PRACTICE OBSERVED

Organising a Practice

Practice policy

E GRAHAM BUCKLEY

The organisation of primary medical care often seems to be a patchwork of tradition and expediency. The purpose of policies is to enable the services provided by general practitioners to become more consistent, rational, and ultimately more effective. All practices have policies or guidelines, and most existing well-defined policies concern practice organisation. The decision to introduce an appointment system is a concrete example of a change of practice policy. The way in which such a change is initiated, agreed, and implemented indicates how a practice is managed. General practitioners seem reluctant to accept their role as managers, even though their status as independent contractors makes them personally responsible for providing a service.

The attachment of staff such as health visitors to general practices and the tendency to form groups of partnerships, for example, have complicated the organisation of primary medical care: management skills are now essential in general practice.

Management

In order to become competent clinicians doctors have lengthy and well defined undergraduate and postgraduate training. Most doctors, however, enter general practice having had no formal training in management; indeed, many doubt the value of studying management. This scepticism is understandable, since descriptive studies of management are usually concerned with business activities and are not directly relevant to our work. Furthermore, studies of management include aspects of sociology and psychology, and doctors reading the standard textbooks may be deterred by the language. This is unfortunate because some of the observations about principles

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of organisation are so universal that they may be applied to our own practices. For example: *In all jobs authority and responsibility should correspond.* If there is a failure of jobs to correspond in this way resentments build up and the whole organisation is seen to suffer. Such a principle seems reasonable. Does it apply to our receptionists, secretaries, or practice managers?

Job satisfaction concerns us both personally and also in our role as managers. Studies indicate that once an individual's basic financial needs have been met a major factor in job satisfaction is the extent to which those in authority are seen to value the work of each individual. Observations such as these give no visionary insights but may be of practical use if we wish to avoid personnel problems in the practice.

Organisation and effectiveness

Let us look again at the example of introducing an appointment system. Who initiates discussion? Who is consulted? Are members of staff other than doctors encouraged to participate in the decision? Are the views of patients ascertained? The answers to these questions will reveal the particular style of management of your own organisation. Likert¹ has described four basic styles of organisation: (1) authoritative exploitive; (2) authoritative benign; (3) consultative; (4) participative. Although practices are likely to modify their style of management according to the particular policy under review, doctors will recognise the basic style of their own organisation in this classification.

The structure of line management in nursing in the National Health Service is an example of an authoritarian style of organisation. It contrasts and may even conflict with the structure in general practice of equal partners who are independent of central administration. It is no coincidence that in his book about policies, *The Prince*, Machiavelli described these two types of organisation. Management is really about politics because it is concerned with achieving the possible.

Particular styles of organisation have no intrinsic merit but are to be judged by their effectiveness. There are now many doctors who would like to know how effective they are, and one expression of this wish is the recent interest in medical audit. To assess effectiveness a clear statement of aims is required. It has been suggested² that suitable aims for primary medical care are that it should be accessible and acceptable to the population and that the most efficient use of resources should be devoted to the needs of the population. The methods used to try to meet these aims are the basis for practice policies. This article will consider practice organisation and a second article will discuss policy on clinical practice.

Work load

Before we can use our clinical skills we must be available to our patients and must have sufficient time to deal with their problems. As well as responding to contacts initiated by the patient, many doctors provide facilities for preventive medicine—for example, by arranging well-women clinics and case-finding programmes for elderly patients. Are there enough doctors, nurses, secretaries, and other staff to provide these services?

List size and rates for consultations and home visits will indicate the total work load. From the average, data on consultations this work load can be expressed in terms of total amount of time required for consultations, and measuring day-to-day and month-to-month variations in consultation rates will identify periods of possible stress for the organisation. Such analyses might show, for instance, that the peak demand for appointments is on Monday afternoons and that September and October are the least busy months in the year. Thus it could become a rule that routine appointments are not made for Monday afternoons and also that all partners consult on Monday afternoons; the general practitioners may decide to take advantage of the comparative lull in early autumn by scheduling screening programmes such as blood pressure clinics then.

Perceived variations in work load between doctors are a potential source of friction. The objective analysis of surgery consultations will show up the variations and may show the need for policies. For example, one doctor has his surgery appointments booked for several days ahead and he feels overworked, while his colleagues are irritated because they consider themselves to be coping with his overspill patients. The analysis might show that the individual doctor is seeing more patients because he asks more of them to return for review. In subsequent discussions new policies on return appointments might be agreed. The doctors could decide, for example, to become individually responsible for their own lists of patients and thus individually responsible for their own work load.

The efficient use of both time and personnel is important in providing the best possible service. Are other members of the team working to their maximum potential? Are they consulted about their work and about the contributions that they could make to the overall service? Is the doctor carrying out tasks that could be performed better by the practice secretary or practice nurse?³

Staffing

The appointment of a new member of staff is an opportunity for change in any organisation. Is a new member or replacement required? Do other members of the team have a clear idea of the work the new person will do? Is it possible to construct a detailed job description? Such a job description should include a list of established practice policies. For example, a new receptionist will be made aware of the practice policy about

how to deal with requests for urgent appointments. Dr Pritchard's book⁴ gives a detailed job description of this nature.

What qualities are you looking for in applicants? Who is concerned in the selection? In a group practice it may be appropriate when selecting a new receptionist for the interview panel to include a doctor, a secretary, and a nurse. As one who will be working with the successful applicant the secretary will be aware of the professional skills required in the post, and the nurse will wish to know whether the appointed person is someone with whom there can be successful liaison.

Time away from the practice

Holidays, sick leave, and study leave all entail time away from the practice. Policies are required to ensure that adequate cover can be arranged for the absent partner. In some practices the method of agreeing these policies is included in the formal practice partnership document. In the case of sick leave it is essential that each partner is aware of the extent of his own responsibility for arranging adequate insurance for sickness benefit.

It is unusual for practices to have any clear guidelines about study leave other than an agreement about the maximum number of days leave that can be taken in each year. The restriction of postgraduate education courses is done on an individual basis, with little consideration given to the educational needs of the practice as a whole. Attempts to clarify the aims of study leave in the practice may show unexpected opportunities for learning. General practitioners are now so accustomed to the concept of continued learning that it may come as something of a shock to realise that practice administrators, practice nurses, and other staff in the practice also require study leave.

There are two questions that need to be considered by the practice when extra commitments are proposed. Do all the partners approve of the new commitment and, if so, will the partners be able to provide cover to enable the doctor to carry out the new duties free from all practice responsibilities? If the practice wishes to become a training practice the selection committee will ask whether all the partners support the application and whether the trainer will be able to devote sufficient time to tutorials.

Communication

No organisation can function efficiently without good internal communication. As practices grow in size and complexity formal methods of communication become essential. Time is the major resource for general practitioners, and they are reluctant to allocate time to practice managers. This work is usually assigned to one partner and the senior secretary or practice manager. This small executive group cannot function on its own, however; other members of staff must participate in decisions that are to be made and must be kept informed of any changes and developments. Meetings between the different groups in the practice should be held regularly so that snags and potential problems in the organisation can be considered before they have developed into major conflicts.

When things go wrong organisation suddenly becomes important. If a complaint is made by a patient the tendency is to see the problem in isolation, when it may be due to a basic weakness or fault in the organisation. For example, a patient may complain that the receptionist was rude and would not let the patient speak directly to the doctor. Such a complaint is not uncommon and indeed most complaints made by patients do concern practice organisation and are possibly on the increase. In the imaginary practice with the imaginary complaint the time is 8.30 am, one doctor is on holiday, two doctors have already started their house calls, the fourth doctor is running late in his surgery, and the receptionist knows that he hates to

be disturbed while consulting. Practice policies now become relevant. How accessible are the doctors? Is the fourth doctor's restricted accessibility wholly justified known to the other three doctors? Should a policy about this be agreed? How is the receptionist to assess the degree of urgency? Have any guidelines been laid down to help her make such an assessment? A real or fictitious complaint is a useful starting point when seeking gaps in providing services.

Conclusion

It will have become apparent that my own preference is for a participative style of management. Nevertheless, I again emphasise that no particular style of management has any intrinsic merit but should be judged only on its effectiveness. One indication of the effectiveness of practice organisation is a satisfied patient. Patient participation groups have been useful both in supplying feedback about changes in practice policy and in suggesting changes. Cartwright and Anderson⁵ have given an up-to-date description of patients' expectations and satisfactions with general practice.

In his descriptive study Lord Taylor⁶ said that the practice of good clinical medicine is made easier by good practice organisation. This dictum is even truer now as the trend of

forming larger group practices continues. Doctors depend increasingly on other members of the primary care team, and clear policies about accessibility and the use of resources are required. I have made no attempt to suggest particular policies. The agreement and implementation of policies will depend upon local circumstances.

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Medical Records

An easy to use A4 age/sex filing system

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Record systems in general practice are always of interest and recently a wealth of useful ideas and innovations has been described. So far, nearly all of these have concentrated on the layout and content of the record—whether A4¹ or medical record envelopes—EC5B and 6B²—or both systems.³

We describe a method of storing A4 records that gives a visible age/sex colour-coded filing system in which any case sheet may be identified and in use in three to five seconds (fig 1). Our system of colour coding is very simple. For each year 0-9 in a decade a distinctive colour is given in felt or marker pen, and each folder is then colour-coded twice on the spine in distinctive bands of colour, making the year of birth obvious at a glance by reading the combination of two colours on the spine. The upper colour of each pair is the decade colour and the lower the year in the decade (fig 2). To make the individual years stand out we use a slightly staggered system of colouring (fig 3). To avoid misfiling case sheets for men and women the bands of colour for each year of birth, though the same colour, are staggered in height (fig 4), thus making it almost impossible for a record to be misfiled outside its year and sex.

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In each group by year of birth records are filed alphabetically from right to left. We also give each patient a six-figure identification number based on year of birth, sex, and surname alphabetically. We start the number with the year of birth in the first two digits—for example, 21 for a patient born in 1921 or 09 for someone born in 1909. The third digit indicates the patient's sex—1 for male, 2 for female. The fourth, fifth, and sixth digits indicate the surname. In each year of birth and sex we have a group of numbers from 000 to 999. We have distributed these numbers among the letters of the alphabet as shown in the table.

Distribution of numbers according to letters of the alphabet

0-999	ABC
100-199	DEF
200-299	GHI
300-399	J-K-L-M-N
400-499	O-P-Q-R-S
500-599	T-U-V
600-699	W-X-Y
700-799	Z
800-899	0123456789
900-999	10111213141516171819

Regional variations in name have to be taken into account. Since we are a Scottish practice we have a preponderance of patients with names beginning with Mac and Mc, and therefore more numbers are allocated to surnames beginning with these letters.

The largest number of patients of one sex that we have in any one year of birth is 64. Therefore in 1982 we still have 936

FIG 1—Medical records filed according to colour coding based on the patient's age and sex.

FIG 2—Colour coding on record folder: black indicates the decade; green and brown indicate the year of birth in the decade.

FIG 3—Colours on record folders are staggered so that the decades and the years in the decade stand out.

spaces vacant—in a practice with 3800 patients. In practices with more than 20 000 patients an identification number of four digits could be used, increasing available numbers ten times. When we number a new case sheet the year of birth and sex are self-evident. The alphabetical identification number is then worked out. Firstly, the group hundred is identified, then the group of numbers—for example, ABC is 000-099 and B is therefore 034-066. The required number is found by choosing one approximately halfway between two adjacent patient numbers—for example, a number for a man called BROADLEY who was born in 1934. Within 1934, male sex we already have BLACK (341090) and BROWN (341090). We would therefore

number BROADLEY as 341055. This number is useful for cross reference to our morbidity index and being a six-digit number may be useful when our records become computerised. It is also useful for laboratory requests when the hospital computer will only "accept" a lab request if it has a "computer" number. Some other practices and health centres use a two-colour coded record system to prevent misfiling, but the colours are based on an arbitrary patient number which patients either have to remember or carry with them on a card, or else the number has to be found from a master index filed alphabetically. Our system depends on a patient's year of birth—a fact that very few people forget, though some do try—and which remains a constant throughout life despite changing addresses and, especially for women, changing names.

FIG 4—Colour bands for year of birth are the same for both sexes but are staggered to prevent misfiling.

Advantages

- As Walker said, "With just a little effort we can really make records work for us."⁴ With our filing system we feel that they do, and this makes our whole job, with its many facets, easier and more enjoyable. Our system gives the following advantages:
- (1) A visual age/sex register.
 - (2) Ease of retrieval, which facilitates (a) talking to patients or their relatives on the telephone; (b) talking to laboratories or hospital practitioners; (c) taking the case sheet on urgent calls.
 - (3) A help for screening.
 - (4) A help for a locum: (a) quick retrieval; (b) summary of past history in case records; (c) the most recent hospital letter faces the continuation notes for ease of updating. This is important because we are a husband and wife partnership with a trainee and therefore holidays have to be covered by a locum. We are extremely fortunate that this is nearly always provided by one of two excellent local general practitioners who now know our practice well, but we feel that any locum would be helped considerably by the record system.
 - (5) The constant date of birth versus changing address.
 - (6) An easy numbering system with a view to computerisation.

When my husband and I took over this practice in August 1979 it was a single-handed open-access practice of 3800 patients with the surgery in the doctor's house. Records consisted of medical record envelopes (EC5B and 6B) filed alphabetically and stored in the consulting room. As we were new to the practice we had an ideal opportunity to modernise and update the practice and premises and we decided on two main objectives: to convert records to A4 format and to file our records using a colour-coded age/sex system.

Implementing the system

The first practical problem was shelving. We have an excellent local joiner who built wooden shelving to our specifications and adapted the shelves to fit round central heating radiators etc,

resulting in a well designed area of shelving placed on two opposing walls of our reception room. This cost us £60 in 1979 and is certainly much cheaper than some of the preformed systems that are available.¹

We then divided all our record envelopes according to sex and then according to year of birth. Then we started the time-consuming task of pruning our records and converting them to A4 folders. This took us about three months for a practice list of 3800 patients and provided much help by us and by the receptionists. The receptionists made up the A4 folders and we then inserted the relevant records. Being new to the practice we had considerable interest in making the record system workable, and we also found it rewarding because we got to know many patients at an early stage through pruning and indexing their records according to disease.

The layout in the A4 record is best suited to our own purposes. It differs slightly from other recognised methods of A4 layout.¹ We decided at first to use as few inserts as possible in the record for simplicity. On the first spine we have a summary sheet of major past history and recent important findings or investigations, and on the reverse of this sheet immunisations are recorded. The second insert page holds laboratory reports and reports of x-ray examinations. On the second spine we mount hospital letters with the most recent uppermost on the left-hand side and facing this the clinical notes sheet on the right-hand side. We use separate cards for contraceptive and obstetric care and these can be filed in the front pocket of the A4 record. Drug sensitivities and other important information, such as treatment with monoamine oxidase inhibitors, are recorded on the inside front cover of the brown folder and also at the top of the clinical notes page.

For many practices it is very difficult to convert records so quickly and the initial effort required to start converting an already workable system of medical record envelopes would be considerable. Many practices convert a small number of those envelopes to A4 folders regularly until all records are converted, as in Ladywell Medical Centre in Edinburgh, where in a practice of 11 500 patients conversion of records was carried out over almost four years.² Since we were radically altering not only the individual records but the whole filing system, this had to be completed relatively quickly.

We have found that new staff quickly learn the colour-coding system. The patients quickly become accustomed to giving their name and year of birth at surgery attendances, and when phoning for home visits, repeat prescriptions, or for any other reason. Telephone queries can be dealt with speedily as the record is to hand in a few seconds, which helps both our patients and us; it also helps when local consultants phone with queries or requests in reducing the amount of time spent on the telephone and in giving accurate information.

Our visual age-sex register makes it easy for us to check and pull the case sheets of, for example, those 35-year-old women requiring cervical smears or 10 or 11-year-old girls needing rubella immunisations. We can also quickly check payments from the family practitioner committee—for example, for patients over 65 years and over 75 years. With a conventional age-sex register, firstly the relevant group of patients is defined, usually on a card index system, then the case notes are retrieved and the information gathered. With our system it is so easy to identify and check to see whether investigations or treatments

have been done that screening processes become very much simpler. We also keep a reserve card index age-sex register in our own home in case of fire or vandalism in the surgery.

Instead of storing our empty medical record envelopes inside the pocket of the A4 we file them alphabetically in cabinets for medical record envelopes. This takes up little space and provides a most useful back up for our main filing system. Any queries from the health board, hospital, social workers, patients' relatives, etc., when they do not know the year of birth, are dealt with by this method.

Benefits and possibilities

Having now rearranged our records and put them into a filing system that is reliable, easy to use, and has been tested over two and a half years, we find that our thoughts on computerisation have changed slightly. Our data for screening, research, and day-to-day medical practice is now so easy to obtain that the benefits of computerisation appear to be few. On the other hand, if computerisation becomes readily available we would agree with others¹⁻³ that one needs a data base like ours that is in a form that would make conversion to a computer feasible and comprehensible and gives us the ability to feed good data into the system.

Summary

We have established an A4 record system in which records are filed according to colour codes based on age and sex. This gives us an almost foolproof filing system with quick retrieval and has the advantage of a visible age-sex register, which is valuable for screening and research.

We are grateful to all those doctors in west and central Scotland who were so generous with their time and with their ideas, which we have adopted to our needs.

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conditions are referred by their doctors or health visitors (though many are self-referred) and attend a six-week course of classes held in a general practitioner's surgery. The course covers subjects such as the ill-effects of chronic drug use, alcohol, and tobacco, and other maladaptive coping mechanisms, but it emphasises positive ways of dealing with stress, including acquiring skills in muscular relaxation.

In a short article it is possible to refer only briefly to some areas of the preventive work that health visitors may do. So I conclude by welcoming the recent recognition of the importance of prevention by the other key member of the primary health care team, as demonstrated by the publication of the reports of the Royal College of General Practitioners' Working Party on prevention. At last there is a glimmer of hope among health visitors that their medical colleagues will begin to appreciate what they have been up to all these years!

The GP and the Specialist

Geriatric medicine

C T CURRIE

Although most elderly people live at home and enjoy good health and independence the care of elderly patients is the major task of the National Health Service, with most of this care being provided by the general practitioner, who is likely to see 10 or more patients over the age of 65 each day. Except in the few areas where geriatricians offer comprehensive age-related hospital services, the hospital care of most elderly patients is likely to be carried out by specialists other than geriatricians.

So where, the average geriatrician must modestly ask himself, does his speciality fit in? What sort of patients should he be seeing? Broadly speaking, the referral of elderly patients with crises of mobility, continence, or family support, and those with multiple and possibly interrelated physical, psychological, and social problems will be appropriate. Referrals are commonly non-specific, and laced with such phrases as "gone off her feet," "relatives at the end of their tether," and "neighbours demanding something must be done." Although the undergraduate curriculum has rarely equipped the doctor to cope with such presentations diagnosis remains his first duty. If the diagnosis or diagnoses are not apparent to the general practitioner the geriatrician may be able to help. Many geriatricians encourage early referral, because an old lady who takes to her bed on Monday can be in serious trouble (dehydration, confusion, immobility, constipation, pressure sores, hypostatic pneumonia) by Friday and early intervention carries obvious benefits, not least for anxious and exhausted relatives.

Like other specialties, geriatric medicine commands its own

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skills and resources. Geriatricians, accustomed to the confused or incontinent patient, familiar with the problems of families supporting old people, practised in the multiple and commonly atypical presentation of disease in the elderly, have perhaps one supreme advantage over other hospital specialists when the referral of an elderly patient is contemplated: they never object to the patient being old. The geriatrician has both an eye for the potentially remediable and an ability to think in terms of compensation for irretrievably lost function. By treating the treatable, managing the manageable, and improving around the rest, he can, in collaboration with the general practitioner, ensure the most satisfactory last few months or years for the patient. Many patients die fairly soon after referral and, when the time comes to settle for comfort, the approach to terminal care is generally both sympathetic and practical.

Services

HOME ASSESSMENT

Home assessment gives the geriatrician first-hand knowledge of the patient (who is seen at her best), her problems, her supporters, and her home. Functional assessment can be carried out in circumstances most relevant for that patient. Relatives can be seen and, more importantly, heard. All this provides a basis for informed discussion and decision-making with the general practitioner.

ACUTE ADMISSION

The most visible role of the geriatrician in support of the general practitioner can be a prompt admission to hospital, where this is indicated either by an urgent medical problem or

Practising Prevention

The health visitor and prevention

SHIRLEY GOODWIN

Prevention has been the raison d'être of health visiting since the profession sprang into existence during the middle of the last century in response to the high infant morbidity and mortality rates in some northern cities. The official functions of the health visitor, as laid down by the statutory training body, include the prevention of mental, physical, and emotional ill-health, the early detection of ill-health, recognising and identifying need, health teaching, and providing care.¹ Preventive activity at each of Caplan's three levels of prevention² is clearly represented in these areas.

Mothers and children

The traditional focus for health visitors has been maternal and child health and, inevitably, preventive strategies with these groups have become more highly developed than with those groups who have come more lately to the attention of health visitors. Foremost of such strategies must surely be the routine home visiting of all families when a baby is expected or when there are children under 5 years of age. The opportunities for educating and giving advice to promote healthy living and for the early detection of illness or abnormality are obvious. But it is difficult to show the beneficial effect of such intervention since health visiting is a statutory service, parts of which may not be withdrawn in order to provide a control group against which to measure any effect. The introduction, however, of a regular home visiting programme (fortnightly from birth to 3 months, and then monthly until 6 months of age) to families with babies who are identified as having a statistically increased risk of "cot death" seems to have been associated with a reduction of six deaths per 10 000. R G Carpenter, in a paper on the evaluation of more health visiting for high-risk children in Sheffield, said that the data suggest that this reduction in mortality (comparable to the number of lives saved by the treatment of paediatric cancers) could be attributed to the visits by health visitors.

Although health visitors themselves are convinced of the value of routine visiting as a means of primary prevention, they sometimes have difficulty in persuading general practitioners that visiting healthy families, and thus a waste of time when there are sick patients to be followed up and supported and others with health-related social problems with whom the health visitor (in the opinion of the doctor) could more usefully spend time. There is probably less disagreement about the value of developmental assessment as a preventive measure. In the practice where I worked until recently a weekly child health clinic is held and children are seen by the health visitor and doctor at 6 weeks, 8 months, 21 years, and 4 years of age. A medical examination is conducted at each check-up, and the health visitor assesses the child's developmental progress. A

screening test for hearing is carried out at 8 months at a separate session. The Royal College of General Practitioners' child developmental record card is used to record observations and is kept in the medical notes. This arrangement is popular with parents, children, and health workers, not least for the continuity of care that such a system provides, and in my experience there are fewer failures to attend than when check-ups are available only at the health authority clinic.

The need for routine medical examination to be an invariable part of developmental assessment has been challenged recently, and a new approach to screening is being adopted in which the health visitors conduct the assessments, using a structured screening tool. One example is the Denver Developmental Screening Test.³ This test was developed in the United States but has been standardised⁴ for use with British children, and has been used by health visitors in South Glamorgan since 1974. One important aspect of the test is that it contains a clear-cut indication of when it is necessary to refer a child for more detailed medical assessment. I have been concerned in supervising student health visitors who are taught to use this test and have been particularly impressed with the thoroughness and practicality of the training programme, and how fast students gain confidence in the knowledge and skills relating to normal child development.

Others

At the other end of the life cycle are the elderly people who are becoming a greater proportion of the general practitioner's list and the health visitor's case load. Health visitors are constantly aware that they are in contact with only a minority of the individuals over retirement age to whom they could be of some service in terms of prevention. Case-finding with the help of the age-sex register is possible to do, but most health visitors have too great a case load to permit them to take on routine screening and visiting of all the elderly people that they, or their medical and nursing colleagues, would wish. This is unfortunate since the effectiveness of health visitors in this area has been long recognised,⁵ and a recent study⁶ has shown the positive effect of monthly visits by a health visitor on the health of elderly women, an effect that persists for at least six months after visits have ceased.

"The most important single cause of death in the United Kingdom is coronary heart disease," according to the Department of Health and Social Security,⁷ and health visitors are very much aware of the part they have to play in its prevention.⁸ I begin with the advice that they can give on infant feeding, and continue with the information about the harmful effects of smoking, and the benefits of exercise and relaxation, which may be incorporated into health education to individuals and groups, particularly of schoolchildren.

For some years I have been teaching groups of adults how to understand and cope with stress more effectively.⁹ Patients who are being weaned off tranquillisers, or who have hypertension, migraine, phobic symptoms, and other stress-related

an equally urgent crisis of support. To the ill and newly dependent patient the geriatrician offers a period of simultaneous medical and rehabilitation management, with the restoration of independence as its goal.

DAY HOSPITAL

A day hospital should not be confused with the day centre, which is staffed by social services departments. It extends the services of a geriatric unit very considerably. Patients who are even only marginally fit to remain at home may be brought up for assessment, rehabilitation, and nursing care without resort to the expensive and perhaps dependency-inducing facilities of an inpatient unit. Inpatients may be discharged earlier, families may be relieved, and continuing care may be avoided or at least delayed.

RESPIRE ADMISSIONS

The goodwill of relatives supporting patients who would otherwise require institutional care may be preserved by respite admissions—either planned, as for annual holidays, or responding to an unforeseen family crisis such as the illness of a supporter.

LONG-STATE CARE

Responsive and effective acute geriatric services backed up by good community care will minimise pressure on the scarce resource of the geriatric service—the long-stay bed. Though a last resort in terms of both cost and quality of life, it will be necessary for the highly dependent patient for whom all other possibilities have proved inadequate. In practice the management of such beds is only a minor part of the geriatrician's duties, though for a general practitioner faced with a desperate family the availability of a long-stay bed may be the sole standard by which a service is judged. Hence the plea for early referrals. Early involvement, successful therapeutic interventions where possible, and arrangements for support as outlined above not only improve the quality of life for the patient and the supporters but also permits all other possibilities besides long-stay care to be considered before the point of desperation is reached.

Common problems

DRUGS

Drugs are a major cause of ill health in elderly people, who are more susceptible to side effects and more at risk from polypharmacy than younger patients. Many of the most effective interventions by a geriatrician will be achieved simply by stopping or radically simplifying medication. Repeat prescriptions should be used critically and sparingly, and any unwell old person should be assessed with the possibility of drug effects in mind.

FALLS

These are a common and non-specific presentation in elderly people. They may be accidental ("the kind of thing that could happen to anyone"), prodromal—as in an old person developing a silent bronchopneumonia or myocardial infarction—or the outcome of a variety of perhaps age-related dysfunctions, such as postural hypotension, impaired postural control, or stiff and painful joints. Searching for cardiac causes is rarely rewarding. As always, drugs should be suspected. Labyrinthine disorders

are rare, and the various labyrinthine sedatives commonly prescribed are more likely to cause drug-induced Parkinsonism than to prevent falls.

ACUTE CONFUSION

The sudden or rapid onset of confusion in an old person is likely to be a non-specific presentation of a specific and possibly treatable pathology. Infection in the urinary tract or respiratory tract is a likely cause. Drugs are a major but easily reversible cause of confusion in the elderly: sedatives, antidepressants, hypoglycaemics, and digoxin are frequent offenders. Hospitalisation increases confusion, which is therefore best diagnosed and managed at home if possible.

INCONTINENCE

Tactful but fearless questioning may be required to elicit details from a patient on this notoriously underreported symptom. Relatives may be more forthcoming, and for them incontinence may be a last straw. Easily treatable causes of urinary incontinence include urinary tract infection, faecal impaction (readily missed by omitting the rectal examination), inappropriate diuretic treatment, and senile vulvitis. Less easily treated is the incontinence associated with an unstable bladder, which is common in demented patients. Pads and pants, with incontinence pads at night, may make life more bearable for such patients. Faecal incontinence is most commonly caused by faecal impaction and overflow, which is grossly underdiagnosed.

Commonly missed diagnoses

DEMENZA

Appreciable mental impairment occurs in 10% of people over 65 and in 22% of those over 80, but only about one case in five is known to the general practitioner. Most cases of insidious mental loss are caused by either primary neuronal degeneration or cerebrovascular disease and are therefore at present untreatable, but diagnosis still matters because supportive management will defer a crisis and counselling will help relatives and other supporters. Dementia impairs or abolishes drug compliance and increases susceptibility to adverse reactions.

DEPRESSION

Depression is common and commonly missed. Pleomorphic and insidious in onset, depression is perhaps more easily diagnosed by someone who has never seen the patient before. Symptoms disproportionate to signs, sleep disturbance, withdrawal from previously enjoyed activities, and late-onset alcohol abuse should suggest the diagnosis. Suspect unlikable patients, though some will simply be unlikable. Small, one-day doses of the standard drugs, given at night, are tolerated and effective.

PARKINSON'S DISEASE

Again, the insidious onset of the disease may conceal the diagnosis from the patient's usual medical attendant. Tremor is commonly absent. Watching the patient rise from a chair is worthwhile, the agonisingly slow progress up and forward being characteristic. Many commonly prescribed drugs cause Parkinsonism and can be withdrawn, to gratifying effect. True Parkinson's disease usually responds well to L-dopa combination treatment, and in cases of doubt a trial of treatment is justified.

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