and in time that too will be achieved as their knowledge becomes more specialised and therefore less available generally. There was a time when every physician could call himself a cardiologist or a gastroenterologist, but not now. Geriatrics is not a specialty at present in that it could be practised adequately by the general physician *if he wanted to*, but already there are important aspects of it—for example, rehabilitation and drug therapy—in which he lacks the available specialist knowledge. Geriatric medicine has advanced more rapidly than most other branches and has yet plenty of time in hand to achieve the specialty rating. Even then the prejudice will remain.

Anti-elderly, anti-geriatrician prejudice within medicine is a gut reaction, primitive, unreasonable, arrogant, and strong. For this reason Mr Cross's solution is naive and cannot work, quite apart from the fact that it is also irrational. His "gerontologist" and his "physician to the elderly" are puny figures compared even with the present-day geriatrician. Teaching and research in clinical medicine become increasingly phoney when undertaken apart from clinical practice. As for the suggestion that the general physician will take over a chronic ward as well as his acute ward, thereby gaining the ideal complete facility, Mr Cross can rapidly disillusion himself by surveying the number of physicians who have ever been inside a chronic ward. When general medical staff are responsible for the management of chronic wards these wards often become disaster areas used for dumping difficult patients with unsolved problems, receiving the token weekly visit by a junior member of staff, and denied time and imagination, with the result that nursing staff morale is invariably low, work becomes drudgery, and care second-rate.

Whatever their faults geriatricians have grasped the common nettle of chronic illness and disability while many physicians continue to hunt the higher slopes for the tufted saxifrage which grows occasionally in the rarefied air, and who can blame them when their training prepares them for it and the power and the glory still seem to lie in that direction. Students draw the obvious conclusion and hasten after them.

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SIR,—Mr V H Cross's attempt to delineate how the sick elderly should be cared for in future (24 September, p 816) raises more points than can be adequately dealt with in a letter, so perhaps I may concentrate on just one—namely, his apparent assumption that elderly patients needing hospital treatment comprise two categories only—acute and chronic. There are three other very important categories: those requiring prophylactic care and treatment to prevent them becoming "chronic sick"; those requiring rehabilitation—often over many, many weeks—to restore them to an active life outside hospital; and those who can be cared for in the community by supportive relatives provided someone will take them into hospital for periodic "holiday relief admissions."

For all the foregoing categories the physician concentrating on the elderly sick (a better term than geriatrician) has a very important, although not exclusive, part to play. In the

latter regard the sheer magnitude of the future problems of the elderly sick is such that all doctors, inside and outside hospital, must be knowledgeable about how to cope with them, and that means that they must be taught by someone specialising in the subject.

A specialist in the problems of the elderly sick no more has to cope, in my view, with all the elderly sick in his district than a neurologist or a cardiologist has to care for all patients with Parkinsonism or all patients with cardiac failure in his district. All doctors must have at least a degree of competence to cope with the conditions they are likely to meet, but someone in each district must be available to advise his colleagues, within and without hospital, on the problems he or she specialises in. The sheer size of the problem of the elderly sick is such that all available efforts must be mobilised to minimise it—and someone has to be prepared to take the lead.

BRANDON LUSH

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SIR,—As a geriatric physician I read the thought-provoking article by Mr V H Cross (24 September, p 816) with interest. Not yet medically qualified, he reveals a maturity of thought often sadly lacking among even senior members of our profession.

I personally am not at all troubled by what others may feel is my lowly status in the eyes of my colleagues. There has never been any doubt in my mind that I am daily performing the role of a general physician to the elderly. I do not claim to be a super-specialist and few of my patients require that type of physician.

With regard to the quality of doctors in the specialty, in addition to the possession of the MRCP, other qualities are required. I rate management ability as a highly important attribute in successfully running a department and at appointment committees have concurred that where this was manifestly lacking no appointment to a vacant consultant post should be recommended.

I recall some years ago talking to Professor M R P Hall at Southampton and agreeing that to be successful in managing elderly patients one needed to be a superb physician. How many of us measure up to that challenge?

A A BEESON

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SIR,—I read with interest the article by Mr V H Cross concerning geriatrics (24 September, p 816). I am left uncertain at the message that he wishes to bring forth about the future of this specialty, and his schema concerning the future varieties of doctors caring for the elderly seems to me at best confusing and at worst unrepresentative of the views of those doctors who specialise in the field of caring for the elderly, whether you call them geriatricians or physicians in geriatric medicine or general physicians with an interest in the care of the elderly.

It must surely be totally inappropriate that, according to his schema, general physicians should provide the majority of the acute care of the elderly sick and that the majority of slow-stream and continuing care should be provided by a doctor who is termed a physician

for the elderly. In this unit the majority of our patients admitted come in acutely, either from the accident and emergency department or directly from general practitioners, and a high proportion, about 65-70%, are returned home within about a month. No adequate service to the elderly could be supplied by a system which segregates the acute from the continuing care of the elderly patient. Only a doctor who is concerned with the whole spectrum of diseases in the elderly can provide the service required. Notwithstanding this, Mr Cross's division of doctors who care for the elderly into three varieties can lead only to a lesser status for the doctor who does not take part in the care of the acutely ill elderly sick.

I feel that in the time that this medical student has been attached to a geriatric medical firm he has not grasped the message of what that group of doctors is trying to achieve. It is surely premature to say that proper medical teaching of the care of the elderly for medical students is not going to influence the position in relation to recruitment, as in most universities in Britain, and especially in the London medical schools, this has really started only in the last four or five years. Our early impression would suggest that the interest among the students for both the medical and the functional and social care of the elderly is at a high level and perhaps over the next 5-10 years the problems of recruitment for this specialty will be a thing of the past.

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Poisoning with antidepressants

SIR,—Dr C L Brewer (20 August, p 523) is right to remind us of the dangers of overdosage of tricyclic antidepressants, but, like Drs P J Dally and Joan R Gomez (3 September, p 638), I believe that he is misguided in the solutions that he proposes.

The main danger of tricyclic antidepressants is not their justifiable use in depressive illnesses, where the risks have been carefully weighed against the chances of benefit, but their misuse in a wide variety of conditions that are erroneously labelled "depressive illnesses." These include commonplace unhappiness, frustration, disillusionment, boredom, and a host of other emotional states as well as spontaneously occurring and reactive, short-lived down-swings of mood. These occur in normal people and in those with personality and social problems, some of whom may be potentially suicidal. There is little or no evidence that tricyclic antidepressants benefit these conditions, but prescribing them provides a readily available means of self-poisoning. Our attack, therefore, should be not so much on the drugs as on the conditions for which they are prescribed.

Dr Brewer now advocates mianserin and flupenthixol, and previously recommended viloxazine,¹ as alternatives to tricyclics. These or other drugs may indeed one day become the drugs of choice in the treatment of depressive illness, but as yet they are, as Drs Dally and Gomez state, "comparatively untried compounds." It takes many years for the full therapeutic and toxic potential of new drugs to be realised. They should therefore be regarded as experimental agents for a prolonged period after they have been marketed. To advocate the widespread use of one new drug

after another is potentially hazardous; it is better to stick to the devil we know than to flirt with one we don't know.

New drugs are often presented as having therapeutic advantages or less toxicity than their predecessors, yet a critical appraisal of the research undertaken does not usually justify such claims. Statistically significant differences between drugs or between one or more of the numerous variables measured, even in a meticulously conducted trial, can occur by chance alone. The skilful presentation of these should not be accepted as the cue for adopting a new fashion in prescribing. Neither should we be intoxicated by our own clinical impressions because if it requires a large sample and sophisticated methodology to demonstrate differences between drugs it follows that none of us has the mental apparatus to elicit these differences in routine clinical practice.

It is therefore sound practice to (1) use those established drugs that have been in use for the longest period of time, as any longer-term unwanted effects are more likely to have been recognised; (2) learn the difficult task of using them skilfully; (3) adhere to these principles until at least two or three meticulously conducted trials, fulfilling those criteria that have become well established in pharmacological research, have shown unequivocal advantages, including less toxicity, of the new drugs over the old; and (4) resist the pressures that will be put upon us to try the new drug for ourselves.

Paradoxical though it may sound, the main danger of "trying it for yourself" is that good results will probably follow. When dealing with conditions that run a fluctuating course or that are influenced by numerous non-specific factors, including changing drugs and the enthusiasm of the physician, the laws of chance will guarantee that good results will follow in a number of cases. The danger is that they are then attributed to the pharmacological action of the new drug as a post-hoc error of thinking and a stimulus is thereby given to the spread of a new fashion—perhaps with a drug that eventually turns out to be as toxic as its predecessors.

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¹ Brewer, C, *British Medical Journal*, 1975, 4, 409.

"New" operations for cataract extraction

SIR,—Wide publicity has been given recently to reports from a congress and elsewhere of "new" procedures of cataract extraction. Through the mass media assertions have been made of their facilitating the playing of golf and other games within 24 hours of operation. These procedures have also been the subject of a leading article in the *BMJ* (25 June, p 1616), which perhaps did not emphasise sufficiently that no one method is generally applicable to the surgical treatment of cataract.

Regrettably, this publicity has given rise to widespread anxiety and apprehension on the part of patients, who are unable to understand why their personal professional advisers are often less than enthusiastic when asked about the "new" operation for their own individual problems. The fact is that these procedures have been in use for a number of years and are by no means free from their own specific complications and difficulties. They have been discarded by some

surgeons who had used them for an appreciable time.

Your assistance in underlining the undesirability of wide publicity in the mass media which may lead the public to demand of its doctors inappropriate treatment and procedures would render signal service.

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Honorary Secretary
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Compulsory wearing of safety belts

SIR,—We would suggest that those who oppose the compulsory wearing of safety belts on the grounds of interference with the freedom of the individual should be given freedom of access to an accident and emergency department late at night and at the weekends, when an appreciable part of the time of the medical staff is spent suturing wounds of the face inflicted by shattered windscreens in patients who were not wearing safety belts. Much has been made of the reduction in mortality which can be achieved by the introduction of compulsory safety belt wearing. This is indeed important but represents only a small proportion of the total morbidity and the accompanying physical, social, and psychological misery which follows accidents in which car occupants have omitted to fasten their safety belts.

The records of all patients involved in road traffic accidents who attended the accident and emergency department of this hospital in July 1977 were studied. Of the 41 patients, 70% were not wearing safety belts and of these, 50% required surgical toilet for the repair of lacerated wounds (mostly to the head and face). Of the 30% who were wearing safety belts, only 15% required surgical toilet of lacerated wounds.

More detailed studies would be required to ascertain the cost in terms of time and money expended by the NHS. Sadly such surveys would give no idea of the distress caused to those on whom these wounds had been inflicted. If the politicians are genuinely looking for economies in the Health Service, this is one area of many where enormous savings could be effected without in any way jeopardising other essential services.

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Campylobacter-associated diarrhoea in Southampton

SIR,—We have investigated the occurrence of campylobacter infections in Southampton over a four-month period from April this year. A total of 860 faecal samples from patients with acute gastrointestinal symptoms were examined for microaerophilic vibrios using a selective blood agar containing vancomycin, polymyxin, and trimethoprim (VPT agar) and incubated at 43°C under microaerophilic conditions as described by Dr M B Skirrow (2 July, p 9). Campylobacters of the *C. coli-C. jejuni* group¹ were isolated from 36 patients (4.2%) and two healthy carriers. Twenty-two specimens were from adults and

16 from children under 15. Routine techniques for detection of faecal pathogens on the 860 samples gave 24 isolates of salmonellae (2.8%), eight of shigellae (0.9%), and six (0.7%) of enteropathogenic *Escherichia coli*. These figures suggest that during four summer months in Southampton gastrointestinal infection with campylobacter was as common as the combined total of the commonly reported faecal pathogens. Our figures represent more than 15% of the 253 campylobacter isolations reported during the same period in England and Wales (PHLS Communicable Disease Reports).

Detailed histories based on a questionnaire used by King² were obtained from patients. Diarrhoea was the main complaint in 32 out of 36 of the isolate-proved cases. (Of the 38 stool samples received 8 were liquid and 14 semiformed.) The duration of the diarrhoea was ascertained in 27 cases. Twelve patients had severe diarrhoea for more than three days and two gave a history of chronic diarrhoea; in one of these the diarrhoea had started 2-3 months ago and lasted five weeks and the other had had several episodes over a year. All the patients except two complained of general malaise and 19 out of 25 had temperatures between 39 and 40°C. Five patients complained of sore throat, two had bad coughs, one presented with urticaria, and one with swollen lymph nodes in the neck. Nine of the 36 patients were in hospital at the time of diagnosis: four were children with abdominal pain who had been admitted to the paediatric surgical unit, and at appendicectomy two were found to have acutely inflamed appendices and two had acute mesenteric adenitis; three others were children who had been admitted to the paediatric wards with diarrhoea and abdominal pain; the remaining two were adults in whom the infection was an incidental finding one being a 73-year-old woman who had presented with a stroke and diarrhoea and subsequently died and the second a 28-year-old woman who had been admitted because of recently diagnosed diabetes during pregnancy. This last patient was transferred from the antenatal ward to an infectious disease ward, where she was treated with oral neomycin. Faecal cultures were negative five days later and a normal baby was delivered by forceps after induction at 37 weeks. No cases of diarrhoea occurred in the admission ward or among the staff.

In addition to ascertaining clinical information the questionnaire was aimed at discovering factors of possible epidemiological significance. Four people gave histories suggestive of the infection having been contracted abroad. One patient associated the onset of her diarrhoea with eating fresh chicken in Spain and another with the eating of a water-grown vegetable; eight out of 12 people who had had the same vegetable were similarly affected. We assume that in the remaining 32 cases the infection was acquired in the United Kingdom. Campylobacters of the *C. coli-C. jejuni* group have been isolated from chickens in England, but in three family outbreaks (eight cases and two carriers) and in questioning 13 out of the remaining 19 patients chickens could not be directly implicated, though one patient had handled fresh chickens. Five children, however, gave histories suggesting that they could have acquired their infection from environmental sources; two had dug worms for fishing bait, two had been on biological field courses, and one had been camping in the New Forest. Sea-water samples collected from the Solent coast were filtered through 0.45-µm Millipore membranes and the latter incubated on the selective antibiotic media for 16 hours at 43°C. Six out of 13 samples gave campylobacter-like colonies on the VPT agar. Dark-ground and electron microscopy showed organisms which were similar to the human isolates. Five of these six strains were agglutinated by human sera from two people previously infected with campylobacter. Two patients with diarrhoea gave a history of contact with cage birds; in one case the bird had died, and a second patient bred canaries and a campylobacter strain was isolated at 43°C from the canary pen, but all the birds were healthy.