Medical Care of the Elderly: Five Years On

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In the mid-1970s geriatric medicine was more than 30 years old and had changed a great deal since its origin in the chronic sick wards of local authority hospitals. In addition to their traditional responsibilities for rehabilitation and long-term hospital care geriatricians were caring for an increasing proportion of acutely ill old people. Most geriatricians had come to believe practice of this kind made more effective use of their skills. However, development was being held back by lack of the general hospital beds needed to treat acutely ill patients, and by difficulty in recruiting sufficient doctors.

Against this background a Working Party was established by the Royal College of Physicians of London to consider 'the problems which have led to the uneven and sometimes inadequate service for the medical care of the elderly and the difficulties of recruitment of doctors to that service'. The Working Party reported in 1977[1]. It considered that the problems of accommodation and recruitment would both be lessened by 'integration of the diagnostic and therapeutic services of physicians and geriatricians' into common clinical departments. In these departments physicians with a range of special interests such as cardiology, gastroenterology or endocrinology would work alongside colleagues with a special interest in geriatric medicine.

Five years after the Royal College Working Party report a seminar was held at the Manchester Business School to examine progress towards integration, to review the advantages it had brought, and to identify practical difficulties and how they had been overcome. Participants (see Appendix) presented brief papers describing their local services and policies. This report summarises key points made in the papers and in subsequent discussion.

The Stimulus to Integration

In some parts of the country, for example Hexham, geriatric medicine has never been separated from the general medical service; the consultant physicians provide a comprehensive service for patients of all ages. Where separate departments of general and geriatric medicine developed and have subsequently been brought together, a similar commitment to a comprehensive medical service for all age groups has been necessary. Often some local challenge has provided the catalyst and stimulus to integration. In Oxford integration followed difficulties in planning for separate geriatric facilities in a new general hospital. In Great Yarmouth integration was sparked off by inability to recruit specialist geriatricians. It is apparent, however, that there has been a particular growth of integrated services within certain Regional boundaries and this reflects a flow of ideas between medical colleagues as the advantages of integration become apparent. There is no evidence that integration is being imposed on unwilling clinicians by medical committees or health authorities; nor would such an imposition be feasible.

Organisation of Integrated Services

Consultants who serve in integrated departments have in common that they care for medical patients of all ages, but other aspects of operational policy differ greatly from place to place. In most departments the physician with special responsibility for the elderly takes his turn in the ordinary rota for emergency admissions. The physician on duty for emergencies, regardless of his special interest, admits and continues to care for patients of all ages. This pattern is exemplified by the service in Newcastle on Tyne[2]. In the great majority of departments patients requiring transfer to specialist rehabilitation wards or long-term units are transferred to the care of the physician with special responsibility for the elderly, if not already under his care. In other hospitals patients are admitted under the care of the consultant on duty for emergencies, but next day all very elderly patients are transferred to doctors with special responsibility for the elderly. In Oxford, with a relatively large department of medicine, both a physician with special responsibility for the elderly and a physician with some other special interest share emergency duty each day. The physician more appropriate for a particular patient is selected by the referring general practitioner. All medical consultants in Oxford share a single pool of beds for acutely ill patients, but there are separate geriatric units for rehabilitation and long-term care.

Most physicians with special responsibility for the elderly devote more than half their time to their specialty. Some allocate only one or two sessions to younger patients but consider these sessions invaluable in helping to create a single effective medical department. In most Health Districts where integration has been intro-
duced all former consultants in geriatric medicine have elected to work at least some sessions with younger patients. However, examples are known of doctors wholly committed to geriatric medicine working alongside physicians with special responsibility for the elderly. There is great interest in the apparent success of such departments since the British Geriatrics Society did not recommend such arrangements on the grounds that dissection might arise over the fair allocation of workload and resources.

While most integrated departments admit acutely ill elderly patients to any medical ward, in some such patients are admitted to special acute wards additional to rehabilitation and continuing care units. Generally this occurs in hospitals where certain wards are physically better suited to the needs of old people.

Advantages of Integration

Integrated departments of medicine enjoy a number of advantages. Most important, they offer equal access to the facilities of a general hospital to all patients, regardless of age or social background. Admission of elderly patients to general hospital units reduces length of stay by giving more rapid access to diagnostic tests, higher levels of medical staffing, and specialist opinion. The sooner an elderly patient is discharged, the sooner the bed is made available for someone else.

Separate departments of geriatric medicine with an adequate number of general hospital beds are able to achieve an equally rapid turnover of patients. However, a single pool of admission beds is demonstrably more efficient than providing two parallel medical services, one for older and another for younger patients. Integration also prevents the deplorable anomaly of ill elderly people being turned away for lack of geriatric beds while general medical beds remain empty. Although in some hospitals physicians and geriatricians borrow beds freely, such goodwill is not universal, and integrated departments ensure resources are used as productively as possible.

Another major advantage of integration is the opportunity for exchange of knowledge and skills between physicians with a range of special interests. Geriatricians become more quickly aware of relevant developments in other specialties, and other physicians are quicker to appreciate the most effective ways of treating very elderly people. Such exchange of expertise is not confined to consultants. It is equally apparent among junior doctors, medical students and nursing staff who will be able to put geriatric expertise to good use in whatever branch of medicine they subsequently enter.

Elderly patients require wards with certain physical characteristics such as lower beds, adequate space between beds for wheelchairs and walking frames, non-slip flooring, wardrobe accommodation for day clothes and easily accessible lavatories. The improvements needed to make general wards suitable for very elderly patients are also of benefit to younger patients, and this is another positive feature of an integrated service.

Integrated medical departments lead geriatricians to spend a greater part of their time in the general hospital. They are therefore better able to provide specialist advice to consultants caring for elderly patients in other departments in the hospital, notably general and orthopaedic surgery.

Problems of Integration

No system for organising medical work is free from problems, and participants discussed measures taken to overcome potential problems of integration. One fear which has inhibited the development of integrated services is that physicians appointed to serve both elderly and younger patients may neglect the elderly. This was undoubtedly a difficulty in the early years of the Health Service. However, for several reasons, deflection from care of the elderly is no longer an important problem. Demographic change, and change in the pattern of disease, have combined to make old people a much higher proportion of the hospital population. Attitudes towards them have become almost universally kinder compared with attitudes all too frequently encountered in the past. Early experiments in dual appointments involved doctors without training in geriatric medicine: these doctors were unaware of opportunities for treatment and rehabilitation and so derived little satisfaction from their geriatric work. Most had agreed to supervise the geriatric wards only in order to obtain consultant posts at a time when too many physicians had been trained and senior registrars were forced to take geriatric responsibilities or to emigrate. Even at that time, when candidates with a genuine commitment to the care of old people had been selected for dual appointments they did their job well. Nowadays the best evidence of such commitment is enrolment for senior Registrar training in general and geriatric medicine, sufficient for accreditation by the Joint Committee on Higher Medical Training.

Several practical points have to be considered when establishing an integrated service. The physicians as a body must agree about the division of the medical work of the District. This requires more than simply reallocating geriatricians’ sessions to physicians with special responsibility for the elderly. Since integration is an expression of commitment by all the physicians in a service to patients of all ages, work which was previously the responsibility of geriatricians will not automatically become the exclusive work of physicians with special responsibility for the elderly. If the medical work of the district is considered in this spirit it is possible for physicians with special responsibility for the elderly to work alongside geriatricians who prefer to remain exclusively committed to the elderly. Such an arrangement can be used to ease the transition towards integrated services. In some parts of the country full-time geriatricians have been offered opportunities for additional training to fit them for the role of physician with special responsibility for the elderly in an integrated system.

Implementation of Integration

A major consideration when combining departments of general and geriatric medicine is the need to ensure that elderly patients are admitted to wards where the physical
surroundings and nursing practice encourage rehabilitation and independence. It is important not to introduce change faster than wards can be uprated and suitably oriented nursing staff trained or recruited. Some Health Districts already have a policy of systematically improving their ward accommodation to a standard suitable for elderly patients.

In some parts of the country it has not been possible to implement integration as far as is desired because of salary ‘leads’ paid to nurses serving on wards designated as geriatric, separate wards therefore having to remain designated for elderly patients although medical staff would prefer to remove such distinctions.

It is important not to confuse integration with abolition of geriatric medicine as a specialty. Within an integrated clinical department it is essential to maintain effective leadership and management of the geriatric service as a whole. This is necessary for the efficient day-to-day running of the medical department, for fostering research and teaching, and for effective planning, with health and local authorities, for future developments.

Appendix

Participants: Dr R. G. Brackenridge, Hexham; Professor T. E. Chester, Manchester Business School; Dr C. K. A. Foote, Amersham; Dr J. M. Graham, DHSS; Professor J. Grimley Evans, Newcastle; Dr R. E. Irvine, Hastings; Dr J. W. Lorains, Bebington; Dr M. D. W. Lye, Manchester; Dr D. G. MacMahon, Redruth; Dr S. T. McCarthy, Oxford; Professor G. L. Mills, Liverpool; Dr D. Morris, Northern RHA; Dr J. Powell, Welsh Office; Dr P. Robson, Consett; Dr T. K. Sweeney, DHSS; Professor Sir Ronald Tunbridge, Leeds; Dr J. J. Turner, Liverpool; Dr D. J. Wayne, Great Yarmouth; Dr D. Wild, South West Thames RHA; Dr G. V. Williams, Gateshead; Dr L. Wollner, Oxford.

References
1. Report of the Working Party of the Royal College of Physicians of London (1977) ‘Medical Care of the Elderly.’ Lancet, 1, 1092.
2. Evans, J. Grimley (1983) Lancet, 1, 1430.
3. British Geriatrics Society (1982) Standards and requirements for geriatric services. Circular to Health Authorities.

Gibson’s Spoon?

It is not often that distinguished Fellows of our College are constrained to publish their innermost thoughts of personal injustice, but during current research on the overtly innocuous subject of the history of the medicine spoon, an interesting facet of human behaviour has come to light. This concerns Dr Anthony Todd Thomson, a Fellow of the College of Physicians, who practised in London in the first half of the nineteenth century, and a silversmith, Charles Gibson, who worked at Bishopsgate Within in the City of London.

In 1828 Gibson demonstrated to the Society of Arts a particular type of physic spoon, specially designed for the administration of nauseous medicine to children or mentally ill patients and for this invention was honoured by the award of the Isis Medal of this society. He inscribed his name on the spoon with the description ‘Inventor’ beside it and was acclaimed as the innovator of this useful article. It was manufactured as such for years afterwards. However, in a delightfully written and practical work, The Sick Room, first published in 1841 by Dr Thomson, it is evident that Gibson was not the inventor. After a detailed description of the spoon and its use, Dr Thomson adds this note:

The first spoon of this description was made according to the author’s direction by Mr Gibson, a silversmith in the City, who for two or three years afterwards, claimed it as his own invention, and received, as an award, the gold medal of the Society for the Encouragement of Arts; since which time it has been sold as Gibson’s Medicinal-spoon. The author mentions this fact, not to obtain for himself any merit for the invention, but to show the shameless claims that are sometimes set up; and the manner in which Societies, established for the public benefit are often imposed upon.

Dr Thomson was plainly a gentleman in not pursuing the true facts of the case with the Society of Arts. This invalid aid is still known as a Gibson spoon and the truth has therefore never reached the wide public and certainly not his colleagues at the College, collectors of medical instruments or those interested in the history of the medicine spoon. Dr Thomson would undoubtedly have approved of this attempt to right a wrong, even if it is 156 years late.

Cecil Symons