patient, but we were adamant: disposal of this patient was his problem, not ours.

On one occasion, however, a soft-hearted staff physician did admit an elderly man, a gravedigger by trade, who'd had a stroke and had no one to care for him. Since he could not be admitted to a teaching bed, he was admitted to the private pavilion. Very quickly it was realized that, financially, he was utterly ineligible for this privilege, and he was transferred to a public (that is, teaching hospital) bed. The next morning we found him breathing stertorously. He was unconscious. When we made ward rounds, the physician in charge expressed indignation and ordered the patient to be discharged. This meant calling on the social worker to find a nursing home bed. She was able to comply at once, as she had a working relationship with several nursing homes. They called her when they had an empty bed, and she undertook to fill them. So by mid-morning the stroke patient was gone. We didn't know where, nor did we care. I realized later that, as there was no treatment or rehabilitation in nursing homes, the patients sent there quickly developed bed sores and aspiration pneumonia and died. The turnover of cases was quick and efficient.

On another occasion, a patient on the ward became confused, noisy and violent, unsuitable for a nursing home. We decided he should go to a mental hospital. There were two: the Verdun Protestant hospital with 1500 beds, and St. Jean de Dieu with 5000. But these hospitals were always full. In the days before effective therapy they housed many young schizophrenic patients who were there for life. Indeed, their parents were encouraged to consider them deceased and to put a death notice in the newspaper. There were also severely manic or depressed patients and some with dementias arising from syphilis or Alzheimer's disease.

How were we to discharge our noisy patient? We called the police. Two burly officers arrived, saw that the patient was disturbing the peace and took him to jail. The jail medical officer quickly determined that he was a mental hospital case and ordered him transferred to one or the other mental hospital, depending on his religion and language.

Some time later I spent several years in Britain, where the recently established National Health Service was undertaking to provide treatment for all persons "from womb to tomb" or, as we jokingly said, "from erection to resurrection." There I met the remarkable Dr. Marjory Warren, who had shown in the 1930s that with accurate diagnosis and simple rehabilitation many chronically disabled patients could leave institutional care. Her appointment was at a large county hospital with a workhouse attached. She was able to discharge some people to jobs, some to sheltered housing and some to their own homes. The workhouse was converted into a general hospital, which included a 180-bed geriatric unit. Here she treated her own patients as well as those transferred from other hospital wards. Because the other physicians had nothing further to contribute to their patients, they considered such transfers as "clearing their beds," a kind of social work, and referred to Dr. Warren as Miss Warren.

When I returned to Canada I started practice as a geriatrician. Very soon, elderly patients were referred to me by local practitioners. Unfortunately, I quickly discovered that these patients were referred when their hospital insurance had run out and they had to be discharged. They could not afford to pay me. Although there was a small rehabilitation department at the hospital, I explored the possibility of longer-term treatment at a large chronic care hospital that had recently built a rehabilitation unit with a grant from the federal government. This hospital was staffed and administered by a devoted order of nuns. Almost all the patients were in bed, and few used the rehabilitation facility. To occupy their time, a loudspeaker had been installed in each room over which the prayers and religious services of the nuns were broadcast. There were no magazines or radios.

Art Explosion

I proposed to the nuns that I could organize a rehabilitation program and encourage activities. They gave my offer careful consideration for a few days and then declined it. They quietly explained that these patients had not long to live and should profit from their remaining time by preparing for eternity. Moreover, if their own physicians had not ordered rehabilitation, it was probably not needed.

In a town nearby was a home for English-speaking elderly people. I spoke to the physician in charge about the possible need for diagnosis and medical care, especially as on the day of my visit a resident of the home had just died of heart failure because no one had reordered her diuretic medication. He agreed to speak to the board of directors. But, on my return visit, he declined my offer. Apparently the board told him that I was trying to turn the home into a hospital, and that was not its purpose.

I was encouraged to apply for a position in the Department of Veterans' Affairs chronic care and rehabilitation

Putting in time until the party is over

Alone in a corner she sits
hands folded
patiently waiting.

Belle of the ball,
bathing queen,
no longer aware,
she needs
a diaper change.

Robert C. Dickson
Family physician
Hamilton, Ont.