VIEWS AND REVIEWS

ACUTE PERSPECTIVE

David Oliver: “Why did they put her on a geriatric ward?”

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Geriatricians sometimes field formal complaints and informal calls for concern. Patients’ families can be unhappy that their loved one has been admitted or transferred to a geriatric medicine ward, whatever the quality of care or communication. Sometimes it isn’t even a geriatric medicine ward. Fellow patients in 21st century acute medical units or wards are often older, frailer, or more cognitively impaired than the public might expect. I’ve seen this misunderstanding often in my work as an independent expert reviewer for courts, regulators, or complaint resolution.

For doctors who have devoted their professional career to the care of the oldest and most medically complex patients, and for the skilled multidisciplinary teams of nurses and allied health professionals we work closely with, such complaints can be unsettling.

Why are relatives, and sometimes patients who complain on their own account of being “with the old people,” so aggrieved in these cases? You don’t get patients with heart attacks, cancer, or fractures complaining because they’re on a coronary care, oncology, or trauma ward or parents complaining that their child is on a paediatric ward. The animus against putting patients in a ward geared to their specific needs seems almost unique to geriatric medicine.

Strong evidence shows that specialist led, multidisciplinary comprehensive geriatric assessment (CGA) leads to better outcomes than “usual care” in services not equipped for older people’s needs.¹

Stroke units have been proved to save lives and improve outcomes. In the UK their development, clinical leadership, and evidence base have been driven largely by geriatricians, and they effectively offer geriatrician led CGA for many patients.² Care for older patients with hip fracture has benefited similarly from such approaches.³ Older people often get a “right bed, wrong patient” raw deal when cared for on a ward where the staff don’t have the training, values, or clinical leadership to focus on person centred, multidisciplinary care.⁴⁻⁶

Although “geriatrics” describes a branch of medicine that has advocated tirelessly for older people’s care, built an evidence base, and led clinical services,⁷ the “G” word now has unfortunate, even comical connotations in wider society. People don’t like it; nor do they like “frailty” or being defined by age related health problems and functional or cognitive deficits.⁸

Well beyond the specialist geriatric unit, the core business of modern acute healthcare is increasingly the care of vulnerable older people

We see ample evidence of age discrimination in society, the media, and even the caring professions.⁹ We tend to fear ageing or death and often don’t want to identify ourselves as older (or our loved ones, even if well over 80)—or even to imagine entering the last phase of life and having the difficult conversations this may entail,^{10 11} even though we have excellent resources to help with this.¹²⁻¹⁴

Yet around two thirds of NHS hospital bed days are taken up by people over 65; a quarter by people over 80.¹⁵ Many are admitted with or develop immobility, dependence, disability, dementia, delirium, incontinence, or sensory impairment.¹⁶⁻¹⁹ Patients may be near others who are close to death or who show confusion and behavioural symptoms, which can be disruptive or upsetting, though in no way the patients’ fault.

Well beyond the specialist geriatric unit, the core business of modern acute healthcare is increasingly the care of vulnerable older people. In a free at point of delivery universal health service for the many—with very high bed occupancy, open bays, and limited single rooms—it’s near certain that patients will be surrounded by others with age related problems. I’m not sure that we should be apologetic for this reality in responding to complaints, let alone the complaint that someone has been admitted to the specialist ward best able to help their specific needs.

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