

The elderly as underconsulters

Sir,
I was interested to read in Ford and Taylor's paper (May *Journal*, p.244-247) that the relationship between illness perceived and illness reported to the doctor remains largely constant even into old age. They also mention Hannay's findings that medical symptoms are more likely to be ignored by 30-65-year-old patients than by those over 65 years old. However, the perception of a discomfort as an illness or a symptom as a 'medical symptom' implies that the patient is already considering the possibility that the discomfort is within the ambit of medical intervention. What is perceived as an ailment or medical symptom as opposed to a normal discomfort of living by a particular person depends on the expectations of that person. The older person may expect to be deaf, and not complain about the wax in his ears. The younger person under stress may expect to have headaches and not avail themselves of relaxation techniques.

It may be that the reason why women, particularly in the 20-44 year age group have so many more ailments or 'medical' symptoms relates to the medicalization of physiological functions such as fertility, pregnancy, control of periods and the menopause. This may alter their perception of when physiological changes become ailments.

Universal screening of the elderly is declared to be costly and ineffective. However in a recent survey of patients over 70 years of age in my practice,¹ 38% were found to have unidentified needs. Most of these needs were not related to medical problems definable as illnesses.

What Ford and Taylor's survey appears to demonstrate is that, having defined a problem or change as an illness, or a symptom as a medical symptom, there appears to be about a one in three chance of this problem being presented at a consultation by a patient of any age. The definition of illness, however, depends on the patient's expectations, and these may alter dramatically at different ages. Furthermore, many of the problems of the elderly are not related to illnesses. They are more related to whether they can open a tin of food, or get to the toilet easily, or have enough money to heat their houses. If as a primary health care team we hope to look after the physical, psychological and social needs of our patients, we should be screening for these

Table 1. The yearly results of 721 students screened for rubella immunization.

Year	No. of students screened	Non-immune	Positive history of immunization	Positive history of immunization but found non-immune
		No. (%)	No. (%)	
1976	140	23 (16.4)	8 (5.7)	1
1977	131	25 (19.0)	6 (4.5)	0
1978	51	5 (9.8)	20 (39.2)	0
1979	89	3 (3.4)	46 (51.7)	1
1980	86	11 (12.8)	52 (60.5)	4
1981	96	4 (4.2)	57 (59.3)	1
1982	49	3 (6.1)	a a	
1983	45	4 (8.9)	27 (60.0)	2
1984	34	1 (2.9)	23 (67.6)	1
Totals	721	79 —	239 ^b —	10 ^b

^a Figures not available; ^b figures for eight years.

problems. It is very unlikely that they will be volunteered in a consultation.

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Reference

1. Harrison S, Martin E, Rous S, Wilson S. Assessing the needs of the elderly using unsolicited visits by health visitors. *J R Soc Med* 1985; in press.

themselves to be immunized has appeared throughout.

The survey suggests that the number of women at risk to contract rubella when in the child-bearing years is much smaller now than in 1976. However, a risk remains even for those who have been immunized and there is clearly a need for continuing screening of young adult women.

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Rubella immunity screening

Since 1976 rubella immunity screening has been offered to women students about to leave S. Martin's College of Education. Sessions have been arranged with the help of Dr W.R. Falconer, our local Senior Clinical Medical Officer. A record has been kept of the laboratory findings and of the declared history of rubella immunization; 721 students have now been tested. The year by year results are shown in Table 1.

The number of students screened has declined since 1981 because College doctors are no longer required to examine potential teachers as they leave College. Screening was originally offered at this final medical examination. Voluntary attendance for a blood test has proved harder to achieve. In spite of this the percentage of non-immune students shows a progressive reduction in keeping with the marked percentage increase in immunized students. The year of change is 1978 and this fits in chronologically with the commencement of immunization of schoolgirls in 1968-70.

A small number of non-immune students from the group declaring

Agoraphobia study

Sir,

I wonder whether anyone in your readership might be able to help. I am nearing the end of a questionnaire survey of dietary and environmental factors in a group of 240 chronic agoraphobic patients and a matched sample of 100 healthy normal patients (of which I have collected data on 80). As one of the factors on which the controls are to be matched to the agoraphobic patients is approximate geographical distribution (in order to control for regional variations in diet), and as my hypotheses must not bias the selection of individual subjects, I have been recruiting my controls with the help of a number of general practitioners from all over the country. However, with 20 controls still to be found, I have run out of general practitioners and need to find some more who would be willing to recruit five very healthy women in the age range 35-55 years from their practices to take part. Participation is voluntary and involves filling in a long but innocuous and anonymous self-report questionnaire. The study has the approval of the Maudsley Hospital Ethical Committee. I would send large stamped addressed envelopes for the return of the question-