the implementation of the policy. Tasks for the first year are raising awareness about the policy; providing gender specific health information; including the woman's perspective in mental health planning; providing comprehensive well woman clinics; and establishing, in conjunction with Strathclyde Regional Council and Glasgow District Council, a centre for women's health.

While this is the first stage of a long term plan to improve the health of Glasgow women, we believe that consideration of gender has a significant part to play in improving the health of the whole population.

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1 Khaw K-T. Where are the women in studies of coronary heart disease? *BMJ* 1993;**306**:1145-6. (1 May.)

Cardiovascular responses differ between the sexes

EDITOR,—Kay-Tee Khaw's concern with gender bias in the treatment and investigation of cardiac disease[1] is long overdue, as we have emphasised over the years.[2,3] In her concentration on "studies to identify differences in the recognition of symptoms, the results of diagnostic tests, . . . etc" she has, however, failed to address the crux of the problem—namely, the lamentable gap in our knowledge of cardiovascular responses and control in women. Most data on cardiovascular activity are derived from investigations in male subjects; some studies do not even specify the sex studied.[3] This disparity is the more surprising since coronary heart disease is the main cause of death in women after the age of 55, particularly in the United Kingdom, outweighing deaths from breast cancer by a factor of 5 to 1.[4]

Yet when comparative studies have been performed—for example, of the blood pressure and heart rate responses to isometric exercise—the responses in men and women have been found to differ.[3] We have found a differing pattern of change in peripheral blood flow in women of advancing age compared with men; and in ovulatory menstrual cycles we found changes in peripheral flow linked with altered concentrations of endogenous female hormones.[5] Cardiovascular responses are not identical in the two sexes.[2] We would therefore expect the sexes' response to disease and treatment also to differ.

The type of trials conducted in women also needs to change. More and bigger studies of the established beneficial influence of oestrogen replacement treatment on coronary heart disease in women will not solve the basic problem of how oestrogens exert this influence.[3] Nor will further lipid studies answer this question as oestrogen replacement treatment reduces the progression of atheroma in cynomolgus monkeys fed an atherogenic diet after oophorectomy, irrespective of their serum lipid concentrations, and transdermal oestradiol increases forearm flow after only six weeks' treatment before any significant change in lipid concentrations occurs.

Khaw rightly emphasises the potential benefits that may accrue to men by study of the effects of disease in women. This applies even more so to studies of normal cardiovascular performance.

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Long term care of elderly people

Medical supervision is vital

EDITOR,—The British Geriatrics Society welcomes John Kellett's call for an equitable solution to the funding of long term care and considers a national public debate is a necessary prelude.[1]

The Department of Health has no plans to issue central guidelines on what constitutes health rather than social care, preferring this issue to be decided locally.[2] Written and oral ministerial statements have emphasised that where long term care is required by reasons of ill health, such care must be directly funded by health authorities.[3] Yet many health purchasers have failed to follow this guidance and no longer purchase free NHS long term care.[4,5]

Furthermore, NHS care need not be provided on NHS premises but can be purchased in private nursing homes. Thus, the main difference between health and social care lies in the provision of medical supervision, as emphasised by Brian Mawhinney in a conference speech in July 1992: "health authorities continue to be responsible for the care of people with medical needs that cannot be met simply by combining GP and standard nursing home care."

The British Geriatrics Society regrets that the concern over the financial arrangements for long term care have obscured the large scale withdrawal of consultant supervision of long term patients. The current practice of geriatric medicine has grown from the initial responsibility for the continuing care sector but consultants in geriatric medicine continue to be trained to provide medical leadership in this area. The society has issued *Specialist Advice and Long Term Care—A Policy*, in which it defines the way that medical direction of long term care can establish a framework for the development of individual care plans to maximise autonomy.[6] It recommends:

(1) that specialist consultant advice should be considered in the purchasing and provision of long term care;

(2) that nursing homes either individually or in groups should have appointed consultant medical advisors whose responsibility should be to establish a satisfactory standard of care and its maintenance.

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US carefully moniotors the private sector

EDITOR,—J Grimley Evans's editorial on the institutional care of elderly people still promotes the old canard that American long term care is inadequately monitored.[1] It is time to dispose of this notion for once and for all.

This statement was true of the private sector some decades ago but is not at all true now. The private (presumably meaning the for profit) and the non-profit components of long term care are, if anything, overmonitored now, and have been for several years. Both state and federal departments survey individual nursing homes (the locus of all institutional long term care outside the Veterans Administration system) regularly, at least yearly by the individual state health service division of long term care, and less frequently by the federal agencies, at a level of intensity that the British long term care sector would do well to emulate. Such evaluations are codified and comprise all aspects of institutional long term care including nursing, dietary, social, sanitary, medical, rehabilitation, pharmaceutical, and administrative services, not to mention patients' ethical and legal rights and requirements. It would be encouraging to think that an equivalent level of supervision of care standards was equally enforced at yearly intervals by a formal standardised process throughout the United Kingdom. The Hospital Advisory Service is a pale comparison to the state and federal inspection teams, who have the power to stop federal and state reimbursement to long term care institutions and if necessary to shut them down if they are not complying with regulatory standards, and this does happen. The regulatory supervision of long term care has intensified since the Omnibus Budget Reconciliation Act[2] to an almost stifling degree.

Admittedly geriatric medicine in the United States had much to learn from Britain in earlier days and still does. Restraining patients or nursing home residents as a therapeutic measure, either physically or chemically, is not yet a thing of the past and requires an attitude change in the education and practice of nurses, doctors, and lawyers. However, the recent evolution of long term care in Britain along lines not unlike the United States system requires that better standardised and effective systems for monitoring long term care are developed and regularly and fairly implemented.

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1 Grimley Evans J. Institutional care and elderly people. *BMJ* 1993;**306**:806-7. (27 March.)
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Taking a balanced view on triazolam

EDITOR,—G Burton and C Carter complain that we did not take into account "the majority of the published information, let alone the unpublished information on triazolam,"[1] in our editorial.[2] They do not, however, specify what we missed out or what unpublished material we might reasonably have had access to. In a brief editorial it is not possible to cite every piece of published research, but we made an effort to take a balanced view and, in particular, devoted much of our limited available space to discussing the spirited defence of triazolam by Jonas,[3] who is in fact an employee of Upjohn. The other articles on the safety of triazolam that we referred to were the ones that seemed to us to be the most relevant after a conscientious search of the published literature. We were aware of the dangers of a "minority snapshot" and so endeavoured to avoid this and instead to use a very wide angled lens.