The modern cult of marathon running owes more to Robert Browning and his Victorian romanticism than to any recognisable historical fact.¹ ² The marathon was not an event in the classic ancient Olympic games, but the poet's licence with the story of the Greek messenger Pheidippides' heroic run, garnished with his death as he gave the message, led to the modern Olympic marathon and some 70 years later to the mass marathon phenomenon.

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Marathon medicine

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²² Nuffield Professor of Clinical Medicine, University of Oxford, MRC Molecular Haematology Unit, John Radcliffe Hospital, Oxford OX3 9DU
The dynamic approach to residential care of the disabled

Disabled people, it is often said, should be able to choose how to live—just as the rest of us do; and indeed even the most severely handicapped can now be enabled to live in the community. But many disabled people have to be content with residential care because they cannot marshal the intensive support they would need at home. Others become too exhausted or incapable to organise themselves, and some just want the companionship of a group. The individual stories of those who succeed in the community show how much toughness is called for.

Improving the quality of life in residential settings and creating links with the community for those who all too easily feel outcasts is, then, important and was the theme of a recent seminar, held in London under the patronage of the European Community, on “The Dynamic Approach to the Residential Care of Disabled People in an Integrating Society.” Among the more general topics discussed were choice and opportunity, flexibility, and independence and the need for more research and better dissemination of information.

The general requirements were well summarised by A Klapwijk from the Netherlands: making plans always in conjunction with the disabled people themselves, remembering that it is their life; offering a choice of living arrangements, and providing for privacy; making both medical and other services and social facilities readily available; and having a system of funding that makes for easy transfer from one type of accommodation to another. Choice means money among other things and, said several speakers, people should have the money to spend on the kind of care they want, in or out of the community. But there was the proviso that funds need to go directly to institutions as well as to individuals to provide a short term haven for emergencies and intermittent relief and facilities for repeated assessments and rehabilitation.

For residential care, as John Wedgod emphasised, should no longer be thought of as a static or all or nothing affair. Long term care, short term or intermittent care, and outpatient or day care may coexist in a single unit or institution, giving a service that is both more economical and more appropriate; one person may make use of all the types of care at different times. This kind of blurring of boundaries needs to be encouraged. The 300 Netherlands “nursing institutes” provide not only long term care but also day care for people who are independent or in special accommodation in the community and they admit those who become more incapacitated; there is also an invaluable facility for admission for limited periods—within hours in an emergency.