



BGS

n e w s l e t t e r

New BGS Compendium of policy and good practice launched

Over the last two years, the Policy Committee has been carrying out a detailed review of the BGS Compendium of Guidelines. These will be published on the BGS website over the coming months.

Over the years, the BGS has produced a large number of policy statements promoting higher standards of medical education, and care of the older patient. These were produced and publicised to the membership in slightly haphazard fashion until 1994, when the BGS Policy Committee took control of the policy coming out of the Society. It was decided to review all the publications produced by the Society over many years, to update them where necessary, and to bring them together in a compendium. It was a substantial piece of work, carried out under the able leadership over some years by Dr Alistair Main, Dr Clive Bowman and

Dr Doug MacMahon.

By dint of serendipity, as the first compendium reached completion, the BGS was bequeathed a sizeable sum of money by a member of the public, and with the approval of the executors of the estate, the bequest was used to print 3,000 copies of the Compendium. These files were mailed to members of the BGS, but we also publicised their availability to every health authority in the country and received some 400 orders for copies of the file. The project did much to raise the profile of the British Geriatrics Society and demand for the views and recommendations of the Society on a range of issues has been high ever since.

With the advent of the Internet, Dr David Black, in his capacity as Honorary Secretary of the Society, commissioned the BGS Secretariat to develop the BGS website. The Compendium of Guidelines, Policy Statements and Statements of Good Practice formed the backbone of this project. Web statistics indicated that the compendium pages were the target of most visits to the fledgeling website. It was also surprising to find that among the visitors to the online compendium, there was a gratifyingly high

For changes to the abstract submissions for the Autumn meeting - see p19

Also, we are inviting nominations for Hon Secretary and Hon Treasurer of the BGS - see p16

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Honorary Secretaries: Dr Kevin Kelleher and Dr David Beaumont **Meetings Secretaries:** Dr Juanita Pascual and Dr Michael Vassallo
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specialist medical society for health in old age

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Dr David Beaumont

number of overseas visitors. The Society experienced an unprecedented growth in overseas members during this period. In particular, our membership from the Netherlands went from zero to nearly 50 members in just under a year. There was an increasing number of overseas delegates, both attending and participating in our scientific meetings.

Since that time, maintaining and updating this series of documents has been one of the core responsibilities of the Policy Committee, but the speed of change in geriatric medicine has demanded a change in both the structure of the compendium, as well as a timely review of all the documents which form this work. As a result many familiar documents have now been gracefully retired to be replaced by new guidance which we hope members will find interesting, and a valuable source of advice and information.

So how are things changing?

The new Compendium will see the documents re-organised into four sections. **Section 1** will include short statements which crystallise the values and attitudes of the Society. **Section 2** will comprise a series of clinical guidelines drafted by the Clinical Practice Evaluation Committee which

apply to individual patients in the clinical setting. **Section 3** relates particularly to the work of the Policy Committee in providing service guidelines which describe components of service, standards of care and guidance on general issues affecting the health care of older people. An additional **Section 4** has recently been added to include position statements issued by the Society, and other resources such as survey data under the heading of reference material.

Future Challenges

One of the challenging aspects of producing and implementing policy results from the complexities arising out of devolution in the United Kingdom. With policy within the four nations becoming increasingly divergent, it is nevertheless incumbent on the British Geriatrics Society in general, and the Policy Committee in particular, to provide cogent guidance on best practice in the management of the frail older patient. For example, whether a country officially acknowledges the term "intermediate care" or not, the Society needs to take cognisance of the countrywide practice of this form of care, whatever it is called, and to provide guidance on the best practice in intermediate care.

Next Steps

By the time you read this article, some of the new compendium will be available to view on the website and I hope you will all take a few minutes to take a look and let us know your views, either to me directly (david.beaumont@ghnt.nhs.uk) or via the Editor (editor@bgsnet.org.uk).

There are several additional points to make. Firstly, apart from featuring each compendium document in the form of a summary in coming issues of the Newsletter, the full versions of the compendium documents will be available on the website only. In the

Section 1 – Statements of BGS Policy in respect of Health Care of Older People

Readers will recall publication in the 2004 Newsletters, a series of statements which described the attitudes and principles held by the Society concerning the speciality of geriatric medicine. Comment at the time was very favourable and as a result, these policy statements have been transferred verbatim into section 1. The idea will be to review these statements on a regular basis, but also to respond to events outside the Society which call for new or revised advice, as necessary.

Section 2-Clinical Guidelines

A particularly exciting feature of the new compendium will be an expanding section containing clinical guidelines for specific clinical situations. This will include the joint BGS/AGS Falls Guideline, the recently developed Pain guideline and soon, an updated guideline for management of delirium. About to be published, is a concise document on the management of depression in acquired brain injury, which will be added to this section at the time of the launch (see page 21 of this Newsletter).

Section 3-Service Guidelines

This is the largest section and comprises over 20 documents. For ease of reference, these have been grouped into 6 subsections

Subsection 1: The speciality of Geriatric Medicine

This includes statements on the Aims and Functions of the Society, the Strategic review carried out by the President and Chief Executive, the Standards of Specialist Care document and a revised Rehabilitation of Older People statement.

Subsection 2: Ethics and Legal Issues

Included in this section is advice on such issues as Advance directives, Testamentary capacity, CPR decisions, Procedures for compulsory admission of patients with psychiatric illness, Nutritional advice in common clinical situations and Copying letters to patients (featured in this issue of the Newsletter - p25).

Subsection 3: Acute hospital based issues in health care of older people

Here, members will find updated guidance on Acute medical care for older people, Discharge planning and collaboration between geriatricians and psychiatrists of old age. The recent document concerning the older person in the accident and emergency department also appears here.

Subsection 4: Community Interface Issues in Health Care of Older People

This large subsection covers a wide range of topics including Health promotion, Intermediate care, the Role of the geriatrician in the community, and Assessment of older people for continuing care. The second half comprises documents on the Importance of vision in preventing falls, Palliative care, The care of older people in care homes and a recently revised and very topical statement on Abuse of older people.

Subsection 5: Training Section

The Education and Training committee has kindly undertaken development of this section which at the time of writing is almost complete. The finished version will have 5 documents outlining Curricula in geriatric medicine for undergraduates, postgraduates, old age psychiatry trainees, and also GP vocational trainees. The remaining section will be a recommended reading list for specialist registrars and other clinicians training in geriatric medicine

Subsection 6: Individual Service Specifications

Here members will find a small number of documents describing patterns of service for patients with Parkinson's Disease and Limb fractures.

Section 4: Reference Material

Over the last year the Society has been asked to provide Evidence for the House of Lords and the House of Commons Health Committee on a variety of topics including the Assisted Dying Bill, Research, and the Public Health White Paper, "Choosing Health". In addition, the National Councils and other groups within the Society produce survey data, for example the English Councils consultant and reimbursement surveys. It was felt it would be useful if these position statements and data that support policy statements could be available for members to consult, so this additional section has been added to accommodate these statements.

interests of keeping costs down, and given the rate of change in policy, we do not have printed copies of the documents. Nevertheless, copies in Word format will be available for downloading.

Secondly, some of the documents are still being reviewed and will only be added later this year. Please keep an eye open for changes over the next few months.

Acknowledgements

I wish to thank my predecessor, **Gill Turner**

who devised the structure for the new compendium and did much of the work in bringing together this huge piece of work. I am also indebted to my colleagues on **CPEC**, the **Education and Training Committee**, various **SIGs**, and **members of Policy Committee**, past and present, including the **BGS administrative team**.

David Beaumont
Chair, BGS Policy Committee

Editorial

page

By sheer coincidence of the material offered to your Newsletter editorial team this month, this issue pays tribute to people who have and, in some cases still are, the pioneers of innovative service and academic excellence in geriatric medicine.

With reference to George Santayana's quote below, whether the lessons learnt from "another country" affect the decision makers of today is a moot point.

Stories like those of Bim Bhowmick, Noah Morris et al., are often stories of determined individualism, which produces an organic growth of service for a local patient community. Dissemination of good local experience leads to models of care being established elsewhere with local modification. In the twenty-first century service development based on good practice are gone and new methodologies are in use.

The President's column in this issue critiques, with more than a little scepticism, new 'models of service planning'. This raises the question, how much do the views of a Specialist Society for older patients influence these developments? Being "on the side of the angels" after service changes have been implemented, possibly to the detriment of our patients' best interests, helps no one.

Those who cannot remember the past are condemned to repeat it

George Santayana (1863 - 1952), *The Life of Reason, Volume 1, 1905*

History is more or less bunk. It's tradition. We don't want tradition. We want to live in the present and the only history that is worth a tinker's damn is the history we made today.

Henry Ford (1863 - 1947), *Interview with Chicago Tribune, 25 May, 1916*

This brings us, neatly again, to the issue of academic (geriatric) medicine and health services research. Some departments of elderly care medicine have suffered in recent

times, influenced no doubt by such issues as the Research Assessment Exercise (RAE), (<http://195.194.167.103/>) on the rating of their efforts. To an objective observer, never were so many service changes ripe for academic / research review prior to their implementation. However the ground in this field of endeavour seems not entirely fertile at the moment.

I recently attended a Workforce Development Confederation meeting where new roles and responsibilities were being defined and commissioned to deal with the agenda of 'long term conditions'. Clearly this is an agenda that impinges directly on our core business. As we know, three levels of needs-complexity requiring different types of intervention from health and social care have been identified to cope with this agenda, and therefore the Confederation was discussing the arrival of increased numbers of community matrons, case managers, primary care assistant practitioners and intermediate care facilitators. See www.content.modern.nhs.uk/cmsWISE/HIC/HIC7/HIC7.htm. We understand the need for research and evidence to inform service development, but it is quite clear that there are large gaps in the evidence base, especially around the management of chronic disease management/long term conditions.

At this meeting I raised the issue of the lack of evidence to support the proposed changes under discussion and the potential research that should/could be commissioned before the changes were introduced. One response from a fellow attendee was interesting. He mentioned that they had been discussing such issues with a psychiatrist recently, and it was his opinion that the number of changes occurring in the National Health Service at any given time was so large, it was impossible to subject such proposed interventions to a process of randomised controlled trial, and by implication other quantitative methods of research in order to prove their benefit prior to introduction.

This was a stark reminder of belief systems that



lack validity.

Let us hear loud ongoing support for academic (geriatric) medicine and research especially in the health services area. Please watch the compendium on the BGS website as some guidance on academic geriatric medicine will appear under the Training Section.

There are many who are pursuing careers in academic geriatric medicine, as exemplified by Alisdair MacLulich's article in this month's Newsletter. Further reading material on the development of academic careers in the UK in the

next number of years can be found at www.mmc.nhs.uk/academic_medicine.asp?m=7

I was tempted to comment on a recent documentary on television, which covered the quality of care of older hospital in-patients again. Instead I am going to commission some comment on what effect these programmes have on the viewer and policy makers. My objectivity is shot on this one, especially after some folk close to the BGS opined that such programmes made them feel that the sooner voluntary euthanasia was introduced the better!

Kevin Kelleher

President's column

With the drumbeat of the coming General Election becoming louder, health issues are never far from the news.

The government is flexing its muscles to demonstrate that it is increasing investment in the Health Service and delivering better care. The politicians' posturing offers both threats and opportunities for geriatric medicine. The issues are of course, different for different nations in the United Kingdom, and the reformed structure of the BGS is proving of value, allowing improved communication relating to the different political agenda in each country. I would like to draw attention to two political initiatives from the English perspective, to illustrate how the specialty might be shaped by those politicians who might seek to be seen as innovative and reforming.

Patient choice

Firstly, an initiative called 'Choose and Book'. This is aligned to the theme of *patient choice*. Basically, patients will have the right to choose the time and place of their first appointment, and this will be booked electronically without any clinical screening. This initiative has had little input from either patients or clinicians, and it is now hastily being put

in place. If we take our own specialty, widespread use of this system is likely to result in inappropriate and ineffective referrals.

As geriatric medicine becomes more specialised with different clinicians taking leads on falls, stroke, Parkinson's disease, continence etc, what could be more disastrous than electronic appointment booking determined by the day of the week on which the patient wishes to be seen at a particular hospital. One can imagine that the results will be chaotic. There will be a loss of ability to refer to specific clinicians, and the continuity of care will be threatened. In the complex conditions presented by the patients that we see, it would be unthinkable that the screening of referral letters to ensure appropriate referral will be a thing of the past. Nobody can argue against the concept of patient-choice, but will this system really give them that? Many of the patients geriatricians see are particularly vulnerable with very complex needs. Anything that weakens the referral process is likely to increase inefficiency and undermine the quality of service patients receive. The Royal College of Physicians (London) has taken up this issue and I have written to them on behalf of the Society, supporting their constructive criticisms.



Payment by results

The second issue on this theme is payment by results. Undoubtedly this is seen as a tool for reshaping services. On the surface there appear to be some opportunities for geriatric medicine. There will be increased payment for people living alone, which could have a significant earning power for our specialty. On the other hand, it is recognised that outpatient appointments for geriatricians are longer and more complicated, and so will cost more. As an illustration, a patient with Parkinson's disease sent to a neurologist will attract a payment of half that for a patient sent to a geriatrician. The problem of course, is that the payment is a form of commissioning, and one could see that valuable services built up over many years, providing a full range of services to such vulnerable patients, will disappear as PCT's encourage referrals to 'cheaper' neurological clinics. The specialty will have to watch these developments very carefully and will need to consider how to monitor the effects of the so-called reforms.

In facing the effects of political initiatives the specialty is not alone and it is vital that we have forums where we can communicate with other specialties. In January, I attended a Medical Specialties evening at the Royal College of Physicians (London), hosted by the Federation of the Royal Colleges of the United Kingdom. Prof Carol Black, President of the RCP (London), chaired the meeting, with Prof Neil Douglas, President of the RCP (Edinburgh) and Prof Graham Teesdale, President of the RCPS (Glasgow), joining the discussion. The main item on the agenda was **How to maximise the relationship between the specialties within the framework of the Federation of the Royal Colleges of the United Kingdom**. A lengthy discussion took place on how specialist societies interact with the Colleges. It is recognised that there is an added value from having links with the Colleges. The political access and influence of the Colleges is still probably larger than any of the individual specialties. There needs to be joint work on generic issues, particularly training, general medical education and public health issues. There is the ever-present problem of duplication and the need for clarification between the differences of the work of the Colleges and specialist societies. It seems likely that the Federation of Colleges will develop a medical specialties board/forum. I think this will be a vital development for our specialty and one in which we must play the fullest part.

Following this discussion, Dr Fiona Adshead, Deputy CMO, discussed the public health White Paper, **Choosing Health**. Dr Adshead emphasised that the White Paper had produced an unprecedented response and has the full commitment of the government. **Choosing Health** emphasises prevention, much of which is highly relevant to the ageing population. One important effect of the White Paper is that the principle of health needs to be considered in every piece of legislation that is developed. Sitting next to Dr Adshead at the dinner after the meeting, I was encouraged by her awareness of the importance of older people within this initiative. She was certainly aware of the pioneering work of Prof Marion McMurdo on exercise in older people, and sees it as a good example of clinical leadership leading to the improvement of health.

A little reverse-marketing

Following the UKMC meeting of the 20th January, we held a reception for our pharmaceutical sponsors (reversed marketing!). This proved a very pleasant occasion and I was very grateful for the full turnout of office staff and many members of the UKMC. The feedback has been very positive. The Society's meetings are seen to be friendly and worth supporting, and in giving something back with the reception, we will help maintain sponsorship for our scientific meetings. We scored a PR success!

United in Care II

I am delighted that we have reached an agreement with Medical Education Partnership to run a second United in Care Multidisciplinary Meeting in December this year. Peter Crome has kindly agreed to take the lead and it is hoped that a programme will be evolved by May, with full involvement of all the disciplines. It has also been agreed that the Society, together with the RCP (London), will mount a day conference on Medicine for an Ageing Population in February 2006. This will be a great opportunity to showcase geriatrics, highlighting the challenges and achievements of the specialty.

Finally, I would urge geriatricians of all grades to respond to the **"Why geriatrics" survey** enclosed with this Newsletter. While I know we are all regularly pestered with questionnaires, it is very important for the Society to be able to collect accurate data to support our arguments.

Jeremy Playfer

Calling BGS Overseas Members

a word from the President Elect

A key part of the Society's Strategic Plan is to ensure that the BGS continues to play an active role in international organisations, such as the European Union Geriatric Medicine Society and the International Association of Gerontology.



We are also privileged to have a number of overseas members and we need to ensure that their needs are catered for specifically. Our overseas members include those who qualified and trained here and then emigrated; others have joined whilst training here and have continued in membership on their return to their own countries. Most overseas members join

the BGS from their own countries with a view to attending our meetings and having access to the *Age and Ageing* journal.

The British Geriatrics Society values its overseas members. Our colleagues from the Republic of

Ireland have hosted our annual Spring meeting twice, on the Emerald Isle. As for our colleagues from the Netherlands, as mentioned by David Beaumont in the leader article, they came from nowhere to 50 in a short space of time, contributing papers to our bi-annual scientific conferences and providing a strong continental presence in the Society.

Our overseas members have also provided valuable expertise as referees for submissions to *Age & Ageing*, with some serving on the International Editorial Board of the journal.

We have recently received a proposal that we should encourage the formation of an International Section of the BGS, which might hold its meetings alongside Special Interest Groups at our conferences, or co-ordinate joint meetings with sister societies in other countries. Many UK medical societies hold such meetings or organise overseas study tours. At the American Geriatrics Society each year, there is a focus on the practice of the specialty in a particular country. Last year it was on Brazil and this year I am speaking about the UK.

We intend to survey our overseas members to see whether there are other initiatives which we might usefully introduce. In the meantime, overseas members are invited to contact the Editor on editor@bgsnet.org.uk with their suggestions.

We look forward to hearing from you.

Peter Crome

Our overseas members - where in the world are they?

Europe	: 167 (Republic of Ireland - 60; Netherlands 49)
Australia/New Zealand	: 62
Far East	: 32
USA/Canada	: 30
South America	: 17
Middle East	: 7
Caribbean	: 2

BGS members are reminded of the 18th Congress of the International Association of Gerontology to be held in Rio de Janeiro, Brazil on 26 - 30 June (www.gerontology2005.org.br). The BGS is able to provide some financial assistance to members who have had papers accepted for presentation at the congress. Contact: grants@bgs.org.uk

Going into research

by Alasdair MacLulich

Like most iatroblasts*, I started university without knowing exactly what career I would follow, but through various family influences, I started medical school predisposed to the idea of doing research.

I was also eager to find out more about the brain. I know this sounds a tad geeky, but I'm afraid it's true. In the first term I put my name down for a psychology tutorial group. We did a small study on relationships between neuroticism, type A personality, and ischaemic heart disease, and I found that I liked the process of searching the literature, reading journal articles and doing a bit of writing.

Trawling dusty corners

A BSc in psychology followed. In the first few weeks of this I was taken aback by the amount of controversy and debate going on beyond the world of pre-clinical medicine. It took time to realise that arguing around a position, rather than reproducing facts, is central to doing a science degree and, of course, being involved in scientific writing and research. Having got over this hump I had a great time as a psychology undergraduate. I spent hours and hours lost in the dusty corners of the library and, worryingly, enjoyed it rather a lot. Two years later I did a research elective in the Institute of Psychiatry and this convinced me emphatically, that I wanted to do academic medicine.

Towards the end of my medical rotation I was approached by a local academic geriatrician, John Starr, with the idea of doing a project on the associations of variations in cortisol levels with cognitive ageing. I liked the mixture of psychology

and biology and went on to secure funding, starting a PhD about a year later.

Hard lessons and all-nighters

The PhD project combined neuroimaging, cognitive testing, and various measurements of glucocorticoids, in parallel with quite a bit of lab work, mainly in situ hybridisations and radioimmunoassays. It was a bit of a stretch to fit all of this in, especially since I am not quite a virtuoso administrator. I learned through a few

hard lessons and more than one all-nighter,

that research involves a bit more planning than is the norm as an SHO in medicine! But it was an exciting and enjoyable time. The diversity of tasks gave me a good education in a few areas, from molecular biology to cognitive testing, and I picked up some generic skills as well.



Towards the end of the PhD I was lucky enough to get a Clinical Lecturer/Honorary SpR post. In this job, I have been able to continue my research work in parallel with clinical training. I have also been very involved in teaching and examining, in medicine and also in Honours courses relevant to my research (Neuroscience, Endocrine Pharmacology). Because the academic and clinical components of my job are quite different, it does sometimes feel like I have two jobs, and now and again there are clashes. Sometimes I have had to be firm about maintaining my research sessions: a few afternoons can add up to an all-important publication a few months down the line. But I have been fortunate to have worked for understanding senior clinical colleagues throughout my training and, generally, I have not had the restrictions and difficulties that I know some other junior academic physicians have experienced.

There are lots of reasons why I am continuing in academic medicine. I take pleasure in the process

of following up something that has caught my interest, developing some ideas, turning these ideas into projects, producing new data, and putting it together as a paper. Other things I like are the variety, learning about favoured subjects in depth, attending conferences and meeting colleagues from other countries (and health care systems), not to mention the involvement in education. Furthermore, I really enjoy the combination of doing research and being a clinician. The frequency of the three D's (dementia, delirium, and depression) and stroke in our practice means that geriatrics is one of the best specialties to inform research on the brain. One of the main areas of my current research efforts is delirium, and my interest in this has come directly from seeing it so often on the wards. When reading up about it, I am struck by the remarkable lack of knowledge about its pathophysiology. Finally, because research underpins virtually all advances in understanding of psychiatric and neurological disorders, I certainly never feel that my research work is irrelevant to the welfare of patients.

Those of us in geriatrics who take time out for research do so for a range of reasons. After an MD or PhD, some will choose an academic career, and others will re-enter clinical practice armed with the benefits of a research training. My choice to do research and then to stay in academia has been driven by a strong and long-term interest in

the brain and its disorders. My research work complements my clinical practice well. I've been fortunate to have excellent mentors along the way, and importantly, I've done my clinical training in an environment which is highly supportive of academic trainees.

Pursuing an academic career is not as clear-cut as clinical training and there are challenges to overcome. But if you find yourself habitually reading journals and tracking down 'that crucial paper', or getting into long discussions about the whys and hows of your favourite areas of clinical practice, I would strongly recommend giving academic medicine a try.

** iatro = doctor; blast = undifferentiated cell. Therefore iatroblast means 'medical student after a curry' - The Editor*

Alasdair MacLulich is a Lecturer in Geriatric Medicine at the University of Edinburgh. He has been central to the British Geriatrics Society's strategy to promote academic geriatric medicine, contributing to a series of articles on how to get into research and to the Society's Trainees' section on the BGS website.

See:
www.bgsnet.org.uk/Jan04%20NL/16_research.htm
www.bgsnet.org.uk/May04NL/12_trainees2.htm
www.bgsnet.org.uk/Sept04NL/14_trainee_research.htm

Our inspirations

an appeal from the 'Trainees' Chair

I'm sure most of us can remember the first geriatrician who inspired us, as either medical students or junior doctors, to do geriatric medicine. I certainly can.

I was on-call as a medical house officer in a district general hospital, presenting my patients to the registrar (a geriatrician). After finishing with the second patient of the day, who had taken a paracetamol overdose, I suggested that we move on to the next admission, which I breezily dismissed as "just a social admission". His eyebrow raised a little as he enquired who was more deserving of that bed, the young girl who

I hope that my enthusiasm for the job will encourage medical students and junior doctors to consider geriatric medicine as a career

had impulsively taken an overdose after a row with her boyfriend, or the 82 year old lady who was struggling at home, due to a urinary tract infection on top of her severe osteoarthritis. That

one conversation altered the way I viewed my frail older patients.

Old people need good doctors

I'm slightly ashamed to admit that I then compounded my social gaffe by asking this registrar why, being such a good doctor, he was working in geriatrics! He had the grace to smile before replying, "Old people need good doctors even more than young people do".

As a registrar myself now, I hope that my enthusiasm for the job will encourage medical students and junior doctors to consider geriatric medicine as a career. Surely positive role models are one of the best ways to overcome some of the current difficulties in filling NTN's?



With this in mind, I would be grateful if you could spend two minutes completing the "Why Geriatrics" survey enclosed with this Newsletter. Junior doctor training is undergoing huge change with the imminent introduction of Modernising Medical Careers and it is important that geriatric medicine retains a strong presence in medical rotations. It would therefore be very useful to know when and why current trainees and consultants choose geriatric medicine as a career.

I hope to see as many of you as possible at our trainees meeting at lunch time on the Friday of the scientific conference in Birmingham.

Sally Briggs
Chair
Trainees' Group

Osteoporosis and other metabolic bone diseases

**A course for SpRs
4-6 May 2005
St Anne's College, Oxford**

Osteoporosis and other metabolic bone disease is the UK's main multi-disciplinary course addressing this important field. This three-day residential training course aims to provide SpRs in medical specialties such as rheumatology, endocrinology, care of the elderly and gastroenterology with the knowledge and understanding to manage patients with osteoporosis and other metabolic bone diseases. It is strongly recommended for any trainee who foresees that patients with these disorders will form a significant part of their workload in future. The programme has been devised by the Bone Disease Training Forum, which comprises national experts in the bone field, in conjunction with the Bone and Tooth Society, the National Osteoporosis Society, the British Geriatrics Society, the British Society for Rheumatology, and the Society for Endocrinology, and is intended to focus on practical issues relating to patient management. The course will employ a stimulating interactive format combining lectures, panel discussions, debates and workshops. New treatments and the impact of the ongoing NICE appraisals will also be considered. Following the highly successful inaugural course in 2004, the Course will take place at St Anne's College, Oxford, from 4-6 May 2005.

For more information, please contact Liz Brookes at BioScientifica, email; liz.brookes@endocrinology.org or Tel: +44(0) 1454 642240.

Wellcome Trust Clinical Research Fellowship

Our congratulations to Dr Fergus Doubal, specialist registrar in Edinburgh, on being awarded a prestigious Wellcome Trust Clinical Research Fellowship for a PhD project entitled, "Can retinal vascular abnormalities shed light on the pathophysiology of lacunar strokes?" The project will be based in the Division of Clinical Neurosciences, University of Edinburgh.

Reimbursement for Delayed Discharge

results of England Council survey



As a significant time has elapsed since the introduction of the delayed discharge reimbursement policy between NHS and Social Service departments in England, the BGS England Council surveyed the initial impact of the policy.

The questionnaire was sent to each BGS regional secretary for onward transmission to the lead clinician for older people's services in each acute trust.

Twenty seven responses were received from 26 acute trusts. One trust sent separate responses for both social services departments that it relates to.

Eight trusts sent their local delayed discharge data. In only one respondent, was there a convincing downward movement in the number of delayed discharges. In the others, the numbers varied from week to week.

The interim results are summarised here.

James Barrett
Vice Chairman
BGS England Council

Q: Does your trust/directorate produce/receive regular information on delayed discharges? If so, please append the relevant data that will illustrate the recent trend.

Yes: 26
No: 2
Don't know: 0

Q: Is the local council's budget for reimbursement ring fenced?

Yes: 18
No: 3
Don't know: 5

Q: Are the national criteria for reimbursement being used?

Yes: 21
No: 2
Don't know: 2

Q: Have any beds in your trust been designated as 'non-reimbursable' (e.g. rehabilitation beds)?

Yes: 14
No: 12
Don't know: 0

Q: Has reimbursement money been used to stimulate the development of services for older people?

Yes: 22
No: 0
Don't know: 2

The respondents highlighted the following examples of developments that have been or will be funded through this initiative in different local health economies:

- ◆ Development of intermediate care schemes, usually jointly planned, but not always
- ◆ Development of chronic disease case management schemes
- ◆ Discharge co-ordinators
- ◆ Additional social workers e.g. in A&E
- ◆ Falls service developments
- ◆ Transitional care arrangements in care homes (usually 3 or 6 beds per scheme). Two trusts are jointly planning much greater numbers of transitional beds in care home setting.
- ◆ Some existing intermediate care facilities are becoming the delayed discharge waiting area and are no longer able to offer a rehabilitation environment where it had previously existed
- ◆ Change Agent Team cited as contributing to facilitating joint work between all the health and social care agencies

Unsung heroes

Glasgow and the origins of geriatrics

The origin of geriatric medicine is rightly associated with the work of Marjory Warren from the late 1930s. At the same time, a similar and hitherto unacknowledged process was emerging in Glasgow through Noah Morris, Professor of Materia Medica and Therapeutics. This is a brief account of that story.

In the first six months of 1948 (immediately before the institution of the National Health Service), four of the eight medical staff of the Department of Materia Medica and Therapeutics of Glasgow University, with its clinical unit at Stobhill Hospital, were destined to become consultants in geriatric medicine. They were also to share between them, three of the first Professorial Chairs of Geriatric Medicine in the UK, and two Presidencies of the British Geriatrics Society. They were Ferguson Anderson (Senior Lecturer), John Hebbert (Lecturer), Bernard Isaacs and John Brocklehurst (House Physicians). Many others followed. The chain of events leading to this early interest in geriatrics in Glasgow started in 1936 when Sir Hector Hetherington became Principal and Vice Chancellor of the University, and in 1937, Noah Morris was appointed Professor of Materia Medica and Therapeutics.

Hector Hetherington came to Glasgow imbued with a determination to promote academic medicine based on full time professors with scientific backgrounds and proven research orientation¹. He was concerned about the education of medical students. While pre-clinical teaching was organised and carried out by university departments of basic science (including anatomy and physiology), the clinical curricula were the responsibility of the teaching hospitals, organised and undertaken by part time professors

and honorary specialists whose primary interest and source of income was private practice.

Hetherington was able to further this intention by three chairs becoming vacant in the medical faculty shortly after his appointment. These were the Regius Chairs of Medicine, Materia Medica and Therapeutics and Surgery. He altered the process of appointing professors, to be done by a small committee, without necessarily advertising the post. The committee notified the University Court that a suitable candidate had been found and should be appointed¹. By this process, Noah Morris was appointed to the Regius Chair of Materia Medica in 1937, on a full time basis.

Academia meets chronic disease

The previous incumbent in the chair, Prof Ralph Stockman, had his beds in the Glasgow Western Infirmary (one of the two teaching hospitals in Glasgow at the time) but these were not made available to Noah Morris and Hetherington had to look elsewhere. He was convinced of the advantages of the university extending its influence in medical education to the large municipal hospital sector in the city, and with the ready co-operation of the Medical Officer of Health (Sir Alexander McGregor) he brought this about. Noah Morris's beds were to be at Stobhill Hospital. The establishment of an academic department within a municipal hospital was a precedent (and a successful one) giving it the advantages of a teaching hospital, hitherto limited to voluntary hospitals. This was to be a highly significant development for the university, for the hospital and for the not yet existent specialty of geriatrics. For the first time, a university teaching department encountered a large proportion of patients who were old and chronically ill.

Stobhill Hospital² was officially opened in 1903 with 1,867 beds. It provided medical, surgical, obstetric, paediatric and psychiatric beds as well as infirmary wards for the "chronic sick". Following the epidemics of encephalitis lethargica after the first world war, special wards were provided in the 1930s for patients with post encephalitic

Parkinsonism. Stobhill was established as a Poor Law hospital by Glasgow Parish Council but under the 1929 Local Government Act, the hospital was transferred to Glasgow Corporation. Acute patients were allocated by a central agency in the city (called the Bar). They included a high proportion of young people with rheumatic fever and older people with strokes. These were medium and long-term patients, unacceptable to the voluntary hospitals.

Noah Morris

Noah Morris was a physician of outstanding drive, wisdom and humanity. Jewish, with a strong Glasgow accent, he became to the students, the father figure of the medical faculty. It was Morris's background in biochemistry that appealed to Hetherington. Much of his research at the time of his appointment to the Chair had been in acid-base balance and calcium and phosphorus metabolism. His previous appointment as University Lecturer in Pathological Biochemistry involved clinical responsibility at the Royal Hospital for Sick Children in Glasgow, where he established an early hospital biochemistry laboratory^{3,4}.

In his inaugural lecture (chaired by Sir Hector Hetherington) entitled 'Prolegomena to the Study of Therapeutics'⁵, he dealt with the "Art versus Science" situation in medical practice. He quoted Clifford Allbut on the revolution of medicine



Noah Morris

'from a craft of tradition and sagacity to an applied science of analysis and law'.

He stressed the emerging importance of laboratory science but maintained a balanced outlook. He emphasised his belief in what is now called holistic medicine

'the patient is not merely a sort of heart-lung- kidney preparation, but a human being with all the desires, emotions and fears of humanity'.

Perhaps in advance of his time, he believed that social work was to become an ever more important part of therapeutics. In all of this he was demonstrating the qualities which led him to encourage the gradually emerging specialty of geriatric medicine.

At Stobhill Hospital, Noah Morris was given charge of six medical wards and was immediately confronted with chronic disease and old age on a scale which had never before impacted on academic medicine. He established an outstanding department of clinical medicine, in which biochemistry, social medicine and recognition of the uniqueness of the 'person' in each patient played a part. He confronted the challenge of ageing and old age in his Honorary Presidential address to the Glasgow University Medico Chirurgical Society in 1941 entitled, 'De Senectute'⁶. He reviewed the current state of knowledge in ageing in relation to the mammalian homeostasis in the presence of stress and the place of homeostasis in normal ageing and disease in old age. He proposed two questions - is the prolongation of the human lifespan an important goal, and if so, how is it to be achieved?

Research into ageing

He inspired his students and staff with the importance of research including the problems of ageing. He was negotiating with the Nuffield Foundation to set up a geriatric clinic at the time of his tragic death in 1947 at the age of 52⁷. Thus was cut short potential leadership in gerontology and geriatrics in Britain. Members of his staff were to take up this challenge.

Stanley Alstead

Stanley Alstead⁷ who had joined Noah Morris's department in 1936 followed him eleven years

Noah Morris and his staff at Stobhill



later as Professor of Materia Medica and Therapeutics. He continued his interest in chronic disease and old age, facilitating research in those areas. He also encouraged members of the department to become involved in the infirmary of the nearby Glasgow workhouse, Barnhill (renamed Foresthall). It had 600 beds, 90% being occupied by virtually undiagnosed and totally bedfast patients, (as encountered by Marjory Warren and other pioneers of geriatrics).

'Fergie'

Ferguson Anderson⁸ became lecturer in the Department of Materia Medica and consultant physician at Stobhill Hospital in 1937, and returned after war service in 1946 as senior lecturer. He committed himself to geriatric medicine in 1952 when he was appointed Adviser in Diseases of Old Age and Chronic Sickness to the Western Regional Hospital Board of Scotland, and Consultant Physician in Geriatric Medicine in Stobhill Hospital. Characteristically, the Medical Staff Committee of the hospital had opposed the establishment of two geriatric wards, recording that

'the introduction of geriatrics would adversely reflect on its status as a major teaching hospital'². How wrong they were proved as the geriatric department became a Mecca for visitors from across the world (as did the West Middlesex Hospital under Marjory Warren and Cowley Road Hospital, Oxford under Lionel Cosin). Ferguson Anderson was appointed David Cargill Professor of Geriatric Medicine in Glasgow University in 1965, the first such chair in the UK. He was elected President of the British Medical Association in the same year - also the year in which he received his knighthood.

Taylor Brown

However, 'Fergie' was not the first geriatrician in Scotland. That distinction belongs to Dr O Taylor Brown. After five years' service in the Royal Air Force, Dr Taylor Brown joined Noah Morris's department for Post Service Training at Stobhill Hospital in 1946. Noah Morris arranged for him to receive periods of training in geriatric medicine with Marjory Warren (whose work Morris admired) at the West Middlesex Hospital. He was involved in the first recorded postgraduate training event in geriatric medicine in Scotland. This was organised as a weekend seminar by Noah Morris who personally invited the 40 guests⁹.

In 1948, Dr Taylor Brown was appointed to a newly created post of Assistant Physician with an interest in geriatrics at the Southern General Hospital in Glasgow. In 1951, he was appointed consultant physician in geriatric medicine to the Eastern Regional Hospital Board of Scotland and senior lecturer in the Department of Medicine at the University of Dundee. By the time of his retirement in 1984, he had established a comprehensive geriatric service at Ninewells Hospital and the Victoria Hospital in Dundee and a University Department of Geriatric Medicine. In due course, a chair in Geriatric Medicine was established and Prof Marion McMurdo was appointed.

It may be noted that five past presidents of the BGS have been Glasgow graduates, namely, Ferguson Anderson, John Brocklehurst, James Williamson, John Dall and Brian Williams.

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9. Brown W T. Personal Communication, 2004

Prof John Brocklehurst
Past President of the BGS

BGS SOUTH EAST THAMES

BGS Branch Meeting

17 March 2005

Contact: Beth Downes, Postgraduate Centre, Queen Mary's Hosp, Sidcup DA14 6LT. Tel: 020 8302 2678 x 4444

HEART FAILURE IN OLDER PEOPLE

Royal Society of Medicine

22 March 2005

Download programme and registration form from www.bgs.org.uk/Notices

GCA AND PMR

Third International Conference on Giant Cell Arteritis and Polymyalgia Rheumatica

Deadline for abstracts: 31 March 2005

Date of meeting: 24 - 27 July 2005

St John's College, Cambridge

Contact: GCA/PMR Secretariat, Cambridge Conferences, The Lawn, 33 Church St, Great Shelford, Cambridge, CB2 5EL. Tel: +44 (0) 1223 847464. Email: b.ashworth@easynet.co.uk

OLD AGE PSYCHIATRY

Controversies in Old Age Psychiatry

1 April 2005

Victoria, Australia

Tel + 61 3 8344 5598

ADVANCED MEDICINE FOR CONSULTANTS

Join us for a series of key topic General Medicine sessions chaired by respected consultants

London & South East Advanced Medicine Conference for Consultant Physicians (4 - 7 April, Regents Park Marriott Hotel, London)

Scottish Advanced Medicine Conference for Consultant Physicians (25 -26 April & 27 - 28 June, Marriott Dalmahoy Hotel, Edinburgh)

North West Advanced Medicine Conference for Consultant Physicians (23 - 26 May Marriott Worsley Park Hotel & County Club, Manchester)

North East Advanced Medicine Conference for Consultant Physicians (27 - 30 June, Newcastle Marriott Hotel, Gosforth Park, Newcastle)

26 CPD credits

Delegate rate: Early bird rate ends 7th February 2005 for all conferences

Four Days - £600; Four Days Early Bird - £550; Daily Rate - 180 per day

For further information please telephone 01565 752000 or visit www.pastest-hc.co.uk

DERMATOLOGY

Elderly Skin - the Challenge Senior Skin Group

Thursday 7 April 2005

Royal Society of Medicine, London

Download programme and registration form from www.bgs.org.uk/Notices

BGS SCIENTIFIC MEETINGS

**Spring 2005
13 - 15 April in Birmingham**

**Autumn 2005
5 - 7 October in Harrogate**

Contact: Hampton Medical Conferences, 113-119 High Street Hampton Hill, Middlesex TW12 1NJ Tel: + 44 (0) 20 8979 8300

Email: hmc@hamptonmedical.com Register at: www.bgs.org.uk

PD MASTERCLASS 2005

An innovative course for advanced understanding of Parkinson's disease and related movement disorders

Masterclass 6:
Module 1 - 20-22 April
Module 2 - 19-21 October

Masterclass 7:
Module 1 - 14-16 September
Module 2 - 15-17 March 2006

Cost of these residential modules is £400
Provides 26 hours CME

Download an application form from www.bgs.org.uk/Notices

AUSTRIA

International Conference with a focus on frailty

20 - 23 April 2005

Vienna, Austria

Download programme and registration form from www.bgs.org.uk/Notices

IMPORTANT NOTICE TO ALL BGS MEMBERS NOMINATIONS SOUGHT FOR THE POSTS OF BGS HONORARY DEPUTY SECRETARY/HONORARY SECRETARY AND BGS HONORARY DEPUTY TREASURER/HONORARY TREASURER

In accordance with Article 29 of the Society's Articles of Association, nominations are now invited for the post of **Deputy Honorary Secretary / Honorary Secretary**, and for the post of **Deputy Honorary Treasurer / Honorary Treasurer**, both appointments being effective from the 2005 Annual General Meeting to be held in October.

Full members of the Society are free to self-nominate, you do not have to apply via your respective region or council. The only requirement is that any nomination is supported in writing by a minimum of five other members.

In considering putting yourself forward for these important and high profile positions within the Society, please read the job descriptions carefully (the full version of both job descriptions may be found at www.bgs.org.uk/notices). The candidates will be chosen by a national ballot of the membership.

A member wishing to stand must submit a statement of consent in writing, in the form of "I..... do hereby consent that my name be put forward for nomination to the post of Deputy Honorary Treasurer / Honorary Treasurer of the Society for the period 2005 – 2009" or in the case of the Deputy Honorary Secretary's position, "I..... do hereby consent that my name be put forward for nomination to the post of Deputy Honorary Secretary / Honorary Secretary of the Society for the period 2005 – 2009"

Such statement may be submitted via email and it should be supported by no less than five members, each of whom are eligible to vote at an AGM. Statements of support may be submitted via email, independently of the nominee's statement. The statement of consent and supporting statements must be **received by the Company Secretary, no later than Friday 29 April 2005**. Late or incomplete nominations will not be accepted

Should there be more than one nomination, a national ballot will be held. All successful nominees will be encouraged to submit a statement supporting their nomination, together with a photograph, which will appear with the ballot paper. Should a ballot be necessary, instructions on the voting procedure will be distributed to members with their July 2005 Newsletter. Voting will close on Friday 30 September 2005, with the result being announced at the Annual General Meeting on 7 October 2005.

All nominations and supporting statements will be acknowledged by the Company Secretary. Any queries should be addressed to the Company Secretary

Alex Mair, Chief Executive & Company Secretary
British Geriatrics Society, Marjory Warren House
31 St John's Square, London EC1M 4DN

Tel: 020 7608 1369 email: alexander-mair@bgs.org.uk

Key duties of the Honorary Secretary (full job description at www.bgsnet.org.uk (Notices):

- ◆ Working closely with the Sub-editor at the BGS office, the Hon Secretary commissions articles and edits the BGS newsletter. In particular the Hon Secretary writes the editorial column for the Newsletter, of which 6 issues are published each year.
- ◆ Screening of new applications for membership and making recommendations on these to the UKMC.
- ◆ Liaison with external organisations; Department of Health, Royal Colleges, other specialist medical societies, voluntary organisations and allied professional groups.
- ◆ Liaison with the BGS Secretariat to help with enquiries from the press and public.
- ◆ With the other senior officers the Hon Secretary will have a key role in strategic planning. Both the Hon Secretary and Hon Deputy Secretary can expect to be involved in key projects during their term of office.
- ◆ The BGS Office reports to the Hon Secretary.

Key duties of the Honorary Treasurer (full job description at www.bgsnet.org.uk (Notices):

- ◆ Oversee management of the financial affairs of the Society, assisted by the Society's accountant and such other financial/legal advisors that are retained by the Society.
- ◆ Chair Finance Committee Meetings
- ◆ Countersign a limited number of cheques for payments of services received by the Society
- ◆ Report on financial activities of the Society in the Annual Report and at the Annual General Meeting
- ◆ Liaise with all sections of the Society
- ◆ Assist in budget setting with BGS staff
- ◆ Monitor financial performance against budget
- ◆ Monitor the financial strategic plan
- ◆ Monitor investments/resources, assisted by the Society's CEO, accountant and advisors retained by the Society
- ◆ Monitor the financial aspects of risk management
- ◆ Provide a financial viewpoint to the deliberations of the UKMC

ACADEMIC OPPORTUNITIES IN GERIATRIC MEDICINE

**University of Wales Swansea
Swansea Clinical School**

The Swansea Clinical School was established in 2001. It has a strong record in teaching and research. A new graduate entry medical degree course started in Autumn 2004 and a large portfolio of innovative research is already underway. The research base is expanding and there are opportunities for academic geriatricians to be part of this expansion.

To obtain more information on an informal basis contact: Dr Chris Hudson, Clinical Director Geriatric Medicine. Tel: 01792 285042
Email: chris.hudson@swansea-tr.wales.nhs.uk

Professor Julian Hopkin, Professor of Medicine, Director Swansea Clinical School
01792 295149 Email: j.m.hopkin@swan.ac.uk

**TWO SENIOR LECTURER POSTS (HONORARY
CONSULTANTS)**

Brighton and Sussex Medical School

Applications are invited for two Senior Lecturer Posts in Elderly Care at Brighton and Sussex University Hospital NHS Trust.

For more detail on the posts, see www.bgs.org.uk (select Notices/Vacant Posts)

Informal enquiries to: Prof C Rajkumar, Chair of Elderly Care, BSMS (c.rajkumar@bsms.ac.uk) or Dr N Gainsborough, Lead Clinician in Elderly Care and Stroke, RSCH (Nicola.Gainsborough@bsuh.nhs.uk)

PRIMARY CARE

Royal Society of Medicine

25 April 2005

Download programme and registration form from www.bgs.org.uk/Notices

**MEDICINE FOR THE
ELDERLY**

**Eleventh Leicester Medical
Conference
National Conference in Medicine for
the Elderly**

15th June 2005

University of Leicester

Download programme and registration form from www.bgs.org.uk/Notices

**BGS RETIRED
MEMBERS**

**The 2005 meeting of the BGS
Retired Members Group will take
place in Stratford-upon-Avon,
Warwickshire**

6 - 8 May 2005

All members of the BGS now in retirement are welcome to take part. The venue (Falcon Hotel) gives ready access to all places of interest, Shakespearian and otherwise.

The meeting offers the opportunity to meet colleagues, reminisce and there will also be a programme of presentations of medical interest.

For further details and hotel booking form contact: Dr Donald Portsmouth on tel/fax: 01564 775032. Email: dportsmout@aol.com

EPILEPSY

Epilepsy in Later Life

17 - 18 May 2005

**Apex International Hotel,
Edinburgh**

The conference will address implications for health policy and resources and highlight good medical practice within the context of Managed Clinical Networks. We have a world class team of speakers – all acknowledged experts in their field.

Contact details: Anne Macdonald or Rosemary Charlton on macdonald@epilepsyscotland.org.uk or rcharlton@epilepsyscotland.org.uk
Telephone: 0141 427 4911
Website: www.epilepsyscotland.org

CME CONFERENCE

**10th National CME Day
Conference**

9 June 2005

Keele University, Newcastle

To Mark Dr R Brooks and Dr S Hills' Retirement

For further details please contact Mrs. Olwyn Mander Telephone: 01782 553968 or email o.d.mander@keele.ac.uk

FALLS SYMPOSIUM

**East Midlands & Trent Falls
Symposium**

10 June 2005

**Post Graduate Education Centre,
Nottingham City Hospital**

Contact: Post Graduate Education Centre, Nottingham City Hospital, Hucknall Road, Nottingham NG5 1PB.

Tel: 0115 962 7758 Email: gcstell@ncht.trent.nhs.uk

STAFF AND ASSOCIATE SPECIALISTS IN ENGLAND

Nominations are sought for the newly created seat on the England Council for a SAS member

In order that the voice of the Society's SAS members may be better heard, the England Council have created a new seat on their Council, specifically for an SAS member. This initiative will provide a good platform for SAS members to have their views considered at a very high level within the Society.

SAS members who may be interested in being considered need to follow established democratic paths.

If you wish to be considered please contact your respective regional secretary direct. It will be for the regions to gather names of interested candidates and decide regionally who they wish to put forward. Once the regions have nominated their preferred candidates then a ballot can take place.

Procedure:

1. Within each Region members submit

names to their Regional Secretary

2. Members present at a Regional meeting choose the Region's SAS candidate(s) for office from amongst the names submitted

3. Regional nominations are sent to the Society office

4. A ballot is held amongst the members of the England Council which determines the appointment

It is the responsibility of the Regional Secretaries to ensure that:

(i) a notice calling for nominations from SAS members is sent to all Regional members (please allow adequate time to enable members to submit names)

(ii) A Regional meeting is called to select Regional nominations. These should be forwarded to the BGS office no later than 31 March 2005

(iii) assuming a ballot is required, the

BGS office will contact the nominees offering them the opportunity to supply a supporting statement which will go to the members of the England Council with the ballot. The closing date for submission of statements will be 29 April 2005. The ballot will take place in early May 2005 with the result announced towards the end of May 2005.

Regional Secretaries, please note:

Regional Secretaries are requested to actively seek the views of SAS doctors in their region on their preferred candidate.

In the event that a Region is not planning a meeting before 31 March, Regional Secretaries should feel free to use the flexibility of email in circulating details of interested parties and determining the Region's choice.

In the event of any queries, please contact Alex Mair at the BGS office. Email: alex-mair@bgs.org.uk

GASTROENTEROLGY AND CLINICAL NUTRITION

The British Geriatrics Society Special Interest Group for Gastroenterology and Clinical Nutrition

16 - 17 June 2005

Newcastle upon Tyne

Please register your interest in attending with Dr Julie Newton. Email: Julie.Newton@nuth.northy.nhs.uk or Dr Haboubi's secretary Email: Jennifer.Davies@gwent.wales.nhs.uk

STROKE

The Fourth Biennial Sunderland Stroke Meeting - 2005

28 June 2005

St Peter's Campus, Sunderland University

A multidisciplinary educational meeting for doctors, nurses and therapists interested in acute stroke care and rehabilitation

Fee: £60 doctors; £35 others

Includes registration, lunch and refreshments

Contact: Debbi Wallace, Dr O'Connell's Secretary, Dept of Medicine for the Elderly, D41 Doctors Office, Sunderland Royal Hospital, Sunderland, SR4 7TP

Tel: 0191 565 6256 ext 42109 E-mail:

debbie.wallace@chs.northy.nhs.uk

Closing date for registration: 27 May 2005

DEMENTIA - AUSTRALIA

Dementia – Molecules to Management

20 – 22 June 2005

Brisbane, Australia

Details about the conference will be posted on the ASGM website and updated progressively. For further details, please contact Organisers Australia on Int: 61 7 3371 0333 or email **asgm@orgaus.com.au**

FOR MORE EVENTS

We regret that owing to a lack of space we are unable to publish all events which we have been asked to publicise.

Please visit the Notices section of www.bgs.org.uk for details of more events, for downloadable programmes and registration material

BGS Scientific Meetings

update on submission of abstracts

The advent of encouraging the submission of abstracts which do not strictly comply with the definition of “research”, but which fall under the category of “clinical effectiveness” has generated some debate on how submitters might distinguish between the two and the logistics of submitting their abstracts to the appropriate adjudicating body.

The Academic and Research Committee (A&R) and the Clinical Practice Evaluation Committee (CPEC) are keen to ensure that the “research” section of BGS meetings reflects the strength of research undertaken within the Society. Equally they are keen to ensure that work reflecting “clinical effectiveness” is appropriately recognised and that the methodological requirements for good audit, guideline development etc. are encouraged.

To this end the A&R Committee has endorsed the concept of ensuring that:

◆ Abstracts relating to “research” continue to be submitted to the A&R Committee for adjudication. These abstracts may be under the categories of: “*planned research*”, “*work in progress*”, or “*scientific presentation*”.

◆ Abstracts relating to “clinical effectiveness” – e.g. audit, guidelines, benchmarking, literature searches, service and practice review – are submitted to CPEC for adjudication. These abstracts will be submitted under the category of “*Practice*”.

To facilitate this process it should be noted that:

◆ **Abstracts submitted to CPEC as Clinical Effectiveness will now be considered for publication as an abstract in Age and Ageing.**

◆ The accepted posters will be assessed at the BGS meeting and will be accepted depending on specified criteria. Examples of the criteria to be used are shown in Table 1 below.

◆ Abstracts should be submitted to the BGS under the correct category as research (*planned*

Table 1 - Examples of criteria that might be used to determine the acceptability of clinical effectiveness for publication as an abstract in Age & Ageing

Audit

- ◆ Were there clear audit criteria or indicators against which practice was audited?
- ◆ Were these criteria/indicators evidence based or based on sound consensus techniques?
- ◆ Was the population clearly defined.
- ◆ Were changes in practice implemented as a result of the audit?
- ◆ Was there a second round of audit to complete the cycle?
- ◆ Are the methods and messages from the audit generalisable?

Guidelines

- ◆ Was there a Guideline Development Group?
- ◆ Was it multi-professional?
- ◆ Did it include patient/used representation?

- ◆ Was the topic properly scoped?
- ◆ Was a methodologically sound systematic literature search carried out?
- ◆ Was a recognised method used for critical appraisal.
- ◆ Was the guideline submitted to multi-professional peer review?
- ◆ Were any conflicts of interest within the Guideline Development Group recorded?

Systematic Reviews

- ◆ Clear definition of scope
- ◆ Clear definition of search terms
- ◆ Clear definition of search methodology
- ◆ Search for unpublished data
- ◆ Clear definition of appraisal

Table 2 - Clinical Audit and research Differences and Links

The NHS Clinical Effectiveness initiative explicitly links Clinical Audit and Research:

Without research we won't know what clinically effective practice is; without audit we won't know whether it is being practiced

Links between clinical audit and research

♦ Audit can identify areas where research evidence is lacking; likewise research can highlight a need for clinical audit

♦ Audit can be used to disseminate evidence-based practice as defined by research

♦ The audit process can identify how evidence-based practice is being applied; research (particularly 'action' research and qualitative methods) can be used to examine reasons underlying successful or unsuccessful application of good practice

Is your project audit or research (or both)?

Both research and clinical audit may involve measurement of patient outcomes, however the purpose is different. Be clear about your objectives, and concentrate on these 3 key questions:

1. Is the purpose of your project to try and improve the quality of patient care?
2. Will the project involve measuring current practice against standards?
3. Does the project include anything being done to patients beyond their routine clinical management?

If your answers are 'yes' to the first 2 questions and 'no' to the third, your project is very likely to fall within the remit of clinical audit.

This table gives further details regarding differences between audit and research:

	Research	Clinical Audit
Purpose	To provide new knowledge in order to set or change standards	Tests conformity with evidence-based standards
Methods	Randomised trials etc.	Never involves allocation to different treatment groups Completion of audit cycle includes identifying areas of non-conformity with evidence-based standards, implementing practice changes to address these, and then re-auditing standards of care
Data analysis	Extensive statistical analysis	Simple statistical analysis, e.g. descriptive (means, frequencies) and unadjusted comparisons such as t-tests
Ethical approval	Always required	Not required - however patient questionnaire surveys may be interpreted as 'doing something to patients beyond their routine management'. These should be designed to be minimally disruptive to patients, but even so, ethical approval may be required
Sample size	Statistically powered calculation	Sufficiently large case number to influence practice based on audit findings
Significance	Statistical difference (hypothesis driven)	Clinically meaningful performance indicators set against standards (e.g. acceptable adherence threshold may be set at 100%, 90% or 80% depending on the practice being audited and local factors)
Outcome	Improved knowledge	Improved clinical practice
Results, publication and applicability	Generalisable Publishable in peer reviewed journals Findings influence clinical practice as a whole	Relevant to designated setting. Audit methods and findings may be of wider interest (especially with completed audit cycles) and publishable. Findings influence activities of local teams (with responsibility to act on findings resting with clinical directorates)

research, work in progress or scientific presentation) or clinical effectiveness (*practice*). Abstracts may be moved between the A&R Committee and the CPEC following abstract adjudication if it is felt that they would be more appropriately presented under another heading.

◆ The distinction between Research and Audit often causes confusion. Guidance for distinguishing between them has been drawn up by the CPEC with particular input from Ian Taylor and Danielle Harari. Details are shown in Table 2.

◆ The “Instructions to Authors” to be found on the BGS website has been amended to take account of these arrangements.

◆ The A&R Committee and CPEC hope these changes will strengthen the research base of meetings, while promoting improvements in clinical practice through clinical effectiveness.

John Potter

Chairman, Academic and Research Committee

Jonathan Potter

Chairman, CPEC

John Gladman

Associate Editor, Age & Ageing

BGS Clinical Guideline

Anti-depressant medication following ABI

Depression is commonly associated with acquired brain injury (ABI) and can interfere with rehabilitation, leading to poorer outcomes.

Management of depression is typically multi-factorial, and mood may well improve either spontaneously or as a result of rehabilitation and regained independence.

In collaboration with the British Society of Rehabilitative Medicine and in association with the Royal College of Physicians (London) Clinical Effectiveness and Evaluation Unit, the BGS has produced a clinical guideline for the use of anti-depressant medication in adults undergoing recovery or rehabilitation following acquired brain injury. This will be posted onto the BGS website as part of the compendium's new clinical guidelines section in the coming weeks.

Minor or moderate depression

The aim of the guidelines is to provide the general physician, GP or other clinician treating patients with ABI with a safe approach to managing minor to moderate depression in the context of brain injury rehabilitation, whether in hospital or in the community, and to identify those individuals who require more specialist advice and referral to mental health services.

Setting the context

Although the guidelines focus on the use of anti-depressant drugs, these are by no means the only way to manage depression following ABI, and it is important in any event to consider other contributing factors and whether they could be rectified, prior to reaching for the prescription pad. Alternative interventions may include simple measures to address environmental or other factors which contribute to low mood (such as missing their home and family, or worries about life outside hospital). Non-pharmacological interventions, such as cognitive behavioural therapy or psychotherapeutic interventions, may also be suitable for patients who have the

Also indicated is the fact that SSRIs appear generally to be about as effective as tricyclics, but have few reported side-effects and overall appear to be cost-efficient despite the slightly higher drug costs

cognitive and communicative abilities to engage successfully. However, it is accepted that, at the current time, these programmes are rarely available within general medical settings, and tend to be a longer-term intervention. For the purpose of the guidelines therefore, they are considered as a second line intervention which may

follow on from specialist referral, rather than as a practical treatment alternative which is currently available to most general doctors in acute treatment settings.

From the viewpoint of a general clinician considering the prescription of anti-depressant medication, the guidelines give practical advice to support safe practice. They highlight issues for the clinician to consider, such as, does the patient have depression which is severe enough to affect their health or to impede their recovery; and is the patient likely to respond to anti-depressant medication or are other interventions more appropriate?

Evidence

The guidelines consider the evidence for use of anti-depressants in people with ABI. While there is little or no formal research-based evidence to date to inform the most appropriate regimen or length of treatment, general conclusions may be drawn, mainly from the literature on treatment of depression following stroke. This indicates that anti-depressants have seemed reasonably acceptable to patients and are shown to bring about significantly greater reduction in depression than either placebo or no treatment. However, the treatment effect is smaller than was initially supposed. Overall, approximately four patients would need to be treated to produce one recovery from depression which would not have occurred had they been given placebo, and one patient in every ten would drop out because of side-effects. Although change in depressive symptoms is often reported, actual gains in terms of improved function or quality of life are harder to demonstrate. However, isolated studies have

reported reduced mortality and improved function in the treated group, compared with controls. Also indicated is the fact that SSRIs appear generally to be about as effective as tricyclics, but have fewer reported side-effects and overall appear to be cost-efficient despite the slightly higher drug costs.

Diagnosis and treatment

The guideline outlines the diagnosis and measurement of depression, including screening and quantification tools. It touches on issues around “consent”, pointing out that many people believe that depression carries a certain stigma. Patients sometimes report that they feel pressurised into taking anti-depressant medication when they do not believe they are depressed, or when they would rather use other methods to combat the symptoms. The guideline stresses that it is important to ensure that patients give their informed consent to treatment, if they have the capacity to do so.

The guideline covers the choice of anti-depressant agent which, in the absence of formal research, is adapted from Royal College of Physicians’ (London) Guide: The Psychological Care of Medical Patients.

Finally, the Guideline states that implementation will require investment to provide improved training in assessment and management of depression for all clinicians working with ABI patients; better information and awareness among the general public with regard to depression and its management in this context; and better monitoring, follow-up and communication between clinicians across the different settings. However, successful implementation could be expected to reduce unnecessary, unwanted, and potentially dangerous use of medication in a vulnerable patient group – with overall cost-effective results.

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The full clinical guideline has been posted onto the BGS website at www.bgs.org.uk

A hero in Wales

a tribute to Professor Bim Bhowmick OBE MD FRCP

Bim retired in February 2005 after a remarkable career. This tribute is a reflection of Bim's career and his extraordinary life.

It outlines his early years when he triumphed over adversity; his arrival in the UK in the 60's and then the sustained devotion to the advancement of the speciality of geriatric medicine in Wales; and in later years the recognition of this contribution through a number of significant awards – most recently the award of a personal chair by the University of Wales

The early years and the 'great escape'

As the second youngest of ten children, Prof Bimal Bhowmick overcame terrible hardship and poverty as a young man to fulfil his dream of becoming a doctor.

The Indian province of East Bengal (now Bangladesh) erupted into civil unrest and religious rioting in the 1940's and Bim Bhowmick's terrified family fled the violence that had encroached onto their very doorstep. After their dramatic escape the refugee family settled in West Bengal, near Calcutta where, soon after, he lost his father to a treatable illness. The family were simply too poor to pay for proper medical care.

Education was fee paying in India at that time, and the family had no hope of affording the school fees. Learning of his plight, a wealthy businessman, (the father of one of his friends), gave him the start he needed by paying for the first year. He took up the challenge, knowing that his only way forward was to stay 'top of the class' and to win the annually awarded

scholarship for progression to the next school year.

Sustaining this year after year through sheer single-mindedness and extraordinary effort, (he could not even afford to buy text books, pencils and papers), Bim stayed at the top of his class right through school and maintained this position until he qualified as a doctor in 1963.

After senior house officer posts in Calcutta Medical College, he did his postgraduate MD degree in 1968. It consisted of research for two years, writing a thesis and sitting a full-blown examination comprised of theory and a rigorous clinical case-based practical examination.



Prof Bim Bhowmick

Arriving in the UK and his contribution to Wales

After marrying Aparna, his wife of 35 years, Bim came to the UK in 1969. He trained in Blackpool as an SHO then moved to Dudley in the West Midlands as medical registrar. In 1974 he took up a new challenge to specialise in geriatric medicine and obtained a senior registrar post in

North Wales where he had to learn all aspects of geriatric medicine within one year. He was offered a new second consultant's post in HM Stanley Hospital, St Asaph, and decided to settle in picturesque North Wales. During his career as a consultant, he was working nearly twelve hours a day and practically seven days a week.

Bim Bhowmick's major contribution has been the transfer of acute services from a former workhouse to a modern District General Hospital (DGH) - Glan Clwyd, acquiring 90 beds in 1994. It was a long and tremendous struggle, especially as management was determined to centralise orthopaedic services from a peripheral

Bim has been at the forefront of the organisation and delivery of postgraduate education and training, both locally and throughout the whole of Wales for the last two decades

based modern stroke rehabilitation unit with excellent facilities (1989). This became a stroke demonstration centre for Wales, helped by his colleagues. He created the first family stroke support workers in the UK, primed by the Stroke Association and first Stroke Club in Wales in the early eighties. The enthusiasm and pioneering vision he brought to these projects would come to characterise the second part of his career.

Pioneer in academic geriatric medicine

In collaboration with Bangor University, Bim went on to initiate the first diploma course in Stroke rehabilitation for multidisciplinary teams in the UK, together with the first MSc course with a local polytechnic for nurse practitioners. During the mid-eighties he pioneered the medical/clinical audit and steered its expansion to the whole of Wales.

Displaying his customary forward thinking Bim created an academic department in geriatric medicine, the first of its kind in a UK DGH, and this academic department is now a satellite of the Professorial Unit in Cardiff. He also established the first 'Home from Hospital' scheme in Wales with the Red Cross, facilitating planned discharge of older patients. Five years ago he created the Stroke Interest Group and the Welsh Stroke Bulletin, which now plays a significant role in developing All Wales Stroke Services.

Bim has been at the forefront of the organisation and delivery of postgraduate education and training, both locally and throughout the whole of Wales for the last two decades. He chaired the Welsh Standing Committee on postgraduate medical education for nine years and shaped the infrastructure under which a modernised system of training and education has flourished. In recognition of his significant contribution the

hospital to respond to the internal market.

He had a special interest in stroke care from an early stage and developed a DGH complex-

University of Wales College of Medicine honoured Bim by awarding an Honorary Fellowship in 2003, the first of its kind in the history of the College. He has played his role at the centre of The Royal College of Physicians (London), as the first elected ethnic councillor and the first ever Censor from Wales. He was the first ethnic MRCP examiner and now acts as a Nominated Visiting Examiner. He helped to establish the RCP Ethnic Minority Committee, which he now supports and chairs.

Bim has been a loyal member of the British Geriatrics Society since 1974, having served as Councillor and member of the Executive Committee, Secretary and Chair of the Welsh BGS and father figure for over a decade. He has championed the cause of Welsh geriatricians, who hold him in the highest esteem. He has helped and advised the Welsh Office and now the Welsh Assembly on the development of geriatric services. He managed the specialist registrar training programme in geriatric medicine (which is North Wales based) for nine years as Programme Director, and played a central role in the All-Wales Specialty Training Committee.

In recognition of his contribution to geriatric services Bim was awarded the OBE in the millennium year. He has been instrumental in the success of a significant number of distinction awards for geriatricians in Wales. He has been the Associate Postgraduate Dean since 1997, for overseas doctors, and has lately taken on the mantle of project leader for Refugee doctors in Wales, taking them through the re-qualification process. He was Clinical Director for Care of the Elderly and lately of Integrated Medicine at Glan Clwyd hospital for thirteen years.

Bim is retiring as consultant geriatrician in February 2005, but will continue as Associate Postgraduate Dean. Welsh geriatricians, Welsh geriatric services and Postgraduate Education facilities owe him a huge debt of gratitude and on behalf of all these and the rest of the British Geriatrics Society, our good wishes continue to go with him into this new chapter of a remarkable life of service.

Ed Wilkins
Chair, Cymru/Wales Council

BGS Compendium of Policy

guidelines for geriatricians on copying letters to patients

Under the NHS Plan in England, it was proposed that all clinicians send copies of their clinical letters to the patients. This has not been universally adopted, largely because of competing priorities.

Nonetheless, the British Geriatrics Society believes that there is considerable merit in this proposal and commends it as good practice for all specialists working in older people's health care. In any case, all patients have more rights under the freedom of information legislation to access their clinical records, and this guidance should therefore be seen as moving along this path.

The BGS is always in favour of increasing openness and transparency in the clinical care of patients and this document gives guidance on the issue of copying clinical and other letters to patients with reference to our patient group.

This guide has been prepared to help doctors do the best they can for their patients, without compromising confidentiality or causing unnecessary distress. They may also provide information and guidance to managers of older people's services and primary care and, of course, to patients and their carers.

What do patients want?

There is not much evidence about what older people want in this area. Discussions with user and carer groups suggest that the main concerns of patients and their carers centre around good communication and accurate and timely information about diagnosis and management; and

that they are not particularly concerned to receive letters. In response to a direct question on the subject, 80% of patients in contact with older people's mental health services did not wish to receive their clinical letters (*Tony Elliott 2003 - verbal communication*).

Quality of communication

The evidence, therefore, suggests that it is the quality of information and communication that concerns our patients, rather than receiving copy letters. It is possible that this is, to some extent, a cohort effect and that, as people who are accustomed to receiving clinical letters get older, they will prefer to receive the letters as part of the communication and information from clinicians. No patient should receive a copy of the letter if they say they do not want it.

The evidence suggests that the quality of information and communication concerns our patients rather than receiving copy letters.

Frequently, when a patient is seen, the diagnosis is not immediately clear and may require further elucidation over time or specific investigations. It would not be appropriate for a patient to receive a

letter in which there is speculation about diagnosis. In such a situation the clinician should use their judgement and send only letters which are clear, and the content of which has already been discussed. In these circumstances it may even then be distressing and anti-therapeutic for some patients, and the clinician should record the reason for the course of action they follow in the clinical notes.

Construction of the letter

Older people's services will need to educate everyone involved in good practice, including medical secretaries and administrative staff in hospital and primary care settings. Doctors in training will need specific training in letter writing and the associated advice given here. This should include the following advice:

- ◆ Structure the letter (i.e. your thoughts) and make it clear why the patient attended and the outcome of the consultation. Headings or proformas may help achieve this.
- ◆ Use plain English (remember KISS - Keep It Short and Simple)
- ◆ Explain complex terminology so that the average non medical Briton can understand.
- ◆ Construct letters for patient and copy these to GP rather than vice-versa
- ◆ Do not use subjective statements such as 'This delightful old lady'.
- ◆ Do not add information that was not covered in the consultation (test results might be an exception).
- ◆ Remember that the content of the letter can also act as an aide-memoire for the patient to aid adherence to a management plan.

Important points for consideration

- ◆ Patient capacity to read, comprehend and safeguard letters, particularly for patients with cognitive impairment.
- ◆ Patient consent to receive clinical letters.
- ◆ Third-party confidentiality i.e. information given by a third party who needs to consent to that information being given to the patient.
- ◆ Third-party access to the letters.
- ◆ Confidential information which may be detrimental to the patient.

Recommended procedure for patients with capacity

- ◆ Whenever possible all patients should be asked whether they wish to receive the clinical letter, a 'lay orientated' letter or no letter and the answer recorded in the notes. If it is deemed clinically inappropriate even to ask, this should be recorded and the reason given.
- ◆ Third-party consent for disclosure of information to the patient should be sought when needed and the result recorded. This may prevent such information being recorded in the letter or prevent the copying of the letter to the patient.
- ◆ Confidential information detrimental to the patient should be noted and given as the reason for not copying the letter to the patient in the notes.
- ◆ Any such decision should be conveyed to the recipient of the letter e.g. the GP, and the reasons should be given.

Recommended procedure for patients deemed not to have capacity

Because other than in Scotland there is not yet a legal framework for decision-making for adults who lack capacity, clinicians will have to exercise judgement. The reasons for any subsequent decisions made should be recorded in the notes. Where patients lack capacity it cannot be assumed that carers should automatically receive a copy of the clinical letter. It will be a matter of clinical judgement for the clinician as to how appropriate this is, and the result of that judgement and any discussion with the carer should be recorded. In Scotland, even if the patient is deemed not to have capacity, their views must be sought. Ensuring that people, even those without capacity, have the opportunity to express their views on this subject is good practice and should be adopted by geriatricians throughout the UK.

Alternative means of conveying information

Other means of written communication may be more appropriate and also meet the Department of Health requirement. These include:

- ◆ Letter directly to the patient or to the carer having gained and recorded consent, including third-party consent. Such a letter would be a clear, simple explanation and would probably not contain the level of clinical detail as the letter to the GP.
- ◆ A copy of the multidisciplinary care and or discharge plan including important clinical details such as diagnosis and planned or undertaken management. For patients under the care of specialist mental health services in England and Wales this will include a copy of part of the Care Programme Approach (CPA) documentation. Many services will provide this already.
- ◆ It is not necessary for patients to receive multiple letters automatically, particularly where information is repeated.
- ◆ Services may choose to develop formatted letters although this may sacrifice important clinical detail. These might be suitable for both GPs and patients.

BGS Policy Cttee

June 2004

posted onto BGS Compendium site under the Ethics Section

South Birmingham

two trusts in one service

The present shape of the South Birmingham service originates from the need, in the 1960's, to clear the old Poor Law wards at Selly Oak Hospital.

The solution was the conversion, or building, of wards on three outlying sites, Moseley Hall, West Heath, and Rubery, with a relatively small number of beds left on the general hospital site. In the mid 1970s, in order to make the best use of these resources, the policy of admitting selected acute patients to peripheral sites, and of rehabilitating patients wherever they were admitted, was adopted, and greatly improved access to geriatric care. At the same time, Bernard Isaacs was appointed Professor, and established the academic department at Selly Oak.

This disposition of the service made the loss of large long-stay responsibilities in the late 1980s easy to manage, although Moseley Hall and West Heath both shrank, and the Joseph Sheldon Hospital at Rubery closed – to make way for a large retail development. In the early 1990s the shotgun marriage between two health districts and then "integration" with general medicine led to a further loss of general hospital facilities, which had moved from being the responsibility of the Community Unit to the acute sector.

Symbiosis

Since those dark days, there has developed a symbiotic relationship between the two Trusts involved - University Hospital Birmingham Foundation NHS Trust and South Birmingham PCT. Because the community hospitals are well resourced, with SHOs (whose posts have recently been approved for four years by the RCP), plain X-ray facilities and so on – they can take a large number of patients with core geriatric problems directly, from GPs, A&E or the Medical Admissions Unit, into specialist care with an

emphasis on rehabilitation – as well as more traditional transfers after acute care. Within Selly Oak, we have at last been able to start expanding our service in the hope of reaching more of those who need it, with a stroke unit and an orthopaedic intermediate care ward as well as generic geriatrics and out-patient services.

Day assessment and treatment

The community hospitals have adapted and innovated. We have wards specialising in the rehabilitation of people with stroke, amputation and orthopaedic problems, a respite care service, and what was built as an NHS nursing home when such things were in fashion, now provides elite long-term care for people of all age, who are so disabled as to qualify for NHS long-term care, but more importantly a valuable terminal care service, that supplements, but does not compete with, the work of the local hospice. To cure the problem of the traditional Day Hospital – supplying sitting and transport therapy - we operate a day Assessment and Treatment Service, which people attend for a specific appointment for a specific purpose, whether rehabilitation or a specialist clinic such as for falls, stroke, tissue viability or Parkinson's disease. Specialist nurses have been vital in developing these services, and in supporting the wards.

We look after the southern third of the City, ranging from inner-city to a few leafy suburbs – about 65,000 over-65s, with seven consultants, all but one of whom work in both Trusts, which is vital to our cohesion.

EWTD, staff...same ol', same ol'

So what's the catch? We face the same problems that so many do – working with Social Services, nurse and therapy staffing, junior doctors' hours and the EWTD. The Chair remains vacant. We don't meet the needs of frail old people fully in the DGH. We haven't a continence service, or support nursing homes as we should. Despite policies, we sometimes have problems with patients more acutely sick than they appear in the community hospitals, and while a geriatrician may think nothing

of travelling to three sites in a day, some of our more prestigious colleagues find a three mile journey quite a challenge. There's the occasional difference between the two Trusts, but they know they need each other, and our older population needs **one** service, even if between two Trusts.

Ed Dunstan
Jed Rowe

In memoriam

William Henry Moffatt FRCPJ OBE



Former consultant physician at Greenisland and Whiteabbey hospitals, Northern Ireland (b 1926; q Queen's University, Belfast, 1950; FRCPI, OBE), died from liver cancer on 27 November 2004

Bill did his national service in the Royal Army Medical Corps, serving in the Suez Canal zone. After working in hospitals in Doncaster, Cheltenham and Bournemouth, he returned to Northern Ireland as consultant physician in geriatric medicine. He was chairman of the the University of Ulster's ethical committee and a member of Northern Health Board. He became a justice of the peace in 1977. He leaves a wife, Elsie, three children; and four grandchildren

D H Allen

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Should Dr Foster carry a health warning?

A few weeks ago I was informed I had an "excess mortality", and premonitions of doom flooded over me. Over the preceding five months I was reported to have had 10 excess deaths, "indicating poor performance", compared with what would be expected on the basis of age, sex, primary diagnosis and route of admission, according to the Dr Foster database. When I actually looked at records of the patients concerned, it was apparent that "primary diagnosis" was an irrelevance for many of them: most had multiple, and often end-stage, co-morbidities, and some were simply incorrectly coded – one with a total anterior cerebral infarction had gone down as "syncope and collapse".

So why tell this sorry tale to the membership of the BGS? Firstly, in these days of performance monitoring, it's wise to ensure the right things go down on the KMR1 front sheet – and under "Payment by Results" Trusts will have an interest in all relevant diagnoses going down as well. Secondly, and more seriously, is the potential threat to those of us who choose to look after frail old people, of comparisons with systems such as the Dr Foster database, relying on arbitrary principal diagnoses, rather than on the total patient. Just as there's anecdotal evidence to suggest that NCEPOD and mortality monitoring may discourage surgeons from operating on frail people, will there now be pressure on us to avoid the care of those who need us most, or to try and discharge dying people as soon as possible to nursing homes?

Edmund Dunstan

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Team working

www.bmjlearning.com

BGS members are encouraged to visit the website www.bmjlearning.com which has a section for hospital doctors also newly included. One of the articles is on team working written by Dr Abhaya Gupta, Consultant Physician Elderly Care, Carmarthen. There is information on several useful clinical and management topics included here.

For further information contact Dr Gupta at guptaabhaya@hotmail.com