Correspondence

Because of heavy pressure on our space, correspondents are asked to keep their letters short.

Old People in the Cold

SIR,—With the onset of winter there is an urgent need to remind ourselves of the effects of cold on old people, and their need for better nutrition, summarized in your leading article of January 26 (p. 203) and subsequent letters and surveys.

Drs. J. A. P. Trafford and A. Hopkins¹ stated hypothermia to be a common condition of elderly people. There are records of eight deaths in 14 cases.^{1,2} The West London coroner is reported to have said, "Many of our old people died last winter because they lacked the means to obtain the warmth necessary to survive."³ Are all who care for the elderly, district nurses, social workers, doctors, sufficiently aware of the need to prevent hypothermia or suspect it early enough?

Low-reading mouth thermometers were difficult to obtain last winter. They should be in general use. Are supplies available? Most cases of hypothermia are missed because ordinary clinical thermometers in general use do not record the condition. Last winter I recorded room temperatures of old people's bedrooms with a minimum air thermometer. The air temperature of those without continuous heat during the night was an average of 3° F. (1.7° C.) above the outside air. Bedroom temperatures of 7° F. (−13.9° C.) were recorded (25° F. of frost). These old people had no money for heating after early evening.

A recent Ministry of Labour *Family Expenditure Survey*⁴ gives the average expenditure of an old-age pensioner on £4 weekly, living alone, as 32s. 4d. a week or 4s. 7½d. daily on food. Last winter I found expenditure on food to be below 4s. daily with some old people, as they spent everything available on heating.

Surveys of old people in Britain record protein and vitamin deficiencies following years of poor feeding.^{5,6} My own observations⁷ show the frequency of anaemia and tongue and mouth conditions characteristic of the deficiency of the B group of vitamins. Many old people obviously cannot afford enough protein and fruit and vegetables. There are no national figures available of the extent of these problems in Britain, but the evidence shows that hypothermia and undernutrition of the elderly are not uncommon but often unrecognized. Recently hypothermia in African children has been related to protein deficiency and malnutrition.⁸

As we as a profession are more aware of these problems than others, I suggest we should ask the Ministry of Health to initiate and co-ordinate detailed research into the needs of old people for food, warmth, housing, and amenities immediately this winter.

As emergency measures, until the results of this research are available, I suggest that an extra allowance for winter heating (the equivalent of a hundredweight (50.8 kg.) of coal as a minimum weekly) be given to all old-age pensioners. And also as an attempt to remedy undernutrition one pint (0.6 litre) of free milk be given to all old-age pensioners.

Finally, low-reading thermometers should be made available to all who have the elderly in their medical care, with a statement on the dangers of hypothermia and undernutrition.—I am, etc.,

GEOFFREY TAYLOR.

Ilminster, Somerset.

REFERENCES

- 1 Trafford, J. A. P., and Hopkins, A., *Brit. med. J.*, 1963, 1, 400.
- 2 Prescott, L. F., Peard, M. C., and Wallace, I. R., *ibid.*, 1962, 2, 1367.
- 3 *Daily Sketch*, November 12, 1963.
- 4 Ministry of Labour, *Family Expenditure Survey*, 1963. H.M.S.O., London.
- 5 Snelgrove, R. D., *A Report on the Elderly who are Incapacitated*, 1963. White Crescent Press, Luton.
- 6 Kemp, R., *Lancet*, 1963, 2, 897.
- 7 *The Guardian*, March 14, 1963.
- 8 Lawless, J., and Lawless, M., *Lancet*, 1963, 2, 972.

Teaching in Regional Hospitals

SIR,—The useful discussion between Messrs. O. Gayer Morgan (September 21, p. 743), I. A. Tumarkin (November 23, p. 1340), and R. G. Macbeth (November 2, p. 1127) upon the aim and content of the F.R.C.S. examination ought to remind us that before examination we must teach and educate. Recent letters should not allow us to forget that the examiners may have a teaching hospital background, while those of us who have to train some of the candidates are not in such a fortunate position.

Teaching and the provision of suitable experience is important in the peripheral non-teaching hospitals, where 75% of the National Health Service work is carried out. It is increasingly difficult to attract the right sort of man, for many of them realize that study for an academic examination is impossible in a department with a heavy load of routine work. With the clearance of long waiting-lists, filling them again rapidly from out-patient clinics, a fair burden of emergency work, and a staff-patient ratio below that of the teaching hospital, the keen edge of ambition may be replaced by frustration, and the clinically experienced but academically unproved registrar takes himself abroad. He cannot walk over to a physiology laboratory in the afternoon or spend a couple of hours each day in the dissecting-room when the nearest medical school is 50 miles away, and the Inland Revenue Department decrees that such travelling expenses,

even if he could afford the time, would be a capital expenditure. At the age of 28 or 30 he will have done more clinical work than his colleague in a teaching hospital who has just passed the primary F.R.C.S., but he cannot obtain a senior registrar appointment since this examination is a prerequisite for such posts, which are increasingly restricted to teaching centres.

It is essential that higher qualifications should be seen to be of a high standard, and the thoughtful and responsible would not have it otherwise. The implication is that the N.H.S. must provide better opportunities for training registrars in peripheral hospitals. They should be granted realistic periods of study leave of up to six months within a three-year contract, their jobs held open, and all expenses paid for approved courses of full-time study. The problem of locums will have to be met, but there must be enough far-sighted seniors in our profession who could cope with this situation in some way or another. Administrative arrangements must be made to help this hard-working group maintain their loyalty to the hospital service and to ensure a succession of competent men for the future.

Before the last war salaries in teaching hospitals were less than those at the periphery, but this should be the day of fringe benefits to even the score and lessen the gap. There will be inevitable bureaucratic objections, but in an experimental and scientific age, such as we claim this to be, these objections must be overcome. The N.H.S. is now a big nationalized industry and should follow the lead of the Coal Board, British Railways, the armed Services, and other public undertakings by investing money in its staff. Local authorities send their assistant medical officers on courses for the D.P.H., and nursing and administrative staff are given opportunities and expenses for full-time study. Education at all levels and proper use of our national manpower is the one means by which this country can survive, and the N.H.S., being a large and important functional element of our national life, can no longer afford to ignore the training of its medical staff, nor to cling to recruitment methods that were successful 30 years ago under a different socio-economic system.—I am, etc.,

E. N. OWEN.

Eye, Ear, and Throat Hospital,
Murivance, Shrewsbury.

Rheumatoid Oto-arthritis?

SIR,—A female out-patient aged 54 was seen recently who had suffered with rheumatoid arthritis for nine years. The onset of this disease had been acute and severe, but there had been several long periods of clinical remission subsequently. She had, however, gradually become almost chairbound. This patient informed me that during her last two "flare-ups" of pain and peripheral joint swelling she had suffered also with partial deafness.