Abstracts

Geriatric Medicine — John Bond

Report of a Working Party of the Royal College of Physicians of London, Medication for the Elderly. *Journal of the Royal College of Physicians of London*, **18** (1984), 7–17

The Journal of the Royal College of Physicians of London has recently published two important articles of relevance to geriatric medicine. The first comprised the Report about Medication for the Elderly which examined the provision of drug treatment for older people and identified five aspects where the situation in Britain could be improved; inadequate clinical assessment; excessive prescribing; inadequate supervision of long-term medication; appreciation of changes in pharmacokinetics and pharmacodynamics with age; and the patients' compliance.

The detailed recommendations of the Working Party have been set out in sections and relate to different professional groups.

Recommendations to doctors generally:

(1) Make a careful clinical assessment of the situation and then consider whether the patient is taking any unnecessary drugs and whether any additional medication is really required. At this stage, take account of any factors which might modify the patient's responsiveness to the proposed drug and his/her susceptibility to medications in general.
(2) Simplify the dose and drug regime as far as possible. This will help in explaining the regime to the patient (where appropriate in speech and by writing) – a process which cannot be hurried. Then try to discover if the patient has really understood your explanation. Supply each patient with a drug card record.
(3) In your prescription to the pharmacist, specify the dose and timing of the drugs as precisely as possible so that he has the necessary information to label the container clearly and correctly.
(4) Before a patient leaves you, advise him or her of any serious adverse drug effects. Arrange for adequate follow-up, which may initially have to be at frequent intervals, to check that the desired therapeutic effect is being obtained and that there are no serious reactions. Patients should be asked to bring their medicines with them when attending follow-up to enable compliance to be assessed.
(5) Ensure good communication with any medical and other colleagues who are sharing the care and the treatment of the patient with you.
(6) Avoid inappropriate or over-energetic treatment when the patient's

physical and mental problems and disabilities indicate a less active therapeutic role.
(7) Doctors should report any suspected drug reactions to the Committee on the Safety of Medicines.

Recommendations to doctors in hospital practice:
(1) A senior member of the clinical team should regularly review all medication given to older patients
(2) A ward prescribing policy should be established
(3) Prescriptions for patients should be confirmed every ten days

Recommendations to doctors in general Practice:
(1) Patients who fail to keep appointments at surgery should be identified, followed up and, if necessary, placed on an 'at risk' register.
(2) The number of repeat prescriptions that a patient may obtain without seeing the doctor must be specified and the practice staff so informed.
(3) Appropriate members of the primary health care team who visit the elderly at home should review the drug therapy and check that drugs prescribed for a particular patient are not used for any other purpose.
(4) Bulk prescribing in old people's homes should be avoided.

Recommendations to the nursing profession:
(1) Nurses should be well aware of the need for accurate prescribing and compliance so that they may take advantage of their close and understanding relationship with the patient to assist them to co-operate in their treatment.
(2) They should in addition be alert to the problems of over-dosage and adverse effects on the one hand and those of inadequate therapeutic effect or lack of compliance on the other.

Recommendations to pharmacists:
(1) Because of their special training, pharmacists are well placed to make prescribed medicines simple of access and to help patients with appropriate explanations.
(2) When dispensing medicines pharmacists should use containers which elderly people can open and should label the medicine in such a way that it can be clearly understood. They should be able to advise on memory aids such as the Dosett box.
(3) They should enquire about current drug therapy before selling over-the-counter medicines.
(4) The ward pharmacist can play a role in the education of doctors on the ward.
(5) The District Pharmaceutical Officer has responsibility to improve supervision of medication in old people's homes.

Recommendation to the pharmaceutical industry:
Since elderly people are given medicine out of proportion to their numbers, and are also vulnerable to many drugs, the industry has

particular responsibility to consider the special needs of elderly patients. It follows that adequate numbers of aged and very aged patients should be included in the trials of drugs which are likely to be prescribed to the elderly. Drug data sheets should contain specific prescribing advice for the elderly.

COMMENT

It would be pretentious, and perhaps even imperialistic of a sociologist, to make judgements about the medical or pharmacological aspects of this report. However I will comment on the policy aspects. For many readers of this Journal most of the recommendations of the Working Party are self-evident. Yet, the fact that the Royal College of Physicians established a Working Party to discuss medication for the elderly indicates the concern expressed by the medical profession about some aspects of drug treatment. A large body of research which is assumed by this Report suggests that these concerns are well founded. What will be of interest in the future to all of us whether as health professionals, potential patients or even tax payers is whether this initiative has any effect on the quality of drug treatment for the elderly. A review five years on would be an indication of continuing concern and provide a further catalyst for action.

J. G. Evans and J. M. Graham. Medical care of the elderly: five years on. *Journal of the Royal College of Physicians of London*, **18** (1984), 18–21.

An earlier Working Party of the Royal College of Physicians of London reported on 'the problems which have led to the uneven and sometimes inadequate service for the medical care of the elderly and the difficulties of recruitment of doctors to that service' (p. 18). This article reviews changes which have occurred during the five years following on from the publication of the Working Party report in 1977.

The Working Party considered that the problems of accommodation and recruitment would be lessened by 'integration of the diagnostic and therapeutic services of physicians and geriatricians' into common clinical departments. Integration is now a policy which has the support of the College and DHSS. What progress toward integration has been made?

Five years after the Working Party reported a seminar was held to examine progress toward integration. Participants were asked to present brief papers describing their local services and policies. The selection of participants was not necessarily representative of the views of

clinicians throughout the country but this report of the seminar does provide an indication of the advantages and disadvantages of integration in different areas.

In some parts of the country integration has always existed – geriatric medicine has never been separated from the general medical service; in other parts integration is now well established; and in some parts no progress has been made toward integration. Evans and Graham comment that there is no evidence that integration is being imposed on unwilling clinicians by medical committees or health authorities.

The seminar highlighted the variety of integrated services across the country. Consultants who work in integrated departments have in common that they care for medical patients of all ages. In most departments the physician with special responsibility for the elderly takes his turn in the ordinary rota for emergency admissions of all ages. In the majority of integrated departments patients requiring specialist rehabilitation services are transferred to the consultant with special interest in the elderly. In other integrated departments all very old patients are transferred to their care. Most physicians with special responsibility for the elderly devote more than half their time to their sub-speciality.

Participants of the seminar highlighted a number of advantages of integration. In particular integrated departments offer equal access to the facilities of a general hospital to all patients, regardless of age. It is argued that admission of elderly patients to general hospital units reduces length of stay by giving more rapid access to diagnostic tests, higher levels of medical staffing, and specialist opinion. Integration is seen as a more efficient method than the provision of separate departments of geriatric and general medicine, providing parallel services where surplus resources for older patients are not made available to younger patients, and vice versa.

Another advantage of integration, emerging from this seminar, is the opportunity for exchange of knowledge and skills between physicians with a range of special interests. It is argued that geriatricians working in integrated services become more quickly aware of relevant developments in other specialities, and other physicians are quicker to appreciate the most effective ways of treating very elderly people. This advantage accrues not only to consultants but to junior medical staff, nursing staff, and medical and nursing students. It is also argued that improvements to the physical environment of wards benefit both old and young patients, alike.

The seminar also discussed the potential problems of integration. It was suggested that the development of integration had been inhibited by the fear that general physicians appointed to care for both old and

young patients would neglect the older patients. However, Evans and Graham suggest that this poses much less of a problem nowadays. The increasing proportion of patients being admitted to hospital who are old would make it difficult for consultants to avoid the elderly. In addition there appears to be among the medical profession a much more positive attitude toward the care of old people.

A number of practical problems were also highlighted at the seminar. In particular the physicians as a body must agree about the division of the medical work of the District. This means that the transition toward integration must accommodate specialists in geriatrics in general medicine through refresher courses or more intensive training. Similarly general physicians require additional training in the application of their skills to the older patients.

One significant obstacle to integration is the existence of cash incentives ('leads') to nursing staff to work in wards currently designated 'geriatric'. Such labels, of course, inhibit the development of a fully integrated service for the care of the elderly.

COMMENT

It is, perhaps, somewhat surprising that the move toward an integrated service for the medical care of the elderly is not apparently being more carefully monitored. The views and opinions of a selected group of participants is unlikely to be representative of the country as a whole. But, in the absence of other data, those views provide a useful insight into the potential advantages and disadvantages of such a change. The authors of this article are strong advocates of integration. I suspect, therefore, that some of the statements show a more positive tone toward integration than is supported by the facts. For example to assert that integration may reduce length of stay by giving rapid access to diagnostic tests, higher levels of medical staffing, and specialist opinion may be true. However, it does not accord with other assertions reported elsewhere which suggest that Departments of Geriatric Medicine are able to get patients out of hospital quicker and in better shape.[1] We need to see more evidence before we accept unquestionably the opinions of the participants of this seminar and their amanuenses.

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NOTE

1 Irvine, R. E. Geriatric medicine and general internal medicine. *Journal of the Royal College of Physicians of London*, **18** (1984), 21.