MEDICAL PRACTICE

Contemporary Themes

No Apology for Geriatrics

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Summary

A geriatric department is described where turnover has more than kept pace with demand over a period of 17 years. The department provides two basic services—a hospital service to the pensionable population in the community, and support to other hospital departments that care for the elderly.

Community emphasis is on a high turnover of patients, enabling early contact and treatment. Over the years a fall in the proportion of "chronic" to "acute" beds has occurred and this has been achieved by having the majority of beds in the general hospital, where it is possible to provide a comprehensive medical service. The hospital role has been to prevent overloading acute resources with potential long-stay cases, and this has been possible without compromising our community obligations.

Introduction

Recent articles have drawn attention to the inability of geriatric departments to match their output to the needs of the elderly community.¹⁻⁶ Here we describe our experience in a department where turnover has more than kept pace with demand. Our object has been to provide a comprehensive geriatric service to the community and to establish a working arrangement with other hospital specialties.

The Oldham catchment area shows certain advantages. It is compact, the bed complement approximates to the "norm" recommended by the Department of Health, and 276 out of a total of 296 beds are situated within the district general hospital. In comparison with many other units medical staffing has been adequate. Close co-operation exists between hospital and local authority services, with an active "joint planning group" (formerly a geriatric liaison committee).

Methods

Our method of working is based on six points.

(1) The department offers total medical care. We accept responsibility for all medical emergencies in the pensionable age group, including all cases brought to the accident and emergency department requiring medical care.

(2) In most non-urgent cases assessment at home is arranged within 12 hours of referral. The consultant geriatrician is often accompanied by the district nurse liaison officer or local authority welfare officer, as the visit is not concerned merely with medical diagnosis. Careful consideration is given to the patient's total needs with a view to eventual discharge and effective return to the community.

(3) Because of the high turnover and available empty beds we have been able to work with virtually no waiting list and to admit cases rapidly. Geriatric patients' medical and social problems tend to multiply if there is delay in dealing with them.

(4) We provide the general practitioner with a wide choice of help—namely, emergency and casualty admissions, home visits, and outpatient and day hospital facilities. In this way the potential long-stay patient in the community is seen early in his illness at a time when preventive geriatrics can be applied successfully.

(5) Colleagues in other hospital specialties, particularly orthopaedics, accident and emergency departments, and general surgery, have come to recognise our expertise in the care of the elderly and consult us at an early stage to bring about joint

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management of cases in an attempt to prevent the creation of long-stay cases in their departments.

(6) We are fortunate in our association with our two psychiatric colleagues and the close proximity of our respective units within the general hospital. Each specialty accepts the decision of the general practitioner on the department to which the patient with organic brain syndrome is referred. There is free interchange between departments—for instance, a case of dementia with predominantly physical disability is transferred to the geriatric department, while a case with behaviour difficulties is transferred to the psychiatric department. As yet there has been no necessity for a psychogeriatric assessment unit. Hospital Activity Analysis has shown that the geriatric and psychiatric departments deal with most of the cases referred from this catchment area.

Results

Basic statistical information on the hospital and community services to the elderly in this group is given in table I. The rates of discharge and death in the department are compared in fig. 1 with the average figures for geriatric departments within the Manchester Region. When compared with the number of persons aged 65 and over in the Manchester Region both local and average regional hospital turnover is increasing at a greater rate than the elderly population. This is in contrast with the fall in turnover implied by Parnell *et al.*⁵ for the Birmingham area.

TABLE 1—Basic Statistical Data relating to Geriatric Unit of Oldham and District General Hospital.

Population	
Total population of catchment area	286,551
No. aged 65 and over	32,925
No. aged 75 and over	11,895
Existing Provision (1972)	
Total No. of staffed beds	297
Beds per 1,000 population aged 65 and over	9.1
Welfare part III beds per 1,000 population aged 65 and over	20.1
Total referrals to geriatric unit	2,754
Total No. of cases admitted (accident and emergency 263)	2,041
Total No. of patients visited	2,107
Discharges and deaths (deaths 786)	1,998
Total outpatient attendances	2,585
Total geriatric day hospital attendances	13,563
Hospital Staff	
Medical:	
Two consultants	
One registrar	
Three senior house officers	
One junior house officer (preregistration)	
Five senior medical assistants	
Nurse: patient ratio 1:1.8	
Physiotherapy 42 hours a week	
Occupational therapy 8½ hours a week (including craft worker)	

Perhaps of even more interest is a comparison of local with regional hospital turnover.⁷ Not only has the total figure for discharges and deaths kept ahead of the regional average but the percentage increase has been higher, and on present estimates the trend shows no sign of levelling off. The implication of this constant trend appears to be that there are still needs within the local community which are unmet.

If we take the graph for the regional hospital average as our "norm" then we should be prepared to justify a deviation of such magnitude.⁸ Fig. 2 enlarges the picture and compares the local discharges and deaths per 100 occupied beds with both the average daily number of vacant beds and the average length of stay in days of patients who have been discharged or died. Apart from 1954, where a disparity between vacant beds and turnover (discharges and deaths) existed, the general trend is clear. The increase in turnover is accompanied by an increase in the number of vacant beds and a decrease in the average length of stay. The

FIG 1—Discharges and deaths in Oldham and District General Hospital compared with average figures for Manchester Region.

FIG 2—Comparison of local discharges and deaths per 100 occupied beds with average daily number of vacant beds and average length of stay of patients who have been discharged or died.

virtual absence of any waiting list, the reduction in the number of available beds, and the consistent increase in discharges and deaths indicate that the proportion of "chronic" long-stay beds to "acute" short-stay beds has fallen over the years. In January 1955, for instance, 66% of the beds were occupied by patients

in hospital for more than one year, but table II shows that at 10 October 1972 only 23% of the beds in the unit were so occupied. This reduction in long-stay patients suggests that some geriatric hospital long-stay patients may owe more to man than nature for their predicament.

TABLE II—Length of Stay of Patients in Geriatric Department on 10 October 1972.

	0-2 Months	3-6 Months	7-11 Months	1-2 Years	3 Years and Over	Total	Percent- age Under 1 Year
Males	15	34	8	8	7	72	79.16
Females	22	93	31	38	7	191	76.43
Total	37	127	39	46	14	263	77.18

We have examined as far as possible the repercussions of our policy on hospital specialties which are liable to deal with fairly large numbers of elderly patients. The proportion of patients admitted over the age of 65 and the average length of stay in each hospital specialty are shown in table III. The group (local) figures are derived from the Hospital Activity Analysis from July 1971 to June 1972. For convenience these are compared with the Hospital Inpatient Enquiry figures for 1970.⁹ Avoiding a strict statistical comparison it is worth while noting that the average length of stay in the geriatric department in this group is well below the figure derived from the Hospital Inpatient Enquiry and that the proportion of elderly patients managed by the general medical, chest, and psychiatric departments is lower than usual.

Discussion

In this paper we have shown that a high turnover can be achieved by better use of existing beds rather than by an increase in the number of beds.⁴⁻¹⁰ The ability of our unit to meet the demands of the community has been associated with a rising consumer expectation. (The term "consumer" includes our patients, their relatives, friends, neighbours, and general practitioners.) This rise in consumer expectation has occurred slowly over the years and has been associated with a change of attitude on the part of the consumers. More and more of our patients have come to see themselves, and in turn have come to be seen by their relatives, friends, neighbours, and general practitioners, as ill and in need of investigation and treatment rather than merely old, senile, and irremediable. Perhaps the "iceberg" of hidden disease in the elderly has begun to surface in this area. We believe that the rise in consumer expectation is probably the reason why, as time has passed, progressively more of our patients are referred to us at an earlier stage in their illness and why we must match the quality of care given to the geriatric patient in hospital by an equal concern for those cases needing hospital care but remaining in the community. As indicated above there has been a reduction

in demand for long-stay beds, as predicted by Hallsall and Lloyd in 1961.¹⁰

W. H. Lloyd (personal communication) has drawn our attention to marked differences in attitude to elderly people in trouble shown by hospital, local authority, and general practitioner services which exist in different parts of the country. Those services in areas which have been served by a comprehensive hospital geriatric service for several years show a constructive optimistic attitude to old people in trouble which contrasts strikingly with the defeatist attitude which usually prevails in less fortunate areas. We think that we have proved the value of a comprehensive geriatric hospital service as a means of preventing the accumulation of potential long-stay hospital cases in the community.

While we, and perhaps most geriatricians, regard the community as having prior claim on our services over other hospital departments we accept that our geriatric department has responsibility towards the other hospital specialties. Parnell¹¹ indicated that these two aspects of service may clash. *Rehabilitation*, a report of a subcommittee of the Standing Medical Advisory Committee,¹² indicates that over 60% of all admissions to "acute medical wards" are of persons of pensionable age and over. The *Annual Report of the Hospital Advisory Service for 1971*¹³ also deals with the same point. "The team has been bombarded with requests in almost every area visited to take into account the number of elderly sick people occupying beds in general medical and orthopaedic wards, in convalescent and chest hospitals and in general practitioner hospitals. There are thousands of patients who are said to be disposal problems and said to be blocking beds."

In our relationship with other hospital departments our aim has been to avoid overloading limited "acute" resources with long-stay "chronic" cases. There is a real need to define the term "acute" as applied to hospital beds. We suggest that an acute hospital bed is one that possesses all the facilities for dealing with any case, whether emergency or waiting list, admitted direct from the community to the hospital. Such a bed will necessarily be in a district general hospital and the possession of such a bed is as essential to geriatrics as to any other specialty. Happily this need has now been recognized by the Department of Health and Social Security¹ and the Royal College of Physicians,¹⁵ and the latter rightly emphasizes that "most geriatric in-patient beds should be in the district general hospital." Oldham and a few similarly placed units illustrate this point well. Nevertheless, there are few areas in the country where the provisions suggested actually prevail.

As previously indicated, table II shows that geriatrics is not necessarily a long-stay specialty. Only 23% of the cases in this unit have been in hospital for one year and over. This figure reflects the large proportion of beds which are being used in the "acute" sense above. This is one advantage of having most of our beds in a district general hospital, and in this respect our unit is possibly exceptional. Nationally there appears to be disproportionately many geriatric beds outside the district general hospital. It is clearly the rule for such outlying hospital

TABLE III—Comparative Information from Specialities

Specialty (Available Beds)	Group Total All Ages*	Group Total 65 and Over*	Percentage 65 and Over		Average Length of Stay in Days—All Ages		Internal Transfers
			Group*	National†	Group*	National†	
General medicine (91)	1,795	191	10.6	34.7	14.1	16.0	6
Chest Disease (102)	438	112	25.6	37.7	51.7	30.1	0
Geriatric department (297)	1,816	1,661	91.5	94.1	45.8	91.2	0
General surgery (137)	4,869	1,062	21.8	22.0	8.7	10.1	40
Ear, nose and throat (30)	1,464	94	6.4	5.8	3.9	4.7	3
Orthopaedic department (60)	990	220	22.2	20.3	17.0	16.5	44
Ophthalmology (17)	573	178	31.1	33.5	7.0	9.5	5
Gynaecology (60)	2,687	107	4.0	5.0	6.7	6.9	3
Psychiatric department (207)	820	128	15.6	21.5	59.7	†	13

* Group figures derived from Hospital Activity Analysis July 1971 to June 1972.

† National figures derived from Hospital Inpatient Enquiry (1970).

‡ Figure not available for psychiatric units in general hospitals.

beds to become a form of "storage unit." It is, however, important to indicate that there may be a place for so-called "community hospitals" in large catchment areas, though their precise function, size, staffing, and siting remains to be defined.

We have maintained a policy of giving parallel service to the general medical department in cases of patients of pensionable age and over. Even when they suffer from acute medical conditions this category of patient is better managed by physicians who are already orientated to social medicine and rehabilitation. Our policy is reflected in table III, as fewer than six cases were referred for transfer from general medicine to our department in one year. As our performance becomes comparable with that of acute specialties, resources—particularly medical and nursing staff—will have to be adjusted. Consultants in other specialties must, in return for help with their potential long-stay cases, accord the geriatric department full support and encouragement, particularly with regard to resources. For instance, we agree with the recommendations laid down by the Council of the British Geriatric Society for a minimum of three full-time consultant physicians in geriatrics for a population of 200,000. It seems more practicable to create new consultant geriatricians in place of readvertising some existing consultant physician posts in general medicine.

It is common sense for every hospital group to centre its interest on the development of geriatric departments. The greatest single contribution which can be made to improve the working of acute resources and hence economic considerations is to reduce the incidence of long-stay cases in acute areas. This can best be done by encouraging the development of efficient geriatric management by effective geriatric resources.

Finally, education in geriatric care and recruitment to the specialty is influenced by the "image" created by our work. The

appropriate image is more likely to emanate from hospitals dealing with "total patient care" than "disposal" problems.

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Hospital Topics

Hospital Family Planning: Termination of Pregnancy and Contraceptive Use

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Summary

A review of termination of pregnancy in a district hospital catchment area for 1970 to 1972 shows how a decrease in total numbers of terminations and repeat terminations may be effected by the use of intensive family planning. In 1972 over 80% had first trimester abortions, but most

of the second trimester abortions came from the manual skilled, semi-skilled, and unskilled occupational groups. Over half those attending for termination had never used any method of contraception. Acceptance of family planning after termination was high but motivation poor, emphasizing the suitability of intrauterine devices inserted at the time of termination. The complication rate after termination was low.

Introduction

Much has been written since the introduction in England of the Abortion Act 1967 about methods and the complications of termination of pregnancy.^{1 2} The purpose of this study was to investigate the changes that have occurred in contraceptive practice, the implementation of effective contraception after termination of pregnancy, and family planning follow-up in relation to social class (by husband's occupation).³

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