BRITISH MEDICAL JOURNAL

SATURDAY 21 JUNE 1975

LEADING ARTICLES

PAPERS AND ORIGINALS

MEDICAL PRACTICE

NEWS AND NOTES

SUPPLEMENT

NO. 5972 BRITISH MEDICAL JOURNAL 1975 VOLUME 2 647-704 ASTM CODEN: BMJOAE 2 (5972) 647-704 (1975)
BRITISH MEDICAL ASSOCIATION TAVISTOCK SQUARE LONDON WC1H 9JR. SECOND CLASS POSTAGE PAID AT NEW YORK N.Y. WEEKLY 70p

CORRESPONDENCE

Correspondents are urged to write briefly so that readers may be offered as wide a selection of letters as possible. So many are now being received that the omission of some is inevitable. Letters should be signed personally by all their authors.

Society's Responsibility

SIR,—As a clinician practising general psychiatry from a peripheral hospital, I am increasingly worried at our inability within the Health Service to provide for our patients' needs. I am particularly concerned at the steadily decreasing number of beds for two groups of patients—those who need care and rehabilitation extending over a period of three to 12 months and those who are elderly and mentally confused.

The run-down of our psychiatric hospitals was accomplished by the discharge of many patients who, admittedly, at that time appeared no longer to need a psychiatric ward as such. Over the ensuing years, however, these patients either have had acute exacerbations, have steadily deteriorated, or have inevitably imposed enormous stresses on their caring relatives. The time has now arrived where within my own area alone there are a number of chronically mentally disabled persons who really need full-time, longer-term care within a protective and supervised environment yet for whom no beds are available. There are a considerable number of mentally confused old people who should be in hospital at this moment both for their own safety and for the mental well-being of their relatives, yet for whom there are no beds. If patients from either of these two groups are readmitted to an "acute" bed in the district general hospital psychiatric unit, then that bed may well be occupied for many months (or, in the elderly group, for years) to the detriment of those patients who need shorter-term care only.

How much longer will the clinician be expected to offer a service with so few facilities? To whom will blame be apportioned when some calamity occurs—an elderly patient burned to death through inadequate supervision, a chronic schizophrenic attacking a bystander? What will society expect when increasing numbers of presently supporting relatives gradually die and leave their mentally disabled patient bereft of support? Is it not time that we as a society should discuss these problems now in our midst and attempt at a national level to devise some contingency plans for the inevitable?

No longer can society expect clinicians to "cover up" for the lack of hospital and community services. The problems we now face in psychiatry alone can be solved only at a political level.—I am, etc.,

B. W. DURRANT

Oakwood Hospital,
Maidstone, Kent

SIR,—In the past five years there has been an increased interest in the community and social care of the mentally retarded. At the same time new permanent residents have continued to enter hospitals for the mentally handicapped.

Fewer long-stay patients are now being admitted compared with the position 5-10 years ago. Today many who at that time would have become permanent residents are managed by repeated short-stay care or day attendance until in course of time inpatient admission becomes inevitable, when relatives can no longer look after them. For this group long-term hospital admission is delayed, not prevented, and in the meantime families may carry a considerable burden of care. Despite the much-publicized undesirability and unsuitability of hospital for the mentally handicapped, their families, general practitioners, and social workers continue to request hospital admission. Apart from a minority referred because of their profound mental handicap and physical helplessness or infirmity, most of the admissions come with behaviour problems which cannot be managed at home or in hostels, special schools, or day training centres.

If an appreciable decrease in patients at hospitals for the mentally handicapped is to be achieved in the future a large number of mentally handicapped people who are at present socially unacceptable because of their behaviour or helplessness will have to be managed by alternatives to hospital. If they cannot live at home some form of institution, be it hostel or mini-hospital, is necessary. I am, etc.,

D. A. SPENCER

Meanwood Park Hospital,
Leeds

SIR,—We were disheartened to read (17 May, p. 376) that as a result of a cost-benefit analysis Drs. M. J. Buxton and R. R. West came to the conclusion that society must look carefully at alternative uses for health expenditure before we continue or extend haemodialysis therapy. We believe this analysis to be faulty.

We do not doubt the stated expenditure on dialysis, though in our unit one-third of the patients attend for night dialysis, completely unattended by nurses, before going into their homes, cutting down the expenditure of hospital dialysis from the staff point of view, and this enables the unit to be run at slightly more than half-time.

We would like to challenge the figures given for the income of those able to work as the average annual wages of our patients on brief inquiry are at least twice those mentioned in the text; actual expense should be compared with actual income in Cardiff or elsewhere. The second serious fault is the assumption that if we do not treat patients by dialysis then they will just disappear. This is not true, and though we do not practise selection, we do have the occasional patient who is undialysable for medical or psychiatric reasons and these have taken a very long time to die with good nursing in hospital, some up to three or four months, and if dialysis ceases we still have to care