with the routine work of general practice along with tutorials and wide reading will suffice, they are inevitably pressurized by membership courses, books and pamphlets (published to help pass the examination), plus the general air of concern among their fellow trainees.

It has taken some years to get vocational training generally recognized and the Joint Committee on Postgraduate Training for General Practice (JCPTGP) has laid down rules which in this region are applied fairly firmly. A trainee is not allowed to do less than one year in a training practice before becoming a principal, yet the pressure to study for and pass the examination tends to erode the last two or three months of the trainee year.

We appreciate the need for a certificate of satisfactory completion of vocational training which hopefully implies the attainment of a minimum standard, but would suggest that the College examination should not be taken until a minimum of six months to one year as a principal in general practice has been completed.

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Trainer/trainee workload

Sir,

As a trainer participating in their study, I was most interested to read the paper by N. Caine and colleagues (September *Journal,* pp. 419-422). It should be pointed out however, that most of the data were obtained in 1979 and this may affect the validity of the conclusions drawn.

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Part III — home, hotel or hospital?

Sir,

Having provided medical care for the majority of the residents of our local part III 'home' in Corsham, Wiltshire for 10 years, I have now carried out a survey of the physical, mental and social state of those living there at the beginning of this year. Fifty-three residents were assessed with an age range of 66 to 99 years. The average age of those entering the home is now 86 years.

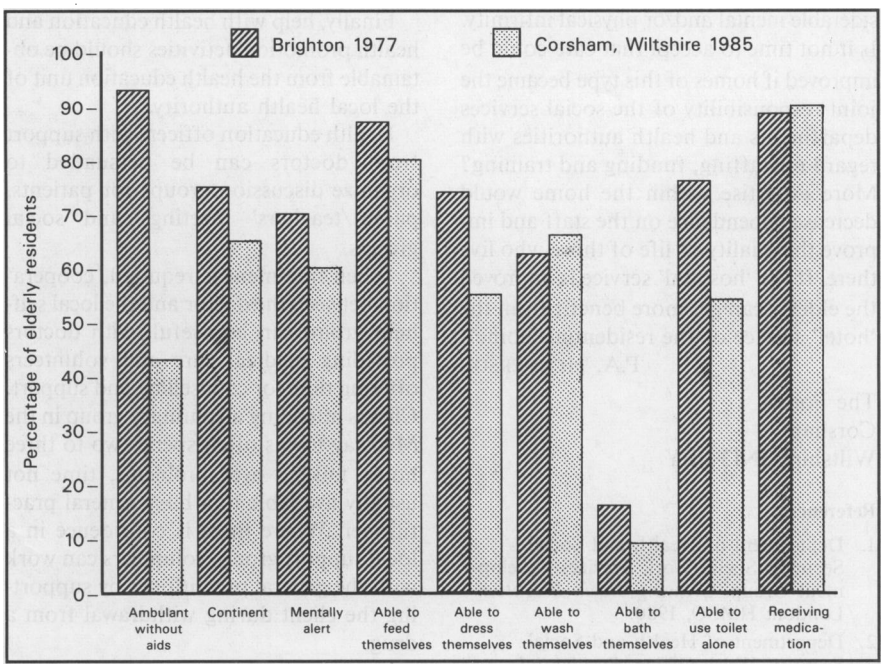

Figure 1. *The degree of dependence of elderly people in residential care (n = 53 for Corsham, Wiltshire).*

Forty-five different medical conditions were identified. The 10 most common were: arthritis (19), cardiac failure (12), senile confusion (11), defective vision (9), defective hearing (6), schizophrenia (5), depression (5), iron deficiency anaemia (5), hypertension (4) and vitamin B12 deficiency (4). In spite of a policy of regular review to reduce medication, 136 different oral drugs were being administered by the staff. The degree of dependence on the staff is shown in Figure 1 and the results of a similar survey carried out in Brighton in 1977 are also shown for comparison.[1]

Sixteen residents were mildly confused, 10 moderately so and five severely. This was a subjective assessment with no formal testing. The lack of both psychogeriatric beds and social services homes locally for the elderly mentally infirm means that our home must provide what help it can. It is no wonder that clear-headed residents find it distressing to live with those whose habits range from the mildly bizarre to the frankly disgusting.

The staff of part III homes are not required to have any health care training and few have had any formal training for the work. The work would not be undertaken by anyone who did not have a genuine caring attitude towards the elderly. However, the natural thing is for the staff to carry out tasks for partially disabled people rather than to encourage them to make the most of their residual faculties. When time is short and there are many tasks to be done, maximal help is the only answer in the short term, however counterproductive this may be in the long term.

With regard to transfer to hospital, our aim has been to apply the same criteria that would be used for a patient remaining at home if there was considerable family support. This includes terminal care if the last illness is not too prolonged. The Department of Health and Social Security guidelines for residential homes for the elderly[2] makes a distinction between professional health care and that which might be provided by a competent caring relative. If the former is required the health authority should provide it. If the latter is required, it is the responsibility of the social services department. But where is the dividing line? We know that unqualified people can learn complex skills — for example, the relative who gives home renal dialysis. The caring relative has to cope with only one patient suffering from a few conditions and taking a few drugs. The untrained staff at this home are expected to deal with over 50 residents with 45 different medical conditions and taking 136 different drugs. In addition they are expected to divide their time between the physical, mental and social needs of all in their care. Does this not suggest a need for professional expertise among the staff members rather than expecting them to call when necessary on the already overstretched domiciliary health care professionals?

As greater effort is made to keep the increasing elderly population in their homes, who are to be the part III home residents? It will be only those with con-