perhaps unduly pessimistic in their conclusion that such evidence is never likely to become available. A randomised prospective clinical trial is not practicable, and it would certainly seem desirable before embarking on a routine policy of nutritional therapy involving the daily administration of nitrogen, calories, vitamins, and trace elements.

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Anglo-American contrasts in general practice

Sr,-Good general practice is an entity which is difficult to define and quantify and Dr G N Marsh and his colleagues (29 May, p 1321) are to be congratulated on their excellent contribution to the subject. The general practitioner is subjected to numerous incentives and their effect is shown very clearly in their paper. The percentage distributions of all diagnoses made in ill patients (table VII) are remarkably similar, yet in the American cases there is a strong bias towards examination—even over-examination—of their patients. In family planning consultations (table XIV) 77.7% of the patients in the American series had pelvic and 50% had rectal examinations, so at least 27.7% had both, which seems absurd since they were presumed to be healthy people. It appears that medicine there must not only be practised, it must be seen to be practised.

All medical procedures have a cost and a benefit and the requirement for their use must have some relation between their cost benefit ratio and the general standard of living. One might use the 10th, abnormality ratio as a yardstick in this consideration. For example, if less than 10% of the routine chest x-rays one orders are abnormal it is quite likely that the investigation is being requested too frequently. Clearly when the investigation is cheap and convenient or its results of greater importance lower ratios are acceptable. On the other hand many GPs in this country dispense with, for example, the frequent use of the clinical thermometer since a pyrexia that is not clinically obvious is often unimportant. In any investigation a factor of human observation exists and the vigilance that ensures its efficiency is likely to be relaxed when the expectation of the abnormality is likely to be unduly low. Large batches of routine physical examinations on healthy people tend to be self-defeating for this reason.

Perhaps we should not ask ourselves what is good general practice. When the patient is satisfied it is sometimes at the cost of doctor dependence or even patient dependence. Perhaps we should ask ourselves what is effective general practice, and here we are on sounder ground. The GP casts a net and we should really be concerned with what is caught and what passes through and in this respect the paper, as the authors point out, is not very helpful to us. Despite wide variations in the magnitudes with which the patients are investigated there is no evidence that the patients were any the better or worse for it. Clearly in America medicine is more visibly seen to be practised. What remains to be seen in whether it is more effective.

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Can geriatrics survive?

Sr,-Dr J C Leonard (29 May, p 1335) has written a provocative article and has done a service in bringing the misunderstandings of geriatrics by physicians into the open. Central to his arguments against the continuation of geriatrics as a specialty is his assertion that "the average age of the patients in many acute medical wards is probably not very different from that of those admitted to an acute geriatric ward." Furthermore, "every physician accepting general medical emergencies accustomed to the routine of acute illness is likely to be faced with, at most, occasional patients over the age of 65." Such is the basis for his conclusion that "in view of the similarity of the acute inpatient workload there seems no justification for separate general medical and acute geriatric units. Physicians accepting a general medical intake . . . will be at least as competent as the staff of geriatric units to deal with acute illness in the elderly and assess elderly patients with long-term problems or who are brought into hospital for "somatic examination."" These erroneous views appear to be held by many general physicians—the "we’re all geriatricians now" school. It perhaps relates to careless use of the terms "old" or "elderly" and the fact that many of those we encounter are in the over-75 age group. The average age of those admitted to geriatric departments is very high, our own average of 79.5 years being quite typical. In a study based on the geriatric department of the North Middlesex Hospital, where I was formerly consultant, we showed highly significant differences in the age pattern of admissions between medical departments and the geriatric service. Of the patients admitted to general departments from a defined area, 29% of the 65-74 age group were admitted to medical departments and 24% to the geriatric department. In contrast, only 16% of patients over 75 went to the medical wards whereas 57% were admitted to the geriatric department. Admission statistics for Northwick Park Hospital for the first quarter of this year show a similar picture and allow a comparison to be made between my own experience as a geriatrician and that of my whole NHS physician colleagues. On average, each of them saw rather more patients aged 75-84 in a month than I did. However, I saw five times as many over-75s and 15 times as many over-85s as they did.

I see quite a number of patients with cardiac, gastroenterological, or joint diseases and they see quite a number of elderly patients, but our experience is still surprisingly different. They are no more "all geriatricians now" than I am a cardiologist, gastroenterologist, or rheumatologist. Their specialist skills and mine equally depend on our different special experience coupled with special training, study, interest, and commitment in our particular fields. Dr Leonard’s outlandish criteria of what constitutes a specialty seem to me to be totally irrelevant.

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1 Hodkinson, H M. British Medical Journal, 1972, 4, 536.

Sr,-Dr J C Leonard’s arguments (29 May, p 1335) were well held above the water line by the consultants (12 June, pp 1464-66) who answered his question. May a general practitioner now explode the powder in the magazine?

Geriatrics has emerged not only because the elderly were not properly cared for heretofore but just as paediatrics developed from the demonstration by Ashby, Still, and Thomson in 1840, when it was of medical interest to understand biological modification by age. They did not wait, as Dr Leonard implied they should, until a firm foundation in clinical processes or unique techniques brought their techniques into being. They proceeded to uncover the basis of variant anatomy and physiology previously unrecognised in children as the basis of their clinical endeavours.

Now is Dr Leonard going to deny that since I qualified 25 years ago the most dramatic advance in geriatric care has been the development of geriatricians or that many over-75s have a stage of old age. Age is a factor in the requirement for the full time, a more complete understanding of this group. Having said this, geriatricians have been and are still needed to care for elderly patients, to work with the geriatrician and that of my whole NHS physician colleagues. On average, each of them saw rather more patients aged 75-84 in a month than I did. However, I saw five times as many over-75s and 15 times as many over-85s as they did.

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