homes is a prime responsibility and a core function of general practitioners and other members of the primary care team, for which they possess the appropriate knowledge and skills. What is the evidence that this system is not working well? Why does it need to be replaced by an alternative in which the planning of care for elderly people in the community becomes a consultant's responsibility?

As the reorganisation of the NHS proceeds, issues of responsibility at the interface between generalist and specialist are assuming prominence in every specialty. The division of responsibility embodied in the referral process has served the health service well and should not be discarded lightly. It allows the patient access, when appropriate, to two opinions—that of the general practitioner, who has special knowledge of the patient and the context of his or her problem, and that of the consultant, for a condition that may need specialist skill. In times of limited resources only those with a clear need for specialist care should be referred for it. Any erosion of the referral process will undermine the skills of both specialists and generalists and thereby the effectiveness of their complementary combination.

General practitioners broadly support the tendency for more specialist care to be delivered in community settings. We contend, however, that the referral process must remain intact if both generalists and specialists are to be maximally effective. General practitioners must retain the responsibility for referring patients for specialist care regardless of the setting in which that care is to be delivered. There are no grounds for making the care of elderly people in the community an exception and for general practitioners not to take the lead when older people are being assessed for long term care.

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Elderly people need "high tech" services too

EDITOR,—Jackie Morris is rightly concerned that the health needs of vulnerable elderly patients may be overlooked by local authority assessment for community care.[1] We disagree, however, with the assertion that the creation of community geriatricians would solve the problem.

Successful rehabilitation and placement of elderly patients depend on the patients' acute medical problems being assessed and treated, early and appropriately, by physicians with a special interest in elderly people. The reduction in mean length of hospital stay (to about 15 days in our unit) has not been achieved just by shifting people into local authority, private, and voluntary homes. It has been achieved by multidisciplinary teams, including geriatricians, ensuring that their elderly patients have full and timely access to all the "high tech" services of the acute hospital, linked to a holistic, rehabilitative approach.[2-4] To this end the role of the geriatrician has always entailed close liaison with community services, carers, and primary health care teams. This sometimes necessitates community assessment and treatment, but not as a substitute for acute hospital admission.

By supporting the creation of community geriatricians Morris encourages the view that the medical problems of elderly people can be dealt with by "low tech" services and suggests that existing geriatricians do not work in the community. Morris's views may be welcomed by some managers and purchasers, and even by some colleagues in other specialties, but we do not believe that this approach will deliver the best health care to elderly people. Recent press reports suggest that the public may no longer accept that elderly people should receive only low tech services.

Improved liaison between community services and acute hospital services is essential but is not going to be served by pushing geriatricians out into the community.

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Clinical medical officers could provide service

EDITOR,—Jackie Morris proposes that the gap between community and hospital services for elderly people should be bridged by a new subspecialty of community geriatric medicine.[1] Since the formation of trusts and the implementation of community care, consultants in medicine of old age have been more involved in hospital work. The role of community geriatrician as specified by Morris seems the same as the role of a consultant geriatrician used to be when the specialty of geriatric medicine came into force. The role has changed along with the attitudes of physicians, who prefer not to be called geriatricians; as a result of amalgamation of this specialty with general medicine, the sharing of the medical intake and out of hours duty rota makes it difficult to continue to fulfil the traditional role of providing care in the community. My concern is that the same would happen with community geriatricians in the future.

Morris is unaware that the gap between community and hospital services is filled in certain districts by clinical medical officers or senior clinical medical officers. Their involvement in acute care, rehabilitation, and continuing care varies across districts. The number of doctors is small but requires a review, as happened with the child health service.[2] The joint working party on non-child health community services is working on producing guidelines.[3] Clinical medical officers and senior clinical medical officers have provided these services for years, and their experience should be recognised. Appointment as a community geriatrician should be an option for senior clinical medical officers with higher qualifications. If an employer considered that a senior medical officer had the relevant skill to undertake consultant work it could seek dispensation from the requirement to advertise. Senior clinical medical officers should be given other options, such as training or being allowed to retain their posts. Similarly, clinical medical officers should be offered appropriate options. It is of paramount importance that senior registrars training for this subspecialty should have acquired experience in community geriatric medicine before being accredited; in this the Royal College of Physicians should work closely with the Faculty of Community Health.

It is time for us to create such posts to make community care successful. Those who are involved in this aspect of care must continue to influence purchasers. Funding jointly by health and social services would be appropriate for these posts.

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More geriatricians are needed

EDITOR,—Jackie Morris reminds us of the challenge to primary care of both the increasing numbers of frail elderly people in the community and the complexity of the problems they present.[1] The issue of community geriatricians is, unfortunately, also complex. One of the main driving forces behind the interest in community geriatricians has been purchasers frightened by the apparently irresistible rise in emergency admissions to hospital—about 10% last year. They have raised the question whether the appointment of community geriatricians could reverse this trend. I believe that there are several problems.

Firstly, we have no idea why emergency admissions are rising, although there are plenty of theories.

Secondly, no studies have been carried out in Britain to look at the effectiveness of a community geriatrician compared with that of a properly staffed service for elderly people based in a district general hospital where all the consultants have both a hospital view and a community view of their patients' needs.

Thirdly, there is concern that community geriatricians might be used to restrict acute hospital care for frail elderly people—for example, those already in institutional care.

Fourthly, community appointments that might seem to have a primary care role in some areas have not found favour with the Royal College of General Practitioners. When I surveyed 30 local general practitioners recently 27 were opposed to consultants having continuing responsibility for patients in institutional care.

Fifthly, while a community geriatrician would certainly need to have accredited training in geriatric medicine, no specific training schemes exist that address the other training needs of such a consultant—for example, time in general practice and in public health medicine.

Lastly, at present there is concern about the calibre and training of people who might apply for such a post. A recent advertisement for a community geriatrician in south east Thames region failed to result in an appointment, which led to considerable changes in the job description.

Urgent research certainly needs to be done into the reasons for the rise in emergency admissions to hospital, but the real way forward for purchasers is to ensure that in each locality enough consultant time is available for older patients to ensure a seamless service in both the hospital and the community sectors. Far too many districts still fail to have the minimum standard of one whole time equivalent consultant in elderly medicine for 4000 of the population over 75.

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Drink-driving

EDITOR,—I echo Andrew Guppy's call for a more scientifically based campaign to prevent drink-driving.[1] To call for a change in legislation merely on the basis of a discussion of measured blood alcohol concentrations, however, is to oversimplify the matter. The case-control studies quoted may