ADMISSION OF ELDERLY PEOPLE TO HOSPITAL

RELATIVE IMPORTANCE OF MEDICAL AND SOCIAL FACTORS

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As a result of the publicity given to the social aspects of old age many people assume that the problems created by the aged in our population are social rather than medical in origin. In this paper we report a survey which was carried out to determine the relative importance of the medical and social factors which led general practitioners to refer a group of elderly people for admission to hospital.

Material and Methods

During the 12-month period from January 1 to December 31, 1957, we visited at home as many of the people as possible who were referred to us for admission by their own doctor. We excluded those classed by their doctor as acutely ill. Such cases were generally admitted within 48 hours without prior visiting. We visited 558 patients, all of whom had been referred by their doctor—the majority for admission, a few (approximately 20%) for a medical opinion. In most cases information about the patient was given by the G.P. to a central bed bureau. This information was typed on to a punched card, specially designed for this survey. About 50 patients were seen by one of us (W. H. L.) alone; the remainder were visited by both of us at the same time. The patients were visited once at home; the medical and social information gathered on this visit was in many cases amplified in subsequent interviews in the out-patient department or hospital wards. The G.P. was present at about 20% of these visits.

Results

When we considered the G.P.s' reasons for referring patients for admission to the geriatric unit, we found that these could be grouped as follows:

1. *Medical Reasons.*—(a) Those cases where the G.P. felt uncertain of the diagnosis and sought a medical opinion. (b) Those cases where the G.P. was confident of the diagnosis but experienced difficulty in carrying out the appropriate treatment at home.

2. *Social Reasons.*—In this group the medical condition of the patient was thought to be relatively unimportant by the G.P. (a) He thought the patients in this subgroup were in need of nursing care and attention, which he felt could not be maintained at home. (b) He felt that the nursing care and attention given at home was adequate. He referred these cases to hospital because of the pressure exerted on him by those caring for the patient.

Table I shows the age-and-sex distribution of the sample. Table II shows the action taken in the cases of those visited at home: 59% were subsequently admitted to the geriatric unit. They formed 29% of the total number (1,139) of people admitted to the unit in the

12-month period. The remaining 71% were admitted as emergencies or from the out-patient department.

Table III shows the distribution of the "medical" and "social" cases according to sex and to the action taken: 66% of the social group and 40% of the medical group were admitted to the unit.

TABLE I.—Age-and-Sex Distribution

Age:	<50	50–	55–	60–	65–	70–	75–	80–	85+	Not Known	Total
Males	1	3	6	18	23	59	43	27	14	4	198
Females	9	6	10	31	31	91	73	74	28	7	360
Total	10	9	16	49	54	150	116	101	42	11	558

TABLE II

	Action Taken				
	Out-patient	In-patient	Welfare	General Practitioner	Other Hospital Departments
Males	42	107	3	39	7
Females	50	220	8	75	7
Total	92 16.5%	327 58.5%	11 2%	114 20.5%	14 2.5%

TABLE III

TABLE IV

	Action Taken					Total
	Out-patient	In-patient	Welfare	General Practitioner	Other Hospital Departments	
<i>Medical Group</i>						
Males ..	19	22	—	18	2	61
Females ..	24	38	—	26	3	91
Total ..	43 28.3%	60 39.5%	—	44 29%	5 3.2%	152 100%
<i>Social Group</i>						
Males ..	23	85	3	21	5	137
Females ..	26	182	8	49	4	269
Total ..	49 12%	267 65.7%	11 2.9%	70 17.2%	9 2.2%	406 100%

We have undertaken a comparison of these two groups on a number of different counts:

1. *Age.*
2. *Sex.*
3. *Marital Status* (Table IV).—Each group closely followed the whole sample.
4. *Housing* (Table V).—There was no significant difference between the two groups.
5. *Household Composition* (Table VI).—The following groups were differentiated: (a) those living with spouse; (b) those living with relatives; (c) those living

TABLE IV.—Marital Status

	Married		Single		Widowed		Separated	
	No.	%	No.	%	No.	%	No.	%
Males	80	40.4	11	5.6	105	53.0	2	1.0
Females	76	21.2	49	13.7	231	64.1	4	1.0

TABLE V.—Type of Housing

	Medical Group		Social Group	
	No.	%	No.	%
Old person's bungalow	3	2	23	5.6
Back-to-back house	4	2.7	13	3.2
Terrace house	109	71.8	269	66.3
Council	10	6.6	43	10.5
Modern	8	5.3	29	7.2
Hostel	6	3.8	12	3.0
Other*	12	7.8	17	4.2

* Farmhouses, public houses, shops, etc.

in lodgings or with friends, and (d) those living alone. It will be seen from Table VI that 17% of the medical group lived alone, whereas 32.7% of the social group lived alone. In Table VII the medical and social groups have each been divided into three according to the household composition. Medical and social group A are those people living with relatives or spouse; group B, those living in lodgings or with friends; and group C,

ill for so long that they and everyone attending them had almost forgotten that they had ever been well, whereas the medical group still remembered what it was like to be well.

2. *Type of Illness Suffered by Patient.*—Of the social group 62% were judged to suffer from diseases of the cerebrovascular system.

We were much interested in the genesis of the social cases. We felt that they had become socially crippled by disease; many had progressed to the point of personal demoralization and were partially or completely rejected by their relatives.

We were in no doubt that the most important factor in producing the tensions which we found in the social group was the feeling, often shared by the patient and those caring for him, that "nothing more could be done." The patient's awareness of this attitude had in the course of time resulted in his demoralization and regression, which in turn did nothing to slow the process of rejection. We found, however, that many of the social group were suffering from conditions which could be alleviated sufficiently to allow them to return to some sort of life outside hospital. The problem of reorientating patients and their relatives in such circumstances is often long and difficult, and we are preparing a further paper dealing with this aspect of the problem. It is sufficient to say that of the 267 cases in the social group admitted to hospital 120 (44%) were satisfactorily resettled at home.

The position of the general practitioner, who is primarily responsible for the care and treatment of these patients, is unenviable. At the present time, despite the fact that as much as 25% of the general practitioner's time is taken by the elderly sick, little or no instruction in this field is given to the medical student. One result of this is to be seen in the confusion regarding the ageing process. Although the normal process of ageing remains to be defined, many people still believe that age alone can be responsible for all sorts of symptoms and signs. One disease that appears to be commonly confused with ageing is hypothyroidism (Lloyd and Goldberg, 1961); as more work in this field is done, further similar diseases will probably emerge. If to all this is added the fact that in most areas it is difficult to get an elderly person into hospital, it is not hard to understand how the patients in the social group came to be so labelled.

We feel that the social group referred to us for admission are analogous to the institutionalized "inheritance," which almost all newly appointed geriatricians find occupying their hospital beds. The social group largely represent the surplus of sick people, many meriting further hospital investigation and treatment, who wait too long for investigation and treatment simply because there are insufficient hospital facilities for them at present.

There is a tendency to overlook the fact that hospitals derive their patients primarily from the general practitioner. In assessing the needs for hospital beds it is important to bear in mind this part played by the

TABLE VI.—Household Composition

	Medical Group		Social Group		Total	
	No.	%	No.	%	No.	%
Living with spouse	47	31	109	26.9	156	27.9
" " relatives	67	44	138	33.9	205	36.8
Living in lodgings or with friends	12	8	26	6.5	38	6.9
Living alone	26	17	133	32.7	159	28.4

TABLE VII

		Out-patient		In-patient		Welfare		G.P.		Other Hospital		Total
		No.	%	No.	%	No.	%	No.	%	No.	%	
Medical Group												
A	..	32	28.1	41	36	—	—	38	33	3	2.6	114
B	..	3	2.5	6	5.0	—	—	2	16.7	1	8.3	12
C	..	8	30.7	13	50	—	—	4	15.4	1	3.9	26
Social Group												
A	..	25	10.5	155	62.6	2	0.8	57	23	8	3.1	247
B	..	4	15.4	17	65.4	2	7.6	3	11.6	—	—	26
C	..	20	15	95	71.4	7	5.3	10	7.5	1	0.8	133

those living alone. The action taken in each group is shown. The figures in the medical group are too small to judge any difference between the subgroups. The finding that 63% of social group A and 71% of social group C were admitted to hospital suggests that the fact of living alone was not of supreme importance in causing their admission to hospital.

6. *Duration of Illness.*—An attempt was made in every case to assess the duration of illness. Although no accuracy was possible on this score, the majority of medical cases presented with an illness measurable in days or weeks, while most of the social cases presented with an illness measurable in months or years.

7. *Medical Condition.*—A clinical diagnosis was made in every case after a history and physical examination. The distribution of diseases diagnosed according to the *International Classification of Diseases* is shown in Table VIII. This illustrates a wide distribution of diseases with a maximum incidence of disease in groups II, VI, VII, and VIII. We feel that the high incidence in the social group of diseases in group VI is significant.

Discussion

Our results suggest that the differences between the medical and social groups as classified by the general practitioner were:

1. *In the Duration of Illness.*—It is possible to make the generalization that the patients in the social group had been

TABLE VIII

	I	II	III	IV	V	VI	VII	VIII	IX	X	XII	XIII	XVI	XVII
<i>Medical Group</i>														
No.	3	16	6	4	4	38	37	16	8	8	2	8	—	2
%	1.8	10.6	3.9	2.7	2.7	25	24.3	10.6	5.2	5.2	1.4	5.2	—	1.4
<i>Social Group</i>														
No.	4	42	14	5	5	179	79	50	5	5	3	13	—	2
%	1	10.4	3.5	1.2	1.2	44.2	19.4	12.3	1.2	1.2	0.7	3.2	—	0.5

general practitioner. In certain circumstances he tends to be a very variable factor. We feel that, in the field of the elderly sick at least, insufficient attention has been paid to the factors which may influence the demands made by general practitioners on their local hospital services. In any area lacking a comprehensive geriatric service many general practitioners will have become accustomed to the inability of their hospital service to help them with most of the problems they encounter with their elderly patients. In such an area it is likely that many patients falling into our social group never appear on a hospital waiting-list because the beds available are only sufficient to take those whose social circumstances have so deteriorated that it is impossible for them to exist outside hospital. Such cases usually exhibit irreversible physical and mental deterioration and tend to perpetuate the bed shortage.

A recent survey of all the Birmingham hospitals (McKeown *et al.*, 1961) has demonstrated the need of a very high proportion of elderly patients admitted to hospital for beds with full hospital facilities. It has been the experience of one of us (W. H. L.) in two different areas that the establishment of a comprehensive geriatric unit uncovers unexpectedly large numbers of elderly people who benefit from in-patient or out-patient general hospital investigation and treatment. This observation suggests that the need in any area for comprehensive geriatric beds will not be known until a comprehensive service exists and there is local knowledge amongst the general practitioners of its potentialities.

It is clear that much can be done for many of the social group; more can be done more quickly if they are dealt with early in their illness. We feel that many require a period in hospital.

During their stay in hospital most will initially need all the facilities of an "acute" medical bed for adequate medical assessment; many will then require a period of physical and mental rehabilitation. During this latter period an accurate assessment of their domestic and social circumstances must be made if they are to be satisfactorily resettled outside hospital. This implies a rather more constructive and perhaps wider sphere of action than is generally apportioned to the geriatric unit, but it is in general accordance with McKeown's (1958) concept of a balanced hospital community. In our experience it would seem that such a comprehensive geriatric service is a logical answer to the problem and that it is not more hospital beds that are required for this service but rather better use of existing beds. It follows from what has been said that in any area served by such a unit the number of social cases encountered will gradually decline with the passage of time.

Summary and Conclusions

During a 12-month period, and from an overall population of about 250,000, 1,370 elderly people were referred by their own doctor for admission to a geriatric unit. Of these, 558 were selected and visited in their home. The method of selection is defined. This sample was assessed from the social and medical points of view, details of which are given. An attempt has been made to define the relative importance of the medical and social factors which caused general practitioners to refer this group of their elderly patients for admission to a geriatric unit.

We have concluded that: (1) social problems in the elderly are usually secondary to demonstrable physical

disease; (2) with proper hospital facilities, a high proportion of elderly people socially crippled by disease can be satisfactorily rehabilitated for life outside hospital; (3) lack of proper hospital facilities for the elderly often results in social crippling by disease; and (4) a comprehensive geriatric service is a logical solution to the problem of the elderly sick, and if properly applied would ultimately prevent the accumulation of many of the "social problems of old age."

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EXPERIMENTS WITH THE CURRICULUM ASSOCIATION FOR THE STUDY OF MEDICAL EDUCATION

[FROM A SPECIAL CORRESPONDENT]

On December 7 the Association for the Study of Medical Education held a meeting at the Middlesex Hospital Medical School to discuss changes which individual medical schools have made in their curriculum. Sir ROBERT PLATT, P.R.C.P., chairman of the association, opened the meeting by commenting on the fact that four years had elapsed since the G.M.C. had set the medical schools free to arrange their own curriculum. Schools throughout the country had all been working on this and the discussion would be a preliminary exchange of views based on the changes introduced at Sheffield, Birmingham, and Glasgow.

Changes at Sheffield

Professor C. H. STUART-HARRIS described how thoughts on a new curriculum had begun in 1955, and in 1957 the G.M.C.'s recommendations had invoked flexibility in what had otherwise been a rigid course of instruction and appointments. They had found that there was a marked loss of interest among students in clinical appointments at the end of the fourth year owing to the proximity of the pathology examinations claiming their greater attention. The object at Sheffield was to preserve the students' interest in the three facets of teaching—clinical appointments, lectures, and examinations—without the presence of conflicting obligations. Thus in the fourth year Part I of the final M.B., Ch.B. examination was held in pathology, bacteriology, pharmacology, and clinical subjects. Thereafter all systematic lectures and demonstrations in these subjects ceased. Part II of the finals occurred in the fifth year in obstetrics and gynaecology, preventive medicine, public health, child health, and special subjects (dermatology, ophthalmology, oto-rhino-laryngology), leaving the sixth year free for the teaching of medicine and surgery. Part III in surgery, medicine (including psychiatry), and clinical science was the final, qualifying examination.

The course included two elective periods, in the fourth and fifth years. Time for this was obtained by shortening the length of some of the clinical appointments (e.g., obstetrics and gynaecology to three months), though medicine and surgery were maintained as six-month appointments. Integrated lectures, clinico-pathological