NOTES FOR A SPEECH BY

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THE NEW ENVIRONMENT IN EXTENDED CARE

"Doctors are trained all wrong ... they are trained very well to treat 15% of man's ills, but, the other primary health care needs are neglected."

This statement was only one among the many profound and disturbing comments expressed by the Medical Educator's Section to more than 8,000 concerned scientists who met in Washington, D.C., in December, for the Annual Convention for the Advancement of Science.

"Nurses need not preen themselves", the scientists said, "For the same is true of them." "Even though they don't like to admit it, few nurses in hospitals actually give the patient the care for which they are trained."

Through the years medical scientists have made vast strides; today, we can live with the heart of another; the nurse, too, was part of this miraculous advancement. During this evolution, the nurse eagerly adapted to each new demand and she became a technical expert. In her muted environment, many times she fought to save a life, and did so. The challenging work naturally created prestige and recognition and became a status symbol.

Over the years attitudes developed, and these are reflected in our policies and procedures, but, are they truly valid today? Eg. still restricting visiting hours. Like the Commandments, the emphasis was placed on the negative; and, to provide greater control and safety, they tended to be restrictive, with many built in "shalt nots". The good which we should have done was not stressed. In the eyes of some, this good was considered to be frivolous and an added luxury, for which there was no time, thus the adage became, "Don't get involved".

Nursing tended to become a mechanical function. The 15%, previously referred to, fared well under this care, while the other 85% were, many times, shamefully neglected. The well, long term person with a disability, was treated as a sick patient in the same sterile environment as the acutely ill. His plight was even worse, because he was written off, as energies were channeled toward more interest

ing cases. This impersonal nursing tended to become destructive to a person's dignity. Today, it is deeply entrenched. The nurse, however, is no longer needed, even for this 15%; the computer has already replaced her at the University of Alabama Medical Centre. So effective and efficient is the computer, the nurse cannot hope to compete in carrying out the many patient care functions. The computer has greatly reduced recovery time... 75% of heart surgery patients are able to be moved out of intensive care within 24 hours ... as compared to periods of up to 3 days prior to automation. Sheppard, the Association Professor and Engineer, stated the care which the computer can give 4 patients in 15 seconds, used to take 9 nurses 15-30 minutes per patient.

Why belabor acute care when discussing the extended care environment? This is precisely our problem .. we are forced to hire this impersonal, mechanical and dehumanizing care which creates an anti-therapeutic environment for the extended care people.

Here, the nurse is lost as she searches for the Holy Grail in the form of mechanical duties. She observes psychosocial concern as non-nursing functions and resents the involvement. She wants to nurse, she says, but, her actions belie her words. She busies herself with tasks such as staffing, housekeeping, in requisitioning and answering telephones. She "overnurses" the chart with meaningless entries. It is extremely difficult for some to change from former established hospital attitudes, policies and procedures. People have been adverse to change throughout the ages, and the nursing profession is no exception. Consequently, when the nurse is introduced to a people-oriented environment, and she is stripped of many non-nursing functions, she lacks confidence and knowledge. She has not been adequately prepared to deal with emotional, social and rehabilitative problems. Her limitations and her resistance to the new work environment contribute to poor morale as her attitudes and conflict become apparent to the lower echelon.

These scientists must have grave concern regarding the inadequacies of our present

disciplines as they relate to the ill and disabled. Extensive changes are needed to make training of doctors and nurses fit the needs of the patients. They say we need new kinds of doctors and nurses, new kinds of health professions who can give basic medical care.

Why should we add more disciplines to fragment care even more? This is not the answer to our problem. The inadequacies in all our professional disciplines lies in the fact that we do not understand man himself. We are at a loss when it comes to dealing with behavior which deviates from a receptive, agreeable, happy norm. We are expected to be, and should be, the comforters of our patient's battered and frustrated psyches along with his physical aliments, but, we don't know how. Our education in this area has been grossly neglected.

In comparison, the life saving and life prolonging technologies are easily understood and applied, and, so over the years these have become the dominant skills and procedures in hospitals. The human being, in the process, became a non-person, and was treated as though he was devoid of feelings.

Scientists tell us that man is the product of his environment. Little wonder, then that our professional environment can destroy human dignity and replace it with vegetation in a person who is deprived of adequate emotional and social care for long periods of time. Frequently, the education received would be adequate and could be improved by experience and study, but, many times, when dedicated, eager students are introduced into a working situation they are expected to do it as it has always been done, and not as they were taught, and so growth is stifled in their formative years.

We rely too heavily on our own disciplines' research and do not use the brilliant findings of our related sciences. The mathematical, social, and psychological disciplines and many others, point to greater understanding of the human

organism and his relationship to his space than our own professions. They bring to light the presence of many hidden deprivations and errors in our hospital environment, which deteriorate a human being's behavior and vitality. Doctor Howard H. Hialt, Dean of Harvard School of Public Health in Boston, dealt with this diversification of our professional disciplines and stated, "We have not considered....the translation of our present knowledge into effective operating systems, to be among our responsibilities." Therefore, we must consolidate this wealth of knowledge and apply it in a practical way so as to enrich the care of people in hospitals.

Perhaps, the ordinary housewife has more access to scientific material than our own publications as it relates to the Long Term patient. Recently, Vogue covered a 7 year research project carried out by the National Aeronautics and Space Administration. The study included the effects of human crowding, particularly, the effects of restricted isolated monotony. Dr. Seward Smith and Dr. Donald Haythorn found that there is greater hostility when 2 people are confined. A larger group stays friendlier even when there is less space per person. Variety among partners helps to ease the stresses created by congregate dwelling. Claims are made that old people cannot adjust to large crowds and large institutions; it creates stress and is very confusing to them. They tend to function more adequately in smaller intimate groups where they have a face to face encounter. This would make us believe that large activity and dining areas are not ideal, and that our private and semi-private rooms for the aged are, perhaps, more status symbols than therapeutic spaces because they lead to social isolation. We need more of this information in planning so that, at least, our physical environment will not do our patients any harm.

The November issue of the Ladies Home Journal gave excerpts of Vance Packard's book "Nation of Strangers", which portrays the deteriorating effects of rootlessness. A person moved from place to place, finally, loses his identity because he

remains anonymous and anonymity de-individ[illegible]

aggressive actions. Uprooting deteriorates the behavior because the person is in constant flux as he attempts to adapt to each change of the environment. Old and sick people simply cannot adjust to the many emotional stresses created. It surrounds them with futility and, we virtually break their hearts. Finally, they steel themselves against further hurt by simply copping out. Visualize the anguish we create when we separate devoted couples who don't quite fit the criteria of an agencie's care; they are separated for life, each deteriorating due to the pain of mourning and longing.

The U.S. Navy at San Diego has studied illness created by traumatic change such as recent residential and job change, death in the family, and changes in the circle of friends, to mention a few. From this data, they developed a check list to be filled out by the officers prior to embarkation. From it, they can forecast the illness pattern of the men. The 10% high on the list of change are almost twice as prone to serious illness as the lowest 10%. The disruptions which are especially stress producing were those that shatter or deprive us of friendships, kinfolk, and the community.

We are born with instincts and we are influenced by our culture. We should, therefore, plan environments which compliment our inalienable needs and rights, rather than disrupt or ignore them, thereby, creating a far greater work load for staff because of an inappropriate and anti-therapeutic environment. We read about the habits of animals and how they stake out their territory. In the animal kingdom, the strongest male dominates the herd. In chickens, we have a pecking order, the most dominate character comes first and the weaker follow in their turn. In humans we have a parallel. We follow rites of protocol and rules of etiquette. Scientists have found that we, too, lay claim to OUR area. Just think about it, do YOU choose the same spot at a table during coffee break? As long as we are not

restricted, we are not fettish or insistent on having MY chair, or MY table. What the heck! Now, let us consider for a moment that you are placed in a small room and have to share the limited furniture and comforts. Immediately, you size up the situation, "I think the red chair is more comfortable, I'll take that." "I want the bed next to the window". You will stake your claim. As you pine over your confinement to an institution, you will try to console yourself through this territorial structuring. It will become MY bed, and MY table as a symbolic value to bolster your insecurity. Stress, created by anxiety, will be generated as you contemplate your lot. Whether you will get your own way will depend on who has the most dominant or dogmatic character. In this struggle, behavior can become noisy or even hostile. An aggressive person would tend to get along well with an affiliate who is less egotistical, who likes people and will conform in order to win favor. This person doesn't care about his territory as intently as does the more aggressive person. There is, however, a trap within this relationship, the acquiescent person lacks stamina and will be the first to deteriorate if not grouped knowledgeably by the staff.

Territoriality has been proven to be intensified by isolation and tends to make the person withdraw from the rest into a cocoon-like shell. This person hordes and stands guard over his area and personal treasures, in order to assure his power, control, comfort and status. He discourages friendship because he doesn't want to share his limited space and possessions, and as a result, spends more and more time alone. He does this because, as Skinner says, "Ownership of something helps a person maintain his identity." The confined person discourages friendship with the body language, using threatening positions and gestures. These manouvers are, generally, respected. If, however, this person can't get the message across quietly, he will speak up, and if he is aggressive, he may even become violent when one approaches his area or forcibly takes him away from it. By understanding the reason for this behavior, changes should be kept to a minimum and the desire

for personal belongings should be respected.

We see the emotional stresses, and eventual deterioration, we subject people to when we isolate them to rooms which are too confining. Our buildings and policies, therefore, have to counteract these tendencies so that this territorial instinct will not be so intense as to create withdrawal and depression. Communal dining, indoor and outdoor recreational areas, community outings and functions all help to alleviate this difficult problem. Moving an aged person, even from one room to another, can create real havoc in that they frequently become disoriented. Visualize the stress from trauma created every time this person is moved, from home for example, to the different levels of care, each move promoting mental deterioration and regression. Add to these moves the anxiety due to social amputation with the loss of his new found friends and staff. Once more he has to adjust to strangers who do not understand him. Truly, each is a shattering experience, yet, they are repeated over and over again. Our policies and attitudes build a veritable mountain of stress.

On a recent T.V. program, Dr. Selya of the Institute of Experimental Medicine and Surgery in Montreal, discussed his 36 years of research on stress. He has proven that stress caused by prolonged physical discomfort and trauma or psychological frustrations creates a hormone imbalance which produces biochemical changes in the body. This imbalance is the cause of such diseases as headaches, ulcers, hypertension, cardiac accidents, asthma, arthritis and even death.

There is another deprivation suffered by confined people and that is the absence of sexual fulfillment. Could we not provide locked doors which assure privacy for intimacies in which love between married couples could be renewed? Dr. Oberleder, PhD, Chief Psychologist of geriatric service, Bronx State Hospital, feels strongly that many senile symptoms are but substitutes for frustrated sexual impulses.

Segregation of the sexes isn't a normal way of life and tends to deteriorate the personality and encourages desocialization. Mixing of the sexes enhances group therapy effectiveness as it re-establishes socialization. Patients, invariably, show an improvement in their personal grooming, become more cooperative and less irritable. Dr. William Glasser says we are all born with basic needs and the most important is to love and be loved, and to feel worthwhile as a human being. We constantly strive in search of this; if we cannot find it in a realistic, rational way, we, finally, in futility, turn to irrational acts and so escape from reality ... not that we wish it, but, nothing else worked. For this reason, patients even indulge in incontinence in an effort to gain the attention they crave.

Incontinence becomes a real problem in extended care. In many facilities, the problem is solved with a catheter for the express purpose of maintaining a dry bed. The sufferings and complications are not considered. To solve this problem, our physical plants have to provide us with adequate numbers of toilets to give every person the opportunity of bathroom privileges. Generally, we do not have enough toilets to permit accustomed bathroom rituals, so, we supplement toileting with commodes which are very hazardous and create many incidents. At the Priory, most toileting is done in a toilet environment away from the resident's living quarters. We average 6 lbs. of laundry per pd, as compared to 12, and even 18 lbs, in some units. This difference in cost for 100 patients can be as high as $40,000 a year. This toileting does not require more staff if there are sufficient numbers of toilets.

There are many more costly expenditures due to misconceptions, both in hospital policies and in the physical plant, but, time does not permit further discussion.

Scientists also tell us that man deteriorates when he hasn't sufficient sensory stimulation. He tends to withdraw and escapes from reality, therefore, our environment has to build in these stimulations. Stimulators are gay pictures, indoor and outdoor gardens, adequate space, patios, music, suitable and tasteful

appointments, clocks, and beautiful and therapeutic colors. Color can effect a person physically and psycologically, eg. red raises vital signs, while blue reduces them. Discotheque use color to great advantage in stimulating mind expansion. The markets have taken advantage of space, color and music for years in order to compel the purchaser to reach out for a product. Utilizing the outdoors provides tremendous stimulation and the sun is a great therapeutic source. This free energy, however, will not be utilized if we place too many obstacles in the way of limited staff. The obstacles would include heavy portering by poorly manipulating chairs, elevators, long corridors to unsupervised areas which would make surveillance of the confused person an impossibility. If we provide an interesting and motivating environment, our staff will not have to set aside precious and valuable time to contrive sensory stimulations and reality orientation exercises, and numerous other activities to stem vegetation.

Nurses and doctors must place more emphasis on education and preventative and rehabilitative measures in dealing with the disabled and the elderly. Some physicians are remiss in this area in that diagnosis, histories, and orders are inadequate, and highly superficial. This neglect, in turn, prevents other professional disciplines from planning care knowledgeably and effectively.

Nurses were taught rehabilitative nursing, yet, we find patients reduced to fetal positions after some months in an active hospital. Why? I believe they rely too heavily on physician's orders and on physio and occupational therapists who can devote only a short period of time to each patient. The nurse has to be actively involved in following therapy through on a 24 hour basis or deterioration occurs. Virginia Henderson, Research Associate of Yale University of Nursing, clearly outlines the 14 components which comprise the Basic Principles of Nursing Care. These have been adopted by the International Council of Nurses as their guidelines. Our own hospital, and nursing associations in B.C. greatly underestimate the role of the nurse, as recently outlined in the Guidelines on the Optimum Utilization of

Nursing Personnel, 1972. It does not reflect Henderson's principles in that it does not define nursing as an extension from occupational and physio therapists. In fact, it does not define her role at all.

Dr. James C. Folsom, Medical Director of the DVA Hospital in Tuscaloosa, discussed some fallacies in regard to exercises; one being that we believe we have to have expensive exercise equipment. Some of the best programs he has seen had none at all. He cited two hospitals who had fully equipped exercise clinics, which proved unproductive. In one hospital it was considered prohibitive due to the excessive amount of staff time required to porter the patients back and forth. To overcome this problem, the exercises were brought to the ward. Beds were pushed aside forming a circular space in which patients and staff combined exercises, games, and socializing. The equipment used was wastepaper baskets, balls, rolls of crumpled paper, plastic and tin cans, bean bags, etc.

In the other hospital, they found isolated activity on expensive equipment didn't work, so they got rid of it and went into this simple type of group participation where people can interact. In this way, the patients motivate each other as they observe the performance of another. They recognize an accomplishment and give immediate group approval which reinforces the person receiving the attention.

We all need admiration, but, the aged, especially, come to life in an environment which gives encouraging applause. At the Priory, we strive to build in [illegible] exercises in all activities throughout the day. One example: While dining, food is served in bowls. Residents reach and pass and serve themselves. This affords them more exercise than lifting a spoon to the mouth.

The physical facilities must also be designed so as to eliminate all barriers which inhibit independence. The handicapped people and staff working in the environment must be utilized in planning in order to avoid hindsight and errors. The well meant efforts to meet their needs have often been wasted due to wrong calculations and misconceptions. Hence money is wasted. The handicapped people continue to

be short changed by this token effort and the staff as to adapt to the many built-in problems for the lifetime of the building.

Positive concepts must be built into all areas in order to alleviate deterioration and ease the workload. I have seen a 3 year old senior citizen's home in which windows were placed in such a way as to make it impossible for the average sized person to look out unless he was sitting down. Naturally, it will create immobility by making sitters out of well people. Immobility will eventually rob them of their strength and it will contribute to deformities because of disuse. Patients will be created, so, we hire therapists and their aides to rectify the contractures and help patients regain their mobility. Then, we have to develop an intricate communications system between the various disciplines and their aides. We must set aside valuable and expensive time to talk and deliberate, to set goals in order to overcome this deterioration, that need not have occured in the first place.

Our environment also has to provide meaningful and purposeful work. Work is a vital necessity of life. It provides a demonstrated accomplishment which becomes an ego enhancing experience. Without this constant nourishment, "behavior undergoes extinction". We must guard against thinking that arts and crafts and similar activities suit all residents. Some find them boring, others consider them idle nonsense. The true need of every person has to be assessed and freedom of choice should be considered whenever possible, however, positive suggestions for involvement should be made. Families and the community can be utilized with great advantage in setting up reactivation programs. Many simple community activities can be brought to facilities, generally, at no extra cost. Volunteers are a tremendous asset and a good program cannot work without them. The following give a few examples of how we utilize community resources at the Priory:

To instil pride, we bring in hair-dressers, wig and make-up demonstrators, introducing the latest styles and trends; it is all in fun ... you should hear

the giggling that goes on when one of the husbands slips in the demonstrations. Children bring their pets to show them off. Last summer, again, saw the Priory Stampede. Performing horses were brought right on to the hospital grounds. You should hear the ladies, "I like the bucking one", "Just like Calgary". Our staff lend the proper atmosphere by coming in western garb. A Mutt show has also been a lot of fun. Children come from miles around; they all receive prizes, and can you imagine the pleasure of our ladies, when they are the judges and dole out the prizes. Suddenly, they are useful, they can still bring joy and pleasure to someone. We have many outings to tourist attractions, made possible by utilizing the families and the indispensable volunteers.

Our ladies have their own kitchenette,and often, with the help of volunteers, make sandwiches and cookies for festive occasions; they can smell cooking again...talk about stimulating the senses!

They participate in the Christmas concerts and send favours to children in hospitals. We have wine and cheese parties and gambling at the Casino. I have been quoted as saying, "Vice is a great stimulator". We are now in the wine making business.

Our care is built on the creativity and innovative ability of our staff. I could list many more activities, but, again, time does not permit. All staff members, in turn, participate in these activities, which they enjoy themselves. Frustrations are therefore, reduced and there is less likelihood of hostility and aggressive actions. The film, The Priory Method, shows community involvement in greater depth.

The community could be utilized to a greater extent, but, there is always the difficulty of transportation and transferring handicapped people in and out of wheelchairs, and it takes personnel, time, and overtime, and expensive vehicles. I would like to suggest we attach a large auditorium to long term facilities and encourage community participation. Allow the community ladies to have their working sessions, bazaars and bingo parties. Let the children play games and put on concerts. Have a stage for entertainment and movies, then all we would have to have would

be to wheel our residents in, and the community would provide the stimulation and motivation which is so beneficial. Some aged do not have the strength, nor can they tolerate the excitement and confusion of an unfamiliar outing, therefore, functions at home would not create apprehension. The community would help to provide the psychosocial needs we have such difficulty coming to grips with. This auditorium could also be a day care and gym for the aged in the neighborhood, creating more stimulation for all. The stronger members could help the weaker, thereby, giving them a purpose in life. The aged utilizing the day care centre would be in familiar surroundings when their time for admission arrives, making the break from their home environment less traumatic. No doubt the time of admission would be delayed because of the effects of active involvement in the centre.

Because man is a social being, he has to be a member of a full, natural community. Above all, the aged need stability, security, surveillance and social participation. Our governments are now providing many services, but, the system is unwieldy, disjointed, and facilities are widely dispersed, so continuity of care is disrupted. Perhaps, we could develop communities of health care for the elderly and chronically ill. These would be under a parent body, and from this base, all home care needs could be dispensed. This would eliminate fragmentation and the many duplications we, sometimes, experience. Day care, personal care, and extended care could be provided. This complex could be grouped around a clinic, or, perhaps, a mobile clinic could be utilized. Professional staff of various disciplines could be pooled and dispersed to various levels to provide counseling and education in promoting health and prevention of illness, as well as, provide continuum of care in a sheltered environment.

This community cannot rely solely on professional input; we have to provide a normal neighborhood to avoid segregation of the aged. Vance Packard warns against one-layer communities in which only the aged reside. Selecting the site which will provide a full community is very important. Possibly, a high-rise district would only

further intensify layering, which is harmful and unnatural. One needs a mix of all ages, babies, children, teenagers, and the mature, and, in addition, a mode of life and recreations to which people are accustomed and they should remain in familiar locales in order to establish roots. In this environment people can flourish, couples would not be separated; the elderly would have the stability of a home, and they would remain within their circle of friends and staff. They would continue to share in all the indoor and outdoor facilities and activities they formerly enjoyed as they pass from one level of care to another.

One could go a step further, and house the aging and disabled in one building without segregation as to the various levels of care. Rates could be charged according to an assessment determing the work load. The only reason these levels of care are kept apart at present is because of our funding policies.

Is the environment we provide always humane? We have been taught the steps of problem solving, but, we don't use them on our people in trouble. For example, a patient may be wet a few times, so we insert a catheter. We do not take the time to find out why. It may be a very simple problem such as the nurse not answering the light in time, or, perhaps, difficulty with a zipper. We solved our OWN problem ... we now have a dry bed. Again, a patient may be noisy, we phone the doctor for orders and sedate the person; if this doesn't work, we increase the dose Perhaps, just listening and comforting the person would have alleyed the anxiety and sedation would not have been necessary at all. Again, we solved our OWN problem ...we will now have silence.

We also use these tactics when we are understaffed. Along with overdrugging, we use restraints, and so a docile, vegetated person will become a "good patient" as he assumes a patient role (he is expected to play) which has to be bathed, dressed, washed, fed and changed. In the end, he will be a far greater nursing problem,' but, if there isn't sufficient time for limited, staff, he will suffer the consequences when he develops many complications due to immobility - one being pressure sores.

Let us consider for a moment the administration of drugs to the aged .. to 80-90 year olds. Many of these patients cannot, or do not, swallow pills. The pills are, therefore, crushed and camouflaged in apple sauce, or some other sweet tasting host, so as to make it more acceptable. But, is it really? Some patients flatly or violently refuse to take these bitter pills. Here, intrigue comes into play... the crushed medication, which, perhaps, hasn't been reviewed in months, is slipped into the coffee, dessert or other food. We spoil every remaining day on earth for this person, by feeding him gall 3 or 4 times a day. Many of our residents cannot tell us of the adverse symptoms and discomforts due to drugs, so, we cannot intelligently assess their value. The irony of it all is that we are not even certain that this daily medication extends the very old person's life to any appreciable degree. Consider the liability we subject ourselves to for the administration of drugs against the wishes of the patient. Possibly, wine 3 times a day, and again at bedtime, would provide a more humane and happy environment. Doctors and nurses do not communicate sufficiently on these problems. I feel sure that the doctors are not aware of the many ramifications that a prescription has in the life of the aged.

This subject leads to another sensitive area ... that of death and dying. The miraculous technological and life saving procedures provide us with a new set of problems. We hear it said a doctor cannot play God, he has to use heroic means to save a life. This is true, but, does he not also play God when he intervenes in the normal cycle of growth and development in which old age finally degenerates to termination and dies? Intervention at this stage can have dire consequences, the patient, frequently, pays for the reprieve with agony ; when the circulation doesn't return, and the body turns to decay and limbs turn black.

Before closing, perhaps, we should consider some of our negative attitudes as they relate to Extended Care ...

The name, Extended Care, itself promotes negative connotations, as it [illegible]. The names, Hospital, Nurse, and Patient, promote illness. Possibly, nursing should become Caring. We surround our residents with nurses in uniform which reinforces illness, and further maximizes the sterile institutional environment. Many times, staff would rather come in street clothes, but, policies forbid it, and, so, the hospital pays a fortune in purchasing, maintaining, laundering, and altering uniforms and then pays for the heavy nursing care when the patient succumbs to our limited expectations.

Recently, one of our ladies received a Get Well Card, and she said, naively, "I wonder what ever made them think I was ill?" She doesn't see herself as ill, but, how long can she hold out against this constant bombardment of negative input, which we have conveyed even to the community at large. We need to feed the public the positive aspects of aging, all must understand that a disability is not necessarily an illness.

Today we must analyse our philosophies and priorities when planning physical and human environments. Are we content to provide mere storage facilities for the aged and handicapped? Are we interested mainly in maximum efficiency which places the emphasis on the cost factors rather than human needs? Are we going to provide physical facilities and education for all disciplines so that the end product will truly center on the needs of human beings?

In summary:

How do I care for thee?

Let me count the many ways.

Upon thy mind I plant an illness, and carelessly contort thy frame,

While thou sittest with grief and boredom

I rob thee of thy person and distort thy soul,

I heed not thee, nor the learned scientists, who teach a better way,

I deprive thee of the healing sun and thy abode called home.

I encourage not the intimacies of a loved one,

Nor involvement with the living.

When thy frail body racks with pain and illness

I feed thee gall with every meal.

When thy spirit is truly broken,

And thy Master finally calls thee home,

Even here, I rob thee of thy peaceful end

I prolong it, to make thy pain and anguish even more.

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