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## LEADING ARTICLES



## PAPERS AND ORIGINALS



## MEDICAL PRACTICE



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# CORRESPONDENCE

*Correspondents are asked to be brief*



## State of the Economy and the Geriatric Services

SIR,—As a geriatrician I am profoundly concerned at the state of the economy and the parlous state of the National Health Service. It seems to me that the major crisis in the hospital service is no longer bricks and mortar but simply pairs of hands to do the job. One gathers that the social services departments are cut to the absolute minimum expansion, and that all the propaganda and publicity together with new legislation heaped on their shoulders means they cannot possibly hope to cope.

Family practitioners whom I would normally regard as honest and competent seem to be sending elderly people into hospital with at times what can be described only as a totally fictitious medical diagnosis. The reason seems to be to obtain relief from an intolerable domestic situation in which the old person finds herself and from which neither she, the district nurse, home help, nor family doctor can escape. These old people rapidly get better with simple care and perhaps virtually nothing in the way of medicine. But when one tries to restore them to the community or seek alternative care within it such a resistance is put up or they return to such a hostile atmosphere that they inevitably break down again. This seems in turn to be leading to increasing disharmony among the various groups who are trying to provide against all the odds some service for this large, very frail, and grossly neglected section of society. Several of my colleagues and, indeed, I myself have now reached a point where the ability to care for genuine patients in hospital is jeopardized by this vicious circle. The simple "pair-of-hands" syndrome is so bad that at times it is positively dangerous to admit proper patients because they cannot receive the care that should be their right.

One sees very clearly that more and more elderly people are going to be admitted to hospital for very dubious "medical" reasons —not only in geriatric wards but also in general medical and surgical wards—because the community cannot support them and that the hospital will not be able to return them to the community because of this lack of support. A hospital is just about the most expensive "hotel" available, and I see us paying enormous sums to keep people in the wrong place at the wrong time for entirely the wrong reasons but with no obvious escape from the situation.—I am, etc.,

G. R. BURSTON

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## Community Hospitals

SIR,—Unlike Mr. H. T. John and his colleagues (30 November, p. 534) I welcome the Department's document on community hospitals.

Devon, like the Bath Health District, has many local hospitals which serve isolated rural communities or small towns. In this county there are also proportionately more old people than in any other and at present the mentally ill among them who require long-term inpatient treatment in a psychiatric hospital must receive it in one hospital situated up to 50 miles (80 km) from their homes and relatives. I therefore welcome the opportunity to offer to these predominantly demented patients a local community service that will minimize their detachment from others and distribute more evenly the responsibility for their care. Professional standards will be maintained by the continued integration of peripheral units into the team practice of the consultant psychiatrists concerned. This is surely an area for "close relationship between the consultant and family practitioner and mutual understanding of each other's problems and the patient's needs."

If it is felt that work with the elderly would result in "greatly diminishing interest and morale" and restriction in the range of work (and it must be accepted that this is a common attitude), then this like any other problem in, for example, medicine or surgery must be examined objectively in the light of the patients' best interests. It should not be accepted as an unremediable fact of life which underlines status differences between different professional disciplines and patient age groups.—I am, etc.,

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## Neuropathy Due to Cytosine Arabinoside

SIR,—We wish to draw attention to a possible neurological complication of treatment with the antineoplastic agent cytosine arabinoside (ARA-C). This is probably the most widely used drug in adult acute leukaemia, but we are not aware of other published reports of peripheral neuropathy associated with this drug, and a recent review on the neurotoxicity of antineoplastic agents makes no mention of it.[1]

We here report two patients who developed symptoms of a sensory peripheral neuropathy following treatment of acute myelogenous leukaemia with ARA-C.

*Case* 1—A 49-year-old man (weight 80 kg) was diagnosed as having acute myelogenous leukaemia in November 1970. He received induction chemotherapy consisting of ARA-C intravenously eight-hourly for 48 hours (total dose 4 mg/kg) followed 48 hours later by daunorubicin 1·5 mg/kg intravenously and a further three daily injections of