MEDICAL PRACTICE

Contemporary Themes

Geriatric medicine in Hull: a comprehensive service

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Summary

A partially age-related admission policy coupled with a "single-ward" scheme for treatment and rehabilitation was introduced by the Hull geriatric department in 1970. With rare exceptions, elderly patients needing hospital care have been admitted directly to the geriatric unit, and the proportion of the retired population admitted by the general physicians has been greatly reduced. The proportion of inpatients needing continuing care has been reduced to less than 20%, the mean length of inpatient stay has fallen to under 30 days, and separate long-stay wards are no longer needed. More than 91% of patients are admitted without preceding domiciliary assessment, and only 5-6% of admissions are transferred from other units within the area.

Introduction

"Geriatric medicine is the branch of general medicine concerned with clinical, preventive, remedial, and social aspects of illness in the elderly."¹ While this definition is generally accepted, difficulties still arise about the role of the geriatric department and its working relations with departments of general medicine. The opportunity of clarifying these inter-

relations arose in the Hull area in 1970 and we describe the outcome.

Population

The population of the urban and suburban area of Hull and the adjacent, mainly rural, parts of North Humberside served by the geriatric department is 442 329 (1971 census), of which 53 585 (12.1%) are aged 65 and over, with a projected rise to 68 200 (15.4%) by 1981. The population is stable with few immigrants; many families have lived in the area for generations. Much of the housing is substandard, but an active housing programme including limited sheltered housing is in progress. Thirty-three per cent of the elderly live alone.

Geriatric and medical facilities

The geriatric unit has 433 beds in three general hospitals providing 8.1 beds per 1000 of the population aged over 65 (1971 population). Geriatric day-hospital places have increased from 50 to 80 during the period under review (1969-76). Local Authority services for the elderly are well developed, although below the DHSS norm with 1173 part III places and eight social day-centres.

Three consultant physicians in geriatric medicine and a medical assistant constituted the senior staffing of the unit during most of the period. Junior staff now includes one senior registrar, two registrars, six senior house officers, and general practitioners with sessional appointments.

There are 307 medical beds distributed as 142 general medical, 90 cardiology, 35 gastroenterology, 24 nephrology, and 16 rheumatology; facilities for medical emergency admissions are provided on a rota by eight physicians, most of whom have a stated specialty within general medicine. In addition, two physicians (105 beds), two clinical haematologists (4), two neurologists (28), and one infectious diseases consultant provide emergency admission within their own specialties. There were no separate facilities for the care of the younger chronically disabled patient in Hull for most of the period. A unit with 26 beds was established in 1975.

There are two major psychiatric hospitals providing a total of 381 beds used by psychogeriatric patients.

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Hull scheme

In 1970 it was agreed that the geriatric department should offer to admit directly all medical emergencies aged 75 and over. Additionally, the unit undertook to readmit any patient previously treated by it and those patients of 74 and below whose circumstances made it likely they would benefit from their first treatment being in the department. The care of the hospital patient with terminal illness generally remained the responsibility of the unit previously providing support. An understanding was established with psychiatric consultant colleagues regarding responsibilities for elderly patients with mental illness.

Requests for admission were received by a senior geriatrician rather than by a house officer. Admission usually took place without a previous domiciliary assessment. Some 5-8% of admission requests were dealt with by outpatient, day hospital, or social services care. Patients were initially directed to an assessment ward, but a policy of not transferring patients from acute to continuing-care wards evolved and led to the unit developing so that all wards were staffed and equipped to deal with emergencies, rehabilitation, and continuing care.

Commitments for providing long-term care and intermittent admission for social and holiday relief were maintained within the same admission ward, thus providing continuity of care by the same team of medical, nursing, and remedial staff.

Results

The appendix gives a summary of the facilities and operational statistics of the unit for 1976. The distribution of elderly patients between geriatric and general medical units (fig 1) shows the increase in inpatient work load, which is clearly seen to originate from an expanding population of patients over 75, of whom an increasing proportion is taken by the geriatric department rather than from those in the first decade of retirement.

Discharges from the unit have steadily increased from 1532 (1969) to 4294 (1976); mean duration of stay has fallen from 186 days (1969) to 30 days (1976); while the turnover per bed has risen from one to nine patients per year (fig 2). The number of available beds has been gradually reduced after upgrading of wards. Of the patients under 75 years 666 were admitted in 1976 (15% of total admissions). During the past seven years the unit has been able to accommodate all admissions it undertook to receive, apart from two periods of seven days in the winters of 1971 and 1972 when respiratory infections within the city were at epidemic levels.

Discussion

A clearly defined age-related policy for emergency admissions of the elderly has been established in Hull. The identity of the

FIG 2—Bed allocation, number of discharges from the geriatric unit, length of stay, bed occupancy per cent, and turnover per bed a year (1969-76).

unit in relation to its principal role of acute admission has been understood by clinical colleagues and by administrators. Nevertheless, we have been able to continue planned admission for social and holiday relief. As most of the geriatric beds are in general hospital accommodation, the Hull department is better equipped than most to adopt a policy of this type. The wards are mainly in old buildings, and many are overcrowded and lack adequate toilet facilities and day space; the progress so far made in upgrading partly reflects the needs of the admission policy adopted.

Medical and ancillary staffing was initially low but the stimulus that the change in policy brought has been partially responsible for continuing improvement; although staffing is by no means ideal. One major effect of this scheme has been to eliminate effectively "long-stay" wards from our geriatric unit. The proportion of inpatients remaining in hospital over six months has consistently been less than 20%, and in 1976 was down to 14%—only 1.8% of all admissions remaining in hospital for six months or over. When distributed, as they are, throughout the unit, these patients numbering (from 40 to 60 at any one time) are easily integrated within the ward system. Some are eventually seen as late developers and may become fit enough for discharge. About a quarter are waiting for places in welfare homes. The scheme has benefited the morale of both staff and patients. The geriatric waiting list, both at home and in other hospital departments, has been abolished, to good effect, for the adverse effects of such lists on patients and families are well known.²

Early referral of patients in other hospital units, for advice or care or both, has been encouraged and is vital. In 1976 there were 302 requests for transfer of patients to the unit from other hospital departments. After assessment, 259 were admitted (6% of all admissions), and these included only 73 (1.6%) from other medical wards. This small proportion of patients received from other physicians seems to reflect the efficacy of the scheme and the discriminant value of the

FIG 1—Distribution of elderly patients between geriatric and general medical units.

age limit chosen. Although the latter, 75 years, is arbitrary, chosen in the light of available resources, in practice it appears to be a good indicator of geriatric need, and other authors support this.^{3,4} Nationally, also this section of the population will increase by 30% between 1971 and 1986.⁵ We feel strongly that it is right to concentrate geriatric resources on this group.

In common with our system other high-turnover geriatric units^{2,6} have active policies over rehabilitation and resettlement and have most beds usefully placed—that is, in general hospitals. These units also operate with bed numbers well below the suggested DHSS norm of 10 per 1000 population over the age of 65. Our own experience, now more than six years, and that of O'Brien, Joshi, and Warren over 17 years, suggests that high turnover can be maintained, given adequate staffing levels and facilities.

The satisfactory placing of the elderly, confused patient is a problem in most geriatric units. In Hull, most confused patients with organic illness are referred to the geriatric department, while those with overt mental illness are seen by the psychiatric consultants. The almost complete lack of interdepartmental transfer of patients suggests the usefulness of this working rule. In a three-month period in 1976 the psychiatrists admitted a total of 135 patients aged 65 and over, 74 over 75. Only 54 of the total admitted were confused or "demented," and 40 of these were over 75. In the same period a comparable number of patients were discharged with the same diagnostic labels. Only 6% of the discharges and deaths from the psychiatric unit had been in hospital over three months and none had been in over two years. If we can extrapolate from this small survey it seems that there is no build up of confused "long-stay" patients within the psychiatric unit and also the geriatric department is taking a large percentage of this group.

The introduction of comprehensive medical care for those over 75 has produced diverse diagnostic and therapeutic problems. The secondment of medical, nursing, and remedial staff to the unit is easily justified by its enormous educational potential and the opportunities for clinical and epidemiological research.

The complaints of "blocked acute medical beds"^{7,8} could be constructively channelled towards basing geriatric units in general hospitals with equal shares in investigatory and therapeutic facilities and staff. Geriatric units operating without these "privileges" might still develop a comprehensive scheme for the oldest members of the community.

Together with the facilities provided in Hull the policies we have implemented seem to be the essential bases for developing geriatric medicine as a specialty and for providing a comprehensive scheme of care for the elderly sick. The alternative is custodial care for the minority.

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Requests for reprints should be addressed to Dr P Horrocks.

Appendix

Population served	
Over 65 (1971 census)	53 585-12.1% of total
Over 65 (1981 projection)	68 200-15.4% of total
Beds	
Kingston General Hospital, Hull	194
Hull Royal Infirmary	108
Castle Hill Hospital, Cottingham	131
	433
Beds per 1000 over 65 years (1971 population) 8.1	
Admissions 1976	
Total	4421
Emergency	3540 (80%)
Planned	614 (13.8%)
Transfers (all areas)	259 (5.8%)
Deaths	1093 (24.7%)
<65	88 (1.9%)
65-69	113 (2.5%)
70-74	465 (10.5%)
75-79	1245 (28.2%)
80-84	1220 (27.6%)
85-89	851 (19.2%)
≥90	439 (9.9%)
Men:Women	1:1.9 on admission 1:2.4 in the wards
Emergency readmission within 1 month	238 (7.4% of discharges)
Inpatients with stay exceeding 6 months (January 1977)	49 (14% of inpatients)
Bed usage 1976	
Average duration of stay	30 days
Empty beds (average)	91
Occupancy	78%
Turnover/bed	10.2 patients a year
Day hospitals	
North Hull Clinic	50 places
Castle Hill Hospital	30 places
Places per 1000 over 65 years	1.5
Outpatient and day hospital attendances 1976	
New patients	527
Follow-up	1917
Day hospital	16 935
Domiciliary visits/home assessment	926
Admission after visit	377 (41%)
Discharges	
Patients to new Part III place	88 (1976)

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ONE HUNDRED YEARS AGO The treatment of fibroid tumours of the uterus is no doubt one of the problems of the future. Fibroid tumours are much more frequent in women than ovarian tumours; but fortunately they are, in the majority of instances, of much slower growth and attended by less grave symptoms in progress, and the ultimate results are less threatening. By far the largest proportion of fibroids, when once discovered, are most judiciously treated by non-interference surgically. The discomforts may be relieved by appropriate remedies; the haemorrhage, if occurring, can be controlled by rest and styptics; and a prospect may be afforded that, with the arrival of the climacteric, activity and inconvenience will subside. There are, nevertheless, some cases which are attended with such persistent and alarming haemorrhage, or with pain and inconvenience from the bulk or position of the tumour, that the practitioner would be only too glad were it possible to look forward

to an operation for its removal with no greater fear of a fatal issue than appears from the latest results of ovariectomy. Enucleation of the tumour by the vagina, in all its modifications, is a most hazardous proceeding. The large plexuses of veins and the erectile character of the tissues surrounding the womb in the true pelvis eminently predispose to phlebitis, diffuse cellular inflammation, and blood-poisoning; so that a simple incision into the cervix is attended with more risk than a similar incision elsewhere, and the danger increases with the magnitude of the operation. The peril is always enhanced by the difficulty experienced in preventing the retention of septic matters in the neighbourhood of the wounded surfaces, and their consequent absorption. When improvements in surgery obviate this source of danger to the patient, we may possibly procure more favourable results than heretofore. (*British Medical Journal*, 1877.)