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Report of a Conference

in London

18th January, 1947

Chairman: LORD AMULREE, M.D., F.R.C.P.



LONDON COUNCIL OF SOCIAL SERVICE

7 BAYLEY STREET, W.C.1

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Catering Services for Invalids

DR. F. AVERY JONES

CATERING for invalids must first be viewed in perspective with other forms of treatment. The patient may be assisted to overcome a disease process in his body in the following ways. Increased rest will diminish the strain on the body and on the affected region. Suitable and adequate nutrition will supply the material for repair of the tissues. Symptomatic medicines will assist in diminishing the strain on the body by alleviating troublesome symptoms, such as cough or insomnia. Specific remedies may provide an essential missing link, e.g., insulin for diabetes, or have a neutralising effect on an infection, e.g., penicillin and sulphonamides. Finally, surgery may enable a mechanical difficulty to be overcome.

There are most important specific treatments available to-day: Insulin for diabetes, liver extracts for pernicious anaemia, thyroid for myxoedema, digitalis for heart failure, penicillin and sulphonamides for many, but not all, infections. Nevertheless, the major part of the practice of medicine to-day is non-specific and consists of helping the body by rest, proper food and symptomatic drugs.

It is well-known that suitable and adequate food is a first essential for initial recovery, for convalescence and sometimes for the prevention of further illness. During an acute illness, the body ensures a supply of certain essential nutrients needed for repair by breaking down its own tissues. This breakdown of body tissue is minimised but not entirely prevented by adequate food and hence the need for continued special feeding during convalescence.

Lack of Proper Feeding at Home

Good feeding during illness is often a major difficulty at home. To-day there is no surplus of aunts ready to fill a domestic gap, there are few domestic servants and the supply of home helps is scanty. The woman with acute bronchitis may have young children at home, the ill man may have a wife at work. The doctor can prescribe sulphonamides which will cut short the illness, but he cannot supply the food while the unattended patient stays in bed. Would it not be good practical medicine if he could arrange for that sick man to have food sent to him at home?

Admissions to Hospitals

Patients are admitted to hospital, often for an acute medical or surgical emergency, but at least 10-15% of admissions are not for any specific treatment, and need only rest, food and medical supervision which could be provided at home. The stress of domestic circumstances has driven the doctor to arrange admission to the busy hospital: the cripple living by herself, the frail old lady with a varicose ulcer keeping her in her bed, the man with acute dyspepsia, whose wife is debilitated after a confinement, the elderly woman who has had a slight stroke.

Catering assistance is obviously only one facet of the problem, but in many cases might enable the patient to stay at home under the doctor.

Maternity cases at home without nearby relatives would find a food delivery service at least for the midday main meal an inestimable benefit.

It is possible that working in a municipal hospital, I see a more representative cross-section of the medical problems of the community than senior staff at the large voluntary hospitals. At my municipal hospital there is no selection of admissions. Everyone sent there has to be admitted as a statutory obligation. The teaching hospitals quite rightly pick and choose their admissions for teaching purposes. The non-teaching voluntary hospitals have no legal responsibility to provide a comprehensive medical service and select the patients in a remarkable fashion. Elderly folk who may block a bed for some weeks, inoperable cases of cancer and other chronic illnesses, abortions which might have legal repercussions, all these are referred at all hours of the day and night to the nearest municipal hospital. Having had considerable experience in observing the personal and medical problems concerned with these unfortunate sufferers, I know that many of these folk come into hospital, not for any specific treatment, but because their domestic situation has become impossible.

Hospitals are short of nurses and have even closed wards from lack of staff. They must continue to treat the vital medical and surgical emergencies and must concentrate on them. Could not the admissions occasioned by domestic stress be reduced?

Food Delivery Service as an Alternative

A food delivery service in every London borough would help to provide an alternative to hospital admission. A proper midday meal delivered to the patient would bridge the difficult gap between the time the working members of the family leave home, and their return. It is perfectly feasible and is already done on a small scale by the Invalid Kitchens of London.

There is another way in which a special feeding service could reduce hospital admissions. Old people living by themselves do not always eat enough and this produces a vicious circle. They lose energy and have less inclination to queue and cook, their resistance to illness is diminished and they come into hospital with bronchitis, anaemia and other maladies directly conditioned by their malnutrition. When an old age pensioner visits her doctor with early symptoms, he cannot actively assist her to break that vicious circle. Suppose he could arrange for her to visit a local special feeding centre where she could get a well-cooked nutritious midday meal. Would not that be better medicine than the white bottle of placebo? This again is entirely feasible and is available on a small scale in London from the Invalid Kitchens.

Association of Feeding Centres with Hospitals

Such special feeding centres could be co-ordinated with the rehabilitation unit of a general hospital. A patient who has fractured his limb or had a severe septic hand, cannot go to a convalescent home if he is being rehabilitated. Yet he is in special need of nutritious food. Patients convalescent from major operations would certainly find such a service a useful alternative to convalescent homes, for which there are often long waiting lists. There is little doubt that such facilities would help to diminish the time before return to work, a gap which must be shortened for the sake of the individual and of the community.

Such centres could make a useful contribution to preventive medicine. Gastric and duodenal ulcer is a very prevalent condition amongst all classes of society. A survey is being undertaken in London and the preliminary findings show that over five per cent. of men in the factories visited have, or have had, gastric or duodenal ulcer. Many of them are subject to recurring attacks of acute dyspepsia and need a light diet. Fried fish and chips is an excel-

lent meal for the healthy worker, but can be guaranteed to annoy a gastric ulcer and an unsuitable diet may hinder the healing process or even initiate a recurrence.

Peptic ulcer is a cause of tremendous loss of time to the community and it accounts for between 5 and 10 per cent. of the acute beds in a general hospital. These ulcers tend to affect particularly the over-energetic, over-conscientious worker with a high sense of duty, and the loss of his services to production will not pass unnoticed. The worker with a peptic ulcer should have access to a proper diet lunch. Ideally, he should at once stay at home in bed. In practice the majority remain at work until driven by constant pain, haemorrhage or perforation into hospital. A special diet facility may tip the scale in favour of the ulcer-healing process. Many of these dyspeptic workers have long histories of remittent dyspepsia and know from hard experience that a light diet helps to keep them free from further trouble. It is difficult to rely on a suitable diet in public restaurants and a special diet centre is a real boon for such sufferers. Such a centre in each London Borough would be a most valuable contribution to preventive medicine.

Canteens in Factories

In an industrial area, such a centre, useful though it may be, would touch only the fringe of the problem. A factory employing 600 men will have at least 30 employees with an ulcer history and at least 20 will appreciate facilities for light diet. This can be easily organised in the canteen and is already arranged in a number of factories. Catering for workers with gastric or duodenal ulcer is perfectly simple and makes no undue demands on canteen staff. It is idle for doctors and hospitals to advise the transport worker, the skilled artisan, the stoker, to keep to a light diet if the canteen makes no provision for him. Personal experience has shown that the majority of factories are now anxious to accept any advice that comes from the local hospital. Such facilities are well received by the industrial workers. The hospital is anxious that the individual should not have to be re-admitted, the worker appreciates the interest taken and the executives have long since realised the value of healthy staff.

Such advice from hospitals to local industry does need initiating and assisting. In this respect, an advisory centre can fulfil a valuable rôle and the Invalid Kitchens have provided a personal

service for canteen manageresses. Fifty factories have availed themselves of this service. The Factory Department of the Ministry of Labour have issued a pamphlet, the Industrial Welfare Society furthered the work by organising a special conference in 1945.

Permanent Advisory Service

I visualise a permanent advisory service, staffed by able dietitians to help individuals, housewives, canteen manageresses and domestic science students. All aspects of invalid catering could here be co-ordinated and important propaganda devised. For instance, with a suitable backing from the medical profession such a centre could undertake a practical campaign against gross obesity, a cause of much invalidism and unnecessarily prolonged hospitalisation. A mere stone of extra weight in middle age lessens a man's expectation of life by about ten per cent. and fifty pounds overweight at age 45 imposes as much extra mortality as valvular heart disease. Such an advisory centre could dovetail with the existing Ministry of Food advice centres which have done such excellent work. Should this ministerial activity come to an end, in less austere times, their work could be continued.

The special feeding of invalids is only one part of a comprehensive nutritional policy. The feeding of old age pensioners by special centres, the Londoners' Meals Service, the B.R.C.S. "meals on wheels," need co-ordinating. The London Council of Social Service have made an important move in organising this conference. The first essential must be to formulate an objective; this should be a comprehensive, reliable, efficient meal service for invalids and old people. For invalids this should be regarded as a para-hospital service and available on a medical recommendation. A small co-ordinating committee, sponsored by the London Council of Social Service would be an excellent initial step.

Its proposals should then be submitted to the Ministry of Health, who should decide whether the responsibility for such a service rested with the local authorities or with the Regional Hospital Board. In either case, some of the work could be delegated to existing organisations. The Invalid Kitchens of London have a strong claim to official recognition and support, and have served London for forty years. They already have centres in seven London boroughs and have initiated a programme to modernise

and extend their valuable work. To equate services with the needs of London will demand vigorous financial support. It may be that local boroughs, recognising the need, may themselves develop a fine catering service for invalids and old people. It matters not who does the work as long as it is done, and done efficiently.

Well-organised catering services would be a valuable contribution to preventive medicine and would appreciably help to relieve the present strain on hospital accommodation.

The Special Needs of the Aged

DR. MAGNUS PYKE

IN considering the nutritional requirements of the different groups of people within the population, we are accustomed to think of the special needs first of expectant mothers, then of infants, then of children, and next of adolescents. Last of all we consider the requirements of adults. Within this large group of people of, say, 20 years of age or more we usually make no distinction. There is some reason for concentrating on children and the young, since dietary injury inflicted at the beginning of life might be expected to do damage which would last throughout the years. Nevertheless the neglect to study the physiological changes of old age is unscientific and is also calculated to-day to lead to unnecessary hardship and a loss of happiness and efficiency in a group of the population which is steadily increasing in numbers. Many of the important advances in the newer knowledge of nutrition which have been achieved the last 25 years have been based on the study of young animals. It is true to say that there are now many serious gaps in scientific knowledge of the physiological requirements of the old.

The Requirements of Different Age Groups

There are no abrupt breaks in development and growth which can justify the rigid division of a population into infants, children, young and middle aged and old people, although it is often con-

venient to make these groupings. Animal life, in many of its phases, takes the form of a smooth curve. Performance of many functions develops in childhood, reaches a maximum usually in early adult life, and thereafter steadily diminishes. Korenchevsky (*Ann. Eugenics*, 1941-2, 11,314) has collected from the literature a great deal of evidence showing the progression of the changes of functions concerned with perception, physical performance and intellectual achievement in increasing age. To take a single example from this data, visual acuity is greatest at the age of 20. At 35-40 years, there has already been an average loss of 15% and deterioration steadily increases with advancing age.

Experiments on Rats

The main difference in the differing nutritional requirements of the first two decades compared with those of adult life arises from the needs for growth. However, it has been clearly shown by McCay and his colleagues (cf. Cowdry, 'Problems of Ageing,' Baltimore, 1942) that in the case of rats the length of the growth period can be changed by diet and the span of life thereby substantially prolonged. Before we attempt to review the specific needs of the old it is, perhaps, interesting to see how nutrition in earlier life can, at least in rats, influence the length of life. More than a hundred years ago Edmunds (*Life tables*, London, J. Duncan, 1832) devoted a book to the thesis that alternate periods of hardship and prosperity afforded one of the secrets to a long life. He claimed that adversity in youth tended to retard the rate of maturing and estimated that an increase of a year in the duration of infancy tended to increase adult life by seven times this amount.

McCay's studies with rats were carried out in the following manner: In all cases the animals were given diets which provided an adequate daily allowance of protein, minerals and vitamins. One group was given sufficient of the diet to permit the rats to grow at a normal rate. The mean life span of this group was 600 days. Two further lots of rats were given the same diet but in amounts insufficient to supply their calorie needs for growth. Growth was artificially checked in this way for 700 and for 900 days before the animals were allowed to grow to maturity. Members of both the retarded groups were alive when all the normally fed rats had died of old age. This type of experiment has now been repeated many times and has always shown that those rats whose early diet is

restricted in quantity long outlive those whose youthful growth is allowed to proceed at a rapid rate. Thus the work done at Cornell with rats in the 1930's seems to verify Edmunds' hypothesis for man which first appeared in the 1830's.

In considering the work of McCay, it is important to remember that, although he lengthened the average age of survival of rats by restricting the amount of food they obtained in early life, the actual diet used was a well-balanced one. Nothing which has been discovered in this field in any way refutes the value of a properly chosen diet during the early years of growth and development. On the contrary, Sherman and his co-workers (Sherman and Campbell, J. Biol. Chem. 1924, 60, 5; Sherman, Campbell and Rice, J. Nutrition 1937, 14, 609) showed that when a tolerable but not perfect diet, which was good enough to permit the growth and reproduction of rats, was improved by the addition of milk and other supplements, the mean length of life was increased by about 10%.

Calorific Requirements of the Aged

Although our knowledge is by no means complete we do possess some information on the specific needs of the aged. There is a certain amount of information on the metabolic needs of old people to be found in the literature. Much of this has been summarised by Leitch (private communication, 1946) and suggests that the basal metabolic rate of men from 60 to 80 years of age is of the order of 1,400 calories and of women 1,100 calories. If 10% is added to this in the usual manner to allow for specific dynamic action and a moderate estimate made for a measure of muscular activity the net average requirements would be for men between 2,200 and 2,300 calories and for women 1,700 to 1,800 calories. Since it is generally considered that the calorific requirements of normal sedentary adults are 2,500 for men and 2,100 for women, the energy needs of the aged appear to be about 15% below the accepted standards. Is it wise, however, to accept the implications of this evidence unquestioningly? The changes in metabolic rate throughout life and the gradual fall in old age which have been recognised for nearly a hundred years have been given much attention by Benedict and Root (Proc. Nat. Accd. Sci., 1934, 20,389). Although their data shows the generally accepted trend, it also indicates clearly the wide fluctuations from the average curve that must be expected. Benedict in a later paper (New England J. Med. 1935, 212, 1,111) in

a series of measurements upon women between the ages of 66 and 88, found that although the average basal metabolism was about 1,000 calories per 24 hours, individuals varied from 799 to 1,549 calories.

Protein, Calcium and Phosphoric Requirements

There is no evidence to show that the protein requirements of old people are any less than those of younger adults. Few studies of nitrogen balance have been made. Adams, Boothby and Snell in 1936 (*Amer. J. Physiol.* 114,383) studied a woman of 65 years of age for 19 weeks. With an intake of 1.4 g. of protein per kg. body weight, falling later to 1.2 g., she was in positive balance and retained about 5 g. of protein daily. In a second study, Owen, Irving and Lyall (*Acta. med. scand.*, 1940, 103,235) found that four men between 69 and 79 years old stored nitrogen when their protein intake was 0.87 g. per kg. body weight, but one lost nitrogen when the intake was lowered some 10%. Benedict and Root's study of a 91 year old man (*New England J. Med.* 1934, 211,521) suggests that he was maintained in good health with a protein intake equivalent to 0.86 g. per kg. The average requirement for nitrogen equilibrium of normal adults is usually considered to be about 0.83 g. of protein per kg. of body weight which is close to the values found for the old people studied.

The calcium and phosphorus requirements of old people are of practical importance in view of the susceptibility of the aged to bone injuries. Here again one must admit that although the experimental evidence available suggests that the needs of old people are similar to those of other adults we have insufficient information to be able to dogmatise. The subject, like so many aspects of the nutrition of the old, needs further and more thorough study. Adams, Boothby and Snell showed that their aged subject was in negative balance on a basal intake of 0.41 g. calcium daily but stored considerable quantities of calcium when consumption was increased. Owen (*Biochem. J.* 1939, 33,22) studied ten men all over 60 years of age and concluded that their calcium and phosphorus requirements for metabolic balance were no different from those of younger adults and were of the order of 0.52 g. calcium and 1.2 g. phosphorus daily. These conclusions are supported by the work of Robertson (*Lancet*, 1941, 241, 97). The capacity to store calcium is not lost in old age and is facilitated, as in the case of the young,

by vitamin D. Nevertheless, McCay found that although the diets of his rats were designed to supply an adequate allowance of calcium as well as all other nutrients, when he artificially lengthened their life to nearly four years their bones became so fragile that they were crushed by the scalpel in the process of dissecting the muscles. (McCay, Crowell and Maynard. *J. Nutrition* 1935, 10, 63). Once more we are brought to see, by reviewing the little we do know about the needs of old age, the extent of what we do not know and must set about investigating. The progressive demineralisation of the skeleton with the development of physiological old age is well known. Whether or not this process can be influenced by nutrition remains to be discussed. The subject is, however, clearly of importance in studying the special needs of the aged.

Iron Requirements

Iron does not appear to be of special significance in the nutrition of old people. Davidson and Fullerton (*Edinb. Med. J., N.S.* (IV) 1938, 45, 1) in their survey of the incidence of anaemia found none in old age except where organic disease was present. The average haemoglobin values of women rise rapidly after the menopause. This finding was confirmed by Worster-Drought and Shafer (*Brit. Med. J.* 1939, ii, 273) who stated that anaemia was uncommon after the age of 50 and rare between 60 and 70. This evidence suggests that the iron requirement of the old is probably less than that of younger adults; indeed, Davidson and Fullerton state that old women can maintain a normal haemoglobin and iron balance on as little as 4 mg. iron daily.

Vitamin Requirements

Nothing precise is known of changes in the vitamin requirements of the aged. So far as B-vitamins are concerned, since the requirement is influenced by the calories of the diet derived from nutrients other than fat, the needs of old people will be less than those of others in proportion as their calorific requirements are smaller. There is some evidence (Seefried, v. Graefes, *Arch. Ophthalmol.* 1938, 138, 620; Remp *et al*, *J. Ment. Sci.*, 1940, 86, 534; and Rafsky and Newman, *Amer. J. Med. Sci.*, 1941, 201, 749) to suggest that the needs of vitamin C in old age are increased. In considering this aspect of the nutrition of old people, however, two related factors must be borne in mind. Firstly, the diet eaten by old people is frequently much restricted in variety either from choice or through

difficulties in biting and digesting. Secondly, hypochlorhydria, the secretion of less active saliva and possibly other losses in digestive efficiency may affect the absorption of vitamins from the diet.

When we try to summarise our information on the special nutritional needs of the aged we see that there is an unsatisfactory story to tell. The requirement of calories is less than for young adults but so far as nutrients are concerned we are compelled to assume, without proof, that the needs of the old are the same as those of normal young individuals. McCay is right when he says: "In the past all nutrition research has centred its efforts upon the first half of life. In spite of the importance of the latter half of life in human well-being this field has been neglected."

Conditions in Vienna

Nutrition is a science which, if it is to be wisely studied, must cover a wide field. When we attempt to assess human nutrition we must do more than work in the laboratory. In investigating man we need to study him in his biological environment. Vienna is at the moment an interesting experiment of applied nutrition in a human community. During the six months from March to October, 1946, the food distribution was arranged to provide as closely as possible the minimum nutritional requirements of the different physiological groups making up the population. Under this plan, based on current nutritional knowledge, the rations for old people were the same as those available to other sedentary adults. Yet the older people as a group have become substantially more underweight than younger adults.

The state of affairs existing in Vienna under conditions of rather severe food stringency could be said also in part to obtain in Britain. One must suspect that a number of old people, subject here to similar if less extreme circumstances, also suffer nutritionally. There is clearly need for study. We must tackle the fundamental biochemical and nutritional problems of ageing. But also and more immediately we must investigate the diets which old people are at the present time eating in this country so that we may at least apply the knowledge which we possess now of nutritional requirements. Stephenson, Panton and Korenchevsky (*Brit. Med. J.* 1941. ii, 839) showed that improvement in the condition of aged patients in a hospital was brought about in numerous cases by giving supplements of B- vitamins and vitamin C. These results

suggest that the diet eaten was deficient in these factors. Spier and Collins (*J. Gerontology*, 1946, 1, 33) have demonstrated that the hand of a woman of 30 suffering from pellagra curable solely by improved diet, had the appearance of that of a person of 50. We cannot estimate to what extent the appearance of senescence to be seen in this country is due to dietary deficiency if we know nothing of the quality of the diets old people eat here. Accurate surveys of food consumption are not easy to do. If they are to be carried out successfully they need intelligent co-operation on the part of those people studied, as well as skill and competence in those making the investigations. The London Council of Social Service will be making a valuable contribution to the problem if it can help to bring together scientific workers and the aged people whose special needs are so urgently calling for study.

Action by Local Authorities and Voluntary Agencies

MR. FRED MESSER, M.P.

MR. MESSER began by expressing his pleasure at the increasing interest which was being taken in the welfare of old people. In his view one of the tests of our civilisation was how we treated the old and the young. As one of the members of the Survey Committee of the Nuffield Foundation which had just issued its report he recommended the audience to read that report. The definition of old people adopted in the Nuffield report was that of Old Age Pensioners: men over 65 and women over 60. But, in Mr. Messer's view the thing to do was to have regard to the degree of disability rather than to age itself.

There had been a tendency in the past to regard old people at home as a nuisance. This might not be openly stated, but it was a fact, and if it were possible to get the old person into a home for old people it was done. Some of these homes, or rather institutions, Mr. Messer feared, were not much better than they had been in

the days of Charles Dickens. Old people might be divided into three groups (1) old people who led an independent life in their own homes, (2) those who needed some care and attention elsewhere, and (3) the 'chronic sick'. Mr. Messer did not like the term chronic sick and would prefer 'long term sick' or some expression of that kind. The Conference would do good service if it drew attention to the problem of providing food for the aged. It might be that some of the work now being done by voluntary organisations should be done by Local Authorities.

As to the amount of the old age pension, he regarded it as a minimum. One way of supplementing it might be by the provision of meals, but that would involve some alteration in the law. Under Section 29 of the National Health Service Act, a Local Authority had power to provide domestic help. In Mr. Messer's view, if old people could not do what was required in their own home, domestic help should be provided. This would mean that a large number of old people who now went to institutions would be able to remain at home.

It was important that old people should get at least one main meal a day. Under the new legislation County Councils and County Boroughs would be the Health Authorities. They should see to it that communal restaurants were provided. As for the old who could not go out for meals, they should be visited and help given with the mid-day meal. Domiciliary Assistance should be granted on a more generous basis to the old as it is to the blind. While it was true that many old people would have to live in institutions, when houses were built for old people they should be of a special type. Where they were grouped together the residents might be provided for from a kitchen serving a common dining room.

Mr. Messer went on to urge that old people should not be segregated and that young people should not lose their sense of responsibility towards the old. To visit them on Sundays with the gift of a few flowers was not enough. As to the young living in the same house as the old, this was not very desirable where there were grandchildren. Where the domestic situation was such that food could not easily be provided for old people, it should be sent to them in containers. This service had been provided by voluntary agencies, but there was no reason why it should not be undertaken by Local Authorities or by subsidy to voluntary agencies.

Speaking of the food provided in institutions and hospitals, Mr. Messer said that sometimes, although the cook was good, the meals were unappetizing. The conclusion had been reached that food should not be left under the supervision of the matron. Each hospital should have a catering manager who should see that food was prepared according to the instructions of the dietician and should reach the ward in a form palatable to the patient. It was to be hoped that when hospitals became the responsibility of Regional Boards the special needs of the aged who were chronic or long-stay cases would be studied.

Luncheon Clubs and Mobile Meals Services

MISS ROSE SIMMONDS

TOWN planning schemes should include attractive communal restaurants, where nourishing meals can be eaten or bought and carried away into the houses of the people. Also, facilities should be allowed for the cooking of meals prepared by the tenants, especially in cases where the housewife is either ill or in employment.

Present Conditions

Invalid Kitchens of London, British Restaurants, Londoners' Meals Services and school meals services have all proved their worth, and there is no reason why these community feeding centres, where they exist, should not be extended to serve the requirements of individuals for light or special therapeutic diets.

Many patients leaving hospitals may require for a time some form of special diet, e.g. gastric cases, diabetics, obesity cases, which would be difficult to prepare under some home conditions, particularly where the housewife is employed in part or full time work. Old folks living alone, or as lodgers in families, could also avail themselves of these services.

It is well known that many old persons admitted to hospitals are incapacitated only because they have been existing for months on totally inadequate diets. They have not had the energy or the facilities for cooking or the appetite for the unsuitable food sometimes available to them, and they are unable to withstand the strain of shopping under present conditions.

Much nonsense has been written and talked about the specific properties of certain pre-war so-called special diets, which were nearly always successful in the treatment of some hospital patients, because they were calculated and built up from sufficient amounts of the protective foods, a practice which until recently was quite the reverse in the ordinary hospital diet. Catering officers in convalescent homes, canteens and restaurants are, therefore, shy of undertaking to provide special diets, until the food supervisors learn, with surprise, how easy it is to prepare them from the normal daily menus. Often, the only difference between a protective normal, and a special diet is in the method of presentation.

Many persons with gastric disorders must necessarily go on with specially prepared diets long after they are allowed to return to work, and meals suitable for such cases can be prepared by merely serving the same food cooked for other customers in non-residue form: minced meat, sieved vegetables, the same steamed pudding without fruit, which can be served with a sauce.

In the Invalid Kitchens, in many factory canteens and some British Restaurants, a meal of this kind not only serves persons with gastric disorders, but those needing a light diet for other reasons, such as those suffering with fatigue, or undergoing dental treatment.

In communal feeding centres and canteens, the daily menu may be modified to suit obese cases by increasing the vegetables and providing fruit instead of sweet dishes. Modern diabetic diets more nearly approach the normal, the only difference being that sugar is eliminated and starchy foods, such as bread and potatoes, are given by household measure or weighed.

Feeding Centres for Old People and Others

Similarly, food for old people can be modified or prepared to suit their needs and their appetites. The very few special therapeutic diets which have outlived the rationing conditions can be easily served in any canteen or feeding centre.

Others to be catered for are office workers and shop assistants, often young persons with limited time and means, who are forced to buy buns or sandwiches, which must be consumed in offices, or whilst walking about the street. Improved forms of coffee stalls might be provided for such persons in some of the side-streets.

The extension of communal feeding centres to include brightly furnished and comfortable rest rooms, which need not take up very much extra space, should not present insuperable difficulties. Such premises would be greatly appreciated, not only by young workers during their lunch hour, but by convalescents and many old persons who could spend most of the day happily in such surroundings, thus taking them out of homes where they are often lonely, unwanted, and sometimes rather a nuisance. It should be possible for all customers taking their meals in communal centres to carry away packed meals for home consumption. Such meals can be just as nourishing and palatable as the main meals and, in order to economize time and fuel, they can be prepared and cooked at the same time. The addition of a packed snack meal service would involve very few administrative changes in any feeding centre.

Mobile Meals Service

This presents rather different problems. Such a service should proceed either from the already existing meals centres, by means of suitably equipped vans; or, preferably, a number of such vans could operate from one large cooking centre.

Each van should be staffed with a driver and a helper, and should be furnished with adequate thermostatic equipment designed to hold meals, which may include hot and cold dishes. These containers could be left at the doors of people requiring the service; a double set of such equipment would allow of the collection of empty containers, when the full were delivered.

Customers for the mobile meals service might include convalescent patients discharged from hospitals, or those who have to continue to live out their lives as chronic sick cases in their own homes. Old persons, perhaps more than any other members of the community, may require this service which, in their cases as with the chronic sick, would necessarily be prolonged. These mobile meals services could never become entirely self-supporting and the question arises whether they should be provided by individual charities or local authorities or both.

Groups who might avail themselves of mobile meals services are (1) maternity cases in the home, (2) patients discharged from hospitals, needing convalescent treatment, (3) old persons, (4) those employing home helps or district nurses, as in the case of tuberculosis.

Consideration might be given towards transporting old people and some convalescents to communal meals centres such as by the adaption of the bus service provided for taking children to schools.

Local Authorities now provide mobile laundries, disinfestation vans and in some cases, far too few as yet, mobile meals services. At the present time, because of uncomfortable and crowded living conditions, there is an urgent need for the extension of the mobile services, which so efficiently met the needs of many people during the blitzes. Why should they not do so under present conditions?

Services Provided in London

The usual full charges in Invalid Kitchens and other communal feeding centres range from 1/- to 1/6d. per main meal. These can be fully met by some customers. For others, expenses could be covered by means of allowances.

The Invalid Kitchens of London run restaurants which supply meals for the aged and infirm, and special diet meals for gastric and diabetic cases. Some of these meals are distributed by van to individual homes. Particulars are as follows:—

Total meals served per day.				Mobile Service
Acton	...	...	90	Provided by Hammersmith Borough Council
Bethnal Green	...	...	50	Van supplied by the Invalid Kitchens of London
Lambeth	...	...	45	Van supplied by the Invalid Kitchens of London
Islington	...	...	40—50	Van supplied by the Invalid Kitchens of London
Southwark	...	...	50	Van supplied by the Invalid Kitchens of London
St. Pancras	...	...	40—50	Van supplied by the Invalid Kitchens of London
Stepney	...	...	20—30	No mobile service

Charges are up to 1s. for a full meal; some people offer to pay 1s. 6d., others pay nothing.

Other mobile meals services, delivering hot meals to the home, are as follows:—

Old People's Welfare Committees

Finchley	} The meals are cooked by the Londoners' Meals Service and distributed by the Old Peoples' Welfare Committee.
Battersea	...	...	...
Woolwich	...	...	...

Kensington	} The meals are cooked by voluntary communal restaurants and distributed by the Old People's Welfare Committee.
Chelsea	

British Red Cross Society

Greenwich	} Distribution arranged by the Society's "Meals on Wheels" Service.
Deptford	...	...	...
Westminster	...	...	...

Charges are 6d. or 8d. for a main dish;
2d. or 3d. for a sweet.

Many old people in other districts use the Londoners' Meals Service restaurants, where charges are, main dish 10d., sweet 4d., tea 2d. A total of 147 of these restaurants covers every borough in the County of London.

There are 36 old peoples' welfare committees in the London region, 8 of which organise special meals services for the aged.

MISS KATHLEEN PROUD

DR. AVERY JONES formulated an objective for us:—"a comprehensive, reliable, efficient meal service for invalids and old people." Excellent pioneer work has been done by the Invalid Kitchens of London and, more recently, by local Old People's Welfare Committees, the W.V.S. and the B.R.C.S.

During the war the Ministry of Health encouraged local authorities to provide Communal Restaurants by guaranteeing, under certain conditions, losses incurred. From 31st March, 1947, legislation will place full responsibility on Local Authorities. The London County Council has decided to continue the Londoners' Meals Service. In outer London boroughs, some are continuing, some are closing. In addition there are voluntary restaurants which continue in many places.

But Civic Restaurants cater for the healthy worker able to pay 1/2, to 1/6d. a meal. In every borough there is often a large number

of elderly people who would benefit from a service of this kind, but for the majority of them 1/2d. a day is out of the question.

In 1942 the Woolwich Council of Social Service came to special arrangements with the Londoners' Meals Service. It was not the policy of the Londoners' Meals Service to provide meals at reduced prices to any special section of the community except school children, whose meals were subsidised by the Ministry of Education. It was agreed that if the Council of Social Service provided the room, equipment and voluntary staff, the meal would be provided by the Londoners' Meals Service,—1st Course 6d., 2nd Course 2d. The food and the portions were guaranteed to be the same as served in the restaurant, a total reduction of 6d. a meal being made to the old people, as rent and other overhead charges were not included. A permit from the Food Office made it possible for tea to be available at 1d. per cup.

During the first week of attendance at Lunch Clubs, the unaccustomed food upsets some old people. They are absent for a day or two, then return saying, "Had to go to the doctor, he told me to go slow on the potatoes for a few days!"

Clubs for old people, under various names—"The Evergreen Club," "Darby and Joan Club," "The Veterans Club," etc.—are increasing in number, and several quite ambitious schemes are in operation where mid-day meals and high teas are available. We do not want to encourage the segregation of old people too much from the rest of the community, but lunch clubs for the retired have special advantages. They do not want to be hurried and to feel they are in the way and may be hustled by those who have a limited lunch time. They certainly appear to like their own lunch club. It provides the lonely with fellowship, which most of them appreciate as much as the meal.

Mobile Services

Taking meals to the infirm and housebound living alone is a much more difficult service to provide, but if anything, the need is more urgent. The Invalid Kitchens of London have six mobile canteens and in eight other boroughs mobile canteens serve infirm old people. If it were not necessarily a difficult and uneconomic scheme, it seems likely that there would be a mobile meals service for invalids and old people in every London borough. The cost is out of proportion to the cost of the meals served.

For instance, in one borough two mobile canteens, on the road six days a week, serve approximately 100 people with three mid-day meals a week. Running expenses for the two canteens are approximately £600 p.a.—drivers are paid, and garage for one van is free. The meals are provided at a Londoners' Meals Service centre at 8d. for two courses.

Thus the running costs, excluding the cost of food, are £6 per consumer per annum. The cost of food is £5 5s. per consumer per annum, and it is rarely possible to recover this amount from the old people themselves. This, it should be remembered, only provides three meals a week for 100 people. To cover the needs of this particular borough, at least six mobile canteens would be necessary. This is beyond the resources of the voluntary organisations responsible, particularly as wartime help from the Church Army and the British War Relief Society has come to an end.

To those who do not appreciate the need for the service, it is difficult to convince them that one van should be maintained to serve 25-30 meals a day. Such a service should be the responsibility of the local authority. One metropolitan borough, mentioned by Miss Simmonds, is assisting the Invalid Kitchens by providing the van and driver. It is doing it under the Domestic and Home Help Scheme. But the powers of Borough Councils to assist in such schemes are not clearly defined. Given the powers, other Borough Councils may be expected to act quickly.

Discussion

MR. F. LE GROS CLARK opened the discussion as follows:

Dr. Avery Jones and Dr. Pyke have remarked that we know very little as yet about the subjects with which we have been dealing. What, we may ask, is the reason for this? Clearly it is due to the lack of public, and therefore of scientific, interest; and it is thus our task to induce the public to turn its attention to the matter. The problem as a whole is divided into two main parts. First we have the invalids, who may or may not be ageing persons as well; and secondly we have the ageing persons, who are still able and willing to be employed.

We are obviously threatened in this country with two associated dangers. We have not sufficient people for our industries; and the age-structure of our population is slowly changing. We have to encourage and inspire the ageing (and in many cases that will be ourselves) to carry on in the labour market as long as is possible. The problem has become one of vital importance to the nation. Plainly, the longer we remain individually fit and happy in our work, the better for us all. But we must influence both the public and the Government to have the problems investigated without delay or in twenty years time we shall, as they say nowadays, 'have had it'.

A great number of old people and of those who suffer from incipient complaints are, under suitable conditions, quite capable of carrying on with their work. Russia was faced with precisely the same type of dietetic problem about 1930. The Soviet Government appreciated that, if they could not feed correctly the workers with incipient tuberculosis, gastric ulcers and other complaints, they would be deprived yearly of half a million factory hands. They therefore took the obvious steps of establishing in their factory canteens departments serving curative diets; and all the evidence shows that these have been successful. The same problem will be the concern of one country after another. Strong and essential as is the humanitarian motive for making provision of this kind, we can, I think, take this motive for granted. To have its full influence on the public, however, it must be associated with an appeal to social and economic interests. The impression made by

the combined appeal of the two motives upon the public mind should be sufficient to attract the attention we require.

Mr. Le Gros Clark drew attention to the Nutrition Bulletin published by the Central Council for Health Education, Tavistock House, Tavistock Square, W.C.1, of which he was Editor. The first number was about to be issued. The Bulletin would be published every 2 months at an annual subscription of 3/-. It was intended to include notes and memoranda dealing with the social application of nutritional knowledge, and the Bulletin should be of value to all concerned with the problems of developing the nutrition services, whether in the nursery, school, factory or institutional establishment.

The following points were made by other speakers:

Meals in hospitals and institutions should be made more attractive.

Anything that could be done to prevent the present overcrowding of hospitals and to prevent admissions due mainly to mal-nutrition would be worth while.

The margin between the healthy aged and the sick aged was frequently a narrow one.

More canteens were needed. It was possible to draw up suitable diets, but difficult to get them carried out in canteens.

Having regard to the man-power situation and the needs of industry, insufficient consideration had been given to employing women of over 60 and men over 65 on part-time work. Part-time work could end or begin with a mid-day meal in the canteen. An instance was given of a firm which invited their retired employees to take meals at the usual price in the canteen every day.

The need for larger rations of milk for the old was urged. Views were also expressed on the beneficial advantages of alcohol, a glass of port or sherry in the morning. Soup had nutritional value, but some old people did not like it. In general it was felt that far too little was known about proper foods for old people or even about quantities. Research into this question was needed. The teeth of old people were frequently faulty and there would be less wastage of meat if it were minced.

A suggestion was made that industrial canteens and civic restaurants should serve special diets for gastric ulcer and other

cases. This would call for periodical supervision by a trained dietician. Housewives would also welcome guidance with regard to the diet for this digestive disorder which is specially prevalent among dockers.

As to the need for more canteens, an expansion of the mobile meals service, correct diets and other matters discussed by the Conference, one speaker said that before the Government or Local Authorities were asked to do this, it would be well to have clearly in mind what was needed. The way to improvement lay through the education of public opinion.

Summary

LORD AMULREE

FROM what has been heard at this Conference, it is clear that there is a great deal about nutrition that we do not know. We have, therefore, first to decide what we wish done, and should make our requirements as precise and brief as we can. During the past few years a great interest in the welfare of old people has been aroused in the country and the time is now ripe to put forward their claims. The report of the Nuffield Survey on the needs of the aged has secured wide publicity and has prepared the way for more detailed investigation.

First of all, it is clear that we have little or no knowledge of any special nutritional needs of the aged. This is a subject that particularly commends itself to long term scientific investigation, and should provide valuable information for any authority, whether voluntary or municipal, which is providing Homes for old people.

But a second matter which has emerged very clearly from the discussions to-day is that there are many old people in the country who are not getting enough to eat. This does not imply any criticism of the rationing system at present in force. There is general agreement that this is adequate, although for people living alone it may be rather austere, but there are many old people who find it impossible, by reason of their physical condition, to purchase

the food to which they are entitled, and which is available to them. They are too feeble to stand in queues and to cope with all the difficulties of present-day shopping. We have been told that a large number of old people are admitted to hospital because they have not had enough to eat, and that their condition improves rapidly when they have regular meals. It will, therefore, lead to a saving of hospital beds if these people can be kept well enough fed to keep them out of hospital. For this a system of mobile canteens should be more readily available. The British Red Cross Society, with their "Meals on Wheels" service and the Invalid Kitchens of London provide a useful service which could well be extended. It is not necessary that each old person served should receive a daily service. Two or three substantial meals a week will do a great deal to improve their lot. It is important that they should not be encouraged to rely exclusively on such a mobile service: they must not lose the habit of preparing some of their own meals. If a whole-time service were contemplated, the cost would be prohibitive and any breakdown would lead to catastrophe. Some old people are able to avail themselves of meals in Civic Restaurants or in the works canteens of firms where they have been previously employed. Old people's clubs should be encouraged where possible to provide simple inexpensive meals.

A mobile canteen provided by the Local Authority, either from its own resources or by the employment of a voluntary organisation, would provide a useful service of meals for convalescent patients or temporary invalids.

Meals in hospitals and institutions are frequently unattractive to look at, although the quality of the food provided is excellent. The appointment of an officer to act as a general meals supervisor is worthy of encouragement. Too frequently meals are the responsibility of more than one officer, the buyer, the cook, the porter and the ward sister, and the lack of single control leads to the serving of an unappetising stereotyped food; in addition the choice of food from a short menu is a matter of considerable interest and importance to a patient. It might even be possible for a hospital kitchen to undertake provision of meals, by means of a mobile kitchen or canteen, to outpatients who require a special diet. There is no reason also why works canteens in factories should not more generally follow the example of those which provide special meals for certain types of workers, for example those who suffer from "gastric" disorders.



LONDON COUNCIL OF SOCIAL SERVICE

The London Council of Social Service is a consultative and advisory body on social work. It co-ordinates the activities of voluntary bodies with one another and with the statutory services. It keeps under survey the social needs of the community and provides additional services where required. Its activities include

Local Councils of Social Service

Citizens' Advice Bureaux

Old Peoples' Welfare

Information and Research

Community Associations and Centres

Youth Committee

Communal Feeding

Women's Clubs

Arts Committee

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