Future Policy

The alternative policy is to abandon routine infant vaccination and to defer vaccination until it is required for travel or for outbreak control. Individuals requiring vaccination for travel and outbreak control are relatively few, and the number is going to decrease as smallpox becomes eradicated and fewer countries require vaccination for entry.

At the same time it is highly important to vaccinate and revaccinate all high-risk groups such as doctors, nurses and other hospital personnel,* and the military for a few more years. Medical and public health personnel have all too often become indigenous cases and contributed to the dissemination of infection, and greater efforts should be made to ensure that vaccination and revaccination is given to this group of high-risk individuals. This policy of selective vaccination will carry a certain amount of morbidity, but it will be less than the morbidity and death associated with our present practice.

There is little doubt that we shall move in the direction of selective vaccination, and now is the time to make the change. It has been said that before the policy of infant vaccination could be abandoned there would have to be *certainty* that an outbreak in an unvaccinated community could be controlled as effectively as experience has shown it to be possible in a partly vaccinated community. The sense of that statement is that the present policy will be recommended *ad infinitum* (but fewer and fewer doctors will carry it out).

The conservative traditionalists should be reminded that if we now abandon infant vaccination a sudden nightmare situation is not going to arise,† for there can be no sudden shift in the community immunity (which is minimal anyway), and the policy can be changed with any unlikely upsurge in the global prevalence of smallpox or in a world emergency.

Though this policy of deferring vaccination until required was suggested some years ago we are, perhaps, waiting for the Americans to lead us, for Lane and Millar¹⁵ and Foege¹⁹ have recently argued that in the U.S.A. the benefits of childhood

*Though not infectious during the incubation period smallpox patients are highly infective at the onset of the illness—before the rash appears. The disease is difficult to diagnose at the onset and health personnel who have not been recently revaccinated are at high risk.

†The immune population, in any event, in the United Kingdom at present, are essentially the under 5-year-olds, who are unlikely to make much contribution to the control of a disease which spreads essentially in adults in this country.

vaccination no longer outweigh its risks, and they have suggested that consideration should be given to its discontinuance. In Canada in the past 20 years there has been only one fatal case of smallpox but 21 deaths from vaccination complications. It is little wonder that some epidemiologists in Canada are saying that a case can now be made out to reconsider the benefits of vaccination vis-à-vis the risk of death from it.

Many years ago Sir Graham Wilson said, "it is much easier to introduce a given measure into the public health practice of this country than to remove it once it has become firmly established."²⁰ The time is overdue^{3 21} to debate the advantages and disadvantages of retaining smallpox immunization as one of our routine procedures.

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Contemporary Themes

Morale and the Planning of Psychogeriatric Services*

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The psychiatric care of the elderly has become an urgent issue. At the turn of the century the over-65s comprised less than 5% of some 33 million people in England and Wales; now they total over 12% of nearly 50 million, and the number and

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proportion of the very old has risen even more steeply. Admissions of old people to psychiatric hospitals are increasing, and the chronic inpatient population is ageing. Advances in medical and psychiatric treatment and services and the development of the specialty of geriatrics mean that there is now much more to offer to elderly patients—and a good thing too, since they occupy some 45% of both psychiatric and general hospital beds.^{1 2} Changes in society have increased expectations of well-being generally and of well-being in old age, and families, too, rightly expect some relief from the often huge burden of caring for mentally disordered old people. Despite this close on 95% of old people were at home, at least in the early 1960s, rather than in hospitals or other institutions.³

By contrast with the urgency of the need there is a practically total reluctance on the part of our young graduates to go into geriatric work. In 1970 over 80% of junior staff in geriatrics were from overseas, and of by far the largest group—senior house officers—the figure was 92%.⁴ At the same time concern about long-stay institutions, in which the bulk of the care of the elderly takes place, has been stimulated by a series of reports,^{5,6} official and unofficial, with the result that we now have a Hospital Advisory Service and promises that more funds will be deflected into this sector of medical care.⁷ Last year the Department of Health⁸ recommended the establishment of “psychogeriatric assessment units,” and as regards long-term care, even for ambulant demented patients, there have been indications that the Department is thinking in terms of allotting responsibility to geriatricians.

The Goodmayes Unit

An account of the origins and early days of the psychiatric unit for old people at Goodmayes Hospital has been given elsewhere,⁹ but I will describe here briefly what we are doing, since much of my argument derives from this experience. Our service looks after all referred patients aged 65 and over in an area of some 370,000 people. It was set up in January 1969 in response not only to the manifest need but also to the challenge that medical work in this field could be satisfying and even exciting. Referrals and admissions are increasing, and discharges even more so, and yet in two years it has been possible to empty over 100 beds—which is over 20% of the elderly inpatient population at the time the unit was set up—to begin to relieve crowding and to concentrate scarce resources on fewer patients; and this has been despite a fall in deaths. At the same time there has developed a happy pattern of collaboration with local authorities and with the geriatric services. What in some ways has been especially gratifying is that we have managed to recruit for this work a team of young doctors of impressive quality and enthusiasm. My “firm” also runs a general psychiatric service based on a general hospital, but our interest and the great bulk of our activity are firmly centred on the service for old people.

Our medical staff comprises a full-time registrar and three other doctors who are young married women working part-time, and all are fully involved in the ward, domiciliary, and clinical work as well as in planning the service. We thus have something which must surely be rare—a psychogeriatric unit based on a large mental hospital staffed by doctors of enviable quality, and running at high morale and in the face of the usual reluctance to work on geriatric units, even seeing competition among staff of all sorts for attachment to it. With the support of the Department of Health a research sociologist has joined us to look at questions of morale and effectiveness in a service such as ours.

Psychogeriatrics and Assessment

What have we learnt from this still short but intensive experience of the past two years? What in fact is psychogeriatrics? Confusion derives from what is in effect a use of the word in two senses—on the one hand to emphasize the conjunction of old age and mental infirmity, and on the other the collaboration of psychiatrists and geriatricians. Some people limit the term to organic mental disorder in old age, others to chronic organic disorder, and others still to ambulant patients with chronic organic disorders. In practice it has also to take account of those inpatients of mental hospitals who have “graduated,” as the Scottish working party put it,¹⁰ into the geriatric age group. Finally, it can mean the psychiatry of old age, functional and organic, acute and chronic alike.

Now there are clues which suggest that the Department of

Health regards psychogeriatrics as denoting services for elderly psychiatric patients with primarily organic disorders. Thus the norm of one psychiatric bed per 2,000 population is intended to include the over-65s, but separate further provision is made for “psychogeriatric” patients. There is also an impression that the Department does not wish to preserve the present practical distinction between ambulant and non-ambulant demented patients, since if what appears to be current thinking prevails both groups would become the responsibility of geriatricians, whose enthusiasm for that role is less than headlong.

In my opinion psychogeriatrics should mean the psychiatry of old age. There is nothing to be gained and a lot to be lost by thinking separately of organic and functional disorders; even were such a distinction always clinically realistic, which it is not, it would result in standards falling and in many old people being deprived of the open-minded psychiatric appraisal which is their right. There is another reason why this latter view is the one to be preferred, and this has to do with morale, which is discussed below.

I am worried too about “assessment.” The rationale for psychogeriatric assessment units was worked out by Dr. Kay, Professor Roth, and Professor Hall¹¹ and recently codified in HM (70) 11.⁸ Already, though, there are signs that the actual blueprint for these units is not what is in the minds of many people as they discuss them. Thus I read with surprise in the latest of the valuable new series of reviews of the work of psychiatric hospitals² that my own unit, which at the time had some 300 beds, is a “psychogeriatric assessment unit,” while another hospital in London is said to have a psychogeriatric assessment unit of 819 beds—presumably it serves the whole of south-east England. Such things must confirm one's suspicion that not everyone means the same when they speak of psychogeriatric assessment units. Perhaps we should use the alternative term, “joint assessment units.”

There is also a danger that psychogeriatric assessment units will be regarded as places where old people can be admitted for assessment—that is, *before* assessment. A linchpin of psychogeriatric practice is assessment *at home*. The big decision is whether or not an old person should be moved from home, and it is only after this “primary assessment” that further assessment can proceed if necessary as an inpatient. A disability in an old person is rarely intelligible except in terms of a balance between function and setting, and the former can seldom be properly assessed apart from the latter. The “further assessment” in the unit must not become a substitute for this primary home assessment.

Future Plans and Present Realities

What then should be the form and function of a psychiatric unit for old people? Here one must take account of some “reality factors,” high among which is that at present it is so difficult to interest young doctors in work with old people. There are many reasons for this but they derive largely from two sources—the fact that medical education is not yet in step with today's pattern of medical need, and three years after the Todd report is changing only slowly, and that much of the care of old people takes place amid frightful surroundings and shoddy facilities which any graduate of our medical schools today will quite rightly consider substandard. Thus a first consideration in planning a psychiatric service for old people must be that working in it should be attractive to young doctors. The case that psychiatry belongs in the general hospital, fortunately already accepted for general psychiatry, is in many ways even stronger for old people. Yet who doubts that old people will be at the end of the queue as psychiatry moves into the general hospital? Whatever is agreed for the future it will be many years before the bulk of this work takes place anywhere other than in mental hospitals, and most long-stay psychogeriatric patients will never see the inside of any other place. There

must be contingency planning—a plan for the ideal future, and a plan for the present actuality.

The future should see psychiatric services for old people based on general hospitals, with close collaboration between psychiatrists and geriatricians. This does not mean that every old person should be admitted to a joint assessment unit. Old people with primarily psychiatric disorders need the environment of a psychiatric ward. We must avoid arguing that because the assessment of *some* old people needs the continuous joint involvement of psychiatrists and geriatricians it is therefore always better that both should be involved. Whether the psychiatric unit for old people is separate from or part of the ordinary psychiatric ward is a matter for experiment, and no one has the right to be dogmatic. What is important (and this is discussed below) is that particular psychiatrists should take a special interest in old people. There should in addition be a small joint unit for patients in whom the relative roles of mental and physical components are not clear on domiciliary assessment or who, while posing primarily psychiatric problems, clearly need close general medical care and appraisal, and for those patients who, at first appropriately admitted into the psychiatric unit, may suddenly take a turn for the worse physically, while continuing to need psychiatric care.

How Many Beds?

It is wise to resist being drawn on exact figures, for figures tend to be devoured by the figure-hungry, who do not always pause to hear or recall their limitations. Clearly, needs depend on the local proportion of old people, availability of welfare and related accommodation, the policy of geriatricians, and the pattern of collaboration between services. Our experience tentatively suggests that an acute unit taking all psychiatric problems in over-65s will need about one bed per 1,000 of the elderly population, or in a typical area some 30 beds for a total population of a quarter of a million. This figure would include joint assessment beds, though our impression is that about six would do, and that the "10 to 20" in official estimates is more than is needed, provided that exit from them is kept clear. With an increase in residential accommodation even fewer beds would probably suffice. There need to be day places too, but again the number depends on the alternative day facilities in the area, on local distances, and on the availability of a flexible transport system (by which I mean something more than ambulance collections, which sometimes entail as long being spent in the ambulance on its collection rounds as in hospital). As regards long-stay beds, as my subsequent argument will I hope make clear, one cannot begin to give figures at present; in two years our own requirement for long-stay hospital beds has been greatly reduced.

Our experience at present suggests that old people admitted to hospital are unlikely to fall into the usual three categories of acute, intermediate, and chronic, but rather into two. In our unit a patient is either discharged quickly or needs long-term (though not often hospital) care. Such "intermediate"-stay patients that we have are nearly all waiting for appropriate residential arrangements to be made—in other words, administrative rather than clinical reasons keep them in hospital. But the problem of the long-term patients remains—in effect, the ambulant demented.

Geriatricians or Psychiatrists or Family Doctors?

It is hard to understand the debate about whether these long-term patients should be looked after by geriatricians or by psychiatrists. Very few of them need hospital care at all; certainly they do need the continuous care of specialists. It is residential not hospital care that they need. In many cases ordinary welfare accommodation is entirely appropriate; in

others modified accommodation or a slightly higher staff ratio will be required, or some ad hoc (rather than formal) psychiatric training for the staff to accustom them to occasional behaviour difficulties. Wilson¹² at Redruth and others have shown what can be done.

Such homes could be attended by family doctors, who would be free to call on the services of specialists just as they are at present. If residents became infirm to the point of needing essentially bed-fast nursing care, such that could not continue to be given in the residential home, they would become the responsibility of the geriatric physician, just as if such a change in their condition had arisen in their own home. I am still hoping that someone will explain to me which components of the clinical care of properly assessed ambulant demented patients (or even of aged chronic schizophrenics) are held to require the day-to-day services of consultant psychiatrists or consultant geriatricians; yet it is being widely suggested that the geriatric services, understaffed and faced with frightful problems of recruitment, should take on this burden—it does not make sense, especially if one remembers that for every demented patient in institutional care there are probably about six at home being looked after by families, their general practitioners, and their community services.¹³ The Todd report rightly suggested that much of what is at present "geriatrics" could and ought to be done by family doctors,¹⁴ a point of view which was shared by the working party on primary medical care.¹⁵

Case for Residential Care

Other dividends will accrue from this pattern of care. Residential care is almost always cheaper than hospital care, and one can do some very crude sums. At present the average cost of maintaining a patient in a mental hospital is £17.63 a week, while the so-far-as-possible equivalent cost per week for a resident in a welfare home comes to £11.⁴ There are some 52,000 old people in mental hospitals, and if we say that only two-thirds of them could be in residential homes (I believe that the proportion is much greater, and at present a census of our own inpatients is being taken with this in mind) there is a substantial saving to be made by a shift from hospital to residential care (over £11 million a year on these figures); though the actual figures are open to many objections (ward rather than hospital costing is needed) they deserve at least to be set alongside recent suggestions, political or academic, of ways in which money could be saved in the National Health Service.

But there are benefits more important than money saved, and here I am back to morale. The unattractiveness for staff of long-term care for incurable patients derives in large measure from the fact that *hospitals function on the medical model*. A chronic unit in a hospital willy-nilly sets itself standards similar to an acute unit. It measures success by the traditional aspirations of acute medicine—curing and discharging patients. It is tempting here to digress on how far such criteria are today still appropriate to the bulk of medical practice and how far medical education should be giving them primacy, when chronic disease, and in large measure chronic degenerative disease in an ageing population, is the main challenge which confronts us. Suffice it to say that it is small wonder that few doctors and for that matter few trained nurses want to work in long-stay hospital units.

To pretend that work in long-stay units is as rewarding, by *these standards and for these staff*, as work in acute units will not get us anywhere. The whole spirit of chronic care differs from that of acute care. Chronic ambulant demented patients are very seldom as interesting clinically as the diagnostic problems of acute practice, so why should we expect doctors or trained nurses to find them so? Rather than conjure up inevitably specious reasons why they *ought* to be equally interesting we should begin to recognize that these old folk do not pose primarily medical problems at all. If their need is seen

in terms of residential rather than medical care then a quite different set of aspirations on the part of the staff is evoked.

Those who work in residential care get their satisfactions from seeing their old people well looked after, content, and leading as wholesome and full a day-to-day life as their condition permits. They are not constantly aching to investigate, cure, and discharge. Moreover, such units, inasmuch as they would be small, do not pose the problems of huge complex institutions which hospitals for long-stay patients do. Residential care, of course, has plenty of its own problems of morale, and psychiatrists can often help with these—which is a very different matter from day-to-day clinical responsibility. But it doesn't help morale if objectives are misidentified and if scarce skills are misused or underused. I leave aside the administrative issues, merely saying that it would be a tragedy if such a shift from hospital to residential care continues to be frustrated by the structural shortcomings of a health service which places responsibility for identical patients in chronic mental hospital wards on the one hand and local authority homes on the other on two different sides of a financial fence. Here is an area which cries out for a collaborative approach between the hospital service and the new social service departments.

Psychogeriatric Units and Psychogeriatric Consultants

So much for the future. What are the immediate needs of the services as we have them now and as they are likely in large measure to be for many years yet, services based on mental hospitals such as my own and embracing not only the accumulation of new long-stay admissions but the ageing inpatient population? So long as this work remains in the mental hospital those doing it must function as a team with a common identity and allegiance, and so far as possible all members of the team must be enabled to take part in all aspects of the work, acute and chronic. For instance, at Goodmayes our unit meeting rotates week by week between each ward, acute and chronic alike. Since this involves many social workers and others from outside the hospital, as well as an increasing number of students and visitors, it serves as one way of bringing to the long-stay wards the active issues of the unit.

One physician should be in charge, who should give the whole or nearly the whole of his time to this work. At Goodmayes all its doctors are seen to be putting their main energy into the unit, and it may be that at least in the early days of such units relatively permanent, rather than rotating, junior staff is best. Those looking after the elderly should be able to feel that they have their "own" consultant and their "own" doctors who are not constantly dividing themselves between the demands of work with the elderly and work with the young. So long as pressures and relative priorities are perceived in the way that prevails in medicine today this will lead to the elderly being neglected. The physician in charge can plan his time and his service in a rational way, distributing them according to the needs of all the old people for whom he is responsible—that is, trying to meet the needs of the community as well as the medical and institutional needs of those in hospital. He will develop personal links with the social services, and personal channels of communication will enable him to cut through administrative formalities and to develop reciprocal patterns of collaboration and of training of staff. He will be able to acquire skills in work with old people such as can rarely come to a psychiatrist who simply sees old people in the course of a busy general psychiatric practice. It is important that the man concerned should be responsible for the assessment and management of effectively all referred old people. My own service owes much to my colleagues, who let me deal with substantially the whole of this work. It is only in this way that one can be an effective gate-keeper and at the same time prevent the selective filtering off of patients of good prognosis, for, of

course, morale is greatly helped by the smooth being available along with the rough.

Medical Staffing and Medical Education

The problem of medical staffing depends on a reappraisal by doctors of the priorities in medical care, such as will not become general until medical education itself is reformed to take account of the changed pattern of disease and medical need. The shortage of doctors in Britain means that many of our graduates can train in teaching hospitals, and so long as undergraduate education is centred on the teaching hospitals this will be the natural aspiration of most young doctors. With diffusion of medical education also into the community and into other hospitals and the post-Todd expansion of medical schools things should change. It is sad though to have to look in vain in the Todd report for any emphasis on geriatrics at the undergraduate level, and I suppose it must be regarded merely as realistic that when in the Todd—A.S.M.E. survey students were asked to indicate their career intentions the choice of nearly 30 named specialties which they were offered did not include geriatrics.¹⁴

So long as interest in this work on the part of young psychiatrists is as scanty as it is the actual form and staffing of psychogeriatric units must be flexible. Particularly at the junior levels jobs may have to be tailored to particular candidates as they can be found, rather than that an almost non-existent field of applicants should be offered rigidly-defined posts. The important thing is surely to try to get hold of the right man to head the service, to choose a psychiatrist who wants to do the job because of the geriatrics rather than despite it, to give him decent facilities, and to allow him (as my own regional board has been doing) to tailor supporting jobs to the right individuals as he finds them. Unorthodox set-ups will not only have to be put up with but may even for the time being need to be the rule, at least outside teaching hospitals.

There is another base for morale which would help services for old people to thrive—the "unprestigious" areas of medical care especially need support and stimulus from the teaching centres. In this respect psychogeriatrics has no special claim that is not shared in the field of psychiatry by subnormality or in the field of medicine by geriatrics or chronic disease in general. The fact that these specialties are geographically almost always outside the teaching hospital means that academic departments, despite their heavy commitments, need particularly to go out of their way (often in a literal sense) to encourage work in these fields. More research should be centred on or include this group of medical care problems, and students should everywhere be able to see good work being done.

Conclusion

My argument, then, is this. Psychogeriatrics should be as lively and satisfying as any medical work, for it embraces every aspect of psychiatry and clinical medicine as well as applied social medicine. The problems are that medical education does not orientate our graduates to working in this field, and much of the work takes place in substandard settings. The remedy is likely to come from changes in emphasis in medical education, an up-grading and assimilation into the general and teaching hospital of services for old people, and a transfer of those many patients who need merely residential care from hospitals into residential homes. Facilities must be adequate and at least as good as those of colleagues, otherwise geriatric services will be medical slums. Particular individuals should specialize in this work and should give most of their time to it; and they will

need the special support and encouragement of teaching centres.

There is something else implicit in what has been said and it needs to be stressed as it is one of the pillars of morale. This is the insistence on being not only ready to take responsibility for every patient who properly belongs in one's province but positively jealous to do so. For morale this liability should be an asset, and the sense of being totally responsible, of being the ultimate long-stop, is invigorating. One can take this even further—the way medical care is organized at present, at least in large urban areas, psychogeriatric services have a stronger claim than most to be actually as well as notionally responsible for all problems in a defined population, in that few old people go outside the area for treatment, few go to other general or teaching hospitals, and few seek private medical care; equally, few other practitioners seek to compete. In short, one is doctor to a community in a way in which not many others doctors, at least in cities, are. We are thus particularly well placed to be epidemiologists even as we are doing our clinical work. Certainly for my part, I have never before been in a professional setting where intellectual and emotional satisfaction go more closely hand in hand.

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Effects of Industrial Action by the Ambulance Service on Day Hospital Patients

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Summary

The results of loss of treatment were assessed in a group of 248 day hospital patients when industrial action interrupted the ambulance service for five weeks. Almost 10% of the patients failed to return for treatment and 39% of those who returned had deteriorated appreciably. The groups of patients who were most vulnerable were those most in need of physiotherapy and rehabilitation, and many extra admissions to the wards resulted from the loss of diagnostic and treatment facilities in the day hospitals.

Introduction

In October 1970 Teesside was one of the areas affected by industrial action by the manual workers' unions in support of a pay claim. During a period of five weeks ambulances carried only emergencies—dealing with accidents and urgent admissions to hospital. Outpatients and patients discharged from hospital were not carried, and patients due to attend the day hospital could receive treatment only if taken by relatives in cars or by taxi. There are three day hospitals in the Teesside area dealing with geriatric patients, where in addition to the usual physiotherapy and occupational therapy there are full diagnostic facilities. Biochemical and radiological investigations on a day basis without admission inevitably ceased when the ambulance

service stopped, and only a handful of the patients on treatment were able to attend, most of them being unable to attend for five weeks. When the ambulance service was restored and the patients reappeared an assessment was made of the effects of loss of day hospital treatment over this long period.

The assessment was carried out by the sisters in charge, physiotherapists, and medical staff, and there was little variation in opinion about the state of each patient. Only one basic opinion was given: was the patient unchanged or had there been deterioration?

Patients

Altogether 248 patients were attending the day hospitals, many with multiple problems, but several large diagnostic groups could be identified and the effects of loss of treatment in each group could be observed (see Table).

There was an immediate increase in short-term ward admission for investigations. The geriatric department had become accustomed to carrying out most of the radiological and biochemical investigations in the day hospitals on patients not ill enough to require inpatient treatment. For example, patients for gastrointestinal and renal tract x-ray examinations had to be admitted. Diabetics (usually investigated and stabilized in the day hospital) also had to be admitted.

Many of the patients attending for treatment had been discharged from the wards only partially rehabilitated to continue in the day hospital; others had been considered suitable for day hospital treatment without any period of inpatient care. Many of these patients were in need of considerable therapeutic help and some were in only the early stages of treatment. During the break several patients had to be admitted, some died, and contact was lost with others who failed to reappear. Subsequent inquiries about these missing patients disclosed several reasons

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