

normality, defined as: Loss or severe impairment of the capacity for self-care and self-preservation, or the occurrence of socially unacceptable behaviour, as a result of adverse intellectual or emotional change.

Four symptoms of advanced physical disease—stroke, multiple falls, inability to walk, and incontinence—were looked for in these patients. Two or more were present in 52% of the mentally normal and in 69% of the mentally abnormal. Both groups of patients were treated in the same wards by the same staff. Three months after admission 19% of the normal and 41% of the abnormal patients had died. The higher mortality of the mentally abnormal group might have been due to faulty management of their psychological symptoms or to the association of their mental symptoms with advanced physical disease. The latter explanation seems more likely. This is supported by the findings of Dr. Mezey and his colleagues; and though Kidd¹ in his original study rejected this explanation he did not provide figures comparing the mortality of mentally normal and mentally abnormal patients with physical disease treated in the same unit. I have not attempted to distinguish between physical-mental and mental-physical cases as defined by Kidd; my experience, however, lends no support to the view that "misplacement" is a significant factor in the high mortality of patients with mental symptoms admitted to a geriatric unit.

In the area covered by the study of Mezey and his colleagues many more old people were admitted to the geriatric than to the psychiatric unit. Similarly in this area I was able to estimate roughly that for every patient aged 65 or over admitted to the psychiatric service four entered the geriatric unit, and two of these had significant mental abnormality. Thus two-thirds of mentally abnormal old people requiring hospitalization in this area are treated in the geriatric unit.

Historically, our hospitals developed separate facilities and separate staff-training for the physically and mentally ill, and were then embarrassed by the arrival of a population of old people in whom physical and mental symptoms frequently coexisted. It is no solution to divide patients into arbitrary categories; to define some as "misplaced"; and to suggest the establishment of a third type of hospital unit to deal with them. A more obvious solution is to provide facilities for the diagnosis and treatment of physical and mental symptoms at the point of admission. This already happens in geriatric assessment units, though of course their staffs would benefit from more formal training in the management of psychological disease in the elderly. The special jointly staffed psychogeriatric unit advocated by Kay and colleagues,² located in teaching centres, could provide this training as well as teaching medical students and nurses and conducting research. But the service needs of the country as a whole would, in my opinion, best be met by the admission in the first instance to the geriatric assessment unit of all physically ill old people, whether or not they have mental symptoms. It would be difficult and uneconomical for many psychiatric hospitals to duplicate the complex diagnostic and treatment facilities of the modern geriatric admission unit. Psychiatrists would continue to deal with the com-

paratively few mentally ill old people whose physical health is normal (these comprised some 8% of the patients in the series of Dr. Mezey and his colleagues). Psychiatrists could also help greatly by their attendance at case conferences and seminars in their local geriatric units, to whose staffs they could communicate their specialized knowledge and insight. Such a scheme could lead to a situation where the medical care of the elderly depends on the principle that mental and physical diseases occur together and should be treated together.—I am, etc.,

BERNARD ISAACS.

Glasgow Royal Infirmary.

REFERENCES

- ¹ Kidd, C. B., *Brit. med. J.*, 1962, 2, 1491.
² Kay, D. W. K., Roth, M., and Hall, M. R. P., *Brit. med. J.*, 1966, 2, 967.

Old People in Hospital

SIR,—I hope that the somewhat detached tone of your comments on the outcome of the *Sans Everything* controversy (20 July, p. 135) is not an accurate reflection of the degree to which doctors feel themselves involved in the matter.

The *Findings and Recommendations*¹ which the Minister of Health presented to Parliament comments on overcrowding and shortage of nursing staff. Overcrowding occurs because doctors admit more patients than the hospital has room for. Shortage of nurses implies that doctors admit more patients than the nurses can properly look after. The inquiries also comment on the need for improved communications between doctors and nursing staff. Five of the seven hospitals named have between 1,288 and 2,258 beds—an average of 1,708. This piece of information is not stated in the reports but is the only finding of interest resulting from publicly naming the hospitals concerned, which I otherwise think unjustifiable. Revans has shown how large hospitals tend to have communication difficulties and low morale, so this finding is not surprising.² Doctors faced with an elderly patient living in unhealthy conditions in the community have to decide whether to admit her to an institution where she will increase the overcrowding and impose an extra burden on inadequate nursing staff—thus increasing the risk of allegations against them (not against the doctors) of cruelty or negligence; or on the other hand to leave her where she is to deteriorate and die in her familiar, if objectively squalid, surroundings.

Perhaps it is easier for the doctor to admit, and pretend that he is being compassionate to the patient (if cruel to his nursing staff), than to refuse to admit, on the realistic grounds that the community is failing to provide adequate facilities. But let us not pretend that we think that *Sans Everything* (even if exaggerated) was an unjustified publication, and that anyway it is no responsibility of the doctors.—I am, etc.,

JAMES R. MATHERS.

Birmingham.

REFERENCE

- ¹ *Findings and Recommendations Following Enquiries into Allegations Concerning the Care of Elderly Patients in Certain Hospitals*, Cmnd. 3687, 1968. H.M.S.O., London.
² Revans, R. W., *Standards for Morale*, 1964. London.

Intraperitoneal Transfusion in Anaemia

SIR,—We should be grateful to Dr. J. M. Fowler and others ("Intraperitoneal blood transfusion in African adults with hookworm anaemia") (27 July, p. 220) for providing such a clear demonstration of the potential usefulness of intraperitoneal transfusion in tropical practice. Their extension of the technique to the treatment of adults should prove to be of great value, particularly "in rural hospitals where . . . a simple, safe and effective method is obviously needed." Their implication that the therapeutic value of such transfusions in children has already been established is, however, open to question. No controlled clinical trial to compare it with the conventional intravenous route has yet been made.

Last year in a rural West African mission hospital both the intravenous and intraperitoneal method were being used in children under 5 years of age in whom malaria, severe pyogenic infections, and protein-calorie malnutrition were the main cause of anaemia; hookworm was rare. No attempt was made at pairing or random allocation between the two methods, and in general the most seriously ill children received intravenous blood. But even when this was taken into account the results of intraperitoneal transfusions were disappointing by comparison. In 57 such transfusions there were 17 deaths (30%), while among 48 cases where intravenous blood was given initially (18 of these subsequently had some intraperitoneal blood as well) there were only seven deaths (15%). In three cases of the first group it seemed likely that the intraperitoneal transfusion itself was a contributory cause of death. Only 38% of the group having intraperitoneal blood showed a satisfactory rise in haemoglobin concentration (at least 5 g./100 ml. in four weeks), while 62% of the intravenous transfusions produced a similar rise.

We concluded that in these severe anaemias in young children, where cardiac failure was not often a presenting feature, intraperitoneal transfusions did not seem to be a satisfactory alternative. Nevertheless, we thought they were worth a clinical trial in childhood cases of chronic, compensated anaemia.

We had another striking finding that is corroborated by the results of Dr. Fowler and colleagues. This was the wide variation between patients in the response of the haemoglobin concentration to intraperitoneal transfusion. While a few showed a dramatic rise of as much as 2 g./100 ml. per day, others showed little or no change, and the difference could not be correlated with the cause, the severity, or the chronicity of the anaemia.—I am, etc.,

J. M. PATRICK.

Department of Physiology,
The University,
Dundee.

Electric Convulsion Therapy

SIR,—Your leading article (25 May, p. 448) on electric convulsion therapy was most welcome as an attempt to explain one of the most successful and least understood therapies in medicine. Unfortunately it has not so far stimulated the discussion it deserved.

Your leading article discusses the effects of E.C.T. at the biochemical level and dismisses any theory that its efficacy could be due to factors at the conscious or behavioural level. The statement that E.C.T. is not a "punishment" is misleading. Though it does not