Geriatric Medicine and General Internal Medicine

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In 1977, the College published its report *Medical Care of the Elderly*. Two of the problems it identified were the increasing number of the elderly in the population and the uneven distribution of medical services to meet their needs. It recognised geriatric medicine as a true specialty but advocated closer collaboration between geriatric and general (internal) medicine[1].

Demography

During the next 20 years the total number in the population aged over 65 will remain almost static, but within this total there will be a much greater proportion of the very old (Table 1). The peak in the expansion of the young elderly, those between 65 and 74, was reached in 1978 and projections show that there will be a fall of 13 per cent in their numbers by the year 2001. The peak in numbers of those between 75 and 84 will come in 1991 when they will have increased by 17 per cent above the 1978 level. The peak in the number of those over 85 will come in the year 2001 when they will have increased by 60 per cent above the 1978 level[2].

Table 1. Projected population aged 65 and over in Great Britain, 1978-2001. (From OPCS Population Projections 1972-2017. (1978 = 100.)

	65-74	75-84	85 +	65 +
1978 (thous)	*5,022*	*2,393*	*527*	*7,942*
1981 (per cent)	99.6	107.2	105.9	102.3
1991 (per cent)	95.3	117.3	140.0	104.9
2001 (per cent)	86.9	115.7	160.7	100.5

The Over-75s in Hospital

In 1979 128,000 patients over 75 were discharged from general medical wards and 186,000 from geriatric wards, giving a split of roughly 40 per cent to general medicine and 60 per cent to geriatric medicine. In terms of beds, patients over 75 currently occupy about one-quarter of medical beds and three-quarters of geriatric beds[3]. If the trend of the last few years is extrapolated to the end of the century it has been calculated by Dr Brian Livesley, to whom I am much indebted, that of all acute beds, not just general medical beds, 90 per cent will be occupied by people over 65 and 70 per cent by people who are aged 75 or more years.

In the lives of many people the age of 75 is an important watershed. Below this age the vast majority of patients do not differ significantly from those of middle age, but after 75 the problems of physical and mental frailty, with their attendant social difficulties, begin to bulk large. This is the age when the skills of geriatric medicine become necessary, though they should not, of course, be denied to younger patients when appropriate.

Changes in Geriatric Medicine

A feature of the 1970s was the increase in numbers of patients treated in departments of geriatric medicine. These grew by 39 per cent between 1972 and 1979, discharges increasing from 185,000 to 258,000; the average length of stay fell by 25 per cent from 105 days in 1972 to 77 days in 1979. The median length of stay, the time by which half of all patients are discharged, was 20 days in 1979[4].

Geriatric medicine is moving away from its traditional role of long-stay specialty towards a more acute model. Patients treated in geriatric wards already outnumber inpatients treated in departments of thoracic medicine, neurology, cardiology, infectious diseases, rheumatology and rehabilitation combined (Table 2). Although many people regard the essential feature of geriatric medicine as expertise in long-stay care, this is a misapprehension. The great value of departments of geriatric medicine to the National Health Service is their ability to get more patients out of hospital quicker and in better shape.

Table 2. Discharges by specialty, England 1979[4].

Specialty	No.
Thoracic Medicine	73,449
Neurology	40,868
Cardiology	41,351
Infectious Diseases	33,258
Rheumatology	24,095
Rehabilitation	9,297
Total	222,378
Geriatric Medicine	258,819

Knowing also how to support them in the community, departments of geriatric medicine are able to reduce to a minimum the numbers requiring long-stay care, which is the most expensive facility in terms of cost per patient that the NHS has to offer. It is well known in the world of geriatric medicine that patients transferred from other wards as irremediable are discharged after treatment almost as often as those admitted directly from the community. In our department in 1981, of 67 such transfers, 63 from surgical wards and 4 from general medicine, 49 were discharged, 13 died and 5 required long-stay care. In a well-developed department patients requiring long-term care in hospital should be less than 5 per cent. In Hull the figure is only 2 per cent[5].

Table 3. Beds for the elderly, Hastings district.

Population 151,000—47,750 (27.6%) over 65	
—18,800 (12.4%) over 75	
Beds with general hospital facilities	
Two-thirds of 89 general medical beds used by patients over 65	58
Geriatric beds—acute	74
—rehabilitation	88
—geriatric orthopaedic	20
Total beds for patients over 65	240
General medical + geriatric beds per 1,000 over 65	5.75
Discharges 1982	
General Medicine (all ages)	2,251
Geriatric Medicine (including 323 geriatric orthopaedic)	2,117
Average days of stay	
General Medicine	11.4
Geriatric —acute only	22
—including long stay	41
Long-stay facilities	
NHS geriatric beds	108
Psychogeriatric beds	50
Private nursing home beds	711

Location of Beds

The greater activity of the geriatric service is largely a result of improved location of hospital beds. Between 1972 and 1978 the proportion of geriatric beds in hospitals with acute facilities increased from 28 per cent to 35 per cent. Geriatricians believe that this figure should be at least 50 per cent. However, the service is uneven. In 1978 there were 42 Health Districts, one in eight of all districts in the country, without a single geriatric medical bed in an acute hospital[3]. The DHSS currently thinks that future District Hospitals will have to be smaller rather than larger. While it will remain DHSS policy to maintain a presence for geriatric medicine in the District General Hospitals, this is likely to be smaller than was intended at one time and may create problems for the development of geriatric medicine. The greatest danger to good medical care for the elderly would be a proliferation of isolated geriatric hospitals, cut off from the mainstream of medical activity.

Medical and Geriatric Beds

It has been claimed that where medical services for the elderly work well, geriatric beds with general hospital facilities and general medical beds combined provide a total of at least 9 beds per 1,000 population over 65. The most successful departments of geriatric medicine, those able to operate without a waiting list, are ones where more than two-thirds of the beds have access to general hospital facilities and operate alongside general medical wards, not in isolated geriatric hospitals[6]. In Hastings we find just under 6 beds per 1,000 population over 65, shared between acute geriatric and general medicine, to be adequate (Table 3). Hastings is fortunate in that two-thirds of the geriatric beds are in general hospitals. A flourishing private sector facilitates discharge and reduces the average length of stay.

Other Resources

General medicine and geriatric beds cannot, however, be seen in isolation. They are part of a spectrum of resources. Weakness in one element always affects the others. The presence of an effective psychogeriatric service, for example, will make a considerable difference to the physician in geriatric medicine. Acute beds always seem to be more plentiful when the outlets from the hospital are good and beds are not blocked by patients who should have moved to other facilities. This depends not only on hospital resources, but on adequate community health services, Part III accommodation and collaboration between the health and social services.

Private Sector

In some parts of the country the private sector, both through nursing homes registered with the health authority and residential homes registered with the social services, provide an important addition to the statutory resources available to the elderly. The attendance allowance and the board and lodging allowance available under the supplementary benefit scheme have brought private care within the reach of many who could not previously have contemplated it. Collaboration with the private sector is to be encouraged.

Manpower

Another reason for the greater activity of geriatric medicine is better staffing. During the 1970s the number of consultants in geriatric medicine increased by 50 per cent, the number of senior registrars by 71 per cent and the number of registrars by 91 per cent. This growth started from a low base and has not been fast enough. There are currently 424 physicians in geriatric medicine in England and Wales and 500 in the UK. This makes geriatric medicine the third largest specialty after general medicine and paediatrics, but geriatricians feel the num-

bers to be inadequate. There is no firm yardstick for the numbers of physicians required in geriatric medicine, but the DHSS study showed that, aiming at one consultant in geriatric medicine per 10,000 population over 65, we need 780 physicians now, an increase of about 350[3]. A survey by the British Geriatrics Society has shown that 20 per cent of consultant posts were held jointly in geriatric and general medicine at the end of 1981.

Recruitment

Recruitment to geriatric medicine has never been easy and we have been heavily dependent on the contribution made by overseas graduates. In 1981 42 per cent of newly appointed consultants in geriatric medicine were overseas graduates, compared with 7 per cent in general medicine. The proportion of overseas graduates becoming senior registrars in geriatric medicine has, however, shown a fall from 48 per cent in 1979 to 40 per cent in 1981. It seems likely that in future there will be improved recruitment of physicians trained in this country.

Geriatric medicine could offer satisfying jobs to many of the surplus trainees in other specialties. A plea has been made for physicians to be able to practise geriatric medicine and an organ specialty together in the same way as is done by general physicians with a special interest[7].

Training

If geriatric medicine and general internal medicine are to come together it is important to establish more posts that lead to simultaneous accreditation in both specialties. A number of these are now in existence, but they should be increased. Dual accreditation is an important requirement for the future. Even those who are not going to become geriatricians need special experience in geriatric medicine. Perhaps no one should be accredited as a cardiologist, gastroenterologist, neurologist or any other kind of specialist without a period of training in a department of geriatric medicine so that he may gain expertise in the problems of the elderly.

We also need obligatory questions on old age in the Membership examination. Multiple choice questions in geriatrics are not easy to set, but W. B. Wright has published a whole series of multiple choice questions in the journal *Geriatric Medicine*[8]. These could well be considered by the College for inclusion in the Membership examination. Undergraduate training in the problems of old age is scanty and physicians in the future would be better adapted to the needs of the next 20 years if they received as much training about the needs of the elderly as they do today about children. An important part of training is to help students to see old people in functional terms. It is vital to establish what an old person is capable of doing, rather than merely to attach a diagnostic label to his disease.

Patterns of Practice

The patterns of practice in individual departments of geriatric medicine still vary enormously. What happens is largely determined by the facilities available[9]. It is perhaps possible to distinguish four types of geriatric service.

Chronic Sick

This was the original pattern of geriatric medicine. All acute work was done by the general physicians. The department of geriatric medicine was supposed to concentrate on rehabilitation and long-stay care. This type of service is invariably associated with long waiting lists. It is no longer a generally acceptable method, but it may be the only one practicable in the most deprived areas.

Independent

The department of geriatric medicine operates independently of general medicine, directly accepting as many patients as possible. Where reasonable diagnostic facilities exist this leads gradually to a more acute service that ultimately competes with general medicine. A common difficulty with this arrangement arises when the department of geriatric medicine has filled its beds for the day and later referrals have to go to the department of general medicine. Collaboration and improved results may be promoted by attaching a geriatrician to the general medical firm[10].

Age-Related Service

An alternative pattern is the age-related service. By agreement the physicians in geriatric medicine accept responsibility for all those patients above a certain age, in the same way as the paediatricians accept responsibility for all children. The benefits of this sort of organisation have been persuasively argued by Horrocks[5]. The Department of Medicine for the Elderly in Hastings is organised along these lines and all the physicians find it a satisfactory arrangement. This form of service is favoured by the majority of members of the British Geriatrics Society but it is appropriate only where the department of geriatric medicine has facilities in the District General Hospital comparable to those available to general medicine. Where this situation obtains it is favourable to the rotation of junior staff.

From the point of view of the general physician, the exclusive care of those over 75 by the department of geriatric medicine largely obviates the problems of blocked beds. It does not preclude a specialist from admitting anyone over the age limit in whom he is particularly interested. In 1981 in our hospital 73 elderly patients over the age of 76 were admitted by general physicians and 92 under 76 were admitted to the Department of Medicine for the Elderly. Four patients were transferred from general medical wards to the Department of Medicine for the Elderly during 1981. Neither department has a waiting list.

The age-defined approach is very satisfactory, but it is only viable if the department of geriatric medicine has sufficient resources and sufficient beds in the right place, the District General Hospital. It is probably not generally

applicable when we reflect that 40 per cent of the medicine of the over-75s is done in general medical wards and that general physicians outnumber those in geriatric medicine by 2.5 to 1. We are a long way from being able to implement an age-defined system as a general policy unless the age is set much higher than 75 or the general physicians hand over a quarter of their beds. These are the reasons that underlie the alternative approach which is practised in Newcastle, Oxford and a number of other centres—the integrated approach[6].

Integrated System

The essence of this system is that there is only one set of acute wards for both general and geriatric medicine. There is no separate acute geriatric ward. The combined ward takes patients of all ages and constitutes a single point of reference for general practitioners wishing to admit a patient of any age with any acute problem. The ward is staffed by a firm of several physicians, one of whom specialises in geriatric medicine. He also has his 'take' day as a general physician. Each physician in turn has his 'take' day and is responsible for all patients admitted on that day. The consultant in geriatric medicine undertakes to transfer into a geriatric rehabilitation ward any patient referred by his colleagues in the firm. In practice about 5 per cent of patients go on to rehabilitation or long stay. There is rotation of junior staff between the combined acute ward and the geriatric rehabilitation ward. A variant of this system is practised at Oxford. Again there is only one set of acute wards but the referring general practitioner can specify whether he wishes his patient to be under the geriatric medical firm or the general medical firm. In the Oxford system the physicians in geriatric medicine also do a general medical 'take' in rotation with their colleagues.

Problems

Fear is often expressed that in a combined appointment the physician may neglect the geriatric aspect of his work. This certainly happened in the past when geriatric medicine was largely a custodial activity and the techniques of operating an effective geriatric service had not been worked out. There is no evidence of this being a real problem now, provided the physicians have been properly trained in geriatric medicine.

A more serious difficulty is the problem of staffing an integrated service when there is already a non-integrated physician in post. He is unlikely to welcome a colleague who, he may fear, will enjoy a higher status than himself and carry less of the geriatric load. This is why the British Geriatrics Society has recommended that normally a district should have one kind of appointment or the other, rather than a mixture of the two. However, if this is rigidly adhered to it amounts to a permanent barrier against change and there are places where this difficulty has been overcome.

A third problem which is now exercising senior registrars in geriatric medicine is that they may be unqualified to accept an integrated appointment. Senior registrar posts in geriatric medicine should be restructured as soon as possible to offer dual accreditation.

Conclusion

The advice of the College's 1977 report that geriatric and general medicine should come together as far as possible has been heeded to a limited extent. A spirit of give and take is needed on both sides. It is not good if the physicians in general medicine keep the physicians in geriatric medicine at arm's length, hoping to perpetuate the original chronic sick pattern. It is equally unsatisfactory if the physicians in geriatric medicine attempt to compete, rather than collaborate, with the physicians in general medicine. It is probably true that today the majority of physicians are appointed to cultivate a special interest and to do some general medicine as a sideline. The older type of general physician is becoming less common. The only true general physician of the future is likely to be one whose main concern is with elderly patients. It is the generalist approach that draws many people towards geriatric medicine and the quality of applicants is rising. The message of the 1977 report remains sound.

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