The cardiologist first trains as a physician and then in his chosen specialty. The psycho-geriatrician trains first as a general psychiatrist and then in the special field of the psychiatry of old age. He needs a good grasp of geriatrics and gerontology and more than a smattering of social medicine, neurology, neurobio-chemistry, neuropathology, and psychology as these are all quite treatable. The problem of dementia is formidable but early diagnosis; the relief of aggravating factors like heart failure, anaemia, malnutrition, and overmedication; and support by day hospitals, intermittent admission, and community psychiatric nurses help to keep the patient at home, thus reducing the pressure on acute (including cardiovascular) as well as psychiatric beds. The effectiveness of specialised psychogeriatric service in reducing or eliminating the use of psychiatric beds, and improving care of the elderly has been demonstrated repeatedly. 1, 2

Cardiology, as Dr Pickering has shown, has much to offer the legion of sufferers from heart disease. Psychogeriatrics may do no less for the unprecedented number of the elderly mentally ill in Britain. Geriatric psychiatry is no more likely to seduce thwarted would-be cardiologists than frustrated psychogeriatricians are likely to turn to cardiology. Both specialties are sorely needed, and should support each other by compete with each other.

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SIR,—Dr Thomas Pickering in his letter (1 August, p 377) expresses his disquiet that there are almost the same number of psychogeriatricians as there are of cardiologists and that in terms of cost effectiveness psychogeriatrics is a luxury which the NHS cannot afford. There are some fallacies in his argument—for example, I would think that many general physicians might be upset by the implication that only older generation of medical care and that esoteric techniques he mentions. He seems contumacious of psychogeriatrics because it “does not require the same degree of specialist training.” It does not require the same sort of training as cardiology but the brilliance and skill it takes. It is. If it “can be as effectively provided by nurses, social workers, and general practi- tioners,” why wasn’t it? Psychogeriatricians exist to provide the leadership of services and they take a great deal of stick from the public, minor politicians, and often local administra- tors in the process—which things, I suspect, our more scientific colleagues would not toler- ate.

The part of Dr Pickering’s letter I find most breathtaking is his peroration—that he finds it sad that there is a “dominance of politics over logic (that is, over what he believes to be right) in the organisation of medical care.” It is sad when doctors fail to realise that it would be possible to spend several times the gross national income on the NHS and people would still become frail and eventually die. Thus, given finite resources, there is no political decision and it is only the political pressures from distraught families struggling to care for demented relatives and getting no help that has led to the setting up of psychogeriatric services. If Dr Pickering really wants to be judged in terms of cost effective- ness, then numbers of patients treated need to be compared; with 6% of the over 65s with some significant degree of dementia, the psychogeriatrician will be helping a large number of people—and not just cost, as there was no complex diagnostic or therapeutic machinery to use. The right way to appportion money I do not know; I am as biased towards my specialty as is Dr Pickering towards his. Luckily, the decision is not ours; it is for society to make. The real problem, the truly depressing fact, is that today society wants both to possess and to eat its cake—and preferably not to pay for it either—so that it demands both the latest and most expensive technical in- novations and a total and all-embracing care for those suffering from chronic problems.

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SIR,—As a social worker with an interest in psychogeriatrics, I read Dr T Pickering’s letter on the future of cardiology and psycho- geriatrics (1 August, p 377) with mixed feelings. I am glad that he appreciates the need for general supportive care of psychogeriatric patients by general practitioners and non- medicinally trained professionals. It is lamentable that there is so little specialist training in any field in the care and needs of the elderly suffering from the wide range of psychiatric disorders which fall under the psychogeriatric “umbrella” or indeed of their supporters.

In my experience, however, the most effective service can be offered by the multi- disciplinary team guided by the psychogeriatrician, who is highly trained in both physical medicine and psychiatry. The management of the psychogeriatric patient depends on accurate diagnosis and the formulation of treatment regimens requiring expert medical knowledge and experience. General practitioners, social workers, and nurses need the guidance of professionals as well as their own individual professional skills if they are to offer effective intervention and care.

The importance of cardiology as a specialty is indisputable, but I find it a sadly distorted logic which can find a place in the mind of psychogeriatricians overrated in comparison.

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SIR,—Dr Thomas Pickering (1 August, p 377) comments on the relative needs for specialism in cardiology and psychogeriatrics. As a former registrar in geriatrics who declares that ear

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