simple. Some may have guessed that deceit was being practised. Others may have picked this up half consciously but still acted on their hunches. Those who swallowed the lie and the pill had a relatively troubled night. (I am not surprised that "women over 60 were significantly less disposed than others to give informed consent." Most grandmothers are better at spotting fibs than most doctors.)

What have we learnt? That doctors who tell small lies may get away with it, but those who tell big ones are unlikely to get cooperation from patients. Even if they do it still does not help the patients much.

There is another lesson too. It is that dishonesty can poison both the doctor-patient relationship and an academic study. You can agree with the authors' conclusions only if you assume that lying has no effects. The responses of the patients, while telling us little or nothing about informed consent, show that the assumption is spurious.

JOHN LAUNER

London N10 1HH

Paying for old age

SIR,—I was dismayed to learn of the remarks made by Mr Fowler about nursing care of elderly patients as reported in your leading article (19 July, p 160).

The issue of long term nursing care is particularly relevant in Brighton, where there is a heavy demand for nursing care with a large population over the age of 75 and a large private nursing home sector. Do Mr Fowler's comments imply that in future my elderly patients in need of nursing care are to be assessed for their ability to pay for their care before their own wishes are taken into account? Am I to be expected to put pressure on an old lady to sell her bungalow (for example) to pay for nursing home fees, when she was wishing to pass on her only asset to her family, perhaps having worked hard all her life and contributed to the NHS and now requiring NHS care for the first time?

If this is so then the NHS is failing the elderly who require nursing care and who have some assets. The suggestion that NHS nursing care would be for only those patients with no personal assets represents a return to a "workhouse" mentality. I for one will continue to regard the patients' wishes as paramount and will not attempt to shore up an underfunded health service by denying old people the right to National Health Service nursing care.

HUGH O'NEAL

Department of Medicine for the Elderly,
Brighton General Hospital,
Brighton BN2 3EW

Compliance with screening for colorectal cancer

SIR,—Ms Sally Nichols and her colleagues (12 July, p 107) found that compliance with screening for colorectal cancer was higher when a self administered Haemoccult test was offered to patients during a routine consultation with their general practitioner (57%) than with any of four other approaches—namely, when the GP (*a*) sent a special appointment (49%), (*b*) sent the test kit (38%), (*c*) asked the patient to make an appointment (27%), or (*d*) asked the patient to collect the test from the receptionist (17%). We have explored yet another approach suitable for women—that is, to offer the test to those already attending a well woman clinic.

The study was done at the early diagnostic unit of the Elizabeth Garrett Anderson Hospital. All the 187 women aged 45 to 74 years who attended the unit between May and September 1985 were studied. Thirty seven were considered ineligible for screening, seven because of known bowel disease and 30 because of haemorrhoids. In retrospect, most of the patients with haemorrhoids need not have been excluded because their haemorrhoids were not bleeding, but there is no reason to believe that the exclusion of these patients would have affected the compliance rate. The remaining 150 women were offered the test, 137 (91%) accepted, and 115 (77%) (95% confidence interval 70 to 83%) returned completed tests.

Our results suggest that colorectal screening, using the Haemoccult test, will have a high compliance rate when administered in well woman clinics. Of course, a high compliance rate is of value only if screening can be shown to reduce mortality from colorectal cancer, and whether this is the case awaits the outcome of randomised clinical trials currently in progress.[1,2]

H S CUCKLE
N J WALD

Department of Environmental and
Preventive Medicine,
Medical College of St Bartholomew's Hospital,
London EC1M 6BQ

E B BUTLER

Early Diagnostic Unit,
Elizabeth Garrett Anderson Hospital,
London NW1 2AP

1 Gilbertson VA, Church TR, Crew FJ, *et al.* The design of a study to assess occult blood screening for colon cancer. *J Chronic Dis* 1980;**33**:107-14.
2 Hardcastle JD, Farrands PA, Balfour TW, Chamberlain J, Amar SS, Sheldon MG. Controlled trial of faecal occult blood testing in the detection of colorectal cancer. *Lancet* 1983;ii:1-4.

Medical housing "lines"

SIR,—Dr Harpreet S Kohli recommends that caseworkers (for example, health visitors, GPs, and social workers) should allocate differing priorities of housing need for their patients or clients. Priority can be allocated only relative to the needs of the population and it is unrealistic to expect caseworkers to allocate priority fairly because of the competing needs of applicants. Independent medical advice is needed on individual cases from community physicians, who should also contribute to the debate on housing and environmental issues as part of their public health function.

Housing departments, particularly in the north west, where housing standards are poor, need independent medical advice on individual cases because of the competing demands made by applicants, their carers, and advocates such as councillors. Rehousing is also not always the most appropriate remedy to underlying problems. Because of the large volume of applicants and the shortage of resources, we depend in most cases on information we obtain from other sources. Only a small number of cases can be assessed personally, and routine feedback to GPs is at present impossible. The process at present is clerically demanding.

Dr Kohli suggests that communication between GPs and housing departments should improve, but we disagree. We think doctors should communicate directly with the community physician. We asked GPs to write directly to us to ensure that adequate medical details are provided and also to guarantee confidentiality. Some GPs now write helpful letters but we still receive hurried scribbles lacking in detail and addressed "to whom it may concern." We feel that this is unfair to the patients' needs and is possibly unethical. More helpful information is usually provided by health visitors, occupational therapists, and environmental health officers.

It might be helpful for GPs to regard communications as similar to referral for elective surgery and the inevitable waiting lists. Indeed, rehousing can command more public resources than sophisticated surgery.

J A REID
E J HUNT

St Helens and Knowsley Health Authority,
Merseyside WA10 2AP

"Homeward bound": a minimal care rehabilitation unit

SIR,—We are concerned that the wrong conclusions may be drawn from the paper of Dr Margaret A W Sutton (2 August, p 319) and we would like to make the following points.

Firstly, several other factors, alone or in combination, could have produced the changes reported in the paper. It is impossible to conclude which factors played a major part as we are not given sufficient details about other changes in the district during 1981—for example, changes in part III provision, nursing home usage, details about numbers admitted with their mean and median duration of stay in designated acute and geriatric beds, the number of patients transferred from acute beds to longstay geriatric wards, and the duration of the interval before transfer. We ourselves have shown that changes in the staffing and admissions policy of the geriatric unit can have a major impact on a health district like Islington,[1] which is probably more deprived than Newham.

Secondly, if one assumes that the number of patients staying for longer than one year remains constant at 4% and the other 20% of patients causing the blocked beds have a turnover interval of 42 days, then this is equivalent to 775 patients a year. We are told about the 114 patients transferred to the minimal rehabilitation unit during the first year and the 173 patients transferred during the second year. What happened to the rest? We would suggest that factors other than this unit largely contributed to the changes noted at Newham and this type of service is no substitute for a comprehensive geriatric service.

Thirdly, it seems remarkable and contrary to clinical practice that none of the patients transferred required continuing care. This suggests that the patients transferred were highly selected and were at the mildest end of the range of disability.

Finally, the reasons for readmission are multifactorial and have been found to be primarily medical[2] and not social.[3] Social readmissions have also been found not to play a major part in the length of stay, and this fact has been noted by many authors.[4,5]

P J MURPHY
G S RAI

Department of Geriatric Medicine,
Whittington Hospital,
London N19 5NF

1 Rai GS, Murphy P, Pluck RA. Who should provide hospital care of the elderly people? *Lancet* 1985;i:683-5.
2 Gooding J, Jette AM. Hospital readmissions among the elderly. *J Am Geriatr Soc* 1985;**33**:595-601.
3 Victor CR, Vetter NJ. The early readmission of the elderly to hospital. *Age Ageing* 1985;**14**:37-42.
4 Maguire PA, Taylor IC, Stout RW. Elderly patients in acute medical wards: factors predicting length of stay in hospital. *Br Med J* 1986;**292**:1251-3.
5 Seymour DG, Pringle R. Elderly patients in a general surgical unit: do they block beds? *Br Med J* 1982;**282**:1921-3.

SIR,—The apparent success of the homeward bound unit described by Dr Margaret A W Sutton (2 August, p 319) could lead many districts to choose this model as a solution to their bed difficulties. However, it would be unwise to attribute the fall in the proportion of "bed blockers" to the existence of the unit alone. The turnover