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## *Original Communications*

# THE OLD SOLDIER

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ONE recalls duties during wartime in which one was intimately connected with the health of the serving soldier and of writing a great deal thereon. It has been suggested that the health of the old soldier is less widely described and that his welfare might interest many. Further it has been pointed out that comparatively few people are directly concerned with such. The discharged man mingles with the rest of the community and becomes a part of it. As a class "the Old Soldier" can probably only be studied in hospitals of the type of those of the Ministry of Pensions, our dear old friends of Chelsea not being of necessity unfit men.

One has had a personal association with Ministry of Pensions Hospitals for a number of years, and one feels considerable pleasure that someone might like to hear about them and their personnel. It is at this point that difficulties arise in one's mind. What is to be recorded as of interest? The strictly scientific may be discarded at the outset. This can be read elsewhere, as the inner workings of "the Old Soldier's" body are much the same as of other peoples! Possibly as good a means as any in producing results would be record free associations that may occur to an open mind.

The first thought is that one must dispel the all too prevalent misapprehension that a Ministry of Pensions' Hospital houses incurables only. All hospital activities are carried on from the initial X-ray of an out-patient to the admission and treatment of the surgical emergency, as well as the attempts to lighten the burden of the case of prolonged illness. Diagnoses range between epidermophytosis and cysticercus epilepsy: incidentally, one has seen both of these in this hospital! Possibly a unique feature in our work is the opportunity of studying the patient's history *in extenso*: the attestation form, the



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A.F.B178 (with all too frequent "blank duplicate"), the A.F.B1318, possibly blood-stained, the I.1220, the A.F.B179, and then all the medical board examinations. How differently the surgeon might have regarded the case in the beginning had he been able to see it in this retrospect! Nevertheless how justified he was in his action at the time, having before him the data he had, and being unable to assess the imponderable. In the attempt to improve the final result, there comes a moral lesson for the young officer, and for all of us at all ages—that our policy should be to effect some constructive improvement, and to help the patient and not to do something clever—"an operation that is feasible is not of necessity reasonable." From the medical aspect one can look back on cases one has known and ask oneself questions to which the answers can be but debatable. Why does the man with an old gun shot wound of 1918, with persistent discharging sinuses ever since, not get amyloid disease? He certainly has chronic suppuration and according to the textbook should be in danger of it. I have not seen one following bone sepsis. Is it because the blood supply to the injured bone is so poor that he does not absorb toxic products? And in such cases how impossible it is to do anything to a tissue now resembling ivory, with only its sparse blood supply to carry any parenteral medication to it! Possibly, it is this same lack of blood which allows the odd Staphylococcus to find a wayside shelter undisturbed by the scavenging phagocyte and so cause the apparently inexplicable "flare." How inexplicable they are. Yesterday, a man with a gun shot wound of the arm sustained in 1917 was discharged with complete healing following an acute "flare," his first. The standard advice one should give any man with bone damage is to seek advice when it troubles him, and to forget it until it does, as it may never do so. The same advice is equally accurate for the man with a retained foreign body. One would suggest that such, without suppuration or pressure symptoms, rarely gives trouble until the carrier knows of its presence. On the contrary, one has known of men carrying an appreciable amount of metal for many years without incident.

Regarding advice to patients, one sometimes wonders how far they are really deceived by euphemism in diagnostic terms. When the patient, going downhill, and the medical officer chat cheerfully about the future, is the patient not perhaps entering into this game of make believe? One recalls a case of carcinoma of the lung losing ground rapidly but apparently being perfectly happy and unrealizing. He was always looking forward to the time when the "abscess would burst." Half an hour before he died he remarked to the matron "Remember, I laughed to the end!"

Moreover, how far can physical condition be influenced by will-power? Does the will to live or die operate upon the body? Many one has seen have put up a grand fight against a failing body, and then renounced the struggle and "turned their faces to the wall." A cardiac patient is recalled living at the end of his myocardial strength for months. One morning he announced to a medical officer that he was tired of all this, and intended to let himself die.

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He passed away peacefully eight hours later; his myocardium apparently was neither better nor worse than before, but die he most certainly did.

As is to be expected, amputation cases are numerous. It has been said that the amputee always suffers from a psychological awareness of being incomplete. This is agreed in some cases but not in all, as some definitely regard their loss with complete stoicism, common sense and apparently perfect adjustment. One suggests that apart from this ideal, amputees fall into two categories. One type lapses into depression and decides he wishes to seek sympathy: "Remember my wooden leg, you chaps." "If only I had two sound legs like you, old man"—types one knows among one's personal friends. The other type decides he intends using his artificial leg to the utmost and to show how clever he can be on it. In fact, he intends to show what can be done with such an appliance by a superman. This is the attitude undoubtedly to be encouraged in reasonable moderation, but scientifically are they not both manifestations of the awareness of a loss, one by emphasis, the other by overcompensation?

For really successful results an amputee must not only be given a suitable artificial leg, he must be taught how to use it to the best purpose. The trainer himself may, with great advantage, be an amputee. A good limb wearer may walk with a little limp or literally none, and there is nothing more convincing to a pupil than to have his remark "It is all very well for you chum, you have two legs" answered by the instructor mutely turning up his trouser leg! Two incidents illustrating at first hand the efficiency of the artificial limb may be given. One worked personally at the same table as an amputee and only realized the fact after four days when he calmly adjusted his sock by the simple expedient of inserting a drawing pin into his shin.

At the time of this association, a patient was seen with a high thigh amputation attending for replacement of his limb. He was a very active man and not only demanded it should be of peg-leg type but also it should have at least a six inch diameter circular base. He explained that the reason for the latter unusual request was that the "Greens Committee" would not allow him on the course otherwise, as he sank in on wet days. His handicap was eight.

Thoughts of amputees lead on to the very topical question of rehabilitation, a word of great portent, and perhaps misused. In ordinary hospital practice one cannot hope to send a patient out fully prepared to take on a skilled job of new type. Craft training cannot be carried out in a general hospital to this degree of perfection. Nevertheless, the preliminary foundations may be laid in the use of occupational therapy. For this and other reasons, *"no patient should do nothing."* On admission a bed patient is encouraged to follow any constructive pastime, such as making table mats, embroidery, or scarves, and the quality of the resultant article is immaterial. What is important is that the man has learned, whatever his previous occupation may have been, that his fingers can be trained to be nimble. When he is up, he progresses to rug making, carpentry or whatever his ability or inclination may suggest. This

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policy fulfils two useful functions. Firstly, it teaches a patient that he *can* learn a manual job even if dexterity be required. Secondly, it occupies his mind. There is no worse hospital influence both on the patient, and for the hospital, than a man of long-term stay doing nothing. A man discharged from hospital after a period during which he has vegetated, may be fearsome of a world where he has to use initiative and stand alone. Besides this, during his stay he is bored and may be recalcitrant, particularly if not having active treatment. If he can be taught that he is capable of learning a new job, if need be, and that such training as is proper will be available when he leaves, he has a different outlook on his future and his present. If such were the end of rehabilitation all would be well, or at any rate better than it is. But there are many other factors in the situation, those of industry, of housing, of travel, that make rehabilitation and welfare an involved task. Rehabilitation is not complete until a disabled man is not only trained but also housed and placed in employment. It is to the latter that the entire process is directed, and training without it is only frustration carried further.

Invariably, in talking of "the Old Soldier," one is asked how one finds him in discipline, and how does one organize it. Such can be summarized in a few words applicable to past, present and future soldiers: that a man should be taught of his badge, be it that of a County Regiment or be it a bright blue uniform . . . "never to disgrace it, for you may rest assured it will never disgrace you." Do not let "the Old Soldier" down, and he won't let you down—in fact, the opposite!

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