BRITISH MEDICAL JOURNAL

SATURDAY 1 AUGUST 1981

LEADING ARTICLES

CLINICAL RESEARCH • PAPERS AND SHORT REPORTS • PRACTICE OBSERVED

MEDICAL PRACTICE

NO 6287 BRITISH MEDICAL JOURNAL 1981 VOLUME 283 335-394
BRITISH MEDICAL ASSOCIATION TAVISTOCK SQUARE LONDON WC1H 9JR.

ASTM CODEN: BMJOAE 283 (6287) 335-394 (1981)
WEEKLY, SECOND CLASS POSTAGE PAID AT NEW YORK NY

CORRESPONDENCE

We may return unduly long letters to the author for shortening so that we can offer readers as wide a selection as possible. We receive so many letters each week that we have to omit some of them. Letters must be signed personally by all their authors. We cannot acknowledge their receipt unless a stamped addressed envelope or an international reply coupon is enclosed.

Correspondents should present their references in the Vancouver style (see examples in these columns). In particular, the names and initials of all authors must be given unless there are more than six, when only the first three should be given, followed by et al; and the first and last page numbers of articles and chapters should be included. Titles of papers are not, however, included in the correspondence section.

The future of cardiology and psychogeriatrics

SIR,—Your 9 May issue, containing a leading article on the future of cardiology (p 1500) and a survey of the present status of psychogeriatrics (p 1529), makes depressing reading. It is stated that there are at present 103 full-time consultant cardiologists and at least 106 psychogeriatricians (full- or part-time) in the UK, and it is clear that the latter group is rapidly expanding while the former is not. With its limited financial resources, it is surely important that the NHS should attempt to compare the cost effectiveness of physicians in different specialties, to see where those resources can be put to most effect. While in most cases this is obviously very difficult, when comparing specialties such as cardiology and psychogeriatrics there are some very clear-cut differences.

Heart disease, mainly as coronary artery disease and hypertension, continues to be the leading cause of death in the United Kingdom as well as in the United States. It is treatable once it becomes manifest, and also to some extent preventable—as shown by the declining incidence of cardiovascular deaths in the United States, although this has not yet occurred in Britain. It is also a field where huge technological advances have been made in the past few years. New diagnostic techniques such as radionuclide cineangiography and therapeutic techniques such as coronary artery bypass surgery offer great potential for reducing morbidity and mortality in selected patients; but their proper application necessitates highly specialised training. They are expensive and can easily be abused; both are probably overused in the United States and underused in Britain.

Psychogeriatrics, on the other hand, does not require the same degree of specialist training. There have been few technological advances, and with few exceptions the process of senility is largely irreversible. What is required for the ever-increasing number of psychogeriatric patients is not so much a team of specialist physicians as general supportive care, which can be as effectively provided by nurses, social workers, and general practitioners as by consultants. When I was an NHS registrar in geriatrics I considered that my most effective therapeutic procedures were syringing ears and debriding bedsores.

To a relatively detached outside observer, it seems clear that the NHS has got its priorities wrong. As one who has worked in both specialties in the NHS, and later emigrated, I find it a sad testament to the dominance of politics over logic in the organisation of medical care.

THOMAS PICKERING

Cardiovascular Center,
New York Hospital-Cornell Medical Center,
New York, NY 10021, USA

Colorectal surgery—the Cinderella specialty

SIR,—The leading article "Colorectal surgery—the Cinderella specialty" (18 July, p 169) poses an important question with regard to colorectal anastomoses: what can be done to improve the results of hand-sewn techniques? The last of three suggestions indicates that there is a need for the Royal Colleges to invest time and effort in developing ways for surgical trainees to learn their craft while avoiding clinical experimentation on patients.

We were interested in this suggestion as the Royal College of Surgeons of England, having previously staged very successful craft workshops in microvascular and orthopaedic surgery, held an "anastomosis workshop" in March this year. This had been carefully planned during 1980. Pig viscera were used, and proved most satisfactory. Jigs were designed to simulate situations encountered in live-human operating. The workshop dealt with oesophagogastric, small bowel, and arterial anastomoses together with colorectal anastomoses. For the latter the St Mark's pelvis simulator was constructed, and this succeeded in creating some of the obstacles of a low anastomosis.

An account of the workshop together with a description of the jigs will appear in the September issue of the *Annals of the Royal College of Surgeons of England*. All those who