seems unlikely to be true, as the nicotine content of the smoke depends upon the nicotine content of the tobacco, and the tar: nicotine ratio in the smoke is controlled mainly by a suitable choice of tobaccos.

C G JARRETT
Chairman,
Tobacco Research Council

London SW1

¹ Tobacco Research Council, *Review of Activities, 1970-1974*. London, TRC, 1975.

² Hoffmann, D, and Wynder, E L, *Cancer Research*, 1967, 27, 172.

³ Bentley, H R, and Burgan, J G, *Analyst*, 1960, 85, 727.

⁴ Wynder, E L, and Hoffmann, D, *Deutsche Medizinische Wochenschrift*, 1963, 88, 623.

⁵ Terrell, J, and Schmeltz, I, *Tobacco Science*, 1970, 14, 78.

⁶ Burton, H R, and Benner, J F, Tobacco and Health Research Institute Workshop Conference, University of Kentucky, 11-13 January, 1972.

The elderly in a coronary unit

SIR,—The paper by Dr B O Williams and others (21 August, p 451) is an excellent study of the place of the elderly in a coronary unit. In this area the great majority of subjects over 70 presenting with acute chest pain are immediately admitted to this department. These patients and any other seriously ill patient requiring intensive care facilities are initially admitted to our own 12-bed intensive care area equipped with facilities for continuous ECG monitoring on a central display with associated arrhythmia monitors, automatic ECG write-outs, and visual and auditory alarms, together with synchronised DC defibrillation service.

Our experience is in accord with that of Dr Williams and his colleagues that elderly patients with severe confirmed myocardial infarction who require synchronised DC shock and defibrillation respond well to this procedure. But it is sad to note that, having shown the benefit of intensive care facilities for the older patient with an acute myocardial infarction, the authors conclude by suggesting cutting him off from these facilities. May I suggest that the majority of these patients do not require the full services of a coronary care unit but intensive care facilities in an area that is well staffed by nurses and doctors fully conversant with the basic equipment for the adequate monitoring and resuscitation of all acute seriously ill older people.

We in no way set out to be a coronary care unit, having neither the expertise nor the full range of services to do so. Fortunately our cardiology colleagues will immediately take over any of our patients who require pacing or other aspects of their special expertise. Once the period of full coronary care service is completed, the patient is transferred back to our care. This arrangement ensures that the small number of older persons who require very expensive technological services and expertise are not denied it if appropriate to the adequate management of their condition.

M S PATHY

Geriatric Unit,
University Hospital of Wales,
Cardiff

Admission of old people to hospital

SIR,—It is usual for those involved in discussions of the merits of institutional and community care to use emotive language and see no virtue in the other side's arguments. In particular, those in favour of reducing

institutional facilities dwell on infringements of personal freedom, horrors of institutionalisation, and cruel incarceration. Almost every committee of inquiry makes play of the inadequacies or frank malice of those responsible for the care of persistently disabled people.

In the name of preserving personal freedoms, obviating institutionalism, etc, and improving the quality of institutional care available to those acutely ill the number of beds now planned for the adult mentally ill has been reduced to such a low level that in itself this variable determines the sort of patient that can be admitted and the length of time he can stay in hospital. Few chronically disabled patients remain so persistently disordered that they can count on hospital as home.

Dr A A Baker, having contributed to the present state of services for the younger mentally ill,¹ is now heavily involved with old people (4 September, p 571). While I vigorously support the view that home is the best place to live out one's life, in full understanding that dementia carries with it a reduced life expectancy and that hospital admission carries a morbidity, it is clear to me that the "long-stay" ward has an important positive role to play in a comprehensive community service for the elderly mentally ill. For those who care to look farther than "Hello" or "Good morning" a fuller complex of human interactions is there to be seen on a well-run "death-do-us-part" ward. The nursing skills required to elicit maximal communication are comparable with those more tangibly demonstrated in other forms of "intensive care." The management of death is truly as important as anywhere else. When the issues involved are faced up to, unpleasant modes of death can be avoided more surely than among those left in fear and ignorance to their own devices.

Cruelty to the elderly can take many forms.² Let us be no party to reducing those facilities that are capable of giving care. Rather let us make plans for strengthening institutional as well as domiciliary supports.³

D J JOLLEY

Department of Psychiatry,
Withington Hospital,
Manchester

¹ Baker, A A, *Lancet*, 1969, 1, 1090.

² Baker, A A, *Modern Geriatrics*, 1975, 5, 20.

³ Blessed, G, *British Medical Journal*, 1976, 2, 478.

SIR,—As everything that comes from his pen, Dr A A Baker's paper (4 September, p 571) is both humane and provocative. The following response comes to mind.

Much of the problem which Dr Baker describes so vividly arises from our muddled attitudes. It is suggested that we must get used to certain guide lines in our decisions about old people who become increasingly deteriorated in their homes. We must come to realise that, especially towards the end of life, death is not the greatest evil but that pain, dyspnoea, and distressed feelings and thoughts are. This holds for the old women and an occasional old man about whom Dr Baker writes, and as far as distress is concerned also for their neighbours and "responsible" relatives. In general, one would say that an old man or woman who shows no undue decline in orientation, memory, and other mental functions and who clearly wishes to remain in his own home should be left there even if his or her presence causes a lot of distress and annoyance to others. However, where there is more severe mental

disorder (either with or without disturbed thought content) and also perhaps serious physical disease, as well as considerable distress to the human environment, admission ought to be arranged. Continued stay at home would sooner or later cause the patient grave symptoms (burns, fractures, or increasing states of fear due to abnormal thought content and experiences).

The fact that some 25% of elderly confused patients die within three weeks of admission should not worry us unduly. Although in many cases the sequence of events is no doubt that described by Dr Baker and related to removal from home, those of us who have studied elderly patients in the old mental observation wards know that in many cases admission had, in fact, been precipitated by the physical illness which led to early death. Much more serious is the situation which is described by Dr Baker in his case report enumerating a long sequence of treatments. No doubt he gave it to demonstrate that there are unfortunately still some doctors who are not sufficiently sensitive to the significance of pain and distress and who "strive officiously to keep alive."

FELIX POST

Maudsley Hospital,
London SE5

SIR,—Dr A A Baker's perceptive article on the treatment of old people living alone (4 September, p 571) rings true in every detail. The thinly disguised bullying which goes on to force these defenceless patients into hospital is conducted out of deference to three distinct errors.

(1) The assumption that the ordered life of the hospital ward must necessarily be preferable to the untidy state of affairs to which the patient has become adjusted at home. A much greater tolerance of less than perfect conditions with freedom and independence is needed as long as such obvious dangers as fire risks can be avoided.

(2) The obsessional belief that because admission to hospital can often add to length of life it is thereby automatically preferable to a shorter existence in imperfect surroundings. Absolute honesty would also inculpate many of us in that by pressurising the old into hospital we are rid of an unwelcome work load. When principle coincides with expedience the former is that much more attractive.

(3) The heresy born of contemporary materialism that living is always preferable to dying. We need to accept dying as something positively desirable in advanced age, not as an enemy but as a friend. Mere extension of life has no inherent merit except that of an unreasoning sentiment. "Enough is better than more" is a sounder philosophical attitude than "as much as possible," and any old person who takes the former view should receive the utmost respect.

S L H SMITH

Huddersfield

Fetal activity and fetal wellbeing

SIR,—I wish to congratulate Mr J F Pearson and Miss Judith B Weaver for their interesting article on this subject (29 May, p 1305). Most of their data agree with my own observations. I would like to make the following comments:

(1) We have observed that women who record fetal movements for 12 hours a day, as