six years. During this period, he has visited Mrs and Miss H, on the average, once a fortnight—thus about 150 calls. As each of these involves at least 30 minutes, it can be seen what a tremendous drain on the time available for running the practice this type of case entails. Attempts to lengthen the period between visits have always led to emergency calls after a few days, often with a fabricated story as bait. Their doctor calculates that only about six of these visits have been medical necessities. The rest have consisted in the main of reassurance and writing prescriptions for placebos—the daughter was many years

ago put on digoxin, gr. ½ daily, a therapeutically useless dose, from which it has proved impossible to wean her, and Mrs H receives several paregorics in addition to her digitalis and chlorothiazide.

The doctor has four main tasks in his regular visits to these people,—controlling, if necessary, the cardiac failure by adjusting the drugs; secondly, ensuring that the social services, e.g. the daily meals, are maintained; thirdly, the very important prevention of bed and heel sores in Mrs H by forcing her to move around—and lastly, also very important, is reassurance and encouragement.

All these tasks, except drug prescriptions, could be performed by the district nurse, or similar visitor who might specialize in such long-term cases, and the doctor need not really visit more frequently than monthly or every six weeks. Their doctor feels that it is to some degree his own fault for being too liberal with his calls at an early stage, but now the penalty for non-attendance is an emergency visit.

A firmer line from the doctor after the daughter left the sanatorium might have persuaded her to have taken a more active interest in her own welfare, but this is rather doubtful and is now certainly impossible.

Summary

The case histories of two people—a mother and daughter who have lived together as invalids for 30 years—are described. Mrs H 84, has been in chronic heart failure for many years, and is blind and senile. Her daughter, 52, otherwise healthy, suffered from pulmonary tuberculosis at the age of 26, which apart from some pulmonary fibrosis and probably a minor degree of bronchiectasis, has remained completely quiescent.

As a result of our social system, she has been enabled to live an entirely dependant life with her mother. They have a reasonable combined income, and draw on many social services and, also, much on their doctor who is expected to make regular social visits, most of which could be carried out adequately by the district nurse. They demonstrate that the Welfare State has no mechanism for dealing with the intrinsically lazy and intransigent patient, and that the burden is carried by the general practitioner.