stay and bed use factor are better than the average for Wales, where most hospitals have parallel systems for admitting acute medical and geriatric emergencies.

The appointment of a bed manager, flexible use of all acute beds in the hospital, and protocols for early discharge and transfer have failed to prevent constant overflows into non-medical wards, waits on trolleys in the accident and emergency department, and temporary closures, even though some general practices have access to community type hospital beds. Brief analysis (to be audited in more detail) suggests that few of the admissions are inappropriate. Major factors include patients' increased demands and expectations and general practitioners' fear of complaints and litigation. Given this, it is difficult to envisage any reduction in beds, let alone the 30% predicted in acute district general hospitals,[3] whose surgeons are already practising day case surgery to a maximum.

General practitioners have neither the time nor, probably, the skill needed to treat most of our acute medical admissions, even if they were provided with more facilities. Planning must be modified to take account of these issues.

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1 Hobbs R. Rising emergency admissions. *BMJ* 1995;**310**:207-8. (28 January.)
2 Edwards N, Weneke U. In the fast lane. *Health Service Journal* 1994;**104**(5432):30.
3 Audit Commission. *Lying in wait.* London: HMSO, 1992.

Bed crises are occurring almost daily in some hospitals

EDITOR,—Richard Hobbs is correct in stating that emergency admissions are increasing.[1] The figure shows the trend in acute admissions through the accident and emergency department of a large general hospital. After a period of stability between 1984 and 1991 the number has almost doubled. It has taken a great deal of hard work and managerial flexibility from all doctors in the hospital to help the department cope with this throughput.

A medical admissions ward has been opened, bed managers have been introduced, and the hospital allows emergency admissions into any available bed regardless of specialty; a surgical directorate even funded an increase in medical beds during the winter to enable continued elective surgical activity. Despite these measures, however, bed crises occur almost daily and staff find themselves on the seemingly endless treadmill of processing these large numbers of admissions. The reasons for the increase are many, but we think that the following points are important.

Firstly, there are increasing numbers of frail elderly patients living alone at the margins of safety in the community, in whom a minor fall, infection, or other small mishap can seriously impair independence. This often necessitates admission for rehabilitation. When community care fails it is easy to phone the emergency services whatever the time, whereas it is not easy to mobilise social services to provide support for elderly patients requiring emergency social care.

Quarterly admissions through accident and emergency department 1984-94

Secondly, expectations that doctors should not make errors are increasing. To this end, our junior staff are advised to have a low threshold for seeking a further opinion and admission in cases of atypical chest pain; it is better to admit a patient for a day than run the risk of complaint, litigation, or even a charge of manslaughter.

Thirdly, use of the emergency services has increased. Partly, this may be accounted for by policies that encourage patients with chest pain to phone for an ambulance rather than phone their general practitioner.

Finally, early discharge of patients may result in early readmission.

Hospitals can be made more efficient in their handling of acute medical cases, but with every step taken to increase efficiency the size of the problem seems to increase. It is a tribute to the hard work and dedication of staff that hospitals do not grind to a halt because of people requiring emergency care.

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More resources are required to facilitate the discharge of acutely ill elderly people

EDITOR,—Richard Hobbs's editorial on the increase in emergency admissions draws attention to an important trend, which, as he states, should be the subject of urgent research to see exactly what is happening and why.[1] It is surprising that he does not mention demographic changes leading to relative increases in the numbers of very elderly people as these changes are likely to be one important reason for the rising rates of emergency admissions. Unfortunately, in advance of any results from research he suggests solutions that are born of political correctness rather than reasoned appraisal.

The trends towards shorter stays in surgery seem unlikely to happen quickly enough for the problems on medical wards to be solved simply by the renaming of surgical beds as medical beds. For example, on the basis of retrospective studies a substantially shorter stay was one of the benefits expected from the widespread introduction of laparoscopic cholecystectomy. Prospective studies, however, have shown only marginal advantages over minicholecystectomy.[2]

More sinister is Hobbs's rediscovery of "low dependency medical crises." He presumably has elderly people in mind since he advocates that general practitioners should be allocated budgets to place patients perceived to have conditions in this category into nursing homes. We believe, however, that this solution signals a return to the days of the workhouse since it was the exposure of the myth of this approach that led to the development of modern geriatric medicine.[3] Hobbs's own example of acute myocardial infarction well illustrates the reasons for our concern. As he states, modern treatment of this condition is one of the driving forces behind appropriate increases in acute medical admissions. Like many other acute medical problems in older people, however, myocardial infarction commonly presents with atypical symptoms, and specialised investigations are often required to establish the true diagnosis.[4] Yet it is these patients, presenting perhaps with a fall or with confusion, whom Hobbs would consign to nursing homes or, in some localities, to low tech community hospitals. Leaving aside the moral question of the re-creation of an underclass of acutely ill elderly people not thought to be worthy of investigation and treatment in acute hospitals, the denial of timely fibrinolytic treatment to such patients is likely to lengthen their stay in institutions and thus be more expensive; it would also increase dependency after the acute illness, leading to less successful or unsuccessful discharge.

Research is indeed needed, as Hobbs suggests, but it should start in acute hospitals, not in nursing homes. Meanwhile, community resources should be directed at facilitating discharge from hospital rather than at placing hurdles in the way of the appropriate investigation and treatment of acutely ill elderly people.

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1 Hobbs R. Rising emergency admissions. *BMJ* 1995;**310**:207-8. (28 January.)
2 Hobbs KEF. Laparoscopic cholecystectomy. *Gut* 1995;**36**:161-4.
3 Warren MW. Care of the chronic aged sick. *Lancet* 1946;**i**:841-3.
4 Northridge D, Hall RJC. Cardiological services for the elderly. *J R Coll Physicians Lond* 1995;**29**:9-10.

Health promotion in general practice

EDITOR,—We wish to respond to A S Wierzbicki and T M Reynolds's letter[1] regarding our study of health promotion in general practice.[2] Our objective was to observe the effect of personal health education on the lives of patients with angina; hence this was our obvious criterion for inclusion in the study. It is incorrect that a 50% reduction in the incidence of angina was the criterion chosen to indicate a successful outcome. Rather, in determining our sample size we suggested that effective intervention might reduce the frequency of episodes of angina in those who were categorised as severely affected by about 50%. This criterion was purely arbitrary, but other relevant criteria for determining sample size were unavailable.

The difference in death rate was an incidental finding: further follow up may elucidate the importance of this observation. Our report stated that 38 of the 42 deaths that occurred were attributed to cardiovascular causes.

Our study did not show that personal health education had any additional effect on body mass index, but this may have been because our intervention emphasised the frequency of consumption of various foodstuffs rather than quantities. As a change in frequency of consumption was reported, more detailed dietary intervention might have been of further value. Full validation of reported smoking habit was not completed for all patients, but errors of underrecording would be unlikely to affect our conclusion. While more of the intervention group, as might be expected, reported having stopped smoking, the reported change in smoking habit did not differ significantly between the two groups.

Unfortunately, Wierzbicki and Reynolds seem to have misread our paper. We stated that the intervention group reported a decrease in frequency of attacks of angina and that significantly more of those patients reported taking prophylactic treatment: the possibility of self prophylaxis before exercise was not neglected. Exercise tolerance was not validated independently, but this would not have been appropriate in the study, which was carried out fully within general practice.

The conclusion of our paper supports, rather