tions, the local authority services, and the provision of suitable living accommodation.

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Nutritional problems encountered in social work among the elderly

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Many of today's medical problems clearly have a large social content, and the possibility that the converse is true is currently receiving attention. Only a few weeks ago the Central Office for Health Education called a conference to consider how far the social worker should be concerned with health education: nutritional advice to the elderly was glibly mentioned as a possible field of activity.

With the eventual implementation of the Younghusband Report on the Working Party on Social Workers in the Local Authority Health and Welfare Services this suggestion may well cease to be of merely academic interest.

The National Old People's Welfare Council (NOPWC) is particularly grateful to The Nutrition Society for arranging today's symposium. It will help to focus interest on an aspect of work for the elderly which has so far received insufficient attention.

It would not come amiss here if I outlined the dilemma which prompted the Council to approach the Ministry of Health with the suggestion that an advisory group be set up to consider nutritional policy in respect of the elderly.

The function of the National Old People's Welfare Council is to co-ordinate in its field the work of statutory and voluntary agencies and it has some 57 county and 1500 local committees for this purpose.

Reports from voluntary workers visiting the housebound aged expressed concern at the poor standards of feeding often found. Various reasons were given: some of the old people were unaware of the importance of feeding, with others shortage of money apparently prevented them from having adequate meals, and some showed disinclination to bother with food through physical infirmity or general apathy.

Because of such findings several local old people's welfare committees produced food advisory leaflets, the value of which was questionable. Some contained information and precepts which shocked dietitians.

The British Dietetic Association was invited to collaborate in the preparation of suitable basic advice. A set of notes for speakers was published, for use where dietitians or other informed persons were not available to give talks in old people's clubs or to groups of voluntary workers.

An illustrated leaflet of simple feeding instructions for use by old people themselves was also made available, and 8000 of these have already been sold.

The NOPWC was later approached by food suppliers who wished for an introduction to old people's clubs to demonstrate and give nutrition talks with their products. It was not found possible to accede to this request because agreement would have implied approval of whatever was said or offered.

The Ministry of Health was subsequently approached about national policy regarding the food requirements of old people but the Council was unable to get any lead from this source and was referred to its own limited publications as being a suitable guide.

This episode reveals the gap: much-needed scientific knowledge is missing. Questions about optimum diet or minimal nutritional needs of the aged cannot be answered.

The problem has become more acute because there has been a change of emphasis from residential care to domiciliary care in housing the elderly. In the nineteen-forties, when the effects of the increasing number over pensionable age were first making themselves felt, it was considered that the provision of sufficient residential accommodation would be the answer to many problems. Certainly there is evidence that individuals admitted to old people's Homes in poor physical shape have benefited from good regular meals. They have put on weight (too much in some instances) and the senile confused cases have improved. That the settled conditions and the release from anxiety had their part to play cannot be denied, but much of the improvement could reasonably be attributed to better feeding.

Policy has now been reversed, however, and old people are being kept at home whenever possible for reasons which are well known. This throws us back on the problem of nutritional advice.

We are encouraging a stay-at-home situation where we know from experience that there is danger of the old people's living in a state of malnutrition. This is a predictable problem where more information about their nutritional needs is required not only for individuals and their care, but in the formation of policies by local housing authorities which might include communal feeding.

Whatever the housing, Homes or other provision made for the elderly, we still have to contend with the intensely personal nature of eating habits, which can make or mar a service, however well planned. Should there, in that event, be a national programme of nutritional education which is framed in accordance with an awareness of the pitfalls mentioned above?

We are familiar with the present pattern of communication that teaches the schoolchild the simple fundamentals of good eating, then loses the teenagers to buns and 'cokes', that gathers in the young mums and fails to retain the interest of the middle-aged housewife, and that lastly alerts the spreading waistline and loses out to the price of a good fire. Is this inevitable? Or could a long-term campaign of instruction at all ages alter it?

Just over 3 years ago a study group was set up by the NOPWC to consider the question of adjustment to ageing and preparation for retirement. The group's

findings indicate that many of the problems of old age might be alleviated or avoided if preparatory action were taken earlier in life. An officer is now being appointed to make approaches to industry and commerce, educational and religious bodies, voluntary organizations, and statutory authorities to promote interest and preventive action.

The group's discussions of the mental and physical aspects of health covered nutritional needs. There was little information on the part played by nutrition in the ageing processes. In the matter of dietary guidance there was nothing to meet the needs of those approaching retirement, and little to steer people into an awareness of the importance of this subject in their later years. In this field also we miss a lead from the nutritionists.

Fears are frequently expressed that for a large proportion of the elderly population financial stringency, rather than any other factor, is the chief bar to an adequate dietary. Figures issued by the National Assistance Board (1958) throw some light on the number of old people whose doctors have prescribed for special dietary needs. In 1958 discretionary payments for special needs were made to 780 000 people. Of these, 431 000 were for extra nourishment. The proportion of retirement pensioners can be roughly gauged by reference to the total payments of 1 649 000, of which 1 134 000 were made to those over pensionable age.

Reports from old people's clubs where nutrition talks have been given indicate that most old people say they cannot afford more than half a pint of milk per day. There is support for this in the constant complaints from areas where dairies will not distribute in half-pint bottles. This restriction causes hardship and it is feared that many old people do not buy as much liquid milk as they should.

Quoting again from the work of the retirement group, one member of The Nutrition Society, when approached informally, felt that if old people could be induced to take 1 pint of milk daily, no undue anxiety need be felt on their behalf. On the other hand, another nutritionist would challenge this viewpoint strongly.

Findings of a social and food survey on the elderly, carried out in Sheffield by Bransby & Osborne (1953), have already been published. Some 20% of the subjects were considered to be in a state of poor nutrition. Though the average calorie intake was found in the main to be higher than FAO standards, the clinical condition of the elderly people would suggest that at least for the population of the U.K. these standards were too low. In a Liverpool survey (Fuld & Robinson, 1953) malnutrition showed up as the primary disability in 2·8% of the hospital admissions. No more recent work has done anything to counter these disturbing suggestions.

We are frequently told by workers in the field that the retirement pension, even with the recent increments, does not adequately cover nutritional needs. Yet the Annual Report of the National Food Survey Committee for 1957 (Ministry of Agriculture, Fisheries and Food: National Food Survey Committee, 1959) showed figures that suggest that the weekly per capita expenditure on food by old people compares favourably with the national average. Does this also point to the need to give old people special help in spending wisely, nutritionally speaking.

Experience gained from the administration of the meals-on-wheels service provides conflicting information. There is a general feeling of the great value of such a service, yet it is not used as extensively as it could be. To a certain extent the elderly themselves resist it; and in many areas the recommendations from general practitioners, almoners and health authorities are fewer than the prevailing expected requirement. A leading geriatrician has said that to do its job properly a mobile meal must be available on at least 5 days a week, yet one knows many instances where old people take only one such meal a week although there may be two or three deliveries.

The W.V.S., who control 80% of these services, are making a special drive to ensure that all services are at least twice weekly. This is reflected in the figures for the quarter ended 31 December 1959, when half a million meals were delivered, an increase of 87 000 over the previous quarter. The above figures do not indicate that a great number of old people are taking meals, and there is no sign at present of the number of recipients increasing greatly. There are numerous instances of elderly people having no proper meal if a mobile meal is not available, and many reports of dietaries which because of fads, ignorance or prejudice are low in vitamin C and the B-complex vitamins.

A survey of the meals-on-wheels service, sponsored by the National Corporation for the Care of Old People, and due to be published shortly will, it is hoped, shed some light on these anomalies and furnish valuable information on questions of need, service and distribution.

If a meals service is thought to be a useful and important part of the domiciliary care of the elderly there should be some defined objective such as the supply of the daily protein requirements, as in the school meals service. This is particularly so at present as in a Bill now before Parliament local authorities are seeking powers to enable them to provide old people's meals services directly and not, as at the moment, necessarily through voluntary agencies. The work of The Nutrition Society's members comes in again here as old people's food requirements cannot yet be specified. A great stimulus to the successful formulation of policy on feeding people in their own homes would be given by the working out of an agreed dietary.

From the standpoint of social workers old people living alone or under difficult living conditions tend to become apathetic and lose interest in looking after themselves. Lack of attention to food is among the first symptoms of deterioration and for this reason the NOPWC has laid emphasis on the need for luncheon clubs and for more daily clubs serving meals. Some of the improvement which follows on individuals' taking advantage of these services must be attributed to a return to proper regular meals.

The administrative development of all this work would be facilitated if backed by the mature views of nutritionists.

Current discussion on cholesterol tends to indicate that feeding may be the last-but-one enemy. In 1984 we shall possibly all be taking the daily pill. Meanwhile the multitudes of old people who need care in 1961 and after present considerable problems of policy and administration. The nutritionist's contribution is of basic

importance and will doubtless involve profound and prolonged research to determine how much of what foods old people should eat. It is for others to determine the spirit in which they eat it.

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The clinical medicine of old age

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If the relative increase in the percentage of old people in the community continues, geriatric medicine will in future occupy more and more of the time of both general practitioner and consultant. For many years it had been the custom to accept the disabilities of the elderly because of a subconscious belief that they were really incurable. The more energetic clinicians concentrated on schemes of occupational therapy and rehabilitation often with a fair degree of success but always the price in human effort and material cost was very high in relation to results and these centres of activity remained the exception rather than the rule.

In this country, mainly owing to the pioneer work of Amulree, Exton-Smith & Crockett (1951), Warren (1943), Howell (1943), Cosin (1953), (the late E. B.) Brooke & Wetenhall (1949) and Olbrich, Ferguson, Robson & Stewart (1950), during the last decade there has been a revolutionary change in the medical care of the elderly. These workers showed that the most efficient and, therefore, the cheapest, quickest and easiest way to rehabilitate the elderly patient is to diagnose his disability and treat it according to regular scientific medical principles before applying the techniques of physiotherapy. The very simplicity of the idea has been a difficulty because people have been unable to realize its fundamental importance. So my first point is that geriatrics is not rehabilitation or social medicine, but a part of medical science relating to the health of the ageing, and the aged, including not only problems of disease in later life, but also the complex phenomena of normal senescence, that is, a special application of general clinical medicine.

There are special difficulties in practising general medicine among the aged. During a long life these patients have often accumulated several diseases and many scars. One of the basic principles of medicine is to try to fit all the symptoms and signs into one diagnosis, but this device derives from experience among the young, it is a device that will lead into, rather than away from, error among the aged. Here we accept that some symptoms and signs are due to one disease, some to another