Abuse of elderly people

EDITOR,—The high level of financial abuse of elderly people in respite care has already been reported.¹ We recently conducted a census of a local long stay and rehabilitation hospital for the elderly at Colindale, north London. The results showed that of the 82 long stay patients, nine are being financially abused at present in that the appointee who collects their set personal allowance, income support, or pension is not using it to provide for their needs. An additional five patients had been so mistreated that application to the Department of Social Security has resulted in the allowances being redirected to a hospital fund that nurses can use to purchase necessities for the patients concerned. Two of the patients currently being financially abused have had their homes occupied or appropriated by the appointee without their consent, as have an additional five patients who are receiving their allowances. A total of 19 out of 82 (23%) long stay elderly patients either have been or still are victims of financial abuse by relatives (13 male relatives including 8 sons; 6 female relatives). In seven cases, homes have not been sold to release funds to provide places in private nursing homes even though it was felt by the social workers involved that this would have benefited the elderly person concerned.

Anyone can apply to a local social security office to act on the behalf of an elderly frail person no longer able to claim their own benefits. Only cursory investigations into that person's suitability are ever made, often none at all if the claimant is a relative. The department does not have the resources to check that appointees are acting properly. It relies on information to the contrary becoming available, such as when a person comes into hospital.

Victims of financial abuse are more likely to become long stay patients within the NHS (as opposed to the private sector) when they need nursing care because it is free and no charge is put on any assets. The Department of Health has said that all those wishing to receive long term nursing care within the NHS must be provided for. The changes being introduced next year due to the Community Care Act do not address the problem of free long stay NHS care versus costly care elsewhere, and so we shall continue to need beds for patients whose assets cannot be used to provide for them. Should the patient's charter be extended to include the right of protection from financial abuse?

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1 Homer AC, Gilleard C. Abuse of elderly people by their carers. *BMJ* 1990;301:1359-65.

EDITOR,—Jim Ogg and Jerry Bennett's survey assesses three categories of elder abuse: verbal, financial, and physical.¹ It is important to recognise that a fourth category, sexual abuse, also occurs. Professor Pitt made this point briefly in his editorial,² but little is known about this form of elder abuse.³ This is not surprising as it combines two taboo areas, sexuality in late life and violence towards elderly people.

We have been involved with the cases of several elderly people in which sexual abuse was strongly suspected. Each case was different. At one extreme it was strongly suspected that a male nurse had intimately fondled an elderly woman with dementia. At the other end of the spectrum two demented people in an elderly persons' home became involved in a sexual relationship, which clashed with the expectations of relatives and some staff. This raised questions of informed consent and the degree to which the wishes of staff and relatives can be imposed on patients. Cases that fell

between these two extremes included a husband who continued sexual intercourse with his demented wife against her will, and a demented man who made vigorous unwanted sexual advances to several elderly women. These cases illustrate Professor Pitt's point that elder abuse is an "elastic" term that covers a wide spectrum of presentations.

For research a clear definition of sexual elder abuse is needed, but at a practical level the need is for a low threshold of suspicion. In our experience most of the abusers had psychiatric problems themselves, and, like those who were abused, were in need of help.

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1 Ogg J, Bennett G. Elder abuse in Britain. *BMJ* 1992;305:998-9. (24 October.)

2 Pitt B. Abusing old people. *BMJ* 1992;305:968-9. (24 October.)

3 Ogg J. Elder sexual abuse—the last taboo. *Geriatric Medicine* 1992;22:10.

Applying for disability living allowance

EDITOR,—As one acquainted with medical assessment for the Department of Social Security's mobility and attendance allowance I am, along with Philip Steadman, astonished by the Automobile Association's survey of disabled drivers, 50% of whom are reluctant to undergo medical examination. Perhaps leading questions were unfairly used. Certainly my own experience has been that applicants, normally well accustomed to examination by doctors, rarely if ever resented examination and usually welcomed the additional attention given to their disability.

A far greater deterrent is the length and complexity of the self assessment forms that are required to be completed when applying for the new disability living allowance. Section 1 is 12 pages with about 200 questions and section 2 is 28 pages with about 250 questions. One half page in section 2 is given over to the "customer's" general practitioner and has three small boxes for main diagnosis, other conditions, and additional information. Not surprisingly many of these forms are sent in with most questions unanswered, and I have seen some with only two or three answers given. In some cases these have been from elderly or mentally handicapped patients and some, I suspect, who just have not had the stamina to complete such a marathon. Many others must surely have been deterred from ever starting the application process. A free telephone advice service is available and is no doubt helpful to those disabled people who have a telephone and possess the expressive and receptive powers to benefit from a brief telephone conversation. Even assuming that a substantial proportion of the self assessment forms adequately completed do get through to the department, inevitably some respondents will belittle their disability and rather more will exaggerate. How can the department's adjudication officers, even backed by their medical officers, be expected to fairly and accurately determine functional impairment and need for help and supervision?

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1 Steadman P. Applying for a disability living allowance. *BMJ* 1992;305:893. (10 October.)

EDITOR,—I agree with Philip Steadman that more disabled people qualifying for a disabled living allowance should apply for such help.¹

Though half of those questioned by the Automobile Association avoided claiming because they did not want a medical examination or were afraid of humiliation or unfairness, many disabled applicants welcome an examining doctor's visit. For some it may be the first time anyone has seriously discussed their problems in their home. The interview does not entail intimate examinations but studies how the disability impairs independence.

I am disabled, and in my view the new application form is not satisfactory. It allows for too much subjective assessment and too clever persuasive answers on the one hand and for underrepresentation of the problems on the other. It must be expensive to produce and to process; confidentiality may be difficult to ensure. If all general practitioners knew all their disabled patients and their home environment well and were well trained in assessing disabilities their comments might be adequate. As things stand, trained medical assessors are desirable.

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Unemployment and health

EDITOR,—I am a British general practitioner temporarily working in Oman. Each year that I return to Britain I am painfully aware of increasing social divide and a distinct underclass developing, and of a very divisive society. I agree with Richard Smith that the recent announcement by the Conservative government and the Coal Board of the immediate loss of 30 000 jobs and the closure of numerous pits will doubtless have serious knock on effects on the affected communities.¹

During the early '80s I worked initially as a general practitioner and later as a registrar in psychiatry in south Yorkshire. I stood by and watched helplessly as homes, families, and communities were systematically destroyed and the coal and steel industries decimated. When will this government realise that there is a human cost in all of this—that no amount of redundancy payment will restore a person's self esteem? These mining villages and communities have a social infrastructure of support but their whole fabric is crumbling.

I feel so angry about this: the government seems blind to the recommendations of people in the front line of dealing with this kind of social and economic disaster. Is there any chance of members of the BMA exerting pressure on the government? Several British doctors currently working in Oman are equally angry at the British government's blinkered approach. We would be willing to help in any way. How can we effectively register our protests? The feeling of impotence in the face of great social injustice is difficult to cope with.

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1 Smith R. "Without work all life goes rotten." *BMJ* 1992;305:972. (24 October.)

EDITOR,—In his editorial Richard Smith discusses the "ravages of joblessness."¹ I am a general practitioner in south London; in our ward nearly 60% of the men of working age are unemployed. The women fare little better. So often a patient is in despair. He or she is out of prison or is trying to stay off drugs or alcohol, but life is so empty that

crime, "doing drugs," or alcohol makes life more exciting and tolerable. The boredom and lack of opportunity to start a new life soon change hope and good intentions into disillusionment and relapse.

Do colleagues have any ideas or know of successful community rehabilitation schemes to help these people find a new structure in their lives and find companionship and self respect?

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EDITOR,—Like most general practitioners I see the adverse effect of unemployment on health every day.¹ I also see the effect that the current economic situation is having on the health of those still employed, many of whom are being asked to do the work formerly done by two, three, or even more people. Their families are also presenting with problems attributable to the strain on the working member. The cost to health of unemployment extends way beyond those who have lost their jobs.

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Drugs and the exercise test

EDITOR,—K W Muir and colleagues draw attention to the wide variation in policy concerning a fundamental yet practical aspect of exercise testing: whether cardiac drugs should be stopped or continued.¹ Their findings resemble those of the British Nuclear Cardiology Group, which reported that a third of centres routinely withdrew drug treatment before radionuclide ventriculography, a third did not, and a third depended on the requesting clinician for specific instruction.²

Muir and colleagues' recommendation that all drugs should be stopped before exercise testing takes no account of the purpose of testing. We agree that diagnostic testing should be performed off drug treatment if the main aim is to see whether there is inducible ischaemia—for example, when the diagnosis of ischaemic heart disease is in doubt. When clinically there is already a strong likelihood of underlying coronary artery disease, however, the value of exercise testing shifts to its ability to assess prognosis. In this context we believe that prognostic testing gives more meaningful and useful results if undertaken without interruption of treatment.³

In mildly symptomatic patients referred for prognostic coronary angiography the accuracy of exercise testing before angiography in predicting prognostically important patterns of coronary anatomy (as a surrogate end point for worse prognosis) was unimpaired by treatment in the case of exercise electrocardiography⁴ and was enhanced in the case of exercise radionuclide ventriculography.⁵ These data suggest that in the assessment of prognosis in patients who are well controlled but nonetheless have a high clinical probability of disease, exercise testing should perhaps be undertaken only on treatment, and that there may be no additional role for testing off treatment. The ultimate question is, can coronary revascularisation and therefore angiography be safely deferred in medically treated patients with minimal symptoms unless results of exercise tests on medical treatment are "bad" or deteriorate? The resource implications point to a need for a randomised multicentre study of this important

clinical issue to rationalise the selection of patients for invasive coronary angiography and revascularisation.

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Using guidelines

EDITOR,—We agree with Andrew Haines and Gene Feder¹ that detailed guidelines are more likely to be effective if they are implemented locally and are used interactively within the consultation.² Advances in primary care computing allow interactive guidelines to be presented on screen during the consultation.

In the United Kingdom there are now two clinical primary care computer systems (EMIS and AAH Meditel) that can use data stored in the system to generate patient specific prompts based on relatively complex guidelines. Such computer assisted guidelines will allow the needs of individual patients to be met in a more sophisticated manner than paper records and guidelines can offer. In addition, these "live" clinical guidelines can record a structured clinical record using Read codes; this will improve the assessment of health needs, enable outcomes to be measured, and in the long term provide the means for measuring health gain.

These interactive systems have yet to be scientifically validated, though non-interactive computerised guidelines have already proved their effectiveness.^{3,5} The Derbyshire integrated care diabetes project is currently addressing many of the issues raised by the authors concerning the process and outcome of health care activity across the interface of primary and secondary care.

We are confident that, in the future, effective clinical guidelines will be used interactively within a computerised medical record.

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Severity of imported malaria

EDITOR,—We were interested to read that female sex is associated with severe malaria.¹ Non-immune pregnant women, especially primigravida women, are susceptible to severe malaria. Morbidity is particularly high in the first 20 weeks.² Could early pregnancy have been a confounding factor?

Stephen J Lewis and colleagues suggest that the later presentation of patients taking prophylaxis may have been due to the onset of milder symptoms. An alternative explanation could be that patients taking prophylaxis consider that they are protected from malaria and initially attribute their symptoms to flu. When working for a company in west Africa we found that many of our expatriate patients considered that they were immune to malaria if they took their prophylaxis regularly.

The suggestion that "there may be some genetic advantage [against severe malaria] in this ethnic group [Africans]" is an understatement. Far more genes are known to influence susceptibility to falciparum malaria than any other human disease. The best example is the gene causing sickle cell trait, which occurs in up to 30% of tropical Africans. Recent case-control studies in the Gambia and Kenya have shown 90% protection from cerebral and severe malarial anaemia in children with sickle cell trait.³ Thalassaemia, the commonest genetic defect in humans, also protects against malaria. This defect occurs in up to 38% of tropical Africans.

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- 1 Lewis SJ, Davidson RN, Ross EJ, Hall AP. Severity of imported falciparum malaria: effect of taking antimalaria prophylaxis. *BMJ* 1992;305:741-3. (26 September.)
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- 3 Hill AVS. Malaria resistance genes: a natural selection. *Trans R Soc Trop Med Hyg* 1992;86:225-6.

EDITOR,—In their investigation of the influence of chemoprophylaxis on the severity of malaria in travellers Stephen J Lewis and colleagues, in their own words, "used data collected under field conditions" to test a precise hypothesis on which several other relevant variables, which may not have been recorded in the case notes, have an undoubted influence.¹ A variable not included in their analysis is the patients' use of treatment for malaria.

In a prospective study of 249 non-immune patients with malaria admitted to the Hospital for Tropical Diseases 70 had received malaria treatment, 28 within a month of their first symptom. Chloroquine was the main drug used and has an elimination half life of over 30 days. This may well have affected the severity of the disease and clinical presentation. In contrast with Lewis and colleagues' results, our analysis of the seven day latency in non-immune subjects (malaria presenting within seven days of return) showed similar proportions of travellers not using prophylaxis (23/43, 54%), taking inadequate prophylaxis (34/65, 52%), and reporting full compliance (23/45, 51%). This analysis excluded 96 of the patients, whose first symptom occurred abroad.

The authors' hypothesis is not supported by data on the impact of chemoprophylaxis in fatal malaria. In 89 of 99 fatal cases reported by surveillance bodies in the United States and Britain (Malaria Reference Laboratories, personal communication)² data on use of prophylaxis were available. Two fifths of the patients were using chemoprophylaxis at the time of presentation with malaria. The mean time to clinical presentation was 6.5 days in those who were not using chemoprophylaxis and 7 days in those who were (*t* test, *p*=0.6). Thus in this