so assiduously propagated, that everyone should be kept at home for as long as possible irrespective of the circumstances, should not be carried beyond the dictates of commonsense. As recruitment of home helps is becoming increasingly difficult the good management and maximum efficiency are vital. Training of home helps is becoming more widespread but a national training scheme has not, as yet, emerged. In my county the home helps have a course of training undertaken through further education, and this necessitates their attending an evening college twice weekly for two terms. The course consists of 48-hours practical and 38-hours theoretical training, and deals with the problems arising with the expectant mother, home confinements, care of babies and children, adolescence, menopause, severe illness, old age and family life. The course costs £2 15s. which is paid for by the county council and people living out of the district are paid travelling expenses. At the end of the course an examination is held, three-hours written work followed by a practical session for half an hour. Those who qualify receive a certificate. This training is excellent in giving the home help confidence in dealing with problems which arise in the course of her work, and enables her to carry out her duty in each household in a thorough and most efficient manner.

From that you can see that everything possible is done to provide a home help where necessary, but of course I have not elaborated on the problems. For instance, the amorous elderly gentleman who lives alone, and has very young ideas; the cantankerous and difficult old lady who complains that the home help has either knocked too loudly or not loud enough. Home helps have a difficult if not unrewarding task; they have to be prepared to enter all types of homes where there may be the most modern and up-to-date equipment or nothing more than an old pair of dad's underpants and a broom with only three bristles.

Nevertheless, this is where training of home helps is most necessary and I am very grateful to my medical officer for starting a training scheme for home helps in Kent.

Not only do we provide home helps in homes, but also on boats. No problems arise when the tide is down, but you can imagine what it is like walking the gangplank when the tide is in. I remember having a brief case in one hand and a handbag in the other as I crawled up the gangplank and fell over the side in a most undignified manner. But the real problem was coming back down again, I was told afterwards by a collection of workmen who stood on shore that they hadn't seen anything like it since 'D' day.

## Discussion

**Dr Haire** (*Haywards Heath*): As the symptomatology and rehabilitation of all 'senile vascular casualties' is similar, should not geriatric, psychogeriatric and Part III units all be amalgamated?

**Dr Irvine:** I think there is a great deal to be said for this idea. It has certainly been proved many times over that an elderly patient with a little mental impairment goes where a bed is available rather than according to his or her precise clinical needs. The answer may lie in the concept of psychogeriatric assessment units. There is a need for a common portal of entry into the geriatric services and this ought to begin with proper medical, psychiatric and social assessment. The trouble is that we have to work with the facilities that we have got. In my own hospital, for example, if we could get one more ward, we could provide this service in consultation with the welfare and the psychiatric services but we cannot get another ward.

**Dr Ashley:** We have a combined assessment unit of 20 beds for emergency situations where

there is doubt whether primary responsibility for the patient lies with the welfare authority, the geriatric unit or the psychiatrist. The welfare officer, geriatric physician and psychiatrist have equal admission rights to this unit. A welfare officer called into the home to find a patient at the foot of the stairs mumbling away, a bit unkempt, can admit him direct.

The patient is allowed to stay in the unit for one month, during which he or she is looked after by the geriatric physician and the psychiatrist, and undergoes investigation, treatment and rehabilitation. At the end of one month the situation is always clear and the patient is moved to a geriatric treatment ward, to a mental hospital longer stay bed, into a Part III home, or if progress is good, directly back to his or her own home.

**Dr Bergmann:** In the sixth and seventh age, psyche and soma are inseperable, and it is no use trying to make a distinction. I think one thing Dr Elliott has taught us quite clearly is how much benefit his county has got from the amalgamation of health and welfare. A combined assessment unit under unified direction is perhaps the first step to a proper use of resources.

I would also like to take up something else that Dr Elliott said, and that was that in some way he did not want to soil his nice clean health visitors with old patients. He felt the health visitors were too well trained to be used for that sort of thing. I was very surprised to hear this from someone in preventive and public health, because I think care of the aged depends on highly skilled, early assessment of both mental and physical state by a trained nurse working in conjunction with the family doctor. This may allow us to get over the present hump, which we are not even beginning to cope with.

**Dr Elliott:** One thing I would like to make clear is that running a combined health and welfare department means that we can obtain a medical assessment where needed. I am the last person to say that people should not be properly assessed, but surely it is common experience that moving old people from place to place often makes their condition worse, and I would like to see assessment wherever possible in the person's own home. I cannot recall any case where an old person has fallen between local authority and hospital responsibility. We do not find the decision difficult, and I think it should take place in the person's own home whenever possible. This avoids the adverse effects of moving someone, who is quite happy in one establishment, to another. So many people who are going to be admitted, if the opposition will permit me to say so, really need a commonsense classification rather than consultant expertise, and the general practitioner probably knows most about this particular side. About health visitors, my point is simple. We as a nation are desperately short of trained people and we have a severe shortage of nurses. If health visitors do routine visiting of the aged then there will not be enough for other functions. If general practitioners have nurses attached to them and certain elderly patients need visiting because of their clinical condition then the nurse is the proper person.

Most aged people are not ill, they are extremely lonely, bored and fed up, what they really want is someone to help them, to look after them, to make them want to be loved still. Their proper routine visitation is in my view best provided by volunteers, supplemented where appropriate by specially trained workers.

**Dr Bergmann:** I have great admiration and envy for Dr Elliott's services but I do disagree most violently with the last ideas he expressed. For years we have been trying to fight this idea that all old people need is a little bit of goodwill and love, while the expert stuff can be kept for others. Assessment of the elderly has now been studied in considerable detail under Professor Roth in Newcastle-upon-Tyne and also in the excellent survey done by Drs Williamson and Stokoe in Edinburgh. These revealed considerable undetected disease in the elderly—both psychological and physical. Twelve per cent of those seen by us at Newcastle had moderate or severe psychiatric illness of a depressive type and potentially amenable to therapy, but unknown to their family doctors because the patients did not report their condition, thinking it to be hopeless. Dr Stokoe's team showed in addition an enormous amount of unreported physical illness. The family doctor service is a good demand service, but without the help of highly trained nurses it can never reach out into the preventive field. If Dr Elliott's concept prevails we shall not get very much further.

***Floor*:** I think one of the nice things about coming to these gatherings is that we have a glimpse of Utopia such as we enjoyed this morning. But Dr Haire has brought us back to earth. If Dr Elliott has not met a conflict between the hospital service and the welfare services as to who looks after the patient, then I can only say that I wish I lived in Kent. Because things are

very different with us. I often feel that the geriatric services are summed up in the line "those behind cried 'forward' and those before cried 'back'."

**Dr Ritchie** (*Maidstone*): As a general practitioner, my feeling is that health visitors would be better employed visiting the elderly rather than young mothers, most of whom are already swamped by advice from relatives, books and magazines, and know only too well how to carry on. The over 65's who are now registered in one way or another should be seen at least once by a health visitor.

**Dr Elliott:** We do tell our health visitors to visit the aged, but when they have made one or two visits they should pass them on to another agency. And here I must point out that my exact words were "I don't think that this is the right type of specialist staff in short supply to do *routine visiting*". Of course it happens from time to time that there are differences of opinion between my specialist staff and the consultants—frequently psychiatrists—in the regional board service about where people should go. These issues are resolved within a relatively short time. Consultants sometimes take the view that we could cope in a Part III home with someone who, among other conditions of old age, is wandering. But we have no power of restraint and are particularly vulnerable to criticism from coroners and others. Therefore we are bound to say that if someone wanders we really are not able to cope. I can recall in the recent past no differences of opinion in which both we and the regional board have refused to admit a case.

**Dr Hughes** (*Edenbridge*): I would like to ask Dr Elliott a question on a point which sometimes arises in group practice with the ancillary services out in the country. We may be informed that an old person living alone has not been seen around for a day or two. In the past, the doctor has always started such investigations, which can be very time-consuming and do not always turn out to be a medical matter. My view is that the health visitor is the ideal person to start the investigation and report back. Would Dr Elliott say if he agrees with that?

**Dr Elliott:** In a case like this I should have thought that the police would be the proper people to contact, as they are the only ones who have the power to force entry. We might consider the task if we were relieved by parliament of the duty to arrange visitation of mothers and young children, but with present staffs we cannot pursue new functions unless parliament relieves us of the old.

**Dr Hughes:** Surely a police visit would be likely to frighten an old lady, especially if there is nothing seriously wrong with her, and she has just stayed in bed with a cold. If a policeman's head suddenly appeared through the door after he had broken in, the old lady might well be cross.

**Dr Bergmann:** I would like to take up Dr Elliott's point of the senile wanderers. As one of the psychiatric representatives, I think that his Part III home should cater for people who are somewhat disorientated. After all, wandering is a function of lack of memory plus sufficient physical health still to move, and it seems to me that where there is no gross behaviour disorder, suitably-designed homes should be available for the elderly mental infirm in the community. These are both envisaged and encouraged by the Minister and his advisers, but there has been a singular failure of local authorities to accommodate this type of patient.

I agree that where behaviour is grossly disturbed, violent or aggressive, the mental hospital has to take over, but where little more than the restraint of a locked front door and safe buildings are required, I do not see that this is a mental hospital function. And I would remind Dr Elliott that the local authority has statutory powers under Section 33 of the Mental Health Act—The Guardianship Order, to keep a person within the confines of an appropriate place.

**Dr Page** (*Brighton*): Is domestic help available on public holidays and weekends?

**Dr Elliott:** One difficulty about staff is that so many people are working part-time and also have family commitments. Whilst we do try to provide weekend help, the fact of the matter is that we can provide services only according to the staff we can recruit. We are not averse to weekend work but find it extremely difficult to provide, and not a thing that we could guarantee. In our old people's homes the same difficulty arises—it's the matron and the assistant matron (if there is one) who supply the weekend work.

**Dr Page** (*Brighton*): Dr Elliott referred to encouraging voluntary agencies, would it not be possible to channel some of these into weekend and holiday work?

**Mrs Richardson:** It is my job to try every possible means to provide help where it is neces-

sary, and that might mean for seven days or nights a week. Labour problems are difficult enough without trying to involve a woman with a family in working seven days a week. Most of you here are husbands; how would you feel if your wives were away from you seven days a week? This is one of my biggest difficulties but, every effort is made through church organizations, the Women's Royal Voluntary Services, the British Red Cross Society and many others. In fact, you name it, I use it. Sometimes it is even necessary to recruit neighbours from house to house for a rota service. I find that neighbours are not averse to helping elderly people in the road provided they are not asked to do too much, so I arrange, for example, for meals to be prepared by several neighbours in turn. Even the most difficult patient can be covered in this way. However, when the whole system does fall down—as it has with a particularly cantankerous patient of mine—then there is little to be done except to turn out myself, which is not a good policy in view of the fact that I could be doing this all over the place.

**Dr Elliott:** Might I add something which the general practitioners will be aware of and that is this: in old people's homes the only medical services we are allowed to provide are exactly the same as the patient would receive in his or her own home from the general practitioner. Parliament has prescribed that we should not set up a para-hospital service in old people's homes.

**Dr Rao** (*Dulwich*): Do you consider the need for short term social emergency admissions to welfare homes, night hospitals and so on?

**Mr Allison:** Very important indeed. Up till now the pressure on our accommodation is such that we have not been able to *reserve* beds exclusively for this purpose. However, there is a wonderful lady in the office who deals with about 290 people every summer, thus enabling families to go off for a full holiday, come back refreshed and continue to look after their relatives or friends. We are often struck by the comments of the matrons of our homes about the high quality of care that these people receive in their own homes. We will from now on, all being well, have something like five or even ten per cent of total accommodation reserved for this purpose. Then we can make advance promises of reserved accommodation not only in the summer holiday season, but consistently throughout the year.

**Dr Zutshi** (*West Kingsdown, Kent*): To relieve pressure on day hospitals and relatives, is it not possible to admit old people living in their own houses, on a day basis once a week, to old people's homes; in other words, to base day centres in local authority residential homes?

**Mr Allison:** We are not keen on the idea. In quite a number of our homes people come in for a meal, and this is being extended to a bath and things like this. Personally, I wonder whether it is right to introduce someone into a communal home too soon. I am quite sure if I had to look after myself, and I were taken into a home, I would wonder how on earth I was going to cope with living outside, shopping and all the rest of it again. We would prefer to see day centres which would relieve day hospitals from carrying out a purely social function. Day centres are certainly a problem in the rural areas, and this emphasizes the point I made about trying to provide a county service in every parish.

**Dr Irvine:** As Peter Townsend said in his book *The last refuge* if people could live in proper housing they would not need the same number of staff to look after them. I do not know the comparative capital cost of special housing for old people and residential homes, but I am absolutely sure that the running costs of special housing must be much less.

**Mr Allison:** Dr Irvine is quite right but you will have to wait at least 20 years to get the benefit.

**Miss Bagnall:** Could I come back on the question of holiday admissions? We run a holiday scheme in Hastings and find the most valuable part of it is that we guarantee well in advance to admit elderly relatives on a particular date. We do not say that we may have a bed or may not. Just because the local authorities are not able to give that guarantee I am sure we get a lot of patients in hospital that really could be properly placed in Part III. We are fairly easy on their physical condition just because we know that if we do not take them nobody else will. But they do need very careful social assessment. All the cases are put up to us by the patient's general practitioner, but if we are not careful, what the general practitioner thinks of is a fortnight's break, the family can well be thinking of as a one-way ticket. I find that they need careful assessment, nearly always including a domiciliary visit, before we accept them.

**Mr Allison:** With the greatest respect, what can be done in towns can not necessarily be

done in a large county. I have no doubt I could pick out more than one town in Kent where I could give exactly the same record; I can only say, if Hastings is able to do this then they are extremely fortunate in the number of residential homes they have got in relation to the demand. It may well be that they have got a bonus in accommodation as compared with the more densely populated areas, particularly along by the river where the demand is very great indeed.

## Summing-up

**Dr J. H. Hunt** (*Chairman*)

I am sure you will all agree we have had a most interesting and constructive symposium. We have discussed certain important clinical aspects of old age—rehabilitation, occupational therapy and social problems—and this afternoon, the way local authorities' residential, nursing and domestic help services can help.

An old and wise doctor once said to me, "If you don't know what to do to help a patient, or when you know you cannot do anything, just sit down, cross your legs, have a cup of tea and chat with him; and you will have done more than you could have believed possible". This applies to our management of old folk more than to any other group of patients, and every year that passes makes me realize how wise that advice was. I know that your provost wants to wind up this symposium and to thank those who have helped in arranging it, but before that I want to thank on your behalf your provost, Stanley Cole and your honorary secretary John Squire, for all they have done to make this symposium the success that it has been.

## Closing remarks and thanks

**Dr S. Cole** (*Provost, South-east England Faculty*)

At the start of this symposium I forecast that we were in for an intellectual feast, I think that was the understatement of the year. We have enjoyed a succession of thoughtful and stimulating papers culminating in active discussion. On your behalf I would like to express our gratitude to all the speakers for their magnificent contributions, and to Lord Amulree, Dr Ronald Gibson and Dr John Hunt for chairing the sessions.

This symposium could not have taken place without the financial support and organizing ability of the Pharmaceuticals Division of Geigy (U.K.) Limited. Not only have they sponsored the meeting, but right from the start they have been lavish with their time and expert knowledge in organizing this surprisingly complicated operation, and they will finance the publication of the proceedings. I hope their representative Mr Ruff, who has been so helpful to all those who have been working to ensure the success of this symposium, will convey to Messrs. Geigy our sincere appreciation for their magnificent help.

Within the faculty, Dr Hardwick initiated the whole programme, and our honorary secretary Dr John Squire has put in a prodigious amount of work in organizing and correlating. To all these people go our sincere and grateful thanks.