CORRESPONDENCE

Geriatrics in isolation W B Wright, FRCPED.....	315	Diet and coronary heart disease Sir John McMichael, FRCP, FRS.....	318	Car allowance for consultants M Goldman, MB.....	319
Coronary care unit or ordinary medical ward? B L Pentecost, FRCP, and P J Cadigan, MRCP	315	Abdominal wound dehiscence R T Burkitt, FRCS.....	318	Industrial action J P Taverner, MRCP; D M Burley, MRCP; A I Spriggs, FRCP; R A C McIntosh, MB; A S Ogden, MB; I W W Fingland, MRCPGLAS, and Margaret J Fingland, MB..	320
Fatal agranulocytosis attributed to co-trimoxazole therapy D H Lawson, FRCPED, and D A Henry, MRCP	316	How dangerous is obesity? J J Hobbs, FRCP.....	318	Overseas doctors' difficulties S C Bhattacharya, MB.....	320
Anaesthetic waste gas scavenging systems D W Bethune, FFARCS, and J M Collis, FFARCS.....	316	Campylobacter enteritis B A S Dale, MB.....	318	Common waiting lists P A T Wood, MD.....	321
Litholapaxy Sir Eric Riches, FRCS.....	316	Management of the elderly agitated demented patient G Silverman, MRCPSYCH.....	318	Proclaim it upon the housetops M M Shepherd, MB.....	321
Stress incontinence Cicely D Williams, FRCP; E Schleyer-Saunders, MD.....	316	Alcoholic liver disease A Basile, MD.....	319	Doctors and administrators P A Hill.....	321
Dysarthria with tricyclic antidepressants M Saunders, FRCPED; J N M McIntyre, MRCPSYCH; D Storer, MRCPSYCH.....	317	Abdominal tuberculosis in Britain B K Mandal, MRCP and P F Schofield, FRCS.....	319	Points from Letters Postponing premature labour (I Kennedy); Television epilepsy (D G French); The coughing that gets them down (M Super); Telling the patient (D Murphy); Malaria in returning travellers (P Dransfield).....	321
Safety and danger of piped gases J V I Young, FFARCS.....	317	Carbon dioxide-dependent Staphylococcus aureus from abscess M Rahman, MRCPATH.....	319		
Paget's disease of bone A T Matheson, FRCS.....	317	General practitioner prescribing costs R T A Scott, MRCP.....	319		

Correspondents are urged to write briefly so that readers may be offered as wide a selection of letters as possible. So many are being received that the omission of some is inevitable. Letters should be signed personally by all their authors.

Geriatrics in isolation

SIR,—Dr W E Bagnall and his colleagues have put forward an enthusiastic case for a separate system of hospital care for the elderly (9 July, p 102). Clearly he is one of an energetic team who can make such a system work, but one wonders if it would be so successful in less well-endowed areas. The competition for geriatric posts is minimal compared with those in general medicine, and this must carry implications for the efficiency and potential of these two services.

In any district there are more physicians "on-take" than geriatricians and each has his own special expertise to offer. If the geriatrician withdraws from this into an isolated service is he not that much more likely to be left there, perhaps in an isolated hospital, where the opinion and help of his specialist colleagues is that much harder to obtain? It may be that Dr Bagnall has been able to arrange good rotational systems through his department to give trainees in general medicine and general practice experience in geriatric methods, but how easy would this be for others running an isolated geriatric service elsewhere? What effect would this isolation have on the recruitment of nursing and paramedical staff? Does he believe that to purchase duplicate equipment for two departments, each trying to run the same investigatory service for a population divided only by an arbitrary age barrier, is sensible economics?

And what about the patient? What will the patient feel when on giving his age he is told that he must be moved to another hospital or department? There is already so much stigma surrounding this segregation in hospital that many believe that the word "geriatrics"

should be abandoned. How will it help the general practitioner to be told that his 70-year-old patient with a stroke is too young for the geriatric department?

Difficulties like these must have influenced the Department of Health and Social Security in formulating its proposals for the inclusion of geriatric wards in district and community hospitals, as close to the other specialties as possible rather than in separate institutions.¹ The report of a working party of the Royal College of Physicians² on the integration of general medicine and geriatrics was initiated partly because of the unpopularity of geriatrics as a specialty and its inability to cope with more than a proportion of the elderly sick.

Some powerful recruitment incentive would be required to make Dr Bagnall's proposal workable throughout the country. In the light of past experience the confinement of doctors exclusively to an older group of patients would not provide that incentive. Everyone would agree that the good geriatric physician has something worth while to teach about the management of the elderly patient. He should therefore be working side by side with his physician colleagues so that he can pass on this expertise if we are all to face an enormous increase in the elderly sick.

Should any adult be deprived of hospital care that would be available to him if he were a little younger or a little older?

W B WRIGHT

Royal Devon and Exeter Hospital,
Exeter

¹ DHSS circular DS 329/71, December 1971.

² Working Party of the Royal College of Physicians of London, *Lancet*, 1977, 1, 1092.

Coronary care unit or ordinary medical ward?

SIR,—Dr J D Hill and his colleagues from Nottingham (9 July, p 81) have produced a provocative study, but their data must be interpreted with caution. The significance of their findings depends greatly upon the definition of an "ordinary" ward, about which we are told very little, particularly concerning the matter of nursing and medical staff.

It is true that the therapeutic potential of the coronary care unit (CCU) is limited and that the practical management of patients with acute coronary episodes has not changed greatly in the past decade, in spite of a tremendous amount of research and clinical endeavour. The principle is still to provide first-class resuscitation facilities in a peaceful and reassuring atmosphere, with pacing facilities as a less immediate consideration. Anti-arrhythmic drug regimens and the detection of "warning arrhythmias" have probably only a small role to play in a well-organised CCU, and as yet we lack the ability to influence the outcome of severe cardiac failure. If therefore the availability of nursing and junior medical staff was adequate and the ward design, size, and patient load appropriate, then the finding that coronary patients could be nursed adequately in a medical ward would hold no great surprise. We know that the standard of CCUs varies greatly,¹ but how much greater is the variation between individual medical wards? It is not unknown now for a 26- or 30-bed ward to be left in the charge of a single pupil or student nurse, particularly at night. Under these circumstances it is inconceivable that a patient developing ventricular fibrillation would stand the same chance of survival as in a CCU. This prediction is borne out even in the Nottingham study, where resuscitation was attempted less frequently and significantly less successfully in the ward than in the CCU. The failure of this achievement to influence the overall mortality of patients with myo-