

BRITISH MEDICAL JOURNAL

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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.

Acute hospital services for the elderly

SIR.—As consultant physicians in geriatric medicine in teaching hospitals, we wish to comment on the provision of acute hospital services in London. We are particularly concerned at the use of the word geriatric in the context of non-acute services in the report of the London Advisory Group chaired by Sir John Habakkuk.¹

This report, published in January 1981, supports the case for a reduction of 15% over the next six or seven years in the number of acute beds and recommends that the resultant saving in resources should be reallocated to inpatient and outpatient services to the elderly, the mentally handicapped, and the mentally ill. We submit that the continued convention of divorcing beds in departments of geriatric medicine from calculations concerning the provision of acute hospital services in London no longer reflects the needs of the population over the age of 65 years, and is contrary to the philosophy of contemporary geriatric medicine.

In practice we are involved in the treatment of acutely ill elderly people as well as those who require medium-term or long-term hospital care, and equating "geriatric beds" with non-acute medicine in the eyes of the administration, the profession, and the public alike is to

be deplored. It is well known that the general wards in the London teaching hospitals now contain, and will continue to contain, many elderly patients with diverse medical and surgical problems. We believe that in these hospitals a geriatric medical presence, with adequate resources, is now essential to show by example and advice that these patients, many of whom have complex and interdependent physical, mental, and social problems, can be managed effectively and their stay in hospital reduced to the shortest possible time. Such an active geriatric medical presence on site complements the efforts of other departments and, by increasing bed turnover and cost effectiveness, enables the hospital to work more efficiently.² Moreover, such a concentration on the special needs and problems of the elderly with its emphasis on total patient care, from a base within the main district teaching hospital, would more easily allow the now necessary development of an essential part of undergraduate education.

"Acute" beds must not be considered as a problem in isolation. Our population at all ages needs acute and continuing-care beds. Elderly people, however, make the greatest demands for both. Failure to provide adequate appro-

priate facilities for the acute care of the elderly will lead inevitably to increased demands for long-term care, which is undesirable for both the individuals concerned and the purse of the community, as history has now clearly shown.

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¹ London Advisory Group. *Acute hospital services in London*. London: DHSS, 1981.

² Burley LE, Currie CT, Smith RG, et al. *Br Med J* 1979;ii:90.