wide variation in the time between observations (e.g. 6 months to 4 years), and one-third of the client population was due to mortality and other factors. These methodological and analytical shortcomings would tend to underrepresent the actual decline in functional status for the client population. Even with the bias towards lower rates of decline, over half (52%) of the clients experienced a decline in IADL, 28% declined in ADL and 29% declined in MSQ. The authors correctly point out that functional ability is difficult to improve or maintain among older people with multiple chronic conditions. However, it is impossible for the reader to determine whether the rate of decline in this population is within acceptable limits. The authors do not have a client control group, nor do they present normative rates of decline from other studies.

The authors also fail to evaluate certain qualitative aspects of their project. One of the most important of these is the role of the physician. The physician is the central decision maker for health care in the United States. The Triage project relied on the clinical decision making of the nurse and social worker. Physicians presumably received referrals and were reimbursed only for those services that were determined necessary by the Triage clinical staff. How did physicians respond to their loss of authority? Why weren't physicians included in the core project staff?

The authors also fail to explore the implications of their experience with case management which was the major administrative service of the Triage project. Case management (e.g. assessment, case coordination, and monitoring) can be an expensive service. Not all older people need this type of assistance. Many individuals have only routine problems, requiring little management, or they have their own resources to meet their needs. The authors do not indicate how the experience of Triage might assist other communities or agencies to optimise administrative resources by selecting clients who are most appropriate for case management.

In summary, the authors have presented a very readable and well-organised description of their project. One should be inherently sceptical, however, when the staff attempts an analysis and evaluation of its own project. Triage is an appealing concept. I wish that the authors had provided a more thorough and objective evaluation.

GREG ARLING

Virginia Center on Aging,
Virginia Commonwealth University,
U.S.A.

Robert L. Lane, David H. Solomon, John C. Beck, Emmet B. Keeler, Rosalie A. Kane, *Geriatrics in the United States*, Lexington Books/D.C. Heath & Co., Lexington, Mass,. 1981, 186 pp., no price given. ISBN 0 669 04386 9.

The demographic imperative is the rationale for this estimate of future needs for geriatric manpower in the United States. The rapidly growing numbers and proportions of the elderly, particularly the old-old, have forced consideration of how best to deal with their multiple health problems. Several years

ago the Henry J. Kaiser Foundation funded a Rand Corporation project to forecast the health manpower required to serve the elderly adequately. A task force at Rand (a research study centre in California) produced a thorough and sophisticated report in 1980, which has now been published as a hardcover book. Although the conclusions it reaches are couched in terms of the United States, they are relevant to many other industrialised nations. Increasing numbers of the old and very old, coupled with limited physician interest in geriatrics, is not a phenomenon typical only of one country in the Western hemisphere.

The study group reanalysed data from several sources to develop a profile of existing geriatric practice. A survey among all American medical practitioners active in 1977 (363,619 in the list) revealed that only 629, or about $\frac{2}{10}$ of 1%, indicated an interest in geriatrics medicine, and only a little over one-half of these gave it as a primary speciality. Even more disconcerting was the fact that only a quarter of these self-identified geriatricians were board-certified in any speciality, or about half the general rate, and their membership in professional societies was also below the national average. Moreover most of them were older, with very few in the early post-residency years. Although the typical elderly patient has at least one chronic condition, and often a combination of health problems that should take more physician time than the average for a particular visit, the data showed that mean encounter time was significantly less for the elderly than for younger patients. Medical schools surveyed in 1976 showed that only 15 out of 96 responding taught geriatrics as a separate subject, and it was required in only two. However, the trend is to teach the subject, and the Rand report expects that all 124 schools will be offering instruction by 1995.

The Institute of Medicine has defined the types of knowledge needed by those who give medical care to the elderly, including the nature of changes due to ageing in the way clinical problems are presented, differences in response to treatment, and the importance of considering psychosocial factors. In a chapter on the rationale for geriatric manpower, the authors take no sides in the ongoing debate as to whether geriatrics should become a specialty, but argue that there is a specific set of skills required by primary care providers, the major purveyors of service to the elderly, if they are to correct current inadequacies. A plea is made to develop academic geriatricians who also engage in practice, combining teaching, speciality care and primary care.

Using various projections and calculations, the authors estimate that from 900 to 1,600 faculty are needed to train practitioners, and that at best only a third of this number can be made available by 1990. Using several forecasts of the extent of potential delegation of geriatric tasks to non-physicians, the authors develop a range of manpower estimates, but conclude on balance that 8,000 geriatricians are needed by 1990. Separate calculations for geropsychiatry were also considered, with current faculty needs (as of 1980) at a minimum of 700, but only about 75 actually identified as in practice, much less in faculty postions.

Various problems are outlined and strategies proposed relevant to encouraging the development of institutional programmes of teaching, research and practice in geriatrics medicine. Model curricula are outlined, and issues of

measurement and evaluation analysed. Special attention is given to the goals of meaurement in long-term care, including the importance of developing research tools which can distinguish small increments in patient function, since such increments can have a major effect on quality of life. In addition to proposing a research agenda, the authors provide a set of recommended actions designed to increase the number of persons practising geriatrics medicine, and to improve the quality of the care they provide. A bonus among the book's technical appendices is one listing the areas of clinical knowledge and skills which medical students, residents and geriatric fellows should acquire as a result of their training.

This book will be useful to medical school administrators, gerontologists, practising physicians and medical social scientists, in short all concerned with meeting the health care needs of the elderly.

MARIE R. HAUG

Center on Aging and Health,
Case Western Reserve University

Caroline Godlove, Lesley Richard and Graham Rodwell, *Time for Action: An Observation Study of Elderly People in Four Different Care Environments*. Social Services Monograph, University of Sheffield, 56 pp., £2, ISBN 0907484 02 6.

The true significance of this title becomes clear as the central findings emerge from this absorbing and methodologically thorough piece of research: the elderly in each of the four environments studied (day centre, day hospital, local authority home, and a hospital ward) have a great deal of time at their disposal as a consequence of a minimal engagement in action/activity. Furthermore, classification of the 'activities' which fill the remaining third of the time betrays interesting disjunctions between institutional aims – explicit or implicit – and observed practices. For instance:

'In day hospitals, where it might be expected that a very high proportion of time would be devoted to rehabilitation, the observed percentage was as low as 17.8.

In the main, however, material is offered without deliberate interpretations so that the reader is free to construct his/her own inferences. The important thing about observation studies is that they entail the collection of data that is both complex and specific, and thus allow this kind of interpretive response on the part of the reader.

The ground covered in this monograph is not inconsiderable. In the end, 65 individuals, across 32 establishments of the four types mentioned above, were studied. The aims of the research, though potentially wide-ranging – 'what happens to elderly people when they receive care or services in four different types of environment' – are interpreted modestly and realistically and lead to findings which range from the quantitatively measurable to the impressionistic.

The background to the larger study, of which this monograph is but a part, is outlined in the introduction, which is followed by an illuminating review of