Institutional abuse of older people

Sir,

In his editorial in this issue (Vol 60(6), 1999, p. 396), Dr Bennett has written passionately about the abuse of older people in institution. Although little is known about the prevalence, this is a serious problem as shown by recent shocking reports, such as the Beech House Inquiry, and the evidence of organizations such as Action on Elder Abuse and Counsel and Care. But there is a lack of systematic empirical research.

First we need to find out the scale of the problem and the circumstances in which it occurs. There must be a willingness on the part of funders to commission such research. It is still of low priority compared with research on the abuse of children. Such research is not easy either to conceptualize or undertake. Different types of abuse may have different types of perpetrator and different types of victim, although perpetrators have surprisingly shown a willingness to cooperate with research as Olive Stevenson has so convincingly demonstrated (Stevenson, 1999). This kind of research needs a level of sophistication and a variety of methods that are not for the inexperienced.

The second issue is what to do about the abuse. We need to know more about strategies for intervention. The quality of staff is crucial. Sadly work with older people is neither well paid nor does it carry the prestige of other groups. It is at the top that action must start. Without commitment to a culture of care from those who are responsible, nothing will ever change. Of course inspection and whistle-blowing will help, but it is something more fundamental — a change of attitudes towards older people — that is wanted. In the UN Year of Older People would this be too much to ask?

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Stevenson O (1999) *Elder Protection in Residential Care. What can we learn from child protection.* Department of Health, London

Sir,

Dr Bennett's editorial is a sad indictment of the quality of care received in certain forms of long-term care. A letter that appeared in the *Times* on 9 November 1965 highlighted the problem of abuse of geriatric patients in certain mental hsopitals, and this editorial suggests that the abuses noted over 30 years ago continue to appear with a saddening regularity.

The government has suggested in the new White paper 'Modernising Social Services' that it will not tolerate such abuses. Strict inspection is certainly necessary. However, other agencies have a role to play, for example the UKCC and the new General Social Care Council. These agencies can send a clear message that individuals found to be abusive practitioners will be excluded from their registers. On a preventative note, it is time that elder abuse and domestic violence become mainstream topics for the medical and nursing curricula (Kingston et al, 1995).

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Kingston P et al (1995) Is elder abuse on the curriculum? The relative contribution of child abuse, domestic violence and elder abuse in social work, nursing and medicine qualifying curricula. *Health Social Care Commun* **3(6):** 365–62

Coronary heart disease in China

Sir,

Tomlinson and colleagues (Vol 59(7), 1998, p 549) are correct in that the prevalence of coronary artery disease remains considerably lower in the urban Chinese population than in many Western countries. But I beg to disagree with their statement that 'the prevalence of coronary heart disease has not changed much'.

The prevalence of coronary heart disease has changed considerably in China in the past five decades. Ischaemic heart disease in China has migrated from fifth most common form of heart disease in 1948–58 to second most common in 1959–71 and most common in 1972–79 (*Table 1*) (Tung and Cheng, 1987) where it remains (Cheng, 1997a).

Besides the increases in dietary fat in young people and rising rates of diabetes in the old population, as pointed out by Tomlinson et al, cigarette smoking also played an important role. China ranks as the first in the world in its population and also in output of tobacco products (Cheng, 1990). China today has the biggest smoking habit in the world (Anonymous, 1988). One of every three cigarettes manufactured in the world is consumed in China (Peto, 1994).

Fifty years ago in China, when the present government came to power, the chief cause of death was poverty-related problems — malnutrition, infectious diseases, famine and warfare. Now, while all these causes have been eradicated, the government which has built its legitimacy on doing a better job for the social welfare of the 1.3 billion Chinese people than all the dictators, warlords and emperors of old, has to combat a new disease, a disease of affluence — cigarette smoking, which is the single most important cause of death in modern China. China is about at the stage where the USA was in the 1940s and 1950s when the smoking rate was very high. As China's modernization programme calls for catching up with the Americans, if the Chinese smoke like Americans, then they will die like the Americans.

There are other risk factors which include decreased physical activities as a result of increased mechanization and stresses of urban living. Can we achieve a utopian stage in the 21st century in which the modern Chinese retain their ancestral low rates of cardiovascular diseases while adapting the positive aspects of a modern Western lifestyle (Cheng, 1997b)?

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TABLE 1.
Changing proportion of various types of heart disease in Shanghai, 1948–79

Aetiologic type	1948–58 (%)	1959–71 (%)	1972–79 (%)
Ischaemic heart disease	6	13	29
Rheumatic heart disease	50	40	26
Congenital heart disease	4	9	15
Myocarditis	1	2	8
Chronic cor pulmonale	8	11	6
Hypertensive heart disease	16	12	5
Cardiomyopathies	1	1	3
Pericarditis	2	2	1
Syphilitic heart disease	7	2	1
Thyroid heart disease	2	1	1
Others	3	2	5