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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 should be typed with double spacing between lines and must be signed personally by all their authors, who should include their degrees. Letters critical of a paper may be sent to the authors of the paper so that their reply may appear in the same issue.

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.

Are too many patients with mental handicap being discharged from hospital?

SIR,—I am a consultant in mental handicap who has been in post for 30 years. Until recently all patients in hospitals for the mentally handicapped were admitted and treated by consultants and discharged by them, with the agreement of other members of staff concerned. The consultant, furthermore, was responsible for all resident patients.

During the past few years some district health authorities have allowed the post of consultant in mental handicap to lapse. Numbered among these are Scunthorpe Health District (Rawcliffe Hall Hospital) and Harrogate Health District (Whixley Hospital). In these hospitals patients are being discharged by community physicians without any consultant in mental handicap being involved.

Great reliance is placed on the Wessex scale, which is a scale of ability numbering from 1 to 5: those in category 1 are the most able patients, and those in category 5 are the least able. This scale, however, takes little or no account of the patients' psychiatric state, and in fact most of the Broadmoor and Rampton patients would be eligible for immediate discharge if assessed only on this scale. It is no wonder that the public are getting increasingly concerned about unsuitable patients being discharged into the community.

We are steadily returning to the dark ages of psychiatry when people with psychiatric conditions were found in the workhouse, underneath arches, or in prison. The driving force behind this mass exodus is not clinical but financial. It is hoped that most of these hospitals will be closed down and the money used for other purposes. I do not feel that these patients should be the victims of well intentioned but ill conceived social experiments.

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Relevance of osteoporosis in women with fracture of the femoral neck

SIR,—Dr J M Aitken (25 February, p 597) reminds us that more than osteoporosis is involved in the fracture of the femoral neck in the elderly. There are at least three factors[1]: firstly, bone weakness due to osteoporosis, osteomalacia or bone quality defects[2]; secondly, trauma; a community survey shows that the annual prevalence of falls increases through old age and is higher in women that in men[3]; thirdly, something which has received less attention than it deserves, the age associated impairment of protective responses when falling. The chief epidemiological evidence for this is that the incidence rates of falls and of femoral fractures increase with age in the elderly, but the incidence rates of forearm fractures do not.[4,5] This suggests that old people who fall are less likely to use their arms in time to protect themselves and the stresses placed upon the femora in falling may therefore be disproportionately greater than those on the femur of a younger person who falls.

The obsession, presumably left over from nineteenth century germ theory, for associating each disease with only a single cause seems to have persisted longer in the case of proximal femoral fracture in the elderly than in many other areas in medicine.

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