

Provision of remedial therapists in geriatric medicine

No agreement has been reached about what constitutes a satisfactory norm for the remedial therapy services. In geriatric medicine recommended norms vary from 0.26 to 0.5 trained physiotherapists and from 0.27 to 0.4 trained occupational therapists per thousand population aged 65 and over, with a corresponding number of therapy aides.¹⁻⁴

In the light of the rapid increase in the numbers of very old people we thought it important to assess the present provision of remedial therapists in geriatric departments throughout the United Kingdom.

Methods and results

We received replies to a postal questionnaire on remedial therapist staffing from 213 (76%) of the 280 departments of geriatric medicine, which were responsible for 73% of the elderly (65 years and over) in the United Kingdom.

The table shows the number of remedial therapists in post and the numbers required to reach the lowest recommended norm of 0.25 trained and 0.5 total therapists (trained plus aides) per thousand people aged 65 and over. In each country the average number of therapists is well below these norms: indeed, it would require roughly 890 additional physiotherapists and 1250 occupational therapists to reach them. This would be equivalent to increases of 11% in the number of physiotherapists and of 38% in the number of occupational therapists in post in the National Health Service.

Therapists in geriatric units in the United Kingdom

	England	Wales	Scotland	Northern Ireland
Population ≥ 65 ($\times 1000$):				
Total population	6997	423	711	187
Study population	4926.8	321.5	639.9	137.6
Study population as % of total population	70	76	90	73
Physiotherapists:				
No trained/1000 population*	0.140	0.153	0.166	0.163
Additional No required to reach 0.25/1000 population*	770	41	60	16
No of unfilled posts	46	7	4	9
Total No in NHS	6832	356	983	264
No of trained physiotherapists + aides/1000 population*	0.237	0.271	0.232	0.348
Additional No of trained physiotherapists + aides required to reach 0.5/1000 population*	1840	97	191	28
Occupational therapists:				
No trained/1000 population*	0.098	0.079	0.113	0.148
Additional No required to reach 0.25/1000 population*	1064	72	97	19
No of unfilled posts	110	13	7	2
Total No in NHS	2718	142	348	151
No of trained occupational therapists + aides/1000 population*	0.215	0.219	0.217	0.320
No of trained occupational therapists + aides required to reach 0.5/1000 population*	1994	119	201	34

NHS = National Health Service.
*1000 people aged 65 and over.

Comment

These figures are too large to be solved simply by the provision of extra finance. Even within the departments studied 66 physiotherapy and 132 occupational therapy posts remained unfilled though funded. The problem is the shortage of therapists. To achieve the minimum recommended norms within the next 10 years another 80-100 physiotherapists and occupational therapists would have to be trained each year to supply geriatric medicine alone. This would require the establishment of new training colleges.

As such increases will not be achieved some other way must be found to meet the rehabilitation needs of the community. The table shows that there is also a shortage of therapy aides, which means that untrained helpers are not being used to compensate for the unfilled posts. It would not be desirable, however, for patient management to be left to untrained staff.

One approach would be for some nurses to take more responsibility for active rehabilitation, though they now receive little training in this. Therapists often complain that their work is "undone" by nursing staff through lack of knowledge and unduly custodial attitudes. In successful units nurses continue the process of rehabilitation throughout the day. That they should receive an appropriate training

in rehabilitation seems reasonable. We propose that a certificate of rehabilitation nursing be established as a postbasic qualification, which would train nurses in all aspects of rehabilitation. We would hope that in wards in which a high degree of rehabilitation is necessary the nursing staff would have this certificate. These nurses would be expected to supervise the basic mobilisation and activities of daily living of the patients, thereby allowing therapists to concentrate on more complex and specialised techniques. Patients would benefit from a better organised and continuous programme of rehabilitation. As all specialties, including community care, have similar staffing problems, the training of the rehabilitation nurse should cover all age groups and specialties.

Therapists are unlikely to consider that nurses can carry out functions requiring skills that have taken the therapists many years of specialist training to acquire, and we would support this view. Our concern is to supplement the work of therapists and provide 24 hour rehabilitation by training some nurses to assist in basic rehabilitation. Therapists and nurses could then use their skills to better effect.

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- 1 BMA Board of Science and Education. *Report of working party on care of the elderly*. London: BMA, 1976.
- 2 Wessex Regional Hospital Board. *Report of working party on care of the elderly*. Winchester: Wessex Regional Hospital Board, 1972.
- 3 British Geriatrics Society. *Report on rehabilitation services*. London: British Geriatrics Society, 1974.
- 4 College of Occupational Therapists. *Recommended minimum standards for occupational therapy staff: patient ratios*. London: College of Occupational Therapists, 1980.

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Pituitary infarction and development of the empty sella syndrome after gastrointestinal haemorrhage

Spontaneous destruction of the pituitary may occur after haemorrhage into the gland (usually into a tumour) as in pituitary apoplexy or by infarction after severe hypotension (usually in an enlarged gland) such as in postpartum haemorrhage or Sheehan's syndrome. We describe a patient with acromegaly who sustained spontaneous infarction of her tumour with resolution of her acromegaly after a massive gastrointestinal haemorrhage. She also developed the empty sella syndrome with intrasellar arachnoid herniation of cerebrospinal fluid.

Case report

A 48 year old woman presented with a history of shortness of breath, lethargy, amenorrhoea of two years' duration, acral enlargement, and a hoarse voice. She had typical physical features of acromegaly and congestive heart failure. Investigations showed a raised basal growth hormone concentration of 70 mU/l, which failed to decrease after administration of 100 g oral glucose. Glucose tolerance was normal. Computed tomography (EMI scanner) showed an enlarged pituitary fossa within which was a high attenuation mass that was enhanced after injection of contrast.

Despite treatment with diuretics she developed worsening right heart failure, obstructive sleep apnoea, and hypoventilation and underwent tracheostomy. Two days before planned transphenoidal hypophysectomy she collapsed after a massive gastrointestinal haemorrhage. Her blood pressure was unrecordable for 15 minutes, and she remained hypotensive with a systolic blood pressure of less than 60 mm Hg for a further hour despite transfusion of 16 units of whole blood. She underwent emergency laparotomy, at which a bleeding duodenal ulcer was found and oversewn.

During her convalescence from this episode her acromegalic features resolved. Repeat investigations 12 weeks after her gastrointestinal bleed showed a basal growth hormone concentration of 6 mU/l, which did not alter after administration of 100 g glucose. Repeat computed tomography (Phillips Tomoscan 310) showed no evidence of pituitary tumour, although there was thinning of the sella floor and arachnoid herniation of cerebrospinal fluid