sequential interactions of perhaps half a dozen reactants. The single-drug trial assumes that by blocking one part of one sequence the whole thrombotic process is prevented. But a single block may be bypassed. Then a single drug would not be expected to have dramatic consequences.

Two options are open. Firstly "blunderbuss" therapy in which all patients at risk receive a standard mixed "cocktail," including perhaps an antiplatelet drug, an anticoagulant drug, and a stimulator of fibrinolysis. Such polypharmacy gains respectability from the treatment of leukaemia, in which the use of many drugs acting on different sites was soon shown to be superior to single-drug therapy.

Secondly, there is perhaps a more logical application of polypharmacy in a multifactorial disease. Estimations are made of only those factors which are thought to predispose to thrombosis and which can also be corrected. Individual "tailor-made" therapy then consists in treating the abnormalities indicated by the tests. For example, blood flow is influenced by red cell mass and by the fibrinogen level. These can respectively be corrected by venesection or by phosphorus-32 and clofibrate. Raised antithrombin III and factor VII will respond to warfarin; fibrinolysis if found to be decreased is stimulated by stanozolol; "spontaneous" platelet aggregation is inhibited by aspirin; a short heparin thrombin clotting time is corrected by clofibrate and hyperlipaemia by diet or clofibrate. Other tests and other forms of treatment will emerge. Such tailor-made polypharmacy might carry an increased risk of haemorrhage, but a mild correction of a number of processes might well have clinical benefit with less risk of haemorrhage.

Perhaps some of the effort devoted to single-drug trials should be directed to one in which all identified and treatable abnormalities are corrected.

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Career prospects in geriatric medicine

SIR,—The consultant physician in geriatric medicine has a challenging, exciting, and exacting job, mostly looking after the "old" elderly who have multiple-system diseases, as opposed to physicians in other specialties, who see mainly the "young" elderly with single-system diseases. Those who manage their work in such a way that there is little or no waiting list will see a wealth of pathology and much acute illness in elderly patients, many of whom get well and return home. Such a physician will, of course, have to take a very active interest in rehabilitation, ensure a high standard of quality of life in continuing care units, and maintain a high morale among the nursing and paramedical staff throughout the entire unit. Good rapport with the community services is essential. He must know how the administrative system of the National Health Service works and how to make it work to the advantage of his patients. These aspects of his job require management skills of a high order and specific training in this subject has been available at special courses run by the King's Fund College. If this is not enough of a challenge there are considerable opportunities for research. Consequently, modern geriatrics is far from conforming to the unfortunately

often-held view that it is a dumping ground for unwanted patients and involves only the care of the demented and incontinent.

Career prospects in geriatric medicine are good, as your leading article pointed out (16 February, p 426). The number of elderly, especially the "old" elderly, is increasing in absolute terms and double the number of consultant geriatricians will be needed if the older patients are to be looked after adequately. On the other hand, the number of consultant physicians in general medicine in England and Wales is falling,¹⁻³ the age group of patients with whom they principally deal is not increasing, and money available to create new establishments is limited. If it is assumed that four years are spent by a senior registrar in general medicine, and 31 years as a consultant, to remain in balance about one senior registrar is required for approximately every nine consultant posts in general medicine. However, there is now one senior registrar to every five posts, suggesting that perhaps as many as 70 of the present senior registrars will have some difficulty in obtaining consultant posts in their chosen speciality.

Because of the need for more consultants to be trained in the care of the elderly, the DHSS has created bursary schemes for doctors already appointed to senior registrar posts in general medicine or related subspecialties.⁵ The aim is to enable a doctor to spend up to one year gaining experience in geriatric medicine. The gaining of a bursary is conditional on educational approval and would carry personal manpower approval. It is intended that bursary holders would be trained at various centres of excellence. It is likely that many senior registrars in general medicine have never seen what a modern geriatric unit can achieve, indeed many may not have even entered a department of geriatric medicine. Perhaps this offer may encourage some to "test the temperature of the water."

Thus career prospects in geriatric medicine are excellent and considerable satisfaction is there for the asking.

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¹ Medical Manpower Division, DHSS. *Health Trends* 1977;9:45-7.

² Medical Manpower Division, DHSS. *Health Trends* 1978;10:61-4.

³ Medical Manpower Division, DHSS. *Health Trends* 1979;11:53-6.

SIR,—The leading article on career prospects in geriatrics (16 February, p 426) cites the fact that 9% of geriatric consultants are women as evidence that the specialty "seems particularly to appeal to women physicians."

The proportion of women in geriatrics is, in fact, lower than the proportion of women in consultant posts as a whole, and it is much lower than in some of the other "shortage" specialties. The fact that it is higher than in general medicine and cardiology reflects, almost certainly, not that geriatrics appeals to them more than those do but that it is still relatively difficult for women to obtain consultant posts in specialties which are well supported with male candidates.

A research report completed last year¹ based on a survey of over 6000 doctors of all kinds showed that only 3% of women doctors and 3% of men doctors thought "treating old people only" to be an attractive attribute of medical work. Moreover, the proportion of

women doctors who thought "treating chronic cases" to be an attractive attribute of medical work was 35% (compared with 41% of men).

It is to be hoped that opportunities for women in all specialties will gradually become more evenly distributed as their numbers increase, but evidence at present does not support any assumption that proportionately more women are geriatricians than general physicians because it is particularly attractive to them. Indeed, on the contrary, it is perhaps surprising in view of the career opportunities in geriatrics that more women do not take advantage of these opportunities, as they have done, for example, in anaesthetics (17% women) and mental handicap (20% women).¹

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¹ Hutt R, Parsons D, Pearson R. *The Determinants of doctors' career decisions*. Brighton: Institute of Manpower Studies, 1979: 109-46, 269-75.

SIR,—Your leading article (16 February, p 426) on career prospects in geriatric medicine prompts a number of questions on this expanding specialty which have never been adequately answered. Is geriatrics a good thing, do we need it, why treat the elderly as a race apart, and do old people like the prospect that confronts them?

The answer to the last question is emphatically that they do not. Those who are still articulate but see themselves being funnelled into the system look with utter horror on the geriatric ward as a miserable prison for their declining years, where they will grow senile at an increased rate in company with other old people.

The elderly want and need the company of the young which gives them the stimulus to keep mentally alert and interested. This they used to get when they were managed with other human beings in the general wards. Of course, they got a bit confused at night and kept other patients awake; but by day they were adopted by the younger patients and kept an interest in life. Some of them were a useful pair of hands, a fact which gave them added stimulation and fulfilment. They are actually human beings who have spent their entire lives growing older in mixed company, not isolated in their own age group. Unfortunately, in Britain we are not a caring society and the elderly have no pressure groups worth speaking of. Consequently the way we treat them is particularly shameful.

It is probably too late to reverse the policy decision to isolate the elderly in ever-expanding geriatric units. However, this is the last place the old people themselves want to end up in. And end up there many of them do, overinvestigated and under-cared-for, instead of dying in the relative comfort and familiarity of their own homes, however inadequate many of these may be in Great Britain.

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Motor neurone disease

SIR,—In his personal account of motor neurone disease, Mr Roger Carus tells us "No one cared (16 February, p 455). No one had heard of motor neurone disease. The doctor didn't know what to do. We were just

left alone." He states that his consultant neurologist was of no more use to him than the milkman. These statements do not accord with my own experience of this dreaded disease.

In May 1973 my patient, a healthy father of three, developed pain in his knee. This was soon followed by localised muscular fasciculation and the dread diagnosis of motor neurone disease. I did not tell my patient and he proceeded bravely until he needed the help of a wheelchair. I told his wife the diagnosis and she was adamant that her husband must not be told.

In 1974 came the exciting news that Professor Albert Cook¹ had successfully arrested the progress of motor neurone disease by electrical stimulation of the spinal cord. He had re-established central transmission and three patients had shown significant improvement in voluntary muscular performance. His work followed the original discovery of Illis that regeneration in the central nervous system could occur at the synaptic junction.^{2,3}

My patient was enthusiastic and Professor Cook offered to treat his motor neurone disease by electrical stimulation if I could get him to New York. Our local Lions Club and their Brooklyn counterparts sponsored his visit. Massive press publicity evoked a tremendous response. My patient was flown in his wheelchair to Long Island College Hospital, where two electronic dorsal column stimulators were inserted into his spinal cord. He met patients who had received similar treatment. A newsletter listed every patient in the United States who had received the same electronic stimulation. Some of those with amyotrophic lateral sclerosis reported improvement in their motor function. My patient returned to this country full of hope. I lectured with him at various medical meetings, where he was happy to tell his audiences of his operation and to demonstrate the intricacies of his electronic stimulator. He continued to report and discuss progress with other patients in the United States. Unfortunately the condition progressed, but he never lost hope. He was sure that he would ultimately win. He died suddenly in September 1976 but the day before his death had a wonderful time visiting friends with his family.

Following his death Professor Illis established a similar unit to provide electrical stimulation for progressive lesions of the spinal cord. My patient died a happy man and his family hopes that his experiences will help in the future management of motor neurone disease.

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¹ Cook AW. *Lancet* 1974;ii:230-1.

² Illis LS. *Lancet* 1973;i:1035-7.

³ Cook AW. *Lancet* 1973;i:1442-3.

ECT: balancing risks and benefits

SIR,—Professor D A Pond (9 February, p 403) suggests possible circumstances in which unmodified electric convulsion therapy (that is, ECT without concomitant anaesthesia and muscle relaxation) might still be used. He fails to convince us, however, that such an anachronistic approach to the treatment of disturbed patients has any place whatsoever in contemporary British psychiatric practice.

We believe that it is essential that a clear statement is made on this matter both for the peace of mind of our patients and their relatives

and for the good name and reputation of British psychiatry. We believe that further use of unmodified ECT would be indefensible and that it should be removed from consideration as a treatment approach in any circumstances. We see no need to modify the detailed guidelines on ECT issued by the Royal College of Psychiatrists in 1977, guidelines which nowhere mention the unmodified form of treatment.

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Residential homes for the elderly: arrangements for health care

SIR,—The DHSS circular on residential homes for the elderly¹ was not circulated to appropriate consultants or family doctors in the Health Service. In some respects the advice is good, but it does contain suggestions with which the medical profession would take issue.

The circular proposes that residential homes should no longer have a family doctor who is paid a retaining fee to give general medical advice. The idea that elderly residents should have their own doctors is laudable, though it can cause problems when there are 40 residents with 20 different doctors. A more important issue is the apparent intention to reduce the amount of nursing in these homes despite the general tendency for them to be asked to admit an increasing number of physically and mentally frail people, as the fitter individuals are more happily and appropriately accommodated in warden flatlets or bungalows. Nurses who become residential care officers, however deinstitutionalised we hope they are, will still rightly enjoy carrying out small nursing duties for the residents in the homes who have become their friends. Indeed, such nursing duties may have been a factor in their decision to apply for the post in the first instance. They are in a unique position to draw the doctors' attention to the atypical symptoms of serious illnesses in the elderly. As residents become increasingly frail other residents and the staff will be happy for them to remain so long as simple nursing procedures, such as the dressing of ulcers, giving injections, and introducing catheters, can be carried out satisfactorily. The district nursing service is overstretched and has difficulty in providing the frequency and continuity of care that is so important in the elderly, and those in the community will be given priority in times of shortage. The BMA has proposed that every home should employ one trained nurse who is responsible for the nursing care of the residents.²

It has frequently been argued that domiciliary physiotherapy is a waste of skilled physiotherapists' time. This view has now been challenged by Partridge and Warren.³ In the case of the residential home this argument cannot be sustained as at least one session a week could be fully occupied with individual referrals. A physiotherapy service is important in maintaining the residents' mobility but is still

more important in ensuring that the elderly with acute chest infections in the winter are treated adequately. The suggestion of transporting these people to a physiotherapy outpatient department for this purpose is unrealistic, uneconomical, impractical, and medically dangerous.

I hope that the DHSS will consult the members of the medical and nursing professions who work in residential homes and who have reservations about the wisdom of some of the suggestions made in this circular. If the policy is not reversed many happy residents will have to be hospitalised unnecessarily, to their personal detriment and that of the NHS and social services.

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¹ Department of Health and Social Security and Welsh Office. *Residential homes for the elderly: arrangements for health care. A memorandum of guidance.* London: DHSS, June 1977.

² General Medical Services Committee. *Report of the General Medical Services Committee to the annual conference of representatives of local medical committees, 1976.* London: British Medical Association, 1978.

³ Partridge CJ, Warren MD. *Physiotherapy in the community.* Canterbury: Health Services Research Unit, University of Kent at Canterbury, 1977.

Psychoanalysis, psychotherapy, and health services

SIR,—Dr B Barnett letter (26 January, p 249) appears to be criticising psychiatry, and possibly psychiatrists in general, for a number of failings. He introduces his argument in a general comment about Professor M Shepherd's Personal Paper (15 December, p 1557). It appears that we are to believe that psychiatry is in some way responsible for the continued health hazards of smoking and early teenage pregnancies, and is mysteriously mixed up with the development of social services and the influence of sociology on medical practice in general. It would have been helpful to learn what Dr Barnett feels should be done in order to combat these various problems connected with health. How can psychiatry be on the one hand so powerful that we could assume that it *could* combat these problems which have defeated everybody else, and yet so weak as to be useless?

Dr H A C Mason's letter in the same issue (p 248) is a personal contribution of much interest; I must admit to some bias here since Dr Mason taught me for several years. The two approaches highlight a problem. One offers evidence and personal contribution, the other appears to be a general expression of some feeling or another which, if I am not allowed to use any psychological theory to explain it, must remain obscure in origin.

I have found psychotherapy and the psychoanalytical theories extremely valuable in understanding psychiatric syndromes. I have found in selected patients that psychotherapy works where other treatments which I also use have failed. I do not know what this means and am inclined to an empirical view about all treatment in psychiatry at the present state of knowledge. From my experiences of working in a peripheral psychotherapy clinic entirely within the National Health Service in Plymouth I have found patients referred from many sources who have both had all the usual range of