The 28 patients treated were assessed as to the value of treatment over the year under review.

Definitely improved 13

This included two rheumatoid arthritics who inevitably became less active and two patients with 'frozen shoulder' who in the natural history of the disease should have improved in any case.

No change—i.e. no appreciable deterioration 12

This in itself in a progressive degenerative condition may be regarded as a form of success. Two deteriorated and were referred back to the orthopaedic surgeon. One of these has had a most successful Macmurray osteotomy: another is awaiting the same operation. One lady died three months before the completion of the year.

Summary

An objective and subjective comparison of two steroids, methyl prednisolone and prednisone trimethylacetate, used for the intra-articular injection of 53 joints on 28 patients was made over a period of a year. No significant difference was found in the effects of the two substances injected.

13 patients were improved.

12 patients were no worse.

Each substance should be regarded as extremely useful in the palliative treatment of joints affected by degeneration or local colloid disease.

Acknowledgement

My thanks are due to Mr Vincent Snell, F.R.C.S. and Dr Maurice Hart for their encouragement and for referring patients to me; to Messrs Upjohn for supplies of Depomedrone (Messrs Ciba generously supplied me for my previous work, and were not asked in this case) and to Mrs Wass for her invaluable assistance in running the clinic and for typing this paper, and to the chairman of Harefield-Northwood Group Management Committee for permission to publish.

PERSONAL POINTS OF VIEW

MUST WE KILL OUR PATIENTS ?

ROBERT BRUCE, M.D., M.B., B.S.

Chester-le-Street, Co. Durham

THE PROBLEM OF THE ELDERLY PATIENT confined to bed and succumbing to disease contracted as a direct result of the recumbency is well known. The principle of keeping patients ambulant whenever

possible is reasonable and accepted but could, I think, be applied more generally than is usually seen in general practice. A tendency towards blind acceptance of older dictums regarding therapy for various diseases results in unnecessary confinement to bed of patients who could well remain ambulant. Whatever the initial illness, an old patient, if confined to bed, is placed at risk to lethal complications such as bronchopneumonia, phlebothrombosis, cerebral vascular accident, pulmonary embolus, congestive heart failure, sphincteric dysfunction, urinary infection and uraemia, pressure sores, protein loss, septicaemia. Unless the initial disease process makes such risks unavoidable then clearly confinement to bed is bad and potentially deadly treatment.

I believe that the principle of ambulant therapy should be applied to all age groups and many more illnesses than is usual today. Such an approach would result in more recoveries, quicker recoveries and also ease the burden on other household members.

In general practice there has been a steady increase over the last few years in the number of elderly ill patients. It is so easy to agree with the elderly frail patient's desire to stay warm and comfortable in bed. If we do, let us see what might happen.

1. The patient has confirmed his belief that he has a major illness.
2. Each day in bed results in less joint mobility and more willingness to ' stay put '.
3. If continued, the weakness can result in real inability to get up; the patient loses hope and ' puts his face to the wall '.
4. The patient, though ' out of the way ', becomes a source of increased work to relatives due to cooking needs, stair-work, toilet needs and washing requirements.

All this in addition to the probability of well-meaning faulty nursing by untrained relatives, the hazard of disease complications as outlined earlier, and the depressing atmosphere of illness in the house with a bored, demanding patient upstairs, and a harrassed and anxious housewife downstairs. The final blow is sometimes the occurrence of complications in the patient and the physical collapse of the nursing relative. The picture is virtually a syndrome in general practice; a syndrome that in many cases can be avoided.

The patient who can be nursed at home in a downstairs room is far easier to manage. Meals are easier, beds can be aired, laundry is less as incontinence is less likely, there is less running about to do and supervision of the patient's needs is easier. The sitting position is physiologically sounder for chest and heart conditions and a sitting patient is relatively mobile as regards toilet needs and this will aid his recovery and prevent bed-sores. Old people find much

more to interest them in a downstairs room. They can feel part of the comings and goings, read, listen to the radio, watch television and still feel a member of the family. The choice of night-time in bed or an easy chair has to be considered. Clinically, if coping with the stairs is feasible, bed upstairs for the night is preferable as the patient remains on the same floor as the relatives all the time. Possibly, given the space, a temporary bed downstairs can be arranged with a hand-bell to ring if attention is needed. I often find that a happier arrangement is for the patient to spend the night downstairs in an easy chair with a relative if necessary on a couch in the same room or upstairs if no night attention is needed. This type of arrangement has to be balanced against the needs and comfort of the patient, his tolerance of noise, his ability to settle in a chair and his feelings of security on a different floor with strange toilet facilities. Another factor is the space for downstairs nursing. The questions too of infectivity and depression must be considered. Obviously, infectious ailments require some degree of isolation, although if the illness is so infective as to require true barrier nursing then hospital is necessary in most of these cases. Less stringent methods of nursing can be coped with quite well downstairs with normal hygienic measures. Many patients, particularly those suffering from chronic illnesses, are a source of an almost infectious depression enveloping the whole household. Although such depression in a patient can be countered by occupational therapy, psychotherapy and appropriate drugs, occasionally a stage is reached when isolation of the patient upstairs is desirable for the sake of the relatives if not the patient.

To persuade an elderly patient to remain ambulant is often difficult but can be achieved by slow and careful explanation of the dangers inherent in staying in bed. To persuade the relatives of the same point may prove more difficult as there is a tendency for them to believe that to have ' grandma ' upstairs in bed means that they know where she is, that she is out of their way so that the day's work can be done without interference; after all " she is frail and needs a lot of rest ". In fact, if the avoidance of complications and the work saving are explained, I rarely find that there is much of a problem in convincing relatives of the desirability of ' grandma ' staying ambulant.

Ambulant patients are generally more amenable than bedfast patients and, as they recover quicker, the savings in cost to the nation must be considerable as every patient who avoids complications probably represents a saved hospital bed.

In this television era television viewing can greatly ease the frustration and boredom of illness. Children particularly appreciate this. Most children when confined to bed upstairs sneak out of the bed intermittently for books, toys, window watching and so on. It is

much better to have children under direct supervision downstairs where their antics can be restrained to reasonable proportions and it saves much of the ' stair-work '.

Why therefore, as is often the case, should certain clinical signs and symptoms lead *per se* to confinement of a patient to bed? Patients with fever are usually put to bed. Why? In most febrile illnesses the disease does not warrant such restriction. A person with bronchopneumonia for example is physiologically better off in the sitting position. A chair is built for sitting in whereas a bed is never very comfortable when used as a chair rather than a bed. The pain of bronchopneumonia can be controlled just as easily in a chair, therapy can be given equally well, movement by the patient is easier, toilet needs are more easily satisfied and interest in hobbies can be kept by the patient. Why then is bronchopneumonia commonly nursed in bed? To do so would seem to be less efficient, less comfortable for the patient and less convenient for relatives. The same argument applies to bronchitis, lobar pneumonia, tracheitis, bronchiolitis. Short of a patient being so ill as to not have the strength to maintain the sitting posture all cases of acute chest infections nursed at home can be nursed as sitting cases. Pulmonary tuberculosis presents a different problem although bed rest again is of traditional rather than proven worth as compared to chair rest. My impression is that in all but the most serious cases chair rest could well be instituted without loss of therapeutic efficacy. However, the problem of the serious cases of pulmonary tuberculosis hardly arises in general practice since they are admitted to hospital for isolation, treatment and bacteriological control.

Cardiovascular diseases are usually better nursed in a sitting position and again the mere presence of fever does not in itself invalidate this approach. Why not again ease the nursing burden of the relatives, widen the patient's interests and lessen the risks of complications by nursing in a chair? Personal experience confirms that in acute myocardial infarction and in severe angina, limitation of the initial period of bed rest to that of the period of shock does not result in poorer clinical results. Patients allowed into a chair after one to three days are generally more comfortable and appreciate the ease of toilet management. Patients with rheumatic fever are traditionally nursed for long periods in bed. Is it proven that equally careful nursing and therapy with the patient in a sitting position when patient comfort permits, in an easy chair is any less effective? As such patients are commonly nursed in hospital where even the effort of getting in and out of bed can be eliminated by lifting of the patient, it seems reasonable to apply the physiologically sounder posture of sitting. The same can be said of subacute bacterial endocarditis

though again this hardly comes within the scope of general practice therapy.

Gastrointestinal tract infections are certainly more manageable at home if nursed in an easy chair. Diarrhoea and vomiting distress the patient far less if he is sitting in a chair, treatment can be just as comprehensive and the quantities of soiled linen are less. These factors are appreciated by both patient and nursing relative. Also renal and gall-stone colic seem better managed with the patient seated. I have yet to see a patient with actual renal colic who will stay in bed—the picture is invariably one of an acutely distressed patient rolling about the bed looking desperately for relief in any position and that position is certainly not that of lying flat in bed. Several patients have volunteered the information that they found much relief merely from being held in a sitting position by the chair and the residual ache after the acute attack was less troublesome. I now generally advise the patient to remain in bed only for the duration of the effect of the initial injection and thereafter allow him into a chair. Subsequent therapy can be given perfectly easily with this arrangement. Urinary tract infections also are generally treated more comfortably in a sitting position. Many patients in this area of strongly independent people will not use bedpans but prefer to struggle out of bed and along to the toilet. Why then advise bed rest merely because the patient is febrile? Why not give the same therapy with the patient in a chair with a commode arrangement alongside the chair? No scientific doctrine is being sacrificed and a far more comfortable patient who is less likely to develop any further complications is the result. The distress of renal failure can also be treated along similar lines, at least until the terminal stage.

Cerebrovascular accidents are best nursed in a sitting position since they are particularly liable to develop complicating chest infections and urinary tract troubles. One exception is subarachnoid haemorrhage.

It is well known that in peptic ulcer, rest and relief from the stresses and strains of day-to-day life are important factors in the rate of healing of the ulcer. Rest, however, can be perfectly adequate with the patient in a chair and removal from worry can be complete. It is even better to have the patient in a chair since he can pursue an interesting hobby if he feels like it whereas in bed the variety of hobbies is more limited.

Again, youngsters with infectious fevers are traditionally confined to bed during the febrile stage if not for even longer. Certainly the initial day or so of discomfort may warrant bed rest for the sake of the patient's comfort but once this short phase is over ambulation is both reasonable and wise. Why should a patient with chicken-

pox be kept in bed simply because fever persists for several days? If the child feels well after or even before the first two days, as most do, why not let them up in the house so that they can play happily with their toys? Indeed I let them go outside under supervision with the simple restriction that they should not mix with other children until the infective period is over. Mild fever in a well-feeling youngster is no reason for indoor seclusion; the fever is just as well treated on an outdoor basis as long as the rest of the clinical picture permits outdoor activity. This argument can be adapted to all the infectious fevers and mothers are really grateful for the easing of the problem inherent in trying to keep a well-feeling child amused in bed for days on end.

Why do we not criticize more often the traditional teaching on home therapy? Time lack and turn-over of patients with only minor ailments make the discipline of critical questioning of established methods difficult to maintain. Enthusiasm and interest wane all too easily and the race through the typical day's programme in practice leaves all too little time for meditative examination of rational methods of therapy. In the last few years the change in attitude on the desirability and duration of bed-rest in cases of infective hepatitis is a typical example of how hospital investigation has gradually shown what general-practitioner observation and fact collation could have established sooner. This same fact collation is, however, largely curtailed because of loss of interest due to time lack resulting from the present day circumstances. Time to be critical of methods could lead to improved understanding of disease, and better methods of home therapy and avoid the unhappy consequence of letting patients die, albeit with the best of intentions, due to ill-advised bed restriction.

The above is not new, the principle is widely known. I make no apology for repeating what others have already said; I think it bears frequent repetition. My own bitter disappointments serve to remind me how easily I can fall into the trap of hurriedly following traditional routine rather than using critical clinical observation to assess the best treatment appropriate to each case. After all, time spent in bettering standards of treatment represents time saved for the patient in the truest sense of the word.