EDITORIALS

A good home

WITH the abolition of the last vestiges of the Poor Law, the large institutions which once housed the aged poor have been gradually replaced by smaller 'homes'. Part IV of the National Assistance Act, 1948 placed a duty on local authorities to register and inspect homes provided by private persons and voluntary organizations. Part III accommodation, which the local authority is obliged to provide for those in need of care and attention "not otherwise available to them", has become stretched by increasing numbers of elderly people. Even more important are the problems posed by cohorts of people who are older and more ill than were originally envisaged. The result is that, increasingly, the residents in Part III accommodation are coming to resemble the chronic sick of an earlier age, who gave rise to the pioneer endeavours of Marjorie Warren (1943), the seminal figure in modern geriatric practice.

It is not surprising that there have been many changes in residential homes in recent years, and much debate about their role and purpose. There is concern about the indispensable function provided by places of care and safety for old people who would otherwise be at risk in their own homes, or unnecessarily occupying geriatric hospital beds for social rather than for medical reasons.

The part played by the general practitioner in relation to these homes varies. A dilemma arises in respect of the inalienable right of residents to retain the services of their own family doctor, and the alternative arrangement whereby a practitioner is offered a retainer to look after most, if not all, the residents in a home. In the latter instance, it soon becomes clear that there are advantages in having an overview of a community which consists of both staff and patients, and where regular visits are made for the purpose of reviewing the care needed, and for sorting out administrative problems. The doctor who does no more than visit at the request of his patient makes no contribution to the communal aspect of the home.

How should such doctors be selected? For many the work appears unattractive, and the retaining fee may appear a small inducement to work at a place rich in unsolved or insoluble problems. There is little indication in the literature to show that medical work in an old people's home is a positive feature in the context of the general welfare of the elderly.

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A recent consultative document published by the Welsh Office and the DHSS (1982) indicates governmental concern in this area. Much of the document is concerned with registration of premises and the setting of standards by periodic inspection. It should, however, be obvious by now that the inspection of soldiers on parade cannot provide an estimate of how they will behave under fire. Residential and nursing homes remain isolated, and there is little opportunity for those who work in them to experience any other model. General practitioners who are isolated tend to become demoralized when advances in medical care pass them by, and it is the same with those who work in residential homes.

Just as there are practices, and departments of general practice, which set standards of excellence, so it would follow that local authorities might set up and maintain model homes with a standard-setting and teaching function. This function should be set against a code of practice, which would help these institutions to move away from mere commercialism and towards professionalism. There are instances where this does take place, with provision of in-service training in domestic and nursing skills, but they are too few.

Why can there not be a move away from the rigid provision of services patterned by statutory structures rather than by people's needs? The conceptual link between residential homes, sheltered housing schemes and nursing homes should be recognized, and the differing needs of elderly people reflected in flexible arrangements which offer a graded scale of provision. Every doctor who works in a residential home knows of the difficulties experienced when a resident falls ill. This sudden transition from being a person to being a patient exposes a weakness of the present position. Transfer is not easy, because many geriatric units are hard pressed for beds, and the assumption is made that the patient already has a bed and supervision. The staff, however, usually have no nursing qualifications, although wardens may acquire some understanding and skills by saturation in the climate of old age; nonetheless, the demands of one old, ill, confused person can overload the staff to crisis point.

In the face of the unremitting pressure of numbers of aged individuals, it is essential that links be formed between local authorities and health authorities, between housing associations and voluntary welfare agen-

cies. Such inter-agency arrangements would create administrative problems and financial anomalies. Yet, comprehensive schemes must be the aim, with provision for elderly people ranging from minimal care and supervision in sheltered accommodation to constant nursing attention.

Part of the long-term solution is to introduce more teaching about the care of the elderly into medical nursing and remedial training, with opportunities for joint education (Shegog, 1981). This educational role would not be a function for the so-called teaching hospitals but would be developed at local level from among the associated disciplines with a view to breaking down organizational separation. Many in the caring professions believe they have no interest in the elderly, only to discover when they start work in the field that the work is challenging and rewarding. In the end, however, should not appointments be made to residential homes on the basis of qualification as well as motivation? If competence and prestige in paediatrics and obstetrics derives from the award of diplomas, should not this assessment be extended to the new and dominant specialty of geriatric medicine? (Thompson, 1982.)

Doctors so qualified should be the first to be selected for medical care in homes, and the injection of specially trained doctors into this somewhat amorphous and disparate segment of provision could be expected to go a long way to setting higher professional standards. There is a good case for ensuring that all staff—nursing, administrative and domestic—should be trained for dealing with crisis intervention, and encouraged to develop insight into the triggers of behaviour of older people. The teaching by general practitioners of these fundamentals is a rewarding skill, and one which improves the morale of staff in homes for the aged.

No government can be expected to go too far ahead in this field for fear of arousing professional and political suspicions, but if the voluntary and private sector provides a comprehensive service to the old, should not it be unashamedly recognized as doing so? These private resources have not yet been fully exploited, nor have the links with the public residential sector been adequately forged. There could also be greater co-operation within government, so that housing and health are no longer dealt with as disconnected topics, and partnership between health and social services could also exist at district level (Kinnaird *et al.*, 1981) where the first steps towards an integrated service might be taken. Demarcation lines can be broken down, new partnerships entered into and feasibility studies carried out. Now is the time for new ideas, for the DHSS appears to be at its most responsive to local circumstances.

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Bread for health and bread for slimming

BREAD, the staff of life, has been a steadily decreasing part of the national diet for the past 30 years. During this time the average daily intake in the UK has fallen from 230 to 130 g per day, and we are now eating less bread than most other European countries. Part of this decrease is due to greater affluence—the fall in consumption has been greater in the higher income groups. The passing of the breakfast habit, the virtual elimination of afternoon tea, with its bread and butter, and the advice in most slimming diets to cut down on bread are all important factors. The baking and milling industries are naturally keen to reverse this trend. How justified are they, and what role will bread have in the major changes in the nation's nutrition which are now taking place? These changes centre mainly around eating more natural and fewer refined products. It is becoming accepted that more fibre in the diet makes a valuable contribution to the relief of constipation and may be helpful in preventing peptic ulcer, diverticulitis, haemorrhoids, varicose veins and many other conditions. There also seems to be general acceptance for the reverse side of the fibre coin—reducing the intake of sugar—and it is now also generally accepted that the intake of fats of whatever sort should be reduced.

The DHSS commissioned a report on the nutritional aspects of bread and flour in 1978. As a result, the Committee on Medical Aspects of Food Policy (COMA) set up a panel of experts which produced the report in 1981. A recent Forum organized by the baking and milling industry discussed the report and produced many interesting facts.

But first, a little historical background. Any major