King Edward's Hospital Fund For London

Convalescent Homes Conference, 1962

The twelfth annual Convalescent Homes Conference was held at Queen Elizabeth College, Campden Hill, London, on Thursday, 22nd March, 1962, under the Chairmanship of Mr. J. Chadwick Brooks, O.B.E.

Among those present were representatives from:—

Auxiliary Hospitals Committee of King Edward's Hospital Fund for London.
Ministry of Health.
Metropolitan Regional Hospital Boards.
South Western Regional Hospital Board.
Middlesex County Council.
East Ham Public Health Department.
Bedford Group Hospital Management Committee.
British Red Cross Society.
Bermondsey Medical Mission.
Bristol Hospitals Fund.
Edith Cavell Homes of Rest for Nurses.
Invalid Children's Aid Association.
Jewish Board of Guardians.
Maitland Trust.
Save the Children Fund.
Surrey Convalescent Homes.

Approximately 90 matrons, assistant matrons and staff of convalescent homes attended.

Approximately 80 hospital almoners attended.

In all, some 210 persons attended.

The CHAIRMAN, opening the Conference, said: Ladies and Gentlemen, may I, on behalf of the King Edward's Hospital Fund and the Auxiliary Hospitals Committee, extend to you all a warm welcome to this our 12th Annual Conference? I am sorry that the date this year is rather early—but that is through no fault of ours—and we are denied the pleasure of previous years in seeing the lovely magnolia trees outside this hall, in full bloom.

Once again I am glad to state that the Fund has continued its practice of escorting groups of hospital almoners and ward sisters to various convalescent homes, and since we last met two such visits have been made.

Our subject today is, generally, "Diseases of the Chest", with particular reference to bronchitis. We chose this subject because of its increasing prevalence and its serious effect on the health of the community, and, of course, it concerns men, women and children.

Chronic bronchitis, I am told, is called "the English Disease" because no other country has so much of it. Perhaps it isn't generally realized how widespread and how devastating it is. Two million people in England consult their doctors each year with bronchitis, which means that about one in twenty suffers from this crippling chest complaint. Of men over 40 years of age claiming sickness benefit, one in every seven does so because of bronchitis, and, apart from the personal suffering entailed, the number of working days lost each year is said to be 25 million which is a serious handicap on much needed production.

Bronchitis is very much in the public eye at the moment following the recent publication of the report of a committee of the Royal College of Physicians on the connection between smoking and cancer of the lung and other lung diseases, including bronchitis. Our conference today, however, is not so much concerned with the cause of bronchitis as with the treatment and remedial measures for recovery, including, of course, convalescence.

These Conferences, we believe, are helpful in getting together interested people to hear competent authorities and experienced speakers and to exchange information which will be of practical use, and I feel sure that today's conference will be no exception.

We are fortunate in having with us today Dr. Hurford, the Physician Superintendent of King George V Hospital for Diseases of the Chest, and an acknowledged authority on the subject. I now have very much pleasure in asking Dr. Hurford to address the Conference on "Care of Patients with Intractable Lung Diseases".

(*applause*)

DR. HURFORD: I must first of all thank you for asking me to give this talk today. I know what an important part convalescent homes and holiday homes play in the health service. Strictly speaking, the word "convalescence" applies to the period between illness and recovery (complete or near-complete) and sometimes speakers may have difficulty in applying it to chronic diseases of the lung; yet perhaps at the end of our discussions we will not insist too strictly on terminological exactitude.

(*Slide*) We will take this slide now. It is not a bad one to take for a start. This is about the incidence of bronchitis. These are deaths per year, and you can see that the number of deaths have crept up for well over ten years, and you can see, too, how lung cancer has crept up and where in the 1950's tuberculosis crossed the line of lung cancer and where it has got to now. I put in pneumonia there because I feel it has a connection with chronic bronchitis, and I think that if in fact we were to analyse deaths from pneumonia more exactly we would increase the number of deaths from bronchitis, because, you see, so many cases of bronchitis die of broncho-pneumonia.

Now as for the influenza curve, I am not absolutely sure that it is quite correct—I got it from the Registrar General's figures, I may say—but everybody always talks about the big epidemic in December, 1952. Perhaps Dr. Thompson can tell us whether it is not correct there, but I thought it would mirror to some extent the bronchitis death rate, and of course it does, as you can see, at any rate in the first part.

Now when we talked about the title of this little lecture of mine I was perhaps foolish enough to agree to the title of "Care of Patients with Intractable Lung Diseases", and then when I got home I sat down and pondered about the word "intractable" and I decided that really it was chronic bronchitis which merited most attention and I considered it in preference to others which are less common and of much less importance from the point of view of the community. The words "chronic" and "intractable" I do not think apply to chest illnesses which are usually merely prolonged, such as unresolved pneumonia or empyema, which of course you find in patients who come to convalescent homes, and they do not always apply to allergic asthma, although quite often I think they do. Of course it is a chronic intractable disease quite often.

I am going to say a little about this, and I was going to say just a little bit also about cancer of the lung, though, alas, those words I am afraid, cannot be applied to that and I am debarred from mentioning pulmonary tuberculosis. However I would just like to state that pulmonary tuberculosis as a disease is complicated at times by bronchitis or bronchiectasis, or, indeed, if you think about it, diabetes or a fractured femur, and I think it is wrong in these days to apply what we may call "apartheid" to patients who have had tuberculosis, whether it has been successfully treated or not, and whether the acute phase was far back in time or not. I think it is worth people from convalescent homes remembering just that remark.

When we come to the really chronic, non-tuberculous diseases—chronic bronchitis, bronchiectasis, non-specific fibrosis of the lungs, pneumoconiosis and many cases of asthma—we find that some are characterized by recurrent infection, but all carry, I think, the risk of interference with one of the vital processes of the body: the efficient gaseous exchange within the lungs whereby oxygen is obtained; and as a result all patients suffering from these illnesses carry an additional risk—that of ultimately joining the ranks of sufferers from acquired heart disease, in this case what we call Cor

Pulmonale, or right heart failure. These consequences, the result of ventilatory failure, as it is called, together with frequent cough and production of sputum, may, I suspect, be rather daunting to those who run convalescent homes. I think you will understand what I mean by that.

Another generalization we can make about chronic chest conditions is that they are often social diseases, affecting those who have the least defence against adverse changes in their circumstances.

(*Slide*) Now this slide, very quickly put on, again is about bronchitis but it exemplifies what I have just said, because, you see, I am sure you all know the Registrar General's social classes Nos. 1, 2, 3, 4 and 5, with, obviously, the rich stockbrokers and dukes, and so on, in Class 1. Then when you come down to Class 5 you are dealing with very much the unskilled labourer type, and you can see how high the pedestal, or whatever you call it, is in Classes 4 and 5. Do not pay any attention to the actual figures. These are ratios of men and women. There are far more men than women who get bronchitis, but that is beside the point at this stage.

(*Slide*) Workers in chest medicine find that their main preoccupations outside tuberculosis (and pneumoconiosis where it is common) are with bronchial carcinoma and chronic bronchitis, and to a less extent with allergic asthma.

Now the problem, of course, of lung cancer is as yet unsolved. Of every 100 patients with this condition, in approximately one-third operation will be ruled out at once, another one-third will be found to be inoperable on exploration and in only one-third will the growth-bearing area of lung be resected. Of these last—those who have had a resection operation—perhaps 25% (the figures vary in different hands) will be alive five years later. This is only about 8% of the total diagnosed. Unresected cases will live less than 12 months, and for these patients their own home or hospital is the correct milieu. But there is a place for convalescence of patients who have had a growth removed; it may be a tremendous help in getting them to face life again. And, remember, even though there may be only 8%, (those that are resected, 25%), who actually live five years, a number have to live one, two or three years and during that time they have got to put up a fight.

All of us—hospital workers, relatives and friends, and workers in convalescent homes—have to tackle the problem of informing or not informing the patient about his condition. Let me remind you of the kindly merits of the white lie, and if we are going to tell a lie let us all tell it together. I say that because patients of all types with all kinds of serious diseases go from one institution and unit to another. It is important that each unit should have information as to exactly how much the patient has been told.

I refer next, very briefly, to allergic asthma (bronchitic asthma is really chronic bronchitis in which spasm of the bronchi predominates) because it seems to have two of the characteristics which interfere with convalescence; it is liable to sudden attacks which demand medical attention and after a time may affect the ventilatory capacity—that is, the capacity to breathe. On the other hand, the true asthmatic, like the diabetic, is usually knowledgable about measures which he can take to avert or minimize an attack. As you know, the one advance in treatment of asthma is the use of the corticosteroids, frequently in the form of prednisolone taken by mouth. There are distinct drawbacks in using steroids and many physicians try to avoid them or to use them only in short courses. Then, there are still the great standbys of the antispasmodics of various types, and, of course, breathing exercises help quite a lot. Asthmatics, as you know, are often very intelligent people but not seldom there is a functional background to their illness, which is, I think, worth remembering if you have to deal with them.

On bronchiectasis, I want to say just a sentence or two. Bronchiectasis is a condition, you will remember, where the bronchial tubes in part of the lung are dilated and chronically infected, and the main task is to keep the infection down, because infection, when it occurs, will lead to either localized broncho-pneumonia or to chronic bronchitis, and so bronchiectasis is treated by posture. The bronchial tubes are drained by gravity. That very often means tipping up the foot of the bed or the foot of the couch, because the parts of the lungs most affected of all are the bases of the lungs. There is a case for giving bronchiectatic patients antibiotics during periods of infection. There have been trials with regard to this which have showed that this is of value. Surgical treatment, of course, through removal of the bronchiectatic area, can be very successful.

Now, and last, let us come to chronic bronchitis—and, still more important, the chronic bronchitic.

First, a very few facts about this disease; you can see that I am interpreting the "care of the patient" part of the title rather widely. As the Chairman has said, this is the "English Disease", and this slide will show you why.

(*Slide*) The next two slides were shown by Dr. Reid in a discussion at the Royal Society of Medicine, 1956. The map of England and Wales shows the death rate from bronchitis per million of population in different areas in the country and you will see that the lowest is 512. The high figures are generally related to highly industrialized areas. The next slide which gives Europe as a whole shows that the highest death rate per million population on the Continent is 233, in the Lowlands.

Why should even rural England have such a high death rate from chronic bronchitis? The big figures occur, of course, in the highly industrialized areas, and it has been shown that they are influenced by smoke, fog and certain occupations, and, to a minor extent, by overcrowding.

It is perhaps better to talk of "atmospheric pollution" rather than of smoke and fog, for there seems to be a harmful pollutant (which may be sulphuric acid) which is not necessarily a component of either fog or smoke, though it is always present during the devastating periods of smog which occur from time to time. The effect of smog is accentuated by cold, and cold alone is always responsible for an increase in the mortality from respiratory disorders. I am not going to go into occupations at all, but some of the occupations where chronic bronchitis is most rife are outdoor occupations where people have to

be out of doors in rather badly paid jobs, like refuse people and postmen, and so on, and they are very much exposed to the ordinary conditions of an English winter, which are mainly cold and moisture.

Of personal factors—those are the social factors—the most important seems to be smoking. All observers have noticed a higher incidence of bronchitis amongst smokers than non-smokers, and it is likely that cigarette smoke promotes over-secretion of mucus and bronchial irritation, with local sensitivity to infection.

We do not really know how many chronic bronchitics there are in Great Britain, but a survey by the College of General Practitioners published in 1961 gave an incidence of 17% in men and 8% in women out of a sample of individuals between 45 and 64 randomly selected from doctors' lists. You might say, "Well, this is not a very fair sample—it may leave out people who are not on the lists", but I think it does give us a clue. At any rate it is a very high figure, and at the same time it is estimated that about 27 million working days are lost each year from this cause.

But when we come down to it we know very little, really, about the intrinsic causes of chronic bronchitis even if we realize now what circumstances are associated with it. When we achieve "clean air" in our cities and industrial areas, when the dangers of cigarette smoking appeal to our public concience and common sense, will bronchitis disappear? Or is there an innate tendency to the condition in some individuals or do early, perhaps insignificant upper and lower respiratory infections prepare the soil for the later crop? Is it the "chesty child" who later becomes the chronic bronchitic? We cannot answer these questions.

How soon they will be answered remains to be seen, but just as tuberculosis of the lungs does not necessarily follow infection with the tubercule bacillus alone, it is likely that chronic bronchitis depends not only on the environmental factors we have mentioned but also on something which in our ignorance we may label as a "bronchitic tendency". This might be inborn, though there does not seem to be any evidence to support that. A possible developmental malady, adult muco-vicidosis, which has been suspected, has not been shown to be at all common in adults, and certainly not more common in bronchitics.

I have referred to the "catarrhal" or "chesty" child, meaning by that description something less definite than what Mr. Thomas may be discussing this afternoon. Paediatricians, chest physicians, E.N.T. surgeons and school medical officers frequently see children with allergic rhinitis, sinusitis, bronchitic asthma or prolonged bronchitis, and though these conditions tend to clear up it is possible that they can do some damage which in unfavourable circumstances later on may lead to chronic bronchitis. As one might expect, catarrhal children are more numerous in poor surroundings where there is overcrowding, inadequate nutrition and exposure to cold and damp, and also in the "chesty" families where there are cases of adult sinusitis or bronchitis. So it is clear that there are here, as in chronic bronchitis, environmental factors which it is difficult to change. Early and adequate treatment of each affected child is the best present solution, and this may sometimes involve separating children from over-anxious parents and sending them to an open-air school or even for a few weeks to a convalescent children's home.

In understanding and treating chronic bronchitis of adults we are hampered by the fact that all too often it comes to our notice at an advanced, or relatively advanced stage.

(*Slide*) From what I have said you will understand that we do not know very much about the onset of this condition. Mild bronchitis obviously has to precede the more advanced stages and in my experience the latter occur usually after a very long period. Patients in the more advanced stages when carefully questioned seem to give a history of chest symptoms varying perhaps between 8 and 14 years. Usually, of course, patients are picked up in the middle stage or the advanced stage (2 and 3 on the slide). In stage 2 there is recurrent bronchitis coming back each winter and some times in the summer. History taken from the bronchitic can be a very tedious business. So often a patient when questioned as to how long he has had bronchitis will say "Oh, just a couple of years, Doctor" and when pressed further will claim that he has had "Just the usual cough" for very much longer, for it is amazing how many people will assume that a cough is a normal physiological condition rather than a symptom. It is not normal to have a cough. It may be due to cigarettes, but it is not normal.

The number of headings which we can apply to the pathology of chronic bronchitis are, first of all, infection; secondly, excessive secretion from the mucous glands; thirdly, spasm of the bronchi; and, fourthly, emphysema. The latter precedes the last items on the slide—ventilatory failure, cor pulmonale and recurrent attacks of broncho-pneumonia.

However, emphysema is an end result, and even infection, though typical, is not present continuously at all stages. Excessive mucus production is the most characteristic clinical finding and indicates that what the bronchitic has acquired is an altered bronchial mucosa, very susceptible to all adverse circumstances. We cannot change our climate, which may be one of these circumstances, but we may be able gradually to alter others; but I suspect that real prevention would depend on knowledge of what are the early causes of the changed bronchial physiology.

The problem of deciding where bronchitis starts was exemplified, I think, in the work in 1959 of C. M. Fletcher on middle-aged London postal workers of whom about half the men and a quarter of the women had chronic morning cough, usually with some phlegm. Out of these a much smaller number had such symptoms during the day as well as in the morning, and these were beginning to show slight depression of the lung function.

The individual who has experienced all phases of chronic bronchitis has known first a period of recurrent chest colds, secondly a long middle phase in which returning infections, usually in the winter, lead to lengthening bouts of cough and sputum with mild breathlessness on exertion, and, lastly, a time when such symptoms occupy all the winter and perhaps part of the summer and keep him away from work for longer and longer periods. In the end he may be hardly able to move about the house, and in

addition to chronic infection he has pulmonary emphysema and right heart failure. Living has become a burden to the advanced bronchitic, and, as someone has said, he exists within a few hours of death. A hard winter, an influenza epidemic, a fog or even a chance respiratory infection may swiftly bring the end.

(*Slide*) These two last slides are just pictures of patients. I am not going to go into all the sorts of physical changes and things, but I just want to show you two patients here. This is an advanced case. He has chronic infection and ventilatory tests show that his respiratory function is markedly reduced, so that in practice he can walk only 10 or 20 yards without stopping for breath. He might quite suddenly become a medical emergency should the carbon dioxide pressure in his blood rise to the point where he is on the verge of a coma.

(*Slide*) Let me show you another picture. This is a very old friend of mine. He has been with us for a long time. He is a very good chap, and his case, I think, underlines the cruelty of the disease. His chest, as you can see, is much broader than that of the patient in the previous slide, but it is just as fixed and he is still more prone to infection and relapse, and when that occurs he becomes very ill indeed. He has a small flat in London and a wife with a very good whole time job and when he is with us we can make him reasonably well, but each time he returns to London he relapses very quickly. By reason of his wife's job they must live in London. Now what can this couple do? Should his wife give up her job and try and find a job and a house in Torquay or Sidmouth? She would, if they could afford to buy a house or find one to rent. But of course the situation is very difficult, and it remains with us.

A hospital unit such as mine sees many such patients, and their resuscitation and after-care present many difficult problems. Their treatment at best means temporary success and postponement of the final defeat. Meanwhile there is often a psychological element which hampers recovery. To understand it we have to use a little imagination. I want you to imagine a sunny spring day and a brisk walk on the Sussex Downs with the wind in our faces, breathing in the fresh air and feeling confidence in every muscle. Such sensations are not for the advanced bronchitic, or even for the middle phase bronchitic. His breathing is a conscious uncomfortable action at the best of times, and at the worst a struggle for oxygen, so that he lives in fear and uncertainty and exaggerates the symptoms he has, partly perhaps to justify to himself his fall from the position of head of the family and wage earner. You have only got to think of that last patient with his wife in a good job and he unable to work. Part of the treatment is to restore some confidence, and it is surprising how well many bronchitics can remain when under the care of an interested doctor even though the latter—as in my case—is usually conscious of his own inadequacy.

Now, more hopeful, and perhaps of more interest to you, is what is to be done for the intermediate case—the case in the middle phase: the patient who gets cough and sputum and some breathlessness in the winter and occasionally in the summer, who has to have three or four weeks off work in the winter and who may from time to time have to go into hospital. The usually impracticable advice is to change his environment, and a move to the South of England is usually not more possible than one to the South of France or Bermuda. However, poor housing is often a factor, and I would commend local authorities who give priority for new accommodation to bronchitics. I am tempted to suggest that housing authorities in fair weather areas might develop some link with those in danger areas such as London, but probably this is impracticable. You see, that last case just cannot get a house in a safe area. As regards this, of course, bronchitics want to continue working whilst they can and employment usually exists for them only in their old environment, in any case; but exposure to polluted fumes in a factory and hard physical exertion are detrimental, and employers should "temper the wind" as much as they can.

No doubt you will hear more about housing this afternoon. One of the difficulties, especially in London, is the association of good accommodation with high rent, or at any rate a rent which cannot be afforded if the wage-earner is incapacitated; and if the National Assistance Board subsidizes the rent, a basic income of £4 10s. a week for man and wife remains all too little in a situation where food, warmth and adequate clothing are of great importance.

Of personal actions, the most worthwhile for a bronchitic are to stop smoking, and, if he is like that last man, to avoid overweight. He must also try to avoid infection—colds and influenza—preferring his home to the pub or the cinema. If he must go out in the fog, a simple muffler over the lower part of his face may be a little help. In the home, it is said that ammonia fumes will help to neutralize sulphuric acid in the fog. There has been a trial of that, but I have not seen the results. However, it is at any rate worth trying. One can get an Airwick bottle containing ammonia.

As regards smoking, I must be careful what I say here, I think, but I still think it depends on personal will and encouragement from others, and until we get the results of one or two controlled trials that have been carried out with regard to certain trade preparations I think it is wrong to depend upon them.

There are a number of symptomatic medical therapies, but perhaps only two which have a definite factor. The first is the treatment of infection. It is recognized now that chemotherapy can be used in a semi-preventitive way to minimize relapses. The favourite drug is one of the cyclines, tetracycline or terramycin. This may be given when the sputum shows signs of becoming purulent or in more severe cases throughout the winter. A number of trials have established the value of this, and its justification as regards expense both in the saving of work-days lost and in possible hospital treatment which is much more costly. For instance, a British Tuberculosis Association trial in 1959 pointed this out and showed that a control group of bronchitics in four winter months had nearly twice as much time off work as those in a group given tetracycline.

It is possible that virus infections may trigger off some of the winter exacerbations to which patients are liable, but so far the value of influenza vaccine has not been established. The extensive M.R.C. trial in 1958-1959 was not encouraging, though recently Howells and Tyler in a much smaller but controlled investigation (1960) reported good effects.

The second definitive measure is alteration of breathing habits. The chest of a bronchitic tends to be rigid and his respiratory muscles tense. Breathing exercises aim at relaxation and improvement in the use of the diaphragm and lower costal muscles. Unfortunately, persistence in such exercises demands resolution and some intelligence, and only a proportion of patients is temporarily suitable. Posture to drain the bases of the lungs is less intricate and often of great help: posture as in bronchiectasis, of course.

I am not, however, going to go too deeply into the question of treatment, and as I think my time is getting a little short I will make it even shorter. I am not going to say anything about bronchitic patients who become a medical emergency, because this is a very intricate theme and such patients demand quite high-powered therapy with carefully controlled oxygen, tracheotomy, positive-pressure breathing apparatus, and so on.

With regard to oxygen, I think certainly bronchitics who are likely to come to convalescent homes should not require oxygen. Oxygen is a very double edged weapon, not only because it may lead to coma (I am not going to try and explain why that happens) but because it can also lead to addiction.

But I will just say this: when the condition is established, even if it is in a relatively early stage, an opportunity for full assessment of the position should be sought. Medically, this can be done in a special unit—able to estimate respiratory functions, heart condition, the pathological changes in the lung, and so on. With the clinical picture complete, attention may be paid to the patient's home and employment. Is any change necessary, and, if so, can it be brought about?

The housing authority, the Ministry of Labour, in the shape of the D.R.O., the man's employer, these and others may have to be approached. Basically, of course, the family doctor will be the king pin, but more often than not the problem extends beyond the surgery door, as you will judge from the contributions this afternoon.

Nor is the chronic bronchitic entirely suitable for rehabilitation. A change of occupation would often be indicated, but these patients are in an age group which is not often acceptable to the Ministry of Labour rehabilitation and re-training units. In practice, a change of occupation leads to less remunerative jobs, and increases the tendency to slip further down the social scale. There would, I think, be a place for industrial colonies on the lines of Papworth and Preston Hall, but the problem is so vast, that such schemes could only meet a very small part of it.

Now, you have been very patient, and you may have been asking yourselves why I have said such a lot about chronic bronchitis—and how it can concern the institutions which many of you represent. Well, the answer of course, is that I believed you would be interested in this great social and medical problem, comparable in many ways to tuberculosis, as it was not so very long ago, and it is a problem I think we can do a little to help. Let me be quite frank. The advanced bronchitic is not suitable for recuperation away fron his doctor and the hospital. The middle-phase bronchitic who can still continue at work for most of the year tends to have cough and sputum, to be wheezy and breathless on climbing stairs or even going down to the beach. But I believe that he can be materially helped by a change, even for a few weeks, from his usual environment, perhaps at the beginning of the winter. He does not, of course, require open windows. He does not require to be sent out into the cold breeze. He does need to be cosseted. If that is acceptable, then he can be accepted in a convalescent home.

The problem is so vast that the opening of even some convalescent homes to such people carefully selected would mean a great deal in our attempts to cope with it. However, on this subject I would suggest that you postpone your more searching questions until you have heard the other speakers this afternoon.

THE CHAIRMAN: Thank you, Dr. Hurford. The meeting is now open for questions and general discussion.

Discussion

DR. THOMSON (Ministry of Health): It is always, for all of us, a great pleasure to listen to someone who really knows what he is talking about, and this has been a really delightful and fascinating talk from Dr. Hurford. You may expect that, speaking from the Ministry of Health (you will notice that I do not say *for* the Ministry of Health) I may be able to tell you something about this problem of the future of the convalescent homes and their development in the years to come. You did ask Dr. Winner to come here and I am appearing in her place. If she had come here it might have been rather embarrassing, because, knowing some of the discussions that are going on about convalescent homes and their more vital associations with hospitals, she might have been embarrassed to avoid discussions which are confidential. Fortunately I know nothing whatever about it, and therefore there was no embarrassment to me whatsoever, but it does seem to me that what Dr. Hurford has said partly reinforces what was said in the report of the Working Party of which Commander Peers and various other people were members, when they said that a great many of the convalescent homes should become much more like convalescent hospitals, and that a review should take place with a view to deciding which convalescent homes should undertake that very active role.

Now if that is going to take place, clearly a very close liaison between people like Dr. Hurford and the matrons and staff of the convalescent homes will be very necessary.

Many of you will want to ask Dr. Hurford questions, and so I am not going to talk at any great length, but there are just one or two things I would like to say, and the first thing is in the form of a

question to Dr. Hurford. Is there any way, in his experience, of developing a system by which information on the treatment that is required or the drugs that are being given and the psychological help that is necessary to these patients is being organized by the hospitals when patients are sent to convalescent homes?

The second thing I want to say is how glad I was that he emphasized this problem of smoking, because I do think that if these patients go from Dr. Hurford, having been told that they should stop smoking, into an environment where everybody will be relaxing and has lots of time and probably be smoking more than they would do at work, and if no one does anything whatever to help them, then they may very well perhaps relapse into their smoking habits; and it is vitally important that everything should be done to help them. It is really a question of health regulation and education, and matrons of convalescent homes have a very vital role, I should think, in health education in this field, not only for the patient but also for his kindly family, who think that it is a good thing, since he is convalescing, to bring him 100 cigarettes and help him along.

I think I have said more than enough, and I am sure you will want to ask about the particulars you have had in relation to the treatment, or lack of treatment, of these cases in their own homes, and with that I would ask you to fire your questions at Dr. Hurford now.

DR. HURFORD: I think your first question was on the conveyance of information to convalescent homes? I think it is terribly important, as I said, about lung cancer and other things, and I think if convalescent homes take chest cases they must insist upon punctual and adequate conveyance of information. We ourselves in our unit have such a big turnover of these cases that we have a printed form which gives headings for all the things which must be put in. I usually try to see them the day before a patient leaves.

So far as smoking is concerned, it was mentioned to me that you may get a mixed lot of people with varied conditions and it is going to be jolly difficult to separate the sheep from the goats, or to separate the smokers from the non-smokers. There is nothing worse, really, than for a chronic bronchitic to be in the same room as a man who is smoking away like fury—I see it coming up on the Portsmouth train, in the railway compartments—and I think you have got to evolve some system whereby you have a non-smoking room, or it could be a fresh-air room, if you like. That, I think, is a very good point.

THE CHAIRMAN: I have received a question from Miss Easton, who is a sister at St. George's Hospital. Perhaps she is here, and would like to speak. I will read the question that we have received. It seems to be rather pertinent: "What can one do about the chronic bronchitic who persists in smoking despite medical advice?".

DR. HURFORD: This is a very good question. I must say I did something I regretted the other day. There was a patient who had been with us on, I think, five or six previous occasions, and he was in again then, and each time, of course, we had said to him, "You must give up smoking", and this time I said to him, "Have you given up smoking?", "No, I have cut it down", he said, "I only smoke between 10 and 15 a day". I said, "Look here, you have been occupying a bed at a rate (whatever it was) £35 a week and getting on awful lot of drugs lavished on you. It is not fair and no help to your physician to go on smoking. You can either stop smoking or you can leave us." As a matter of fact he departed the next day! That does not, of course, answer your question, but I am afraid there is no definite answer. I did refer obliquely to the matter of trade preparations for helping people to stop smoking. One particular substance has had a controlled trial by research workers at Guy's which has not supported its claims, and there is another controlled trial going on now through the B.T.A. Research Committee. So far, I think, one must reserve judgement. It is perfectly true, of course, that one can give patients something, the value of which has not been shown scientifically, but which will have effect so long as it is put across strongly enough from the psychological point of view.

Apart from that, obviously one must set an example, and I think if everybody does that—nurses and doctors, and so on—it does have a tremendous effect on helping people to stop smoking. But there is no short cut to it. In the end it is the patient himself who has to decide it by will power, I am afraid, and one has got to encourage him to do so.

MISS READ (St. Thomas's Hospital): Dr. Hurford was inferring that there might be preventive measures such as that patients could go away, presumably from the built-up areas, not in the summer months but during the bad months of the winter before they get an attack. Does he want them to avoid bad weather in London, and is there any harm in their coming back to a smoky area after their having had a successful period away in better surroundings?

DR. HURFORD: Miss Read, this is a difficult question. When I mentioned it I had in mind this: that in a sense we sometimes act as a convalescent home to patients from London because, as you know, we are in the country—Godalming—and we notice this. We can use an awful lot of treatments of different kinds, but at one stage we deliberately said to ourselves, "We won't give the patient any particular treatment during the first three, four or five days and see what happens." Almost invariably unless they were acutely ill they improved simply by coming out into the country air and having to relax. I find that patients who come to us and go back, even if they come, say, at the start of the winter are rather less likely to relapse later than if they had not had that little holiday. I think that is the nearest I can get to it. We are talking now not of the really advanced case, because I do not think he is suitable for convalescent homes. We are talking of the middle phase patient who is pretty good in the summer. He has got some ventilatory loss which is accentuated in the winter. when he tends to get chest colds, and he may have three or four weeks off work or even at times have to go into hospital. That is the kind of case.

Now that kind of case, I think, is benefited from, or could be benefited from, having a change, say, before Christmas or in the early part of the winter.

Alternatively, if he does not have that and if he has to go into hospital with an acute infection, then I think it would benefit him to go to a convalescent home for another few weeks. In any case of bronchitis, of course, it is an advantage to be away from the causative environment for as long as possible, but I think one has got to face up to the fact that unless you set up special units—there is one at Liphook, for instance—you cannot take patients for the whole of the winter. You must give them, as it were a recuperative holiday for a few weeks and then they have got to go back to their environment, because it is not possible to do anything else to help them.

THE CHAIRMAN: I have a comment, rather than a question, from Miss Hunt of the Metropolitan Convalescent Home, Bexhill. If she is here perhaps she would like to say something.

SPEAKER (Bexhill): Actually I am the assistant matron there. The query is that sleeping accommodation is rather difficult. Your bad cougher is inclined to disturb other people very much at night, and consequently the general convalescents get very bad nights sometimes. Do you not think that suitable accommodation would be required for these people? We did wonder whether perhaps a sanatorium might not provide units in which these people could be accommodated for their convalescence.

DR. HURFORD: I sympathize with this convalescent home problem but when you come to sanatoria you are dealing with places where bed costing is very much higher, I imagine. If you are going to make use of convalescent homes for this middle type of case —and I think you could for this middle type of case or middle phase case—then one has got to meet these very real drawbacks about taking such patients, as I said, I think, in my peroration. I did not minimize difficulties like this. Cough and sputum, yes—and they may find a little difficulty in going upstairs. These have all got to be tackled. In fact the cough is not always so marked that it upsets other people—I am not talking about the advanced cases now—and I often go into a ward in the chest hospital at night and hear, maybe, somebody coughing a bit, but usually it is not very much.

SPEAKER (Bexhill): Our smallest rooms are six-bedded and they are mostly upstairs, and the largest ones, which are on the ground floor, already have fifteen beds. Most of the wards have about eight.

DR. HURFORD: You could take six bronchitics?

SPEAKER (Bexhill): Yes.

DR. HURFORD: I should have thought this problem could be overcome but it obviously needs a great deal of thought and discussion.

THE CHAIRMAN: I have another written question from Miss Fulcher, matron of the M.C.I. Men's Home. Perhaps Miss Fulcher would like to speak?

SPEAKER ON BEHALF OF MISS FULCHER: Miss Fulcher, who is my counterpart, has rather expressed the same opinion, but as far as I am concerned I am quite willing to take these convalescents if they are not too advanced; but, as you know, we have no small accommodation—my smallest ward has two beds—and I do feel that we do accept a great many advanced cases, which, as Dr. Hurford has said, should not come to us. But it might solve all our problems if we only had the middle type of patient. However, certainly if we are going to continue to take such patients I think the accommodation will be like this: with our accommodation this year our medical officer, Dr. Andrews, only accepted during the months of December, January and February 12 per cent of our usual number because of these problems.

THE CHAIRMAN: Where is your convalescent home?

SPEAKER ON BEHALF OF MISS FULCHER: It is at Cooden Beach—the Metropolitan Men's Home.

DR. HURFORD: Thank you very much. I think the real difficulty about all this is communication. This is typical, of course, of a good many things—including politics! A convalescent home says, "I will take bronchitics as long as they are not too advanced"—and I am certain in my own mind that they cannot take too advanced cases who might become serious medical emergencies—but then how are they going to ensure that they do not take cases of that type? This is a real problem, is it not, because you know it is easy enough for us in a special unit to be saddled with a case which is quite unsuitable and about which we can do nothing, which takes up work and time, and it would be very easy for convalescent homes to be saddled in a similar way. Of course, if certain convalescent homes are willing to take cases they could be tied up to special units. You see, supposing, in fact, your home is tied up to my hospital, I could send you cases down, and if they were wrong cases you could ring me up and say, "What on earth are you doing, sending me this case? You had better take it back", and I would have to take it back. But if a general practitioner in London sends you a case for some reason or other—you do not know what it is, and you have nowhere to send it on to if unsuitable. Therefore I think a proper method of communication to you and selection of patients is the important thing.

THE CHAIRMAN: Are there any other questions and comments, please? Well, in that case we will close the discussion, which I think, has been most illuminating. I have no doubt that this afternoon other questions will arise which will be equally interesting and informative and instructive.

The Morning Session then terminated and the Conference adjourned for luncheon.

Afternoon Session

The Conference resumed at 2.30 *p.m.*

THE CHAIRMAN: I will ask Miss Gillian Beath, Almoner, Westminster Hospital Chest Clinic, now to address you on "Chronic Lung Disease: Convalescence and its Problems."

MISS BEATH: Ladies and Gentlemen, I think that Dr. Hurford has probably covered much of the ground that I am going to be covering, so that I hope I will not seem to be repeating much of what he has already said.

As an introduction I would like to make clear what I mean by chronic lung disease. I take it to include pulmonary tuberculosis, chronic bronchitis

and bronchiectasis, lung cancer and asthma. Patients suffering from one or more of these are usually short of breath and have a productive cough; because of the very nature of these symptoms convalescent treatment is often difficult to arrange.

First I would like to discuss the groups for whom convalescence is required, concentrating on those with chronic bronchitis who form the majority. Then I will try and make some recommendations based on the special needs of these patients.

1. *Pulmonary Tuberculosis.*

I have been asked not to dwell long on tuberculous patients but I would like to make one point. If a patient has ever had pulmonary tuberculosis he seems to be virtually barred from entering a convalescent home. The Regional Hospital Board application form states specifically 'not to be used for tuberculous patients', and to make quite sure that this is understood the Board asks again at the foot of the form 'is the patient suffering from any form of infectious or non-infectious tuberculosis? Please answer Yes or No.'

It is understandable that convalescent homes are wary of admitting patients recovering from tuberculosis, but this wariness also excludes patients who have had tuberculosis but need a period of convalescence from another illness. This means that patients are sent to chest hospitals to convalescence from, say, a surgical operation, and there the chest physician takes over. We all know of patients, who, instead of getting three weeks' convalescence which was originally recommended, have found themselves back at bed rest and facing a routine of gradual upgrading over several long and tedious months . . . .

2. *Chronic Bronchitis and Bronchiectasis.*

Most referrals for convalescence come from this group and I think the patients can be divided into two fairly distinct categories. The first is the chronic bronchitic who has had the disease for some time but has been able to work. He corresponds to Dr. Hurford's middle stage bronchitic patient. During the winter he gets one or more acute infections and does not recover as quickly as he did after former attacks; he then needs a period of convalescence before he is fit to resume work.

The second is Dr. Hurford's advanced case. He has had bronchitis for many years and is no longer able to work. At intervals he gets acute attacks for which he is treated in bed at home by his general practitioner or in a general hospital. After the acute stage has subsided he needs to get out of London to recuperate, and this is required not only to boost his morale but also to give his long suffering relatives a rest.

At present many of these patients are sent to chest hospitals outside London and not to actual convalescent homes.

3. *Lung Cancer.*

Provision for post-operative lung cancer patients in convalescent homes is fairly satisfactory. However, difficulties arise over convalescence for the patient who, though cured of the actual cancer by resection, is left a respiratory cripple by the extent of the lung removal. His convalescent needs then become similar to those of the chronic bronchitic.

4. *Asthma.*

The needs of asthma patients, as far as convalescence is concerned, are also similar to those of patients with chronic bronchitis.

I want to return now to the patient with chronic bronchitis who needs convalescence. As you know I work in a chest clinic which used to be a tuberculosis dispensary. Much of my time is spent trying to arrange after-care for patients with chronic bronchitis and I would like to dwell for a little on some of the problems. As I have already said provision for convalescence is required for:—

(i) The person who has an acute attack of bronchitis, often in the winter, and does not recover sufficiently from it to return to work.

and

(ii) The person, unable to work because of bronchitis, who needs to be out of London during the winter.

The dictionary says convalescence means the gradual recovery of health after illness, and the patient in the first group can be expected to recover sufficiently to return home and resume work. He may have to be away for a number of weeks each year and his need for convalescence becomes a recurrent one.

Eventually, as the disease progresses, he will fall into the second group where convalescence is not so rewarding. It can be thought of as a palliative measure but a very important and necessary one. A period of convalescence for this advanced bronchitic may save him from going into hospital, and by improving his condition temporarily will enable his family to continue looking after him.

For the person who has neither home nor family and who lives in a hostel or in unsuitable lodgings a few weeks' convalescence does not really meet his need. His return to London after a spell in the country all too often ends in an early admission to hospital again.

What is required?

I suggest that the person who is chronically short of breath and who may have, in addition, a productive cough needs:—

i. To get out of London and breathe clean air.
ii. Not to have to climb stairs.
iii. To have a single room or sound-proof cubicle.
iv. To take part in an active programme of physiotherapy and occupational therapy.
v. To be able to stay for several weeks or even months until he feels able to cope with home conditions.

It is almost enough for some patients just to get out of London, and it is remarkable to see the change in them after quite a short time. A permanent move outside London can be recommended but it is difficult to put into practice for patients with homes and families in the city, even if accommodation and work were available. The idea is attractive however for the single man living alone in unsuitable lodgings, but there are few places where he can go at present.

Breathless patients do not all need ground floor accommodation, but, clearly, the fewer stairs they have to climb the better. Often these patients come from buildings where they must climb many flights and this may mean that they do not go out much and are almost kept prisoners in their own homes.

Provision of single rooms in convalescent homes for all patients who cough a great deal would greatly add to their comfort and incidentally to the comfort of the others with whom they are often required to share rooms. Patients have told me how worried they were lest they disturbed the others in the room and this anxiety tended to make them cough more than usual. One common lodging house in London appreciates this need and allows some bronchitics to remain downstairs in a warm room all night so that they will not disturb the others in the dormitory.

On the fourth point, many people think of convalescence as a passive interim between an acute illness and return to normal health and vigour. A patient is despatched to a south coast resort where the weather is mild and he is expected to do little else but eat, sleep, and go for gentle walks. This is not sufficient for bronchitic patients—not that they desire to be pushed out of doors to face the icy blasts of the east coast or anything like that—but they want to participate in a programme which will make them feel that something positive is being done to help them. One must remember that many of these patients are anything but active at home so that when they go for convalescence they are willing and keen to receive instruction in breathing exercises, postural drainage, occupational therapy, and even in how to give up smoking. Medical men may not agree on the value of physiotherapy for these patients but it certainly improves their general outlook and they, the patients, feel that they really have had some treatment when they are discharged.

The usual period of convalescence is two to three weeks but chest patients are more likely to need at least a month and bronchitic patients even longer. In fact some may need to remain out of London for the worst part of the winter which may last several months, and for many this will be an annual necessity.

Position at present.

The general practitioner whose patient is suffering from an acute attack of bronchitis can treat him at home, send him to the local hospital, or refer him to a chest clinic.

As far as our chest clinic is concerned, if this patient cannot be treated as an out-patient we arrange for his admission to a chest hospital outside London. Here he will be treated for his acute attack and when this subsides he will generally convalescence in the same place. Chest hospitals such as this were formerly tuberculosis sanatoria and are situated in pleasant countryside, offer ground floor accommodation, first class medical care, physiotherapy, occupational therapy, and so in many respects provide the necessary facilities for convalescent care. However they are first and foremost hospitals and one wonders if it is economic that they should continue to provide convalescent accommodation for bronchitic patients.

Suggestions for the future.

Some chest hospitals might consider keeping a sort of convalescent unit which would cater for the advanced bronchitic. This could be run on convalescent home lines but expert medical and nursing care would be readily available. Or perhaps certain convalescent homes in each area might concentrate on having bronchitic patients and keep a close liaison with the nearest chest hospital so that patients could be transferred easily from one to the other either way.

Then there is Dr. Joules' suggestion of making Butlin holiday camps available to bronchitics during the winter months—he even suggests that Billy Butlin should be asked to join the Ministry of Health to make this possible! Although these holiday camps are usually in rather exposed places the chalets each providing accommodation for one or two, would be ideal for chest patients. These patients would appreciate all the facilities for their entertainment, and their families and friends might spend week-ends with them so that they would feel neither deserted nor lonely. But this is probably a pipe dream. . . . . .

A Papworth for bronchitics has also been suggested. This would offer permanent accommodation for those who should not continue to live in London on health grounds and who would be willing to move out permanently.

Perhaps the ideal place to convalesce in is Switzerland. Now that tuberculous patients no longer need pure air and sun to cure them the sanatorium facilities might be made available to bronchitic patients. Actually some non-tuberculous chest patients are able to convalescence in Davos for instance, but their stay is financed privately or through voluntary funds.

Conclusions.

Patients with chronic lung disease requiring convalescence are, first of all, those for whom a period of convalescence will enable to return home and go back to work. They may have to stay out of London for some time, but they will eventually recover enough to resume work.

Secondly, convalescence is required for those who are at home unable to work. Convalescence will relieve their families, give the patient new hope, and probably save a hospital bed.

Then there is a third category whose needs are probably the most difficult to meet. This is the patient who lives in a hostel or in unsuitable lodgings who has no-one to look after him. He requires long-term accommodation if he is to keep out of hospital, and I think he needs somewhere like Papworth every bit as much as did the tuberculous in Varrier-Jones's day. However this situation becomes more a problem of rehabilitation than convalescence.

When considering convalescent provision for patients with chronic lung disease it should be remembered that the need is likely to be recurrent. Once they have to go away in winter they will probably have to go away every subsequent winter for a longer and longer period. Therefore patients want a programme to follow during convalescence

to give them something to do, and they need some kind of treatment such as physiotherapy to help them feel that something positive is being done for their condition.

Discussion

THE CHAIRMAN: Now we will have a discussion following Miss Beath's address. Are there any questions or comments from anyone?

MR. PARKER: Could I ask the lecturer, whose lecture was most enjoyable, if she can form any kind of estimate as to how many chronic bronchitics there are who are suitable for the Papworth sort of establishment? I am only thinking of something notional. Because it is awfully easy to say, "Let's establish a Papworth", and you may get hundreds of people at Papworth, but there are millions of people in the country. Can you give me any idea at all what the wastage of chronic bronchitis is? Would it be tens of thousands or fifteens of hundreds?

MISS BEATH: I think Dr. Hurford would probably be able to speak upon that better than I can. All I can say from my own experience in a chest clinic is that there seem to be many.

MR. PARKER: How many people would you imagine could be accommodated from one period to another?

DR. HURFORD: In Papworth?

MR. PARKER: Yes, in Papworth—150 to 200?

DR. HURFORD: Yes. At the moment Papworth is taking bronchitics—actually very few—through the Ministry of Labour scheme.

MR. PARKER: So you are envisaging something like a Papworth per region, are you?

DR. HURFORD: Yes.

MR. PARKER: Thank you very much. I just wanted a statistical picture, to try and help me.

A SPEAKER: Does Miss Beath find the difficulties of re-housing chronic bronchitics comparable with the difficulties in tuberculous patients and patients with other chest conditions?

MISS BEATH: I think that bronchitics should get as much priority as tuberculous patients. It is certainly a vital problem. Some chest patients are virtually confined indoors if they live in flats which are four, five or six storeys high with no lift. They simply cannot get up and down the stairs. But I suppose there are many patients with other conditions who suffer similar hardships. Nevertheless I think bronchitics deserve more priority.

MISS READ (St. Thomas's Hospital): May I ask Miss Beath this? Does she feel that this idea of going to Papworth would be acceptable to many of these bronchitics and their families? Sometimes we have had experience of this with legless patients, but does she feel that because of the nature of the illness it may make them more unwilling for that to happen?

MISS BEATH: I think probably a Papworth would be the best solution for the lodging house man who has not got any ties in London and who could probably lead a more useful and comfortable life at somewhere like Papworth. I do not suppose many families would want to move out, but with some of these patients it is the only alternative. It is either that or the family splitting up. We have a family where every time the husband and father returns to London he gets ill again. As he lives on the fourth floor where there is no lift he can neither get up nor down the stairs so he remains inside until he gets another acute attack and has to be re-admitted to hospital. Now he has moved out of London and is trying to find accommodation for his wife and family but he has not been successful and at the moment the family is split up. I think that sort of patient might go to somewhere like Papworth.

MR. BAMBER (Jewish Board of Guardians): We do admit bronchitic cases but it would be most helpful if the sending hospitals could provide some information regarding physiotherapy which we could carry out at the home. So far as active treatment is concerned we would like just some simple sheet which would help us, because in the winter, like most convalescent homes we are pretty empty, and we can provide ground floor accommodation and single accommodation to a certain extent even for a prolonged stay of these cases.

The only other point, of course, is that we are on the East Coast, and so therefore another question I would like to ask is this. Does the dictum still hold good today that the East Coast is not suitable for these patients?

MISS BEATH: I do not know what medical people think about this but I feel that bronchitics do not have to go outside and if it is very cold they should not. More important is the treatment offered by the home, and as you would say, if physiotherapy is available I should have thought this would make up for any deficiency in the weather. I do not know what doctors think about the East Coast for bronchitics.

DR. HURFORD: Well, I do not know whether I should speak again, but I think one has got to tackle this question climatically. One has got to make up one's mind that we are not in the South of France or Bermuda or Davos but in England, with fresh air and sea and so on. Despite this, these bronchitics will benefit from getting away from town and their environment, and they should do this. In fact in the winter the convalescent homes have got free accommodation even on the East Coast. As Miss Beath says, they do not need to go out all the time. They can stay indoors. That may be against all your ideas of convalescence—perhaps getting a brisk walk along the front—but it will help the bronchitic. I am sorry to say so much. I agree with the speaker over there who, I think, associates the whole thing with the home factor. I think a lot of work has to be done, actually, in the co-ordination of this thing. I think it is terribly important to have proper co-operation from chest hospitals, and proper links and so on, and proper communications to make sure that everyone knows what has happened.

THE CHAIRMAN: I myself have been under the impression—perhaps erroneously—that there is difficulty in finding accommodation for patients in existing convalescent homes, and I would be glad if any almoner here today who has experienced such difficulty would tell us about it, because it is

rather an important point from the point of view of convalescent homes. Is there difficulty in placing in convalescent homes patients who are suffering from diseases of the chest?

MISS WEBB (University College Hospital): I think the answer to that is simply "Yes". Yes, there is. If one tries to get a bronchitic away in the middle of the winter, if one applies to the Board the Board's reply is that he is an unsuitable candidate for convalescence; then one thinks perhaps of a chest unit such as Dr. Hurford's. But it is difficult, I do find.

THE CHAIRMAN: Would that apply to adults and children?

MISS WEBB: I cannot speak of recent experience with children. I am speaking of adults.

MISS FULCHER: Miss Beath has already mentioned the problem of tuberculous patients. We are still having great difficulty in the way of patients who have had tuberculosis in the past and therefore are not acceptable in Regional Board homes. I do not know if anybody can throw any light on it or has any suggestion to make.

A SPEAKER: Mr. Chairman, we now take patients who have had resections. We have many patients with an old history of tuberculosis, and we do not refuse them.

MISS SHOREY (Hackney Hospital): Mr. Chairman, I think even greater is the problem of asthmatics. There seem to be only two homes for women which are prepared to take asthmatics and neither of those are under the National Health Service. It is a matter of choosing a holiday home and raising the money to send them there. For men I feel it is even more difficult because there is not even a holiday home to send a man to.

DR. ADAMS (S.W. Regional Hospital Board): Mr. Chairman, I am a medical officer, and perhaps I could clarify it from the point of view at least so far as the Board is concerned. In the selection of these patients we really act more as a clearing house than anything else. We in the South Western Region, I believe, take the largest number of patients as convalescents, and in fact we import patients from several other regions in the country, but we have only one convalescent home that is under the Regional Board and all the other homes that we use for convalescence are privately run homes with which we have contractual arrangements; and we are, I am afraid, entirely in the hands of the matrons or the responsible authorities in those homes. It is they who ask us questions about tuberculosis, and we have to submit these forms in each case to the matron or to whoever is responsible in the home and get their agreement to accepting the patient. We—or at least I, speaking as an individual—would not have any objection to submitting a form for a patient who has had tuberculosis in the past (provided he is not now infectious) but we do find that the matrons in the homes—perhaps understandably if they may have had trouble about this in the past—are reluctant to accept these patients.

MR. TRIGGS (Brooklands Convalescent Home): Dealing with the remarks of Miss Beath about lack of accommodation, we have had that experience in the past from time to time, but our main experience has been that these patients have deteriorated very much after coming to us on the East Coast, and our matron has now definitely come to the view that the East Coast is not at all satisfactory for them. With regard to bronchitics, however, we do take quite a lot of what Dr. Hurford referred to as the middle phase, but one of the difficulties we are constantly up against with the advanced bronchitics are the requests to take them, and they, as Dr. Hurford agreed today, are unsuitable for convalescent homes. We have turned down any number of those because we have come to the same conclusion as Dr. Hurford that they are unsuitable for the type of home concerned—but we are quite willing to try the middle phase bronchitic, although there again the question of accommodation arises, because, there is this problem of their several different types of coughs, and patients in the same ward have just got to put up with it.

MR. CLARKE (Barnet General Hospital): It is not our policy generally to have advanced bronchitic cases as convalescents, but the point is that very often you get elderly people who have spent several years in hospital and they say to you and say to the doctor, "Couldn't I possibly get away for a fortnight by the sea? I feel I could face life better if I could do this", and although they do not perhaps, in fact, benefit in their physical condition we feel that it is a very great mental and psychological help to get them away. I have tried on occasions to get this sort of patient into a convalescent home and it is pretty hopeless. But on the other hand you are faced with an elderly man of perhaps 60 or 70 or even older, and one knows that all he wants to do is to get to the sea or the country, but no one can take him—understandably so, because of his night cough. But I do think that there ought to be places where, even though one knows his physical condition would not benefit by it, he could get a few nights' holiday now and again to break the monotony of his existence. I do feel that this would be a tremendous help.

THE CHAIRMAN: That seems to end the discussion on that subject. I was thinking of referring to one or two points on the subject towards the end of our conference, but I think it would be appropriate if I now made such comments as I have.

We have heard from Miss Beath various aspects about her work, although she did not mention the difficulty about getting places in convalescent homes for this category of patient. But from the body of the hall we have had sufficient evidence to accept that there is a difficulty, and that raises rather a complex problem. It is difficult to know what one can say about it, I think, even from a medical man, let alone a laymen like myself, but we have heard from Dr. Hurford this morning (and it has been repeated from the body of the hall) that certain cases which might be termed middle stage cases are suitable for the ordinary convalescent home but I take it that there is even difficulty in finding places for those at the present time, perhaps under erroneous ideas as to the nature of the complaint and the treatment that is required. The difficulty of finding places is one side of the question. The experience of the homes is another. I have been studying statistics about these homes. As a matter of fact, in our directory, we have only five homes for

adults who take this type of patient, and I have been looking at the records for the last five years, and although we hear of difficulties in finding places for patients in homes, one of those homes has not been anything approaching full—in fact the occupancy has been rather low—so one has to try to reconcile that with the statement that it is difficult to find places, for presumably there *were* vacancies at these five homes.

Of course, it may well be, that the categories of cases offered were such that the homes had not the facilities to cope with them, and I think that is probably the answer. But it does then raise the question of what is to be done to provide for convalescence for these cases that need it, and here again it is a problem, because one might suggest steps to be taken now which might in five years be out of date in view of the changes—comparatively rapid changes—that may be taking place throughout the convalescent and medical world under the new Medical Act. But I was going to suggest that these homes that *do* take this category of case might review their arrangements with a view to perhaps extending their facilities to enable them to take more cases and rather wider cases of this type of patient.

The same applies to other convalescent homes with low occupancy who at present do not accept any bronchitic cases at all. They might consider whether they could extend their facilities and make adjustments so that they could accept a few, at any rate, of the middle stage cases. That would tend to help almoners to place their patients, and others who are responsible for that work, and incidentally it might affect favourably the finances of the homes which might be able to finish up their year *in the black* instead of *the red* as at present.

However, as I have said, it is a complex question and one is very diffident of even making suggestions now, in view of the developments that might take place in a few years, but, if I may, I will leave these suggestions with you.

THE CHAIRMAN: I will now ask Miss Margaret Hill, who is a Health Visitor at the Wandsworth Chest Clinic, to address the Conference on "Chronic Lung Disease: Home and Family Problems."

MISS HILL: I know that Dr. Hurford and Miss Beath have talked a great deal about lung diseases, but may I say how much I welcome an opportunity to talk to you this afternoon because I think that more understanding of each other's work must result in better fulfilment of the patients' needs. I am sure that much of what I have to say will be old knowledge but I do please ask you for your forbearance with me this afternoon because I feel that nobody can be reminded of these problems too often. May I steal one more minute, please?

I am asked so often these days what a health visitor is, and I am sure most of you know what a health visitor is, but I think it might be helpful to you if I explain to you how she became one. Perhaps just one person may not know, but she is a trained nurse and a trained midwife, and after her training she has further training in public health work and some knowledge of the social services, and this special sort of experience should enable her to help people to deal with their problems, not only medical and physical health problems but also emotional and psychological needs. At the same time she is a person, who, having been a member of the staff in a hospital, perhaps, or a nursing home or convalescent home, never forgets the difficulties the staff have when dealing with patients there.

Now, in our present day society very few of us live in isolation. Consequently when we are trying to help people —i.e.,our patients—it is necessary to consider the individual as a member of the family and a social circle.

Much of the sort of help we give is in the patient's home, where patients are better able to voice their fears and anxieties in their actual normal surroundings. Moreover it is much easier to appreciate their personal difficulties when sitting perhaps, in the sitting room or the living room of the patient's home talking and listening to the patient and the rest of the family. We sometimes forget what sort of homes these people come from, and, as Dr. Hurford pointed out, very often the chronic chest case is a member of the family in the simpler, lower income group.

The typical sort of house we get to is where we have lines of washing drying round the one room where everybody is assembled—it may be pretty washing, but it can be rather damp and steamy—and in the middle of the washing we have the smoky fire or the very smoky oil stove. Perhaps there is a large window, but very often a large window looks on to the view of a large brick wall. It is surprising how often windows do show you a large brick wall. Then there is another sort of house where you have enormous quantities of very smart, very new furniture, and expensive television sets and radiograms, but they are dreadful worries to people who own them, or partly own them, because they have to pay hire purchase payments on these things. It is not always easy when you buy these beautiful pieces of furniture to realize that even when a bronchitic is often going to be out of work he still has to face his commitments for hire purchase.

When a patient visits us in hospital or a clinic, we, the staff, are the hosts and hostesses. We do, or we should, feel quite natural and relaxed, because we are in our familiar surroundings, but the patient so often is a stranger. Perhaps he is afraid of the unknown—he is bewildered and anxious—and consequently he is not always willing to discuss his problems, which to himself may be distressing. Or perhaps he feels that they are not sufficiently important to discuss with busy professional staff. For these reasons a home visit can be invaluable—I would say almost always—for at home the role is reversed. There the patient is in his normal, natural surroundings, with his family around him and his next door neighbours coming in for a cup of tea, and the visitor is the guest. Then the patient feels that he can say what he wants to say and the neighbours and family can also say what they want to say.

Now if a doctor suggests that a spell in hospital or a spell of convalescence would be beneficial, there is the need almost always for the patient to consider the matter at home with the family, both from the patient's point of view and the other members of the household.

Often these patients are older people. They are used to their own homes and families and the districts in which they live. For example, I can think of the old man who lives and sleeps in the living room, and so many old, chesty cases do throughout the winter time because it is the warmest room in the house. It is the one in which they have managed to stop up draughts most efficiently, and not many people can afford to keep the entire house warmed adequately—that is, of course, unless they have a wonderful centrally heated flat. Most of the chronic chest cases we meet do not live in luxurious centrally heated flats. They usually live in damp little back streets. I cannot say emphatically that this is a main cause, but it is what we find.

Another good reason why he likes to live in the living room and sleep there is because he does not have to climb the stairs to the cold rooms up above, and if he has a restless night and his cough is troublesome he is not going to keep the rest of the family awake. Moreover, he is able to sit upright in his own favourite armchair and he does not have to turn out into a cold room and lie in bed.

Now the rest of the family are used to him. He may be a bit grumpy sometimes but they know he is going to be grumpy when he is not feeling too good and they will tolerate it, we hope. He does not always feel like regular meals but usually if he is lucky there is someone about to make him a cup of tea instead of giving him the stew the rest of the family are going to have, or cook his own favourite dish when he is off his food for a couple of days. Of course they are not all so fortunate, but some old men do manage to collect neighbours and friends, if they have not got relatives, who can arrange these things.

Well, you can see from this sort of picture that although the patient needs to convalesce and needs to get away, he is going to be apprehensive and worried because he is used to his normal existence and he is going to an unknown one. But perhaps his friends have been to it, or he has been to it before. However, he is not quite sure if he will be all right. There are the people who say to the doctor, "Oh yes, Doctor, that will be all right", and two days later I will go to the house and they say, "I shall have to try to climb that lot of stairs and I shall never make it. Shall I be all alone at night? Because if I have one of my attacks I must have somebody I can call. Shall I have to share a room with others who will be disturbed by my cough? I can't possibly go to a place where other people's coughing will keep me awake." People are usually used to their own cough and their own noise, you know. "Shall I have enough pillows, because, you know, my own wife knows I must have my own pillows or I can't sleep. What about the exercises the doctor has told me to do and the physiotherapist has told me to practise, and what about tipping up my bed? Everybody at home knows how to do it. Will anybody else manage?". These are the questions we are asked: "I have got medicines and pills which the doctor gave me. Will I be able to take them when I am away?".

Now to us these are simple, everyday questions which can have a simple reply, but to the patient they so often are terribly important and it gives them sleepless nights even thinking about them.

Well that is the group that is the most common, I suppose, and the most ordinary—the most usual: the elderly patient.

Then, of course, there are other people who suffer from chronic chest conditions. What about the housewife and mother who perhaps has a chronic chest condition and who does care for her family for most of the year, but when from time to time the strain really is too much for her a period of convalescence would be ideal? Her first thought, of course, on hearing the suggestion, will be to say, "Who will care for my children?", and, "How will they possibly manage without me?". But she is only a normal sort of mother: they all ask these questions.

Well, arrangements have to be made for the care of the mother's household. If she has got children at school they will need to be cared for out of school hours, and she realizes what sort of dreadful things her wretched children will get up to between 4 and 7 when Father comes home. You see, they have to be looked after then. If they are very young children they need daily care—perhaps, if possible, by relatives or by child minders living in the district, or a foster mother, day nursery or residential nursery care. Most mothers when they have to go away and leave their children are happier if they are left at home, because they feel it is less of a strain on the children than if they are taken to a strange place. Sometimes if the children are left at home to manage, perhaps with a friend or relative or even among themselves, a visit from the Health Visitor and a subsequent letter to Mother to assure her that they are neither starving, fretting nor freezing can help her to obtain the maximum benefit from her stay.

Not only children are a problem. Occasionally there is an elderly relative who may even be bedridden, and it may be possible to arrange for their temporary admission to a geriatric hospital while the patient is away convalescing.

Apart from human friends we have the pets. People are always very fond of their pets and they always become distracted and upset when the pets have to be cared for by someone other than the person normally caring for them, when that person is too ill to do so. It is not easy, when you have this kind of patient, to find ways and means of boarding out an Alsatian with ten puppies. At Christmas I had this particular problem. It was not so difficult with the mother who was expecting her seventh confinement. We could look after her and also the grandmother and we could look after the children while their father, who was a very bad bronchitic case, was being cared for himself, but everybody refused to budge from the house because of the Alsatian and her litter—even the mother who was having the baby!

When the patient is away happily enjoying convalescence the rest of the family who have the perpetual burden of caring for a chronic invalid need to be encouraged both to take advantage of this respite and to prepare for his return. I do not mean necessarily to celebrate the fact that he is away, but quite often the old man has been living in one room for so long that it really needs redecorating most desperately and because of the smell of paint it cannot be redecorated while he is living and

sleeping in it. It is always a good time to encourage the family to do out his room and show that he is welcome home. Quite often when older people have to go away they are firmly convinced that it is because the family are tired of having them and fed up with them. While they are away it is true that the family do need that little break so that they can carry on so much better when they return. If they are encouraged to do these little things it is proved to the patient upon his return that he is wanted at home.

When the patient is the man of the house and the bread-winner and his wife is left at home, or she is at home looking after him, she needs constant support and encouragement and really friendly advice concerning the various ways in which she can acquire assistance to help her with her financial problems.

I would also like to mention the person living alone. These people really do need a lot of help and a lot of listening to apart from anything else, because even though neighbours will go in and do the shopping and the meals and light the fire they spend many hours alone, and to be alone and breathless, I am sure, must be very trying. They are the people who benefit enormously from a break away from their normal home, although there are difficulties if they have a large rent to pay even while they are away.

Then there is the single man living with an elderly landlady who is very good to him, but who really gets exasperated because he is so difficult. She might continue to look after him and be a very good landlady for years provided that once in a while, when his bronchitis is very bad, he goes away for a time to give them both a break. It also helps tremendously, when one has a patient who has been unable to be an adequate parent. He has difficulty in dealing with and understanding wayward adolescents. We must not forget that the poor adolescent is also having difficulties, because his circumstances are so different from those of his contemporaries. Other friends' fathers go to football matches with him. Other friends' fathers romp with him; but his father is forever sitting in an armchair by the fire grumbling because the pop tune records are being played too loudly on the gramophone, and grumbling because his children want to have fun.

It does cause tremendous discord, and very often in this sort of situation a small period of time away from home helps to ease these people. This same kind of chesty patient needs a tremendous amount of sympathetic listening if he thinks that he has become, because his illness has caused it, someone who is lacking in control over his children and he feels that there is a lack of link with his children. Also very often he realizes that he is not going to get better and he is not going to be able to take a more active part in family life. He does need a lot of understanding, especially if he begins to lose confidence in himself and in his ability to play his role in the family and his ability to return to work.

It is not only the patient himself who can become depressed. His depression may affect the rest of the family, and in this sort of situation it is evident that the entire family needs a tremendous amount of support and encouragement in most winters—not just one.

THE CHAIRMAN: Thank you, Miss Hill. I think Miss Hill has made a very strong case for sympathy from convalescent homes by describing the difficulties and problems that arise in connection with placing these patients who come direct from their own homes, and I am sure that those convalescent homes that are represented here will give it due consideration. It may be that some of them have already received such patients. In any case, we are open to receive such questions as you want to ask on what Miss Hill has said, or any comments.

Miss Hill feels very gratified that you are all completely satisfied, and we will now go on to our next address, which is: "Residential Care and Education of Children with Chronic Respiratory Conditions", by Mr. R. V. Thomas, who is the Headmaster of the Invalid Children's Aid Association, at Meath School, Ottershaw, Surrey.

MR. THOMAS: Ladies and Gentlemen, you have heard this afternoon some of the problems of adults suffering from chronic respiratory conditions who need convalescence. Diseases of the lungs, especially asthma and bronchitis, are among the most common disorders of childhood, too, and where a child suffers from this handicap there is the additional problem of the education of the child to be considered. Such children are classed as delicate children, and special provision is made for them to attend a special school, either at home or away, in the form of day or residential schools.

I am headmaster of a residential special school for 30 delicate boys aged from 7 to not quite 12. Of these 30, four have bronchiectasis and the remaining 26 have asthma, with which of course, is associated infantile eczema. They come from London and the Home Counties in the main, though I do have a few boys from the Midlands and the West of England and sometimes from the East Coast. All of them have histories of repeated chest infections and severe attacks of asthma. They have spent much time in hospital or at home in bed and naturally their schooling has been irregular. I think it might be true to say that most of these children are emotionally unstable. In many cases, too, there are adverse social problems involved, and all these factors have been taken into account in deciding that long term placing in a residential special school is necessary for these children.

The Delicate Child Category of handicap was introduced in 1945 following on the new provisions made in the 1944 Education Act. Many authorities, of course, had schools for delicate children before this time. They were known, and some are still known, as Open Air Schools and Schools of Recovery. In fact the London School Board opened the first of this type of school at Plumstead in 1907. When I first started working with delicate children in 1953 it was at a Convalescent Home with a School of Recovery attached. The matron was responsible for the home and I, as Head Teacher, was responsible solely for the school side. Children were admitted and discharged every week; some stayed for two or three months, a few for six months, and obviously the emphasis was on convalescence. Nowadays, as

you all know, convalescence—short-term convalescence—is being much more adequately catered for by Hospital Boards, the longer term cases being sent to day or residential schools, where the educational needs of these children can best be met.

Thanks to the improvement in child health and social conditions, far fewer children today need the facilities of these delicate children's schools. In the last twenty years figures can show how much this is so. For instance, in 1938 there were just over 15,600 children receiving education in delicate children's schools. By 1960, the number had dropped to 10,600, a drop of 5,000 children, which I am sure you will agree is quite a remarkable advance. More than half these 10,000 are placed in day schools where the children can go home each night and go to school each day for the special facilities which they require, and of those who go away to residential schools, most are discharged home within a year.

There is a small number who need residential care for a much longer period, and it is for those we cater. Our problem is to provide for a boy who requires at least a year's stay at a residential school—possibly much longer, even to the end of his school life, which may be 16, so that apart from meeting the basic needs of the child, such as food, clothing and to be kept clean and so on, we do have additional important responsibilities to the child.

Firstly our task is to educate the child, and as we are a school this is our primary purpose. These children already have a very heavy handicap to bear, and in the competitive world in which we live it is essential that they be given as good an education as is possible.

Secondly, we have to train a child to live with and as far as is possible, to overcome his handicap. Thirdly we have to help the child to grow into an adult and then to live a full life. How we try to meet these responsibilities can be best explained if I enlarge on three aspects of our work, that is to say, the education of the child, the nursing and the child care side, and thirdly the place of the parents in the school's work.

On the question of education, what is the background of the children whom we receive? Most of them have spent long periods away from school either at home or in hospital. They have missed a large part of that important stage of school life, the infant school, where children grasp the fundamentals of learning. They have missed all the practical work with letters, words, numbers, materials and so on, and on average we find that they are two years retarded when they come to us. They are weak in reading, spelling and comprehension of the written word, and especially weak at arithmetic. There are large gaps which have to be found before they can be repaired.

The attitude of these children to the schoolroom has to be much improved since a child who has spent long periods at home or in bed, where little pressure has necessarily been placed upon him, often finds it difficult to settle down to a disciplined routine. Schoolroom concentration and application are often lacking. Many, too, have often met failure in their normal schools because of their frequent absences, and their self confidence is sadly impaired. They really are afraid of trying just in case they fail again. Dr. Hurford mentioned this morning that many asthmatics are of fairly high intelligence and we find this equally so with the children. Many of them are of above average intelligence, and given the right type of teaching and regular attendance at school they can keep pace with normal children, but, as I say, special provision must be made before one can hope to get these results.

We have thirty boys and we divide them equally into two classes, roughly fifteen to a class, mainly by age but we do take intelligence and attainment into account. Each of these two classes is in the charge of an experienced, qualified teacher who is fully conversant with the problems involved. We develop individual methods in the classrooms where each child is allowed to work at his own rate, and at that particular stage of learning which he has reached, and in small classes such as these it is possible for the teacher to know the background of each and every child. It is possible to know each child's educational background, emotional background, and even its medical background, so that by sympathetic encouragement and consideration one can help a child to restore its confidence in itself. Full use is made of practical apparatus and visual aids, especially in the younger boys' school class. They have a small school shop, a post office, scales and weights for measuring and so on. We have the reading books of several popular reading schemes, so that boys can continue from where they were at their previous school when they finally arrive at us. The emphasis is on practical work and we use many of the methods used in infants' schools to teach reading and number concepts.

We use other aids too, in both classes, such as a tape and long playing records for music. We use film strips, the B.B.C. sound and television, school broadcast lessons,—all the things which can help them to improve their background knowledge, and, wherever possible, to keep a strong interest flowing.

Being a residential school we have the additional work of providing for the children's evenings. These children are intelligent children. Therefore they have to be given a chance to express themselves in playing as well as in the schoolroom. Their evenings are catered for by different types of clubs and activities run by the teachers. We have a strong Cub pack, and it is enthusiastic, too. We have a stamp collecting group, an art club, a drama study group—modelling and puppetry, being also popular, at different times. We were pleasantly surprised by the boys' group doing musical mime, as normally they tend to be withdrawn and reluctant to let themselves go. In the familiar atmosphere of their own classroom their imaginations, could find full expression, and they could really 'go to town': I am sure they enjoyed it very much indeed, we certainly did.

In the summer and at weekends when it is warm we make use of our large lawns and an extensive copse in the grounds. These are ideal for this age group with their interest in tracking games, building camps, climbing trees and similar kind of games, and we do encourage them, to do that. Sometimes I think their mothers would have a fit if they saw their boys climbing a tree, but they can be normal

children. They have to be given a chance to be normal children. But they cannot be normal children, if someone says, "Don't climb that tree, don't kick that ball, don't run about—you'll get breathless". They have to be given a chance, and we find more often than not that they do take the chance. A mother when she came to the school said, "Oh, does he play football?" I said, "Yes," and she said, "Oh, he never could play football before; it always gave him an attack of asthma." I said, "We never press them, but when they want to join in with the other boys playing it, and they are interested, we provide them with the full football kit to give them added encouragement (boots, socks and so on)." We have football posts as well! I sometimes wonder if the game really is football but they enjoy it, and if a boy staggers behind the posts to collect his breath, I know that in a few minutes he will be back on the field again. When one sees activities such as this, one is amazed to see what these small boys can do.

You will appreciate, too, that parents are particularly anxious about their child's educational progress in view of its handicap. Often this problem has to be discussed time and time again before one can hope to build up what might be termed a more rational attitude—rational, at least, in my estimation—since even in a special school, one cannot get away from the spectre of the 11-plus examination.

Now these parents, being no different from any other parents, want their children, if possible, to go to a grammar school. Some are, as I said before, very intelligent, but often I feel it is not advisable for them to take the test since they usually get so apprehensive and tense about the whole thing that they usually end up with an asthma attack on the day they are due to take the test and cannot take it. Anyway, even if they do take the examination, sometimes it is a good thing to remember that they are sitting it in competition with healthy children, which is really placing them at a disadvantage. Some authorities postpone the taking of these tests by handicapped children until they are deemed fit to return to normal schools, but again you meet opposition from parents: "I want my boy to take his 11-plus because if he becomes well again he will be able to go to a grammar school." It is not always easy to explain these things to ambitious, anxious parents, especially, perhaps, if brothers or sisters have done very well at school and may have gone to a grammar school or even to a university.

It is not easy, either, to explain to parents that the pace of the work, the long hours and the competition of a grammar school may easily have a deleterious effect upon a boy who is liable to severe attacks of asthma. However, sometimes these boys have to sit the test, and of two asthmatics who have already sat the main test this term I understand that one of them has reached the standard for admission to a grammar school but that the local authority is considering postponing his entry there for at least two years because he is not considered either physically or emotionally well enough to take his place. I have not heard the result of the second boy, but I feel quite confident that in normal circumstances the boy would be placed in a grammar school.

All the boys follow a normal school curriculum, in a normal school day, and we find that in the protected atmosphere of the special school we can get some very good results. The boys do get less asthma, the attacks are less frequent and not so prolonged. They are less liable to pick up infections, and when they do, treatment is immediate. There is the confident attitude of the staff, the relaxed atmosphere of the school and the predictable day—all these things, I am sure, help considerably. Last term, for instance, our percentage attendance figure was 95%, which is a better figure than the normal school in the village ever gets. Only once in three years has the attendance figure dropped below 90%, and that was in a spring term when we had a crop of influenza and colds.

When one refers to the past attendance record of these children at their normal schools, then the improvement becomes more obvious, and the school has the chance fully to help the child to reach the standard which is within his capabilities.

I am sure you will appreciate that the type of handicapped boy for whom we cater requires a trained nursing and child-care staff. I thought perhaps some figures here might be of interest to you. 50% of the boys need drugs of one sort or another daily—some two or three times a day. A third of the boys can at any one time be receiving treatment twice or three times a day for infantile eczema. It is not unusual to have three or four boys in bed at a time with chest infections, while the boys with bronchiectasis and some with asthma require postural drainage once or twice a day, or three times a day. They all need daily physiotherapy and posture correction and so on.

To meet these demands we have a member of the nursing staff on duty throughout the day, since one never knows with this type of child when he may start a severe attack of asthma. Our matron is a trained nurse, the assistant matron is an S.E.N. and the third member holds the NNEB certificate and has also had some hospital training. A qualified physiotherapist attends the school for three hours daily, except Sundays. Each evening a trained nurse comes on duty to take over the care of the children during the night. The three dormitories in which the boys sleep are linked by a communication system to a master set in the night nurse's room so that she can hear any boy as soon as he starts coughing or wheezing and be with him in half a minute. Sometimes only the comforting presence of an adult is required. Sometimes treatment is required, but we do find that it is essential that these little boys are helped as quickly as possible, since otherwise fear builds up, tension increases, and we could find ourselves dealing with a severe attack of asthma before we know where we are. In any case, some boys do have attacks of asthma at night, which make it essential to have a trained nurse on duty. On average the night nurse attends ten boys at night, and sometimes, maybe, the same boy several times.

All these things, I hope, will give you a picture of the type of child we have at our school. The school medical officer is a local general practitioner who visits the school weekly to prescribe medicine and to deal with the ordinary complaints and he also

is on call whenever we need him. Once a month the school Consultant paediatrician visits the school and physically examines every boy. At the same time, each boy is discussed and his treatment is confirmed or revised according to his progress. Before a boy is admitted the Association obtains a fairly comprehensive dossier of the boy, including these things:— a report on the boy's social background; a report from his headmaster or headmistress at his last school; a precis of his past medical history from the family doctor, including previous treatments, information or sensitivities, desensitizing courses, and so on. Then fourthly we have a report from the consultant and almoner at the treating hospital, where this may be applicable. I will say here that of the 30 boys we have, 27 of them were under the care of a consultant before admission.

Well, as you can see from these four reports, we have a good picture of the child before he comes to us. Of course it is only fair that we should do the same thing to interested people once we have the child, so we compile a fairly full report each term which is made up by the form teacher on his school work, by the matron on his health during the term, and by myself, on the child's general progress. The family doctor sees the boy when the parents take him to see the doctor to get medicines for his holiday, and so the doctor sees the report at the same time, since the boy's treatment is listed on the report. The parents are asked to arrange an appointment with the hospital so that the consultant can himself keep in touch. Case workers receive a copy, and a copy is also sent to the local authority responsible for the boy, together with a progress report compiled at regular intervals by the consultant paediatrician and myself. This does entail a lot of administrative work, but we think it is necessary work, especially in view of the chronic order of the handicap.

Lastly, I want to speak of contact with parents. As you know, it is true to say that many of the homes from which these children come do not have a tradition of the boys going away to boarding school. When, therefore, it is first suggested that a boy should go away to boarding school, a certain amount of conflict and opposition is often met. This is sometimes modified where the rest of the family are suffering from the demands made on the mother by the handicapped boy. It is essential that everything possible should be done to reassure the parents and still their doubts and fears, and to obtain their very necessary co-operation. When a boy is due to be admitted to the school, we ask the parents to come to the school to see us during the previous term, and, if possible, to bring their son with them. They are shewn around the school, our aims and methods are discussed, and they see the other boys at school and at play. This gives us the opportunity to re-assure them on the many points that are troubling them, often to interest the boy in the school, and to give us a picture of the parent-child relationship.

Once the boy is admitted, the parents are asked, and reminded if necessary, to write to the boy at least once a week, and to send a little parcel now and again to maintain the very necessary link with home. Parents can visit the boy on any convenient Saturday or Sunday once a month, and there again I try to get the parents to take the boy right away from the school for the day so that he can revert to being one of the family again, away from the possibly restrictive environment of the school and staff. I myself make myself available most weekends so that I can meet the parents when they arrive and have a short talk with them. Sometimes, as you can imagine, this becomes a long discussion, I am afraid; but the fears of these parents are very real ones, and they, as well as the children, need a good deal of bolstering up. It is quite tragic to have a parent ask why their son has so much asthma at home and yet he is so much better at school! How can one answer this question? Sometimes there are suggestions which can be made, but one cannot change personality or inherited weaknesses, and where these are at fault, it would be pointless to blame the parents. It is help which is needed.

I find that all the parents are most co-operative, and they do indeed try hard. I have a boy who has been admitted to hospital many times—23 times before the age of 8—because of severe attacks of asthma, and he was in fact admitted to the school direct from hospital, where he had been for the previous six months.

There was a strong family history of asthma, and the parents were very young when the boy was born. The mother—a sensible, intelligent young woman—really has tried, but her confidence in handling the boy has been entirely destroyed by her experiences with him in the past. During the two years he has been with us his asthma attacks have become less frequent and less severe. He has not had to be admitted to hospital during this time and accordingly he has made very good progress in school. School holidays have sometimes been difficult but bit by bit the mother is regaining her confidence; when with the boy she controls her fears, and has now got a very sensible attitude in handling the lad.

We arrange our school holidays well in advance, so that parents can arrange to take the boys away from home on holiday if they wish to do so. The holidays the boys have are three weeks at Christmas, three at Easter and four weeks in August, and although sometimes when they come back to us we find the boys have not had a good holiday, it does not take us long before we re-establish their pre-holiday condition and the essential home contact has been maintained. The child has taken his place once more within the family group. Our case workers visit the homes during the holidays to see the boys and their parents, and sometimes also, when it is necessary, during term time. We find this a very valuable liaison between home and school. The parents' attitude to the school is a major factor in our chances of success with the child, and so we do all we can to foster good relations with them.

Now I have taken out a few figures here which I thought might also be of interest. During the last three years almost exactly half of the boys who have been discharged were thought fit enough to be returned to their homes and to resume their places in the normal schools. Four boys did not return to school because their parents were not prepared to let them do so. One boy had to be transferred for psychiatric treatment. One boy remained at home because he was unwell and he was not considered fit enough to attend any school.

The remainder, just over a third, were transferred to Pilgrim's School, which is our school for boys of secondary school age at Seaford, because we considered them to need further residential education.

Of our present complement, a third have been with us for two or more years, a third have been with us for one but less than two years and the remainder have been admitted within the last twelve months.

So, from these figures you can see that even in the cases of boys who suffer from severe attacks of asthma in early childhood, it has been possible to allow 50% to return to their homes by the age of 11 plus while their educational standard has been kept at such a level that the boys are not placed at a disadvantage when they do return to the normal schools.

That leaves me to say that we can only justify our taking a child away from his home for a long period if we can show that the separation is a necessary factor in his growing up to take his rightful place as a useful member of the community.

THE CHAIRMAN: Thank you, Mr. Thomas. I am sure you all will agree that Mr. Thomas has given us a most interesting and very complete survey of the residential care and educational needs of children who suffer from chest diseases. Previously, I asked about whether there was difficulty in getting places in convalescent homes for these children and the answer seemed to be "No". As regards special schools and convalescent homes for children we include in our directory some 20 institutions, including the special schools listed as taking children for convalescence.

Only five of these however, furnished us with any statistics, so it is not possible to give you any information as to the occupancy of 15, but as regards the five that *do* give us information, they are always full—100%—and very often they have waiting lists, but as regards the others, I am afraid one cannot arrive at any conclusion as to whether there *are* vacancies or whether there is any difficulty in placing children suffering from diseases of the chest.

The meeting is now open for any questions on the last address.

Discussion

MISS MAYFIELD (Great Ormond Street): The question I would like to ask Mr. Thomas is this: whether he finds that the families of children admitted to his home have been living in unsatisfactory conditions. We all know that unsatisfactory family relationships lie at the root of many of the troubles of children with asthma and eczema, and I cannot help feeling that if the family conditions were better there would be considerably less tension and less likelihood of a collapse on their return home. We have always got an eye on the children when they come back. What can we do to make things better?

MR. THOMAS: It is not a question of the type of homes from which children come. I think it is true to say that the only common factor here is asthma and certainly not the standard of the home. At weekends when parents take children away I have known some come in a Bentley, several come in Consuls, etc., and some walk. It does not link up at all. We do find that the material factors in the home are less important than psychological ones.

MISS CARLING (Royal Victoria Hospital, Bournemouth): Mr. Thomas told us about a child of 8 being admitted to hospital 23 times before going to his school. We all know that hospitals have not always got children's wards. Now if that child had been admitted, which is quite possible, to a general ward of the hospital and smoking was permitted, what would be the effect on that child? It does seem hard lines that smoking—which we are told by the British Medical Association is detrimental to general health—is permitted at certain hours in general wards at hospitals, and I do not know of a single convalescent home that prohibits smoking.

In the voluntary hospital days, of course, a patient was admitted to hospital and accepted the fact that smoking was not allowed. Why is it now permitted when it is recognized as being harmful?

MR. THOMAS: This boy actually came from a hospital which had children's wards. He was a London boy.

THE CHAIRMAN: Perhaps Dr. Hurford might reply to the second part of that question. Why is smoking permitted in hospital wards?

DR. HURFORD: I think we have had enough about smoking, honestly. I think the straight answer to that is of course that there are places where patients can smoke surreptitiously. I am quite serious about that. It is a point. I have done much heart searching, and I have cut ours down as much as I can. It is much more sensible, really, because it is a fact that they are bound to go on smoking. You cannot cut smoking out. They have got to exercise self will, I think, and I would like to congratulate Mr. Thomas very much on his paper, which I enjoyed hearing extremely. I naturally, of course, take a particular interest in special schools and their treatment, and you have told us a little about that by saying that at the age of 12, 50 per cent of them go back to their homes. I think we all realize that there is a very strong psychological effect in these cases, and I would like you to say, if you can, how much that is associated with conflict in the home, if there is any upset in the home in the first place. Then 50% perhaps go on to your special secondary school—

MR. THOMAS: 30%.

DR. HURFORD: What is the follow up there? Does it show any future trend?

MR. THOMAS: On the question of conflict at home, well, it is true to say that with a large number of cases of such boys we get there is conflict at home. Now I have one boy at the moment who is severely maladjusted. The asthma is probably a manifestation of his severe maladjustment. He has a mother who tends to neglect him, and yet the boy always asks for his mother when he is having an attack. I gather that at night when he is at home and he has a coughing session he is told to turn and lie on his tummy or try the other side. Yet when the boy comes back at the beginning of term it takes about a fortnight to get him to settle down. He has really bad asthma for a fortnight. We were at church one Sunday morning, and he had been expecting his parents for two Sundays and they

had not turned up, and the very fear of the thought that they would not be there just about finished him, and I had to carry him back myself—he was quite exhausted—and of course when we got there his parents had not arrived, and as in fact they did not arrive, the boy was quite ill. It was not until I had a telephone call from them saying that they would be down the next Sunday that he perked up again, and now that has passed he is quite well. It is quite an emotional subject.

MISS FULCHER (Metropolitan Convalescent Home): On the subject of follow up, the Association is doing a follow up of all pupils who have left, but it is only now that investigations are beginning. Should that have not been included at the same time?

May I also congratulate Mr. Thomas on his fascinating lecture on his special school? However it does seem all the more unfortunate in the circumstances that the children appear to be there until only 12 instead of 16, or am I wrong in that direction?

MR. THOMAS: We are a school in the junior stage—that is, 7 to 11-plus—and at the end of that time if they are still considered to be in need of further education we have a secondary school at Seaford which is identical, to which we can transfer boys, and where they can stay until they are 16, and if they are sufficiently intelligent, they can take their G.C.E. from there.

THE CHAIRMAN: Are there any other questions?

Well, Ladies and Gentlemen, we seem to have come to the end of our discussion, and there is not very much left for me to say. It must all have been very interesting and instructive to everybody who is connected with convalescent homes, including almoners and ward sisters.

It would appear unfortunately, that chronic bronchitis, with cancer of the lung, rheumatism and mental illness, still remains a major challenge to preventive madicine, but Dr. Hurford, Miss Beath and Miss Hill have shown that much can be done to alleviate suffering and make life bearable for such patients, and in that, convalescent homes have their place.

Before I close the conference, as is our usual practice, I am going to take a few minutes for any general questions and discussion because it is the one occasion in the year when representatives of convalescent homes, almoners and ward sisters can bring forward any particular problem that they wish.

I have received one question which was partially dealt with this morning, but the second part is this question (from Miss Fulcher of the Metropolitan Convalescent Home for Men): "In view of the urgent need for certain accommodation and facilities, can you tell us whether the report of the working party to consider convalescence has yet been completed?" The answer is "Yes" Then she goes on to ask, "When may we expect the implementation of the recommendations contained in the report of the working party on convalescent treatment published in 1959?".

Well, as I said at the conference last year, the Ministry appointed a Standing Joint Advisory Committee on convalescence following the recommendations of the Working Party. I do not know whether Commander Peers, as Chairman of that Committee, is in a position to make any statement, but I will ask him to speak to the conference to the extent that he is able.

COMMANDER PEERS: I am only too glad to have the opportunity to talk about this because I have been involved in this work for some time now. As you know, the original working party published its report in 1959, with various recommendations, the gist of them was that they thought that homes should be able to provide a more active regime of treatment, because that is what the hospitals now wanted for their discharged patients. Another recommendation was that there should be some permanent body set up which would be referred to when there were matters of policy or even instances of closing homes, which were going to affect the four metropolitan regions. It would be a place where all four metropolitan regions and the other bodies concerned—the teaching hospitals, the King's Fund and voluntary bodies—could meet and discuss any possible action. Well, the Minister set up this body which is called the Joint Standing Advisory Committee on Convalescence—it is a bit of a mouthful—to discuss just these very points. Our terms of reference were that if there was consideration to close a home in one region—if one region wanted to close a home for a certain type of case—this should be discussed round the table so that the representatives of the other regions and teaching hospitals could say what they thought about it.

I should also say that the recommendations which were made in the Working Party report, such as the need in convalescent homes for rather more nursing supervision, for ground floor rooms, lifts and so on, were studied very carefully by the regional boards and by the committee, and they are in fact doing all they can to work along those lines. Many of the homes, as you know, still have not got lifts, but many others are now taking patients whom they formerly had to refuse because they could not manage stairs. The requirements of convalescent patients are quite different from what they were ten years ago. There are many problems which concern convalescent homes which are put before this committee, and I should stress that it is an advisory committee. The thing we are working on at the moment is to advise the Ministry of Health and the regional boards as to what kind of pattern is required for a convalescent service in the next ten years. This work entails very careful discussion with our medical members and we have sent the first part of our report to the Minister. It also means fairly extensive enquiries from hospitals, working with physical medicine departments, to try and get some idea of the number of homes which will be required in ten years' time. I can tell you that, following on what has happened in the last ten years, it is realized that a more active type of convalescent treatment will be required in the future.

Another change which has taken place is that there has been quite a dramatic drop in the requirements of children's convalescence. I cannot—and I do

not think it would be right to try—to give you any figures yet, but I can assure you that it is quite remarkable, and it is all to the good. Therefore, although you may be waiting impatiently for our committee, I do assure you that we are working as fast and as hard as we can, and we constantly have your problems in our minds.

THE CHAIRMAN: I am sure the conference will appreciate the fact that Commander Peers' committee has a very big and complex job and it will take some time, so that nobody should look for rapid or startling results, and you may rest assured that the King's Fund will follow closely the work of that Committee.

It only remains for me to thank our excellent speakers—Dr. Hurford, Miss Beath, Miss Hill and Mr. Thomas—for their excellent addresses, and to close the Conference with a warm vote of thanks and appreciation to Miss Stanton and Commander Peers, who, with their able assistants Miss Dean and Miss Fletcher have again organized the Conference so efficiently.

The vote of thanks was accorded with acclamation.

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