THE PREPONDERANCE OF CHRONIC MEDICAL DISEASES AND THE VALUE OF CONTINUING SOCIO-MEDICAL CARE*

MARIE TORRINGTON, M. Soc. Sci., *Department of Medicine, University of Cape Town*

In 1961 a Senior Physician (Comprehensive Medicine), Dr Hymie Gordon, was appointed to the staff of the Department of Medicine at Groote Schuur Hospital. He was given the care of 12 beds in a non-White medical ward (D.6) and requested to develop a hospital and teaching model of comprehensive medical care. Dr Gordon felt that this would involve extensive aftercare and follow-up of his patients as well as detailed social analysis of the patient on admission to the ward. He therefore recommended the establishment of a Comprehensive Care Clinic. Although this clinic was established with a variety of objectives in mind, it developed (between the years 1962 and 1965) into a service concerned with the care of patients who had originally been admitted to the 12 beds in Ward D.6, and so became a demonstration sector in comprehensive medicine care.

The clinic grew and by 1967 comprised 1 physician, 2 general practitioners, a social worker, an assistant, a clerk and ± 450 patients, who were established members of the clinic and who were receiving intensive follow-up care. From 1962 (with the exception of the periods of absence of the physician-in-charge) all patients who were admitted to the 12 beds in Ward D.6 were referred for aftercare to this clinic.

This study is concerned with the 374 patients admitted to these 12 non-White medical beds during the years 1966 - 1967.

ADMISSION

The patients admitted to the Comprehensive Care Clinic beds during the study period 1966 - 1967, belonged exclusively to the non-White group as it is defined in South Africa, i.e. Bantu, Coloureds, Malays and others (which comprised two Asiatics) (Table I).

They were drawn from all economic classes of hospital patients and there was no bias towards 'very wealthy' or 'very poor' patients. They suffered from the diseases shown in Table II.

In consultation with the physician these patients were then divided into 5 categories:

1. *Curable within 3 months.* Patients were placed in this group when the physician in charge had satisfied himself that within the stipulated time, health should be fully restored. Such diseases included typhoid fever, tetanus and acute pneumonia.

2. *Chronic but could be rehabilitated.* As the classification implies, these patients suffered from a chronic disease but this disease could either be controlled or eradicated to such an extent that the patient could anticipate returning to an occupation close to that held in his premorbid state. Diabetic, certain tuberculotic, and mild hypertensive patients belonged to this group.

3. *Permanently partially disabled.* These patients had relatively mild disability (mild only in terms of the groups with which we are dealing) and these disabilities could conceivably, with good medical care, be kept within bounds enabling the patient to undertake some gainful occupation. However, these patients could not hope to return to anything resembling their previous occupation. They suffered from cerebrovascular accidents, heart diseases, etc.

4. *Permanently totally disabled.* These patients comprised the 'stroke' or cerebrovascular accident patients mainly; they were partially ambulant, could just cope with the barest minimum of basic requirements and needed home-care.

5. *Fatal within one year.* The nature of the disease was such that death was both inevitable and rapid; these patients suffered from neoplasms and terminal stages of all other diseases.

As seen from Table III, 21% died in hospital and a mere 14% of all patients admitted to the 12 ward beds could be classed as completely curable. This points to an enormous preponderance of chronic disease admitted and discharged from the medical wards of Groote Schuur Hospital, and it was of interest to analyse what actually happened to these chronically ill patients on discharge.

Excluding the 'died in hospital' group, the stay in hospital of no less than 82% of the non-White patients admitted to the 12 medical beds of the Comprehensive Care Clinic represented only an acute phase of their illness.

FOLLOW-UP STUDY

Before the establishment of the Comprehensive Care Clinic the patient discharged fom hospital was left to his own devices and was probably incapable of coping with the requirements necessary for maintenance of optimum health.

*Date received: 1 September 1970. This article should be read in conjunction with the article by Prof. J. F. Brock on p. 38 of this issue of the *Journal*.

TABLE I. TOTAL ADMISSIONS TO COMPREHENSIVE CARE CLINIC BEDS DURING STUDY PERIOD

	Males			*Females*			*Total*	
	No.	%	*Age (years) mean ± SD*	*No.*	%	*Age (years) mean ± SD*	*No.*	%
Bantu	61	16·3	43·5 ± 15·0	21	5·6	46·6 ± 14·8	82	21·9
Coloured	132	35·2	46·0 ± 17·6	116	31·2	45·0 ± 16·7	248	66·4
Malays	26	6·9	46·9 ± 14·3	14	3·7	39·0 ± 16·2	40	10·7
Others	2	0·5		2	0·5		4	1·1
Total	221	58·9	45·4 ± 16·5	153	41·0	44·1 ± 17·0	374	100·1

TABLE II. DIAGNOSTIC CATEGORIES OF THE 374 PATIENTS ADMITTED TO COMPREHENSIVE CARE CLINIC BEDS, CLASSIFIED BY RACE AND SEX

	Bantu		*Coloureds*		*Malays*		*All races*			
	M	*F*	*M*	*F*	*M*	*F*	*M*	*F*	*Total*	%
Heart Disease										
Rheumatic	3	4	3	6	3	3	10	13	23	
Ischaemic	0	0	14	4	8	0	22	4	26	
Hypertensive	5	0	3	11	0	0	8	11	19	
Cardiomyopathy	1	2	1	7	1	0	3	9	12	
Other	5	1	4	6	0	0	9	7	16	
Total	13	7	29	33	12	3	52	44	96	25
Nervous system disease										
Stroke—CVA	3	5	12	16	1	2	16	24	40	
Other	4	1	6	4	0	0	10	5	15	
Total	7	6	18	20	1	2	26	29	55	15
Respiratory Disease										
Pulmonary TB	7	1	14	2	0	0	21	3	24	
Chronic bronchitis	1	1	17	1	1	0	19	2	21	
Suppuration with lung abscess	3	0	4	1	0	0	7	1	8	
Acute pneumonia	4	0	2	3	1	0	7	3	10	
Other	1	1	2	2	0	0	3	3	6	
Total	16	3	39	9	2	0	57	12	69	18
Renal disease										
Pyelonephritis	0	2	0	9	0	1	0	13	13	
Glomerulonephritis	2	0	0	0	3	0	5	0	5	
Other	0	0	1	0	0	0	1	0	1	
Total	2	2	1	9	3	1	6	13	19	5
Gastro-intestinal disease										
Peptic ulcer	0	0	6	4	1	0	7	4	11	
Haemorrhage (all causes)	1	0	3	5	0	1	4	6	10	
Other	1	0	0	2	1	0	2	2	4	
Total	2	0	9	11	2	1	13	12	25	7
Neoplasms	6	0	15	5	3	2	24	7	31	8
Other infections	6	1	15	5	1	2	22	8	30	8
Diabetic ketosis	4	0	1	2	0	3	5	5	10	3
Toxic states	2	0	4	4	2	2	8	6	14	4
Miscellaneous	2	2	5	15	0	1	7	18	25	7
Total	60	21	136	111	26	17	223	151	374	100
	[81]		[247]		[43]					

TABLE III. PROGNOSTIC CLASSIFICATION OF THE 374 ADMISSIONS (AT TIME OF ADMISSION)

	No.	%	*Age (years) mean ± SD*
Died in hospital	80	21·3	54·8 ± 5·6
I. Curable within 3 months	54	14·4	30·6 ± 12·6
II. Chronic but could be rehabilitated	112	29·9	40·5 ± 13·3
III. Permanent partial disability	69	18·4	46·2 ± 15·2
IV. Permanent total disability	34	9·1	54·6 ± 14·8
V. Fatal within 1 year	25	6·9	56·5 ± 15·0

Since the standard of follow-up of the Comprehensive Care Clinic patients was known (over 90% attended regularly), it was decided to compare these with 86 patients who were in the Comprehensive Care Clinic beds but who were not admitted to the follow-up clinic. They were booked to attend the general medical outpatient department (where they were given routine attention if and when they attended) but lost sight of if they did not attend. Table IV is self-explanatory and clearly shows that approximately 80% of inpatients referred for subsequent attendance at the general outpatient department attend for less than 6 months and 64% do not make a single reattendance.

TABLE IV. STATUS OF THE 86 MEDICAL OUTPATIENT DEPARTMENT PATIENTS AFTER DISCHARGE

Status	*No.*	%
Never returned after discharge	55	64
Attended for a period not longer than 5 months	13	15
Attended for a period up to 1 year	2	2
Attending regularly	16	19

Having shown the difference in the standard of follow-up between the 2 groups, the fate of the 2 groups was compared in order to demonstrate whether there was a significant difference in the prognosis of the 3 groups of patients (rehabilitable, permanently partially disabled and permanently totally disabled). Table V demonstrates the very high mortality of the group who were not followed up; one has little doubt that the morbidity of the survivors must also have been great.

Many reasons have been advanced for the failure of reattendance in the 'average' hospital case and it was felt that the prime reasons were lack of understanding of the illness on the patient's side and failure of communication between patient and the doctors in the wards.

In order to demonstrate this, 251 patients were asked a simple question, namely, 'What is wrong with you?' One

TABLE V. STATUS OF DISABLED PATIENTS

Status	Compr. Care Clinic No.	%	Non-Compr. Care Clinic No.	%
Group II (rehabilitable)				
Alive	53	93	29	76
Dead	4	7	9	24
Group III (perm. partially disabled)				
Alive	38	83	9	50
Dead	8	17	9	50
Group IV (perm. totally disabled)				
Alive	9	45	2	20
Dead	11	55	8	80

TABLE VI. 'WHAT IS WRONG WITH YOU?'

	No. of patients questioned	Reasonably accurate diagnosis given No.	%	Did not know No.	%
Comprehensive Care Clinic	143	126	88	17	12
Non-Comprehensive Care Clinic	108	34	31	74	69

hundred and forty-three patients belonging to the Comprehensive Care Clinic and 108 non-Comprehensive Care Clinic patients were asked the same question on discharge from the hospital wards. The results obtained are shown in Table VI.

REHABILITATION

Having demonstrated that it was possible both to follow a group of chronically ill patients and reasonably maintain their health, the quality of their life after being discharged from hospital and the success or failure of their rehabilitation was investigated (Table VII). The 'curable' and

TABLE VII. COMPREHENSIVE CARE CLINIC PATIENTS (1966 - 1967) PROGNOSTIC CLASSIFICATION

Status	No.	%	Age (years) mean ± SD
I. Curable within 3 months	26	14·6	30·2 ± 12·2
II. Chronic but could be rehabilitated	67	37·6	40·2 ± 12·8
III. Permanent partial disability	49	27·5	46·4 ± 15·4
IV. Permanent total disability	24	13·5	58·3 ± 11·7
V. Fatal within 1 year	11	6·7	54·7 ± 12·8
Total	177	100·0	43·8 ± 15·7

'dying' groups, by virtue of their medical classification, lend themselves to a follow-up of a short duration only. The other 3 groups demanded long-term follow-up. This was carried out over an average period of 2 years and focus was placed primarily on these 3 groups.

Two groups primarily needed rehabilitation or sheltered employment: group II (chronic but could be rehabilitated), and group III (permanently partially disabled). The patients of these groups were divided under 3 headings:

(*a*) No rehabilitation needed because the patient or his family were able to rehabilitate him.

(*b*) Rehabilitation needed and obtained for the patient by the social worker because the patient was unable to find a niche in society.

(*c*) Rehabilitation needed but in spite of all efforts could not be obtained.

Of the 116 patients in the groups II and III, approximately one-third fell under each heading (Table VIII). The value

TABLE VIII. NEED FOR REHABILITATION

	No rehabilitation needed No.	%	Rehabilitation needed and obtained No.	%	Rehabilitation needed and not obtained No.	%
Group II	24	67	22	58	21	50
Group III	12	33	16	42	21	50
Total	36		38		42	

of good social work in group (*b*) is obvious as all 38 patients were successfully rehabilitated. But what of the 42 patients who should have been rehabilitated but were not? These have been divided under two headings:

1. Where the framework of society did not provide avenues for sheltered employment to enable them to rehabilitate themselves. There are no organizations in our society which assist the medically chronically ill to obtain employment, sheltered or otherwise.

2. Where other factors, apart from the purely medical, militate against their rehabilitation, e.g. basic personality defects, low level of intelligence, alcoholism, very poor living conditions, distance from medical help. A tremendous amount of socio-medical work goes into treating these patients to no avail and if the character of this group could be readily identified then endeavours could be directed to more rewarding patients.

Disability grants and/or maintenance grants were obtained for all these 42 patients.

Group IV consisted of 24 patients of whom only 2 had the financial and family resources to provide for themselves. Thus there were 22 totally disabled patients in need of institutional care.

Nine patients were provided with the necessities of life and two years later all of them were still alive. No care could be provided for 13 of the patients and all of these were dead within 2 years. This illustrates the almost total lack of adequate institutions among the Coloured population which provide for care of the totally disabled individual.

SUMMARY

This paper illustrates the preponderance of chronic disabled patients among patients discharged from the medical wards of one hospital in South Africa. Completely inadequate follow-up of the average patient was found; this is due in part to failure in communication between doctor and patient. This failure of follow-up had disastrous effects.

Emphasis is placed on the importance of adequate social work in the rehabilitation of a chronically ill patient, the paucity of adequate facilities for the employment of medically handicapped patients and the institutional care of the totally disabled.

The importance of research into, and provision of facilities for, the general practice of comprehensive medicine in a teaching hospital are realized.

The study described in this report was made possible by effective co-operation between the University of Cape Town and the Cape Provincial Administration through their Joint Medical Service. The project was developed at the request of the Professor of Medicine by Dr H. Gordon, Senior Lecturer in Medicine (Comprehensive) to whom I am deeply indebted. I wish to thank Dr I. Levy, Prof. J. F. Brock (Department of Medicine) and Prof. E. Batson (Department of Sociology and Social Administration) for their guidance in the final preparation of this report, and the Medical Superintendent, Groote Schuur Hospital, for support and assistance. The report is taken in part from my Ph.D. thesis.