CORRESPONDENCE

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.

Isolation of patients with bone marrow depression

SIR,—We read with interest the paper by Dr P C Trexler and others (6 December, p 549) describing a modified gnotobiotic system and how it has been used to isolate patients with acute leukaemia. While in no way wishing to criticise the technical achievement of the authors we do have genuine doubts about the value of reports of this kind.

As Dr Trexler and his colleagues rightly point out, there is no evidence whatever that isolation during the induction phase of therapy for acute myeloblastic leukaemia improves the remission rate or length of survival. Similarly, there are no data available as to whether this approach is of value in the management of other conditions in which bone marrow depression occurs. Indeed, the Seattle group who have pioneered human bone marrow transplantation have pointed out recently that there is no evidence that isolation of patients has a place in the management of the severe bone marrow depression which occurs immediately after transplantation and that properly designed trials need to be carried out to examine this problem.[1] Nevertheless, there is an increasing tendency for centres that are dealing with patients with bone marrow depression to feel that they are not fully equipped if they do not have isolation facilities. Indeed, a recent television programme on the management of leukaemia showed that at least one centre in the United Kingdom nurses its acute myeloblastic leukaemics in isolation during the induction phase, and this programme has caused much anxiety to the relatives of patients who are being treated in centres where this type of procedure is not practised.

The median survival for acute myeloblastic leukaemia in adults is about eight months and if the first three to four months of the illness are to be spent in a plastic tent or other gnotobiotic environment, then surely we must obtain evidence that this approach is improving the remission rate or length of survival for these patients. In Oxford we have adopted a totally different philosophy, and provided the patients are in reasonably good clinical state they spend the majority of their induction period at home with their families regardless of their white cell count. They attend hospital for injections and regular surveillance but do have the advantage of spending a greater amount of the short time which is available to them in a more friendly environment than a plastic tent. This approach is, of course, equally uncontrolled but since all the patients are in the Medical Research Council leukaemia trials there should be enough evidence available to determine whether they do much worse if treated in this way and so far this does not seem to be the case.

Surely the centres in the UK that now have relatively expensive isolation facilities should concentrate on producing data on the real value of this approach for leukaemia therapy by means of randomised trials. This seems particularly important at a time when there is relatively little money available in the NHS and when increasing numbers of centres that are looking after patients with leukaemia or other forms of bone marrow depression are being pressured into obtaining expensive equipment, the value of which is totally unproved.

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[1] Thomas, E D, *et al*, *New England Journal of Medicine*, 1975, **292**, 823.

Geriatric patients in acute medical wards

SIR,—Do Miss Christine McArdle and her colleagues (6 December, p 568) really believe that £20 734·40 would have been saved if 11 patients had been accommodated in geriatric hospitals as soon as they were ready for discharge from the acute medical wards? After all, the authors themselves state that other patients were waiting to fill these acute beds, presumably at the same cost. The question raised in my mind by their article is, why does it cost three and a half times as much to treat patients in an acute teaching hospital as it does in a geriatric hospital?

Some patients in teaching hospitals, especially surgical patients, are justifiably very expensive to treat because they use costly equipment and labour-intensive services; and these few greatly increase the average cost of patient care. The ordinary run of acute medical admissions need not be so very costly, especially if expensive laboratory tests and treatments are used with discrimination. Elderly patients ought to be comparatively expensive to treat because they require, no less than younger ones, to be

thoroughly investigated if their disease is to be properly elucidated; and in addition they require intensive nursing and rehabilitation services to enable them to regain to the maximum degree their health and independence. Money invested in these activities is repaid by early discharge home and prevention of long-term hospital stay. The solution to the problem highlighted in the article might be a more even distribution of costs between the acute teaching hospitals and geriatric medicine, with consequent improvement in the capacity of both to meet the demands of the Health Service.

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SIR,—It is interesting to find the article on "Geriatric patients in an acute medical ward" (6 December, p 568) under the heading of "Contemporary themes." Judged by the south-of-the-border standards it is somewhat anachronistic, and it is disturbing to my Scots genes to find such a time-lag in attitude. Even the diehard brigade of "acute physicians" in the south have sadly acknowledged that the contemporary need of the population is for simpler medical and nursing support, not for more and more high-powered technology. The medical conditions requiring heroic technological action and resources are now few and far between, with "overdoses" leading the small field.

The most vital information required for the proper evaluation of the research recorded in this article surely must be exactly how many "several instances of patients who would have benefited from the specialised resources" there were. What were the conditions that would have benefited and what became of these people? One would postulate that they were admitted to yet another high-resource hospital. While there is a superabundance of fully staffed high-resource beds chasing the very small number of patients fulfilling the criteria of need there will continue to be overspill into these beds of the vast majority of elderly disabled people who constitute the bulk of those in need of institutional support at the present time. Furthermore, while the simpler and, as the article points out, perhaps more appropriate accommodation is starved of staff and resources owing to the greedy demands of the large teaching hospitals the circle of deprivation will continue.

One's mind boggles a little to read that one of the 11 patients who remained in the ward after "medical care had been completed" is recorded as having died. Without the benefit of further qualification of the statement one would conclude that this person was misplaced in the company of 11 bed-blockers.

We are too slowly establishing basic priorities south of the border. Perhaps, having cleared the air a little and fortified by Sassenach example, Scotland can now leapfrog ahead of us into sanity, adapting provision on common-sense lines to match the contemporary needs of an aging, impoverished, and frequently ill-housed population whose needs and desires are mainly for support to live more effectively and comfortably, and die with some dignity, in a residence of their own choosing.

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SIR,—At a time of national economic collapse many will have been impressed by the arguments in the paper from the University Department of Medicine at Glasgow (6 December, p 568). One bed-week in the Western Infirmary now costs £178·60; at a local geriatric hospital it costs £49·01; in local authority accommodation it costs approximately £23. There is surely a clearcut case for rapid transfer of elderly long-stay patients from the acute to the geriatric ward and so on to old people's chronic sick accommodation, and for expanding provision of the latter without delay.

In implementing this policy, may I plead for doctors and administrators always to remember that we are dealing with human beings and not sacks of coal. There is a disturbing trend throughout the country to refuse the elderly admission to all acute beds except for major surgical emergencies. Nor is this exclusion limited to the old, the senile, and the chronically disabled. Recently my local district general hospital issued the horrifying directive that geriatric patients—defined as all those over their 65th birthday—are not to be admitted to the acute psychiatric ward at all. Today I read that admission to a coronary care unit at a hospital in the north of England is likewise limited to those under 65.[1]

Such ruthlessness reflects a poverty of love rather than money. There was a time, not so very long ago, when I was proud to be working in the NHS, which was the envy of the world. Whatever has become of us?

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[1] *World Medicine*, 1975, **11**, 105.

SIR,—I should like to comment on the article by Miss Christine McArdle and others (6 December, p 568). In the first place geriatric patients occupying beds in acute medical wards are probably there because there is a disproportion between the beds available to the over-70s and to the younger members of the community. It is, of course, erroneous to consider a long-stay patient in an acute medical bed as occupying an "expensive bed." She requires only board, lodging, and nursing care and makes no demands on expensive diagnostic and therapeutic services. The cost of maintaining her in bed therefore falls wherever she is.

However, the problem posed by Miss McArdle and her colleagues can be solved relatively simply if the following policy is adopted. All acute and urgent admissions of those over 70 should be under a geriatric physician. Their admission should be to beds where, of course, he can call promptly on the expertise of his specialised medical and surgical colleagues when appropriate. The causes of "geriatric admissions" are complex but the demand for a bed for an elderly patient is acute and urgent in about 80% of cases.

I have had past experience of operating a geriatric service in Wolverhampton on this basis. I believe, and my general practitioner colleagues and the community care services will, I think, confirm, that in consequence a geriatric situation considered desperate and irremediable became manageable. The waiting list was eliminated and patients who needed beds were promptly admitted. The requests from my medical consultant colleagues to transfer patients became negligible.

It may be that in some areas in order to operate such a system a few acute beds need be transferred from the specialised physician to the geriatric physician. I think that they and even more their juniors would benefit by contact with the geriatric physician as well as having more time to exercise their special skills. In teaching it is even more important. Medicine is about sick people. The medical teacher cannot leave the management of the confused, the incontinent, the incurable to someone else in another place while he teaches the current constructs of clinical science. A large slice of the practice medicine of the future is going to be the medicine of old age. It is to be hoped that medical teachers will rise to this challenge and not opt out.

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SIR,—Is it not obvious to Miss Christine McArdle and her colleagues (6 December, p 568) that the services provided for the elderly are cheap, of poor quality, unattractive, inadequate, and inappropriate, and that the provision of acute medical beds is too great? As noted, elderly patients certainly do not stay in acute beds because they like them, nor would they come into them if something more appropriate was available.

It has been evident for a long time now that the acute bed has ceased to be relevant except in very limited areas of medicine. Our main therapeutic instrument now is, as it was in the past, the situation in which people are placed. By this I mean the structure of that situation, the people concerned with and bearing on that situation, the purpose for which the person concerned is living. This in practical structural terms means hospitals at home, sheltered housing, day centres, work centres, day hospitals, and a whole range of community services which many acute wards in teaching hospitals know very little about. The model needed is the effective living or the purposeful living model which calls for very different methods of understanding and outlook.

How do you recruit to geriatrics against the all-pervading acute-bed and teaching-hospital ethos? Just as important, how do you shift your finances from excessive technical provision to community services of quality for the elderly?

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Biopsy of nasopharynx as a staging procedure in Hodgkin's disease

SIR,—We were most interested in the finding by Dr A Biörklund and others (29 November, p 517) of a high incidence of abnormal tissue on biopsy of the nasopharynx in cases of Hodgkin's disease in view of our recent