Medical needs of the mentally handicapped

Sir,

I read with interest the account by Dr Howells (October *Journal,* p.449) on the unmet medical needs of adults with mental handicap.

National policies — not without their critics — are encouraging mentally handicapped patients to live in the community. Admissions to institutions for the mentally handicapped are falling, and increasing numbers of patients are being discharged from hospitals for the mentally handicapped.

These patients are also handicapped by their inability to use general practitioner services — they may be unaware of the services provided, or of how to take advantage of such services. Their communication skills may be poor, and their carers, often elderly, may themselves be low users of services.

If mentally handicapped patients are to receive an adequate medical service, it would have to be service-led, rather than patient-led. The development of community mental handicap teams, with a core membersip of a social worker and mental handicap nurse, is to be encouraged. But these cannot by themselves provide strictly medical services. A system of routine screening for physical disorders is needed, for example, for hearing loss and hypothyroidism in patients with Down's syndrome.

Are general practitioner services adequate to undertake such a screening programme? Unless a practice maintains an at-risk register of such patients, and actively intervenes, these particular patients will not benefit. Case-finding alone is inadequate for these patients. An alternative system, that of appointing clinical medical officers to adult training centres, specifically for such screening, has been tried in some areas. Such a system, however, fails those patients who do not attend such a centre. Undoubtedly, a screening service that is well-organized, and conducted by interested general practitioners, would provide the most adequate and comprehensive service.

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Care of the elderly

Sir,

The paper 'Patterns of care for the elderly in general practice' by David Wilkin and Idris Williams (December *Journal,* p.567) raises a number of issues.

Most important is the lack of an incentive or reward for providing better care for the elderly. Raising capitation fees has not stopped old people finding obstacles when seeking to join NHS lists. The growth of periodicals devoted to the financial gains to be made in practice are concerned exclusively with younger age groups.

Secondly, the workload created by elderly patients hardly justifies these across-the-board payments, to judge by the authors' findings. They indicate that the mean time spent in surgery per week for the 201 doctors was no more than 15.1 hours, yet more than 50% of them felt they were overworked. The mean time spent with each patient per year was about 25 minutes and the mean number of consultations per elderly patient per year averaged five, indicating that these people, with complex physical, social and mental problems were allotted a mean of five minutes per consultation. Not surprisingly, the authors recommend that the discrepancy between high levels of unrecognized morbidity and a low level of investigative work by general practitioners in relation to the elderly should be examined further.

My own view[1] is that we are, as a profession, deficient in education for those presenting with greatest medical needs. My own researches[2] have shown that by the age of 70 years deviations of homeostasis in the body must be present, causing overlap of at least three disturbances of accepted norms. Yet, older people are still accorded the standard five minutes, and usually treated for a single pathology; if they are then placed on a repeat prescribing list there may be risks from polypharmacy.

The authors state that general practitioners hold very different views of what is appropriate for their elderly patients. No one could fail to view the data they collected without the gravest misgivings.

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Accommodation for the elderly

Sir,

In his article 'Accommodation for the elderly' in the *RCGP 1986 members' reference book* John McCarthy states: 'One interesting fact that has emerged from experience and research is that most owners of sheltered housing come from the local area in which the development is built. Indeed 80% are from the local community and 15% are people who have had previous connections in the area. A very small minority represent elderly people coming into the area'.

This is contrary to our experience. A census of the inhabitants of a block of sheltered housing recently built by McCarthy and Stone in Seaton shows the following percentages of the 85 inhabitants: 8% are from the local community, 6% have previous local connections and 86% are elderly people coming into our joint practice areas afresh.

The influx of elderly people from outside the area occupying newly built or converted houses has immediate implications for our practices, as well as for the provision and planning of future services.

We should be grateful if practitioners in areas where purpose-built sheltered housing has been erected could advise us of their figures in order to discover whether our experience is unusual.

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Rural hospitals in South Africa

Sir,

I have recently returned from working in a rural hospital in South Africa and I would like to report the severe shortage of doctors in the rural areas and the resulting suffering of the black population.

The Jane Furse Memorial Hospital, a former Anglican mission, taken over by the Lebowa, homeland government in