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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.

Admission of old people to hospital

SIR,—It is appropriate that Professor A G M Campbell (2 October, p 812) quotes *King Lear*, which is still the most explicit statement of the problems of elderly people in society written for the expressive arts. However, *King Lear* was in no way the recipient of euthanasia, fast or slow. Lear made the first of his mistakes in retiring before he was ready for it. The progressive "un-roling" of elderly people, which starts at retirement and which is accompanied by a different treatment of them by society because they are "old," is the underlying feature of much mental illness.

The second mistake he made was to go and live with his children. Far nicer daughters than Goneril and Regan have become broken down by the close proximity of their parent, their love turned to despair and rejection by the life style of the elderly person—Lear's daughters were concerned not about his habits but the habits of his hundred knights, who were, of course, part of his royal person.

The *King Lear* syndrome is familiar to every general practitioner and hospital doctor. If there had been old people's homes and psychiatric hospitals Regan and Goneril would have been putting their GP under tremendous pressure to "do something." (They would certainly never have paid for a private home.) They committed the same fundamental error which we commit today—ascribing all his symptoms to his age, which thus excused them, and removed any stimulus for action:

"Never afflict yourself to know the cause;
But let his disposition have that scope
That dotage gives it."
(*King Lear*, Act I, Scene IV)

This is the same attitude which makes us interpret all symptoms in old age from visual failure to breathlessness as being primarily due to "their age." The *King Lear* syndrome can be prevented; although it is not possible to change quickly the role of elderly people in society, however, we must aim to make it possible for them to move to live near their children—because almost every local authority considers people from outside its area ineligible for rehousing. The excellent study by the Department of the Environment¹ has shown how well "granny flats" work. If we are to keep the health and social services going we must bring together extended families who wish to come together, and then support them. The housing policy which allows elderly people to move to the vicinity of their families must be an integral part of our health policies. The tragedy of *King Lear* is enacted every day, and it will drive more people mad until we tackle the fundamental housing problems of the elderly and allow *King Lear* to live near Cordelia.

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¹ Tucker, A, *Housing the Elderly: How Successful are Granny Annexes?* Department of the Environment, HDD Occasional Paper 1/76.

The elderly in a coronary unit

SIR,—Dr F F Thompson in his letter (2 October, p 814) claims that our suggestions

(21 August, p 451) could deprive older patients of this type of treatment. It is difficult to understand how he arrives at this interpretation. In many coronary units in Britain there is an age bar at 65 or 70 years, but since our unit opened seven years ago we have accepted patients without respect to age, and we are still operating this policy. We considered our experience sufficiently unusual, if not unique, to make it worth while reporting; hence our publication.

Morbidity and mortality after myocardial infarction are considerably higher in the elderly, but we did indicate that our results still made the effort worth while. Our argument in the last paragraph that intensive coronary care for the elderly shows less cost effectiveness was in the nature of devil's advocacy. We would wish to direct Dr Foster Thompson's attention to our *conclusions*—that ethical and moral considerations would not allow us to withhold treatment from the elderly. This has always been, and still is, our philosophy and our policy.

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Coronary care units

SIR,—I read the article by Dr M F O'Rourke and others (9 October, p 837) with interest, but hope that this collection of beliefs and suppositions will not be misconstrued as evidence of the efficacy of the "new generation coronary care units." The inadequacies of the data and their processing are both manifold and obvious, but perhaps I may make a few points.

(1) Deaths in hospital are not a valid measurement of the outcome of intensive coronary care, since this care may merely postpone the death. The figures show that deaths in the subacute stage were reduced much less than the acute deaths, but unfortunately there are no data for deaths occurring following discharge from hospital.

(2) There is very little information about the admission policy to the new coronary care unit and none about the selection of patients for the old unit. As there are 30 beds in the new unit and only three in the old unit, it seems inevitable that the admission policy must have changed, and this is reflected in the number of patients during the two periods—522 during 1973-5 and 196 during 1967-9. Unfortunately there has been no attempt to match the two groups for characteristics which may influence outcome—for example, age, sex, previous myocardial infarctions—and thus it must be concluded that two very different populations of patients are being compared.

(3) With a disease such as myocardial infarction, where there have been so many recent changes in the management, it is impossible to attribute changes in mortality rates over a six-year interval to any particular cause, since the influence of the other variables cannot be taken into account. Yet this paper attempts to attribute the apparent decline in mortality to the new coronary care unit and specifically to the pieces of technology housed there. In fact they are not very successful in apportioning credit either to arterial counterpulsation or fluoroscopic equipment (the only examples cited) and conclude by stressing the importance of the "quiet and restful atmosphere." "Atmosphere" is an unusual justification of the new generation coronary care unit, and perhaps more easily attainable elsewhere.

(4) Although the introduction suggests that the paper will provide evidence on cost effectiveness, no such information is provided. Nevertheless, the paper ends with the statement that the advances . . . "seem to be justified on economic grounds," a comment less than helpful without supporting information.

In conclusion, I do not consider this paper at all useful in clarifying the coronary care unit controversy. In fact, I am afraid that it may be counterproductive. I am disappointed that a paper of this quality is given so prestigious a position in the *British Medical Journal*.

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Bath-taking made easy

SIR,—The difficulty experienced by many elderly, infirm, or otherwise handicapped persons in being able to have a bath is all too well known, and in spite of various devices which can be obtained to assist such persons to get in and out of the conventional bath the performance, with or without assistance, is often found to be hazardous if not impossible.

It is true to say that most individuals step into their bath facing the taps and the plug, which, of course, they must be able to operate. It seems the natural way. But from this position the difficulty, especially for the infirm, is to be able to sit down in the water in a fully controlled way. If, however, the following simple procedure is adopted most persons who are

ambulant should be able to get in and out of the bath with comparative ease and safety:

(1) Fill the bath to the required amount and temperature and then turn off the taps.

(2) Step into the bath facing the end opposite to the taps (fig 1).

(3) Go down on hands and knees in the bath water (fig 2).

(4) Slide around (fig 3) (either to the right or left, whichever is found to be easier) into a sitting position. You will now be sitting in the bath in the normal position facing the taps (fig 4). It is of help in controlling this turn around if a foot is placed against the vertical end of the bath to act as a pivot.

(5) When finished bathing, first let the bath water run away; then reverse the procedure by turning round on to hands and knees (fig 2), stand up, and step out.

This way of getting in and out of the bath will be found to be surprisingly simple. The ease in which it can be done can be demonstrated on any floor, and it is easier to do in the bath. The procedure can be recommended not only to those classified as handicapped but also to the elderly in general and to many others who, for one reason or another, are less fit or agile. I believe that it might with advantage be adopted as a routine in hospitals and nursing homes.

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Posts in clinical rheumatology

SIR,—I am pleased that Professor W Watson Buchanan and his colleagues (11 September, p 628) have opened a debate on the problems

facing the specialty of clinical rheumatology. There is no doubt that rheumatology and rehabilitation are uneasy bed-fellows and that this combination has resulted in an ill-defined, unattractive specialty with the production of hybrid posts. Part of this problem is semantic. It must be noted that even the Tunbridge Report baulked at defining rehabilitation and indeed Professor Buchanan and his colleagues do not themselves define general medicine, rheumatology, or rehabilitation. In particular, general medicine is not synonymous with the day-to-day management of acute medical emergencies and, although a thorough knowledge of general medicine is very necessary to the practice of rheumatology, the ability to deal with the complete range of medical emergencies has less relevance to a specialty devoted mainly to chronic disease than it obviously has to, say, the practice of cardiology or respiratory medicine, where life-threatening situations are common.

Assuming that we need a rehabilitation specialty, I would contend that the problem is not what to do about clinical rheumatology but how to get people interested in medical rehabilitation. It is clear from Professor Buchanan's article that internal medicine aspirants are put off rheumatology and rehabilitation by the rehabilitation content of a post. This is because rehabilitation requires different skills from those tested in the MRCP examination and I would go so far as to say that medical rehabilitation will never develop successfully as a specialty until it frees itself from the irrelevant pseudorespectability of trying to recruit exclusively from the ranks of general medical aspirants. I would suggest that the diploma in medical rehabilitation should be made a quite thorough and comprehensive enough examination so as to obviate the necessity of having any other postgraduate qualification. This would widen enormously the catchment area for medical rehabilitation recruitment.

In turn, this would allow clinical rheumatology to develop in some cases as general medicine with an interest but also as a specialty in its own right like neurology or dermatology dealing with the whole range of rheumatic and arthritic disease and utilising the complete array of pharmaceutical and physical treatments.

In short, I believe that the best way of furthering clinical rheumatology would be to separate and further the distinct specialty of medical rehabilitation.

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"Statistics at Square One"

SIR,—As one who lectures on probability and statistics to engineering undergraduates, and as the husband of a medical practitioner, may I congratulate the *BMJ* for the recently concluded sequence of 20 articles entitled "Statistics at Square One," presented by the Deputy Editor. My experiences over some years, gained from the teaching (and examining) of the subject and from being asked to handle "real data" from the life sciences, have made me aware of a tendency for investigators, unskilled in statistical techniques, to identify their particular problem with a standard situation which appears "similar" and carry the computation from there. Such attempts