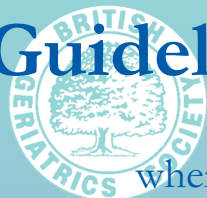




Guidelines on Advance Care Planning



when our patients lose capacity

In April 2007, the Mental Capacity Act came into force. The Act, in combination with NHS initiatives to improve end of life care generally, means that we are likely to see an increase in advance care planning.

Advance care planning has been defined as a process of discussion between an individual, their care providers, and often those close to them, about future care. The discussion may lead to:

- ◆ an advance statement (a statement of wishes and preferences),
- ◆ an advance decision to refuse treatment (ADRT - a specific refusal of treatment(s) in a predefined potential future situation); or
- ◆ the appointment of a personal welfare Lasting Power of Attorney (LPA)

All or any of these can help inform care providers should the individual lose capacity. These terms supersede previous phrases such as 'living wills' and 'advance directives'.

It is likely that geriatricians will be seeing more and more patients with advance decisions and/or advance statements. Whilst the British Geriatrics Society (BGS) has acknowledged that advance care planning has an important role in helping determine best interests when an individual no longer has capacity, there are some concerns about the evidence base underpinning their use. The current literature is dominated by the North American experience – and it is not clear how well this evidence translates to the UK. There are many **known unknowns**, to paraphrase Donald Rumsfeld, including what are the optimal settings in which to introduce advance decision discussions – hospital or community, before or after illness? What will be the impact of Lasting Powers of

Attorney? Will advance decisions lead to the denial of appropriate care?

Given that geriatricians frequently care for individuals likely to lose capacity and in whom end of life discussions are relevant, the BGS Clinical Practice and Effectiveness Committee sought to take the lead on

the development of a set of robust evidence based guidelines for clinicians on advance decisions and advance statements. Initially a BGS venture, these evolved into national guidelines involving the RCP,



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for better health in old age

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Age Concern, the Alzheimer's Society, the Royal College of Nursing, the Royal College of General Practitioners and the Faculty of Old Age Psychiatry. After two years of development the guidelines (**Conroy S, Fade P, Fraser A, Schiff R.** Advance care planning: concise evidence-based guidelines. Concise Guidance to Good Practice series, No 12. London: RCP, 2009) have now been published in concise form and the full version is enclosed with this issue of the newsletter. A downloadable version can be found at: <http://tinyurl.com/bjhs9o>.



The aim of the guideline is to inform health and social care professionals on how best to manage advance care planning (ACP) in clinical practice. The guideline contains a number of recommendations, such as training for and implementation of ACP, when and with whom to consider having ACP discussions, the context and content of discussions, preparing ACP documents and cognitive impairment.

The key recommendations are that discussions should be led sensitively, being aware that many people do not wish to have such discussions thrust upon them, and that the professional leading the discussion has the appropriate knowledge and training to advise the older person.

One specific area of controversy related to advance care planning is the use of advance decisions to refuse treatment (ADRTs). Although

these decisions will only be used in a minority of people (no more than 10%), they can cause considerable uncertainty for health professionals faced with patients who have lost capacity but have prepared a draft statement. Some of the issues are discussed in the guidelines, but more details on ADRTs can be found at www.adrt.nhs.uk

The document is primarily aimed at professionals in England and Wales (there are legal differences in the devolved nations) and will be relevant to all doctors involved in ACP, especially geriatricians, psychiatrists, general practitioners, general physicians and acute medicine specialists. We hope that the guidance will be of use to BGS members and welcome your feedback as to whether or not such guidance is useful.

Simon Conroy

Editorial



The government in England is proposing to unite the various pieces of law on equality and discrimination under the umbrella of one “Equality Bill”.

It might seem surprising that older people are currently not protected in English law from age-based discrimination in the “provision of public goods and services” (such as health and social care). The Parliamentary Inquiry into the human rights of older people in health care (<http://tiny.cc/nB6dn>) has already highlighted that prisoners for instance, currently have more rights than elderly nursing home residents. Even where explicit age based policies have been rooted out (for instance as a result of the 2001 NSF for older people (<http://tinyurl.com/cu6a99>)), we have all seen examples of covert and overt ageism in the attitude of professionals or the public to frailer older people or in the prioritisation of services, resources and performance frameworks, as well as in clinical decision-making.

I recently attended a workshop on behalf of the BGS, along with other stakeholders from medicine, nursing, charities and government bodies to examine this issue. Several examples of services felt to be inherently ageist were highlighted. The issue also arose of cases in which age might be a legitimate exemption as a valid factor in clinical decision making (for instance around the probability of success of IVF, as a factor in prognostic scores for Intensive Care Unit patients or in the utility of bone densitometry as a technology). Even here, it is surely the patient’s overall physical status, co-morbidity and individual outlook which is more material than their chronological age, used arbitrarily and in isolation. As some of the participants pointed out in a discussion about whether NIHCE with its use of cost per QALY might be inherently ageist, we do also need to be critical about what we mean by “evidence-based” practice when so often the

participants in clinical trials do not reflect the complex older patients with whom we deal daily. Nor do the existence of



NIHCE guidelines or

NSF targets guarantee that older people will be adequately addressed or treated, as major recent audits on continence, falls, bone health or delirium indicate and as the dementia strategy have highlighted. Judicial review has tended to focus on access to treatments proscribed/restricted by NIHCE such as herceptin rather than the lack of provision of those recommended by it.

Our relationship with the media and other charities

The BGS has been developing stronger formal links with Help the Aged (to merge with Age Concern on 1 April. They haven’t decided on what to call themselves yet). The charity has been lobbying the government hard to push the agenda around age discrimination in healthcare - the concern being that unless we also have the detailed regulations in place to make the aspiration in the equality bill a reality and before the next election, the whole cause will be put back by a couple of years. There is now a petition for an early day motion to push for this (www.helptheaged.co.uk/justequaltreatment). And as part of this, Help the Aged has worked closely with the BGS – an example of win/win with their high profile and our clinical credibility. A survey was commissioned of BGS members in 2008 with over 200 members replying). The results of this survey were used in a joint press release (see page 8) from the BGS and Help the Aged, on 26 February and I was on hand as the official BGS media contact the following day. The first call I got was from the health correspondent of a national daily who was fairly sceptical about the validity of a survey of specialist geriatricians with a fairly low response rate. I pointed out that these were nonetheless the views of frontline professionals working in the service

and that there was lots of other objective evidence of a raw deal for older people, from the Dignity In Care Reports, the audits and parliamentary inquiry mentioned above. Nonetheless, news values being what they often are, he chose to lead with a story entitled, “masturbation good for the over 50s.” I also gave lots of a copy to a well known “mid-range” national paper, with several examples of inadequate care for older people around continence, fractures, falls, dementia, dignity and the labeling of people with legitimate medical illness as “social admissions”. For the second time this year, said newspaper (which always insists on using the blanket term “the elderly”) didn’t consider these facts newsworthy enough – there being no individual story or scandal of abuse or neglect on which to hang them

Did the press release work?

In my time as Deputy Secretary and Secretary of the BGS, I have done various bits and pieces about geriatric medicine on radio/tv and in the papers, but this was my first taste of working with the highly professional and polished PR machine of Help-the-Aged. I had taken a day’s annual leave to clear the decks which was just as well. I decided right at the outset that there was a handful of key messages I wanted to convey - essentially: a) older people are the biggest group of service users – not a minority (hence my dislike of “the elderly” as a term), b) common conditions in older people tend to be less well recognised, managed and funded, with less training, research funding, resource of performance targets, c) where conditions affect young and old in equal measure, they tend to be treated very differently in the two groups, d) presentations of illness in frailer older people with loss of function tend to be written off as “acopia” or “social” when an actual diagnosis is required as would be expected in a younger patient, e) the current lack of protection in equality law. In the event I found myself talking about the issues non-stop starting at 6:05 on Radio Five Live, through to appearances on Radio Bristol, Cornwall, Ulster and London and a trip to BBC TV centre for an item on News 24. The interest had died down by teatime in favour of kebabs are unhealthy” and “octuplets in America”, which tends to be the way of things with the news media, but we did get a lot of coverage for the cause and stir some debate. It was pretty surreal talking to people whom I usually listen to or watch and even more surreal doing the local stations interspersed with phone-ins about “left handedness”, “farming”, and “filthy lyrics in songs your kids listen to”. I would say that

throughout the day, I was generally asked intelligent and serious questions. The commonest issue which came up (including from the BBC TV people after we had gone off air) was “isn’t it all about money/finite resources?” I pointed out repeatedly that whilst money was finite, it wasn’t down to individual practitioners to make arbitrary decisions based on age alone and that it would be better to have an honest political debate about age-based rationing rather than covert or unwitting prioritisation and that some things such as better attitudes, caring and knowledge didn’t always cost. This point was re-inforced on the BBC later by Joan Bakewell, who made the point that few older people would ever take recourse in law and that inculcating more caring and patient attitudes in staff didn’t always cost.

I am pleased to report that many callers on stations told positive stories about their experiences in the NHS or denied that they had ever experienced ageist attitudes. This is a constant tightrope that the BGS has to walk. We can campaign for dignity in care, we can highlight deficiencies in funding, training or service provision, but we also need to remember that most hospital units receive far more spontaneous thanks and gifts than complaints and most patients are satisfied with the service they receive. So we also want to celebrate good services and caring staff and avoid scaring the bejesus out of potential service users or their relatives. (See Paper by Iliffe et al in the JRSM 2008 <http://tinyurl.com/ch85hh>). I therefore found myself repeatedly using the end of life care strategy as an example of an initiative backed by real “must-do’s” and resource which was already beginning to make tangible improvements to palliative care for older people.

More of the same?

In addition to our growing relationship with allied charities, I am pleased to report that the BGS has recently advertised for a media and publicity officer and that there has been a strong field of applicants. This is a welcome development. Whilst we are often excellent at responding to consultations and enquiries behind the scenes, we have not always been the most pro-active at securing coverage or raising awareness around older people’s healthcare issues, nor have we always been seen as a “go to” organisation. With over 2,500 members and the largest of all the physician specialities in the UK we perhaps need to start punching our weight and this initiative may help. When I was speaking to various journalists they seemed uniformly surprised

when I gave them basic statistics about the prevalence of falls, osteoporotic fractures, incontinence or dementia, or the percentage of bed days occupied by patients over 65. Several were almost unbelieving when I explained the phenomenon of delirium of physical illness manifesting with functional loss. But then lets face it, even within the medical profession, we could be more proactive considering what a huge chunk of adult medicine and surgery involves patients with geriatric syndromes of multiple long term conditions. As a “for-instance”, go into any medical admissions unit in the UK and the junior doctors will be aware of BTS guidelines on pneumonia, asthma or chest drains or BHS guidelines on hypertension management. But how much general awareness is there of our own guidelines on say delirium? Some of this may of course be down to how much we bang the drum in our own hospitals – perhaps our speciality has tended to attract doctors who are sometimes too “reasonable”. Perhaps we really need to acknowledge that the basics of good geriatric medicine should be everyone’s prerogative in adult medicine (for further discussion see article by Dr Thompson in this issue on page 24).

Academic Geriatrics

One way to lever up the profile of our speciality and that of the older people we look after is by academic profile, including research and teaching. Although there are some pockets of very high profile research around the UK and there are around 50 people with the title of professor in the UK and Ireland, there are a number of established medical schools with no academic department or with un-replaced chairs, or with chairs who have no clinical background in our speciality. Whilst we all

know that much of the teaching of undergraduates is led by NHS consultants, this fact does suggest that our position in ensuring geriatrics is at the heart of thinking in medical schools might be weakened, not to mention our ability to generate a better evidence base for what we do. It is also inescapable that a high number of presidents of medical colleges or specialist societies, or others in senior leadership positions in the NHS, are drawn from the ranks of clinical academics. This issue contains a lively debate about the current state and future of academic geriatrics in the UK.

Jed Rowe

A theme of this editorial has been the need for high quality teachers, mentors, role models, campaigners and opinion leaders in the our field and Jed was one such individual. I met Jed when I was a Senior Registrar and went to give a talk at his beloved Moseley Hall Hospital. I was immediately taken with his knowledge and passion and his outspoken and deliberately challenging views. He clearly cared deeply about the welfare of older patients, was not afraid to stir things up on their behalf and as many would attest, took a keen interest in mentoring and developing up and coming young doctors, including my own career even though I was nowhere near his deanery. He was an inspired and frequently mischievous lecturer and a deeply original thinker about the speciality. He will be missed by many of us. At the recent national conference of the falls and bone health section I was reminded that he called his falls clinic “the well-balanced clinic” a decade ahead of the data showing that older people who fall respond better to positive messages than the “F” word. For those who haven’t seen it, the letter in January’s *Age and Ageing* by Paula Nenn would strike at chord even with those who never met Jed and certainly tells of a career which made a real difference to the care of older people. Most tellingly, she says that “I have seen countless young doctors arrive as physicians and leave as geriatricians after 6 months working with Jed”. Evangelism isn’t always a bad thing, especially, as in Jed’s case, it is backed by logical arguments and a clear understanding of the evidence and we could all take something from his example.

National Dementia Strategy

The Strategy has now been published (<http://tiny.cc/OKIOL>) and we hope to have comment in our May issue.

David Oliver

Key messages for the media:

- ◆ older people are the biggest group of service users – not a minority (hence my dislike of “the elderly” as a term);
- ◆ common conditions in older people tend to be less well recognised, managed and funded, with less training, research funding, resource of performance targets;
- ◆ where conditions affect young and old in equal measure, they tend to be treated very differently in the two groups;
- ◆ presentations of illness in frailer older people with loss of function tend to be written off as “acopia” or “social” when an actual diagnosis is required as would be expected in a younger patient;
- ◆ the current lack of protection in equality law.

President's column



I am greatly enjoying the early months of my presidency. I am impressed by the skills, energy and enthusiasm of our members and of the office team.

In this issue, I will focus on ideas which could stimulate and inform us and help us ensure that old people get the very best care in a constantly changing NHS.

Meeting for Medical Directors and Heads of Specialist Societies

I attended this Department of Health conference, which I found enlightening and informative. Sir Bruce Keogh gave an overview, emphasising the key themes of medical leadership, innovation, health promotion and quality. He said that continuous change was inevitable and that Tsars would be major change agents. Lord Darzi summarised the Next Stage Review, iterating the need for quality (i.e. safety, effectiveness and positive patient experience) and arguing that the best teams measure what they do.

Liam Donaldson spoke on re-validation, the most important change in medical regulation since 1858.

David Nicholson described the virtues enshrined in the NHS Constitution - these include care and compassion (geriatricians will be no strangers to these timeless values), quality (again) and ensuring that everyone in the

Congratulations to Dr Michael Vassallo who was elected Deputy Treasurer with immediate effect. The results were as follows:

Dr Michael Vassallo: 91
Dr Richard Day: 56
Dr Aza Abdulla: 30
Turnout was 7% of the membership

NHS matters

The public admission of past errors was refreshing - in the past there has been change without evidence; finance has featured more than patient care; headlines have taken precedence over quality. Top-down management does not work. In future, there will be decentralisation. Translating research into practise will be stimulated. Other themes included the increased focus on prevention and health promotion; Commissioning - which will include working with clinicians to achieve better care and best value; improved efficiency (I was astonished to learn that PCTs spend £200 million a day) and the use of pathways (for clarity as well as for training).

There were many take-home messages for the BGS, most of which resonated with our strategic planning. We need to do more on prevention; encourage the gaining of leadership skills, particularly among our younger members (there may be Darzi grants for this purpose); develop expertise and influence in commissioning, the design of clinical pathways and metrics (quality measures). We have always championed pragmatic research and the increased importance of translational research will be heartening to academics in our specialty.

PR, Press and Parliamentary officer

I was impressed by the presentation at this conference by Sue Saville the ITN health correspondent. She suggested that we welcome the media into our hospitals - they can do much to amplify key messages and help us to make sure that our voice is heard

A comment made by many members is that the BGS does not have much national visibility. Indeed, many otherwise well informed people do not know that it exists. Our past experience with a PR agency was not a resounding success (an



experience shared by other specialist societies). In order to raise the profile of Geriatrics and emphasise our key role and effectiveness, we need a public relations expert. This person would liaise with members in the four countries and the regions, discovering interesting research findings and examples of innovative high quality clinical practice. The PR officer would link with “instant experts” in the BGS, who could give wise and informed responses to news stories

The successful appointee could also help with political lobbying - we should influence the formulation of governmental policy, and not simply respond to departmental initiatives

I am very pleased that the BGS’s “cabinet”, the UKMC, approved the suggestion of such a post. As I write, interviews are being planned. There will be much more on this development in future issues of the Newsletter

Other aspects of Strategy for the BGS

The medical landscape of the future is going to be very different. Hospitals will be fewer and more specialised, focussing on high technology. More care will be delivered in other settings (“nearer to home” is the mantra). Some policy makers are talking of hospitals as “institutions of last resort”. The move towards the community seems to be inexorable. Geriatricians have always had a strong community dimension - for example, domiciliary visits, day hospitals, telephone advice to GPs and other community colleagues. Prof Ferguson Anderson, the world’s first professor of Geriatrics ran retirement classes in Rutherglen health centre in Glasgow. Other pioneers (such as Isaacs, Sheldon and Adams) have also done much good work outside hospital

We are faced with a threat and an opportunity. We must argue the case that to deprive ill old people of the opportunity for timely comprehensive geriatric assessment is ageist and not in keeping with the move to correct inequalities in health. My impression is that nowadays few crisis elderly admissions to hospital could be managed as well - or better - elsewhere. I am equally convinced that much impressive work can be done at home and in a variety of other settings. There are many excellent examples of community geriatrics and it is encouraging that many departments are developing skills in this field

Alex Mair’s Strategic Review explores this in more

detail as well as outlining other important policy themes - commissioning, recertification, training, Specialty Certificate Examinations, the Dignity project. You can read find information or links to them on the BGS website.

Grandeess

There is a veritable snowstorm of documents from such organisations as the Department of Health, Kings Fund, Scottish Parliament, NICE and the Royal Colleges. It is difficult to keep abreast of what has been published and even the most assiduous geriatrician would not be able to read them all. One solution is to appoint people with more time - as well as specialist experience and skills - who could scrutinise selected documents. They could then write a two page summary, giving a geriatric perspective on the publication, together with a brief commentary (which might rate the paper and advise on whether members would benefit from reading the whole document). The reports could feature on the website and in the newsletter

Initially, we plan to invite BGS members who have recently retired to be assessors - or “Grandeess”. If you would like to be part of this enterprise, or know of someone who would make a useful contribution to this new service, please contact the Society’s scientific officer, Jo Gough, at Marjory Warren House (email:

Scientificofficer@bgs.org.uk)

A question for the Secretary of State for health

David Oliver and I attended the BMA Westminster political meeting in February. Alan Johnson, Secretary of State for Health, gave a summary of Labour’s achievements in the health service. I asked him why elderly people received only glancing references in Lord Darzi’s community review and why the planned vascular screening scheme excluded those over 74 years of age. Was this an oversight or an example of institutionalised ageism? He emphasised Labour’s achievements for old people, including the NSF and the recent Dementia strategy. He also promised to go back to his advisers on the question of an upper limit on screening. I have written a follow-up letter.

We need to be vigilant about other examples of (perhaps unwitting) ageism in elderly health care - something that our PR officer might pursue.

Graham Mulley

Half of doctors say

NHS is ageist

Just days after the publication of the NHS constitution, promising equal treatment regardless of age, new research shows almost half of doctors specialising in the care of older people think that the NHS is institutionally ageist.

The research carried out for Help the Aged also found an overwhelming three quarters (77 per cent) of British Geriatrics Society (BGS) members would support the introduction of legislation against age discrimination in the NHS.

The Government has announced age discrimination legislation will be part of the forthcoming Equality Bill - but current proposals mean the regulations protecting older people in health and social care may not be approved before the next election.



Help the Aged is calling on the Government to review their timetable as a matter of urgency. If they do not, older people may be left to wait over a year before the regulations the Government promised older people are even drafted.

Well over half (55 per cent) of the doctors from the BGS said they themselves would be worried about how the NHS will treat them in old age.

Each day without a new law, older people risk being ignored, misdiagnosed or even denied appropriate treatment

Kate Jopling, Head of Public Affairs for Help the Aged, says: 'The Government has taken a bold step towards protecting older people but they are at risk of stumbling before they complete the first stride. Each day without a new law, older people risk being ignored,

misdiagnosed or even denied appropriate treatment. Older people have a right to fair health care, free from ageist prejudice.

'The right time to pass the new age regulations is alongside the new bill, so that older people will be protected as soon as possible. If this opportunity is missed, older people could be left waiting indefinitely for the same protections other groups already enjoy.'

Alex Mair, Chief Executive of the British Geriatrics Society, says: 'What this research makes clear is that the NHS is currently failing older people. We need to ensure that patients of all ages receive the very best care, regardless of their age.'

Main findings of the HtA survey of BGS members:

- ◆ Almost half (47%) of BGS members think the NHS is institutionally ageist.
- ◆ Three quarters (77%) of BGS members would support the introduction of legislation against age discrimination in the NHS.
- ◆ Well over half (55%) of BGS members said they themselves would be worried about how the NHS will treat them in old age.
- ◆ Two thirds (66%) of BGS members agreed that in their experience, older people are less likely to have their symptoms fully investigated.
- ◆ Seven out of ten (72%) BGS members said older people were also less likely to be considered and referred on for essential treatments.

Help the Aged Press Release
published end of January 2009

Another push

to improve end of life care



Good end of life care should mean that people are treated with dignity and respect and, where possible, in their preferred place of care.

Some people receive high standards of care in their final weeks, days and hours, but others do not. Organisations responsible for the care of people approaching the end of their life need to improve the planning and delivery of services, particularly support in the community. There is scope to make these improvements by using both existing and planned additional resources more efficiently and effectively.

This summarises the view of Tim Burr, head of the National Audit Office (NAO – which is totally independent of Government), of the current state of end of life care in England, when in July 2008, the NAO End of Life Care report (NAO, 2008) was launched.

End of life care overview

Of the 500,000 people who die in England each year, two thirds are over 75 years of age. The majority of deaths occur in an acute hospital, usually following a period of chronic illness. Most people want to be cared for and die in their own home but the actual number of people who are able to do so varies with age, geographical area and most significantly, by condition.

End of life care is often delivered by a large number and wide variety of generalist staff, although the exact number involved is not known nationally. Around 5,500 staff work in specialist palliative care delivered by health and social care workers with specific training in the management of pain and other symptoms and the provision of psychological, social and spiritual support. The significant input of care being provided by informal carers such as family, friends or volunteers should not be either underestimated or forgotten. The report reflects this variety of care in its detailed preparation.

More big business

End of life care is yet another billion pound industry. The Department of Health estimates the overall annual cost to NHS and social care services is measured in billions of pounds (in 2006-07 PCTs spent an estimated £245 million on specialist palliative care). The National Audit Office estimates the cost of providing NHS and social care to cancer patients in the year prior to death (27% of total deaths) to be £1.8 billion.

Before the launch of this strategy, the Department of Health (DH) acknowledged the relatively low priority given to end of life care but hopes that the implementation of the Strategy will reduce inappropriate admissions to hospital and be more empowering for people approaching the end of life to live and die in the place of their choice. To add emphasis to their vision, the DH has pledged additional funding of £286 million for 2009-2011.

Place of care

The majority of people (56 – 74%) express a preference to die at home; this proportion may decline however, as death becomes more imminent and people want more extensive support, such as hospice care. The place of death varies by condition – cancer patients are more likely to die at home or in a hospice; the majority of deaths from dementia occur in care homes; and the vast majority of deaths from heart and pulmonary disease occur in hospital.

The reason proposed for end of life care unnecessarily occurring in hospitals is because of a lack of prompt access to services in the community. The report suggests also, that Do Not Resuscitate (DNR) orders are not being communicated to all the multiple agencies involved in care, leading to inappropriate hospital admissions.

The strategy recognises the vital role of independent hospices in providing both inpatient and day care. Independent hospices provide about 2,150 inpatient beds, compared to 450 provided by NHS hospices. The proportion of non-cancer patients receiving hospice services remains low, but is growing.

Training of staff

Frontline staff often lack training in delivering basic

end of life care. The report found that only 29% of doctors and 18% of nurses had received any pre-registration training in end of life care; and only 39% of doctors and 15% of nurses had received pre-registration training in communicating with patients approaching the end of life.

Another survey from the report found that 74% of ninety care homes stated they provided specific training on end of life care, but that in less than half of cases was such training compulsory. High staff turnover rates predictably suggest that care homes are training fewer staff than they lose on an annual basis.

Improving the delivery of end of life care

Fifty four per cent of general nurses and a third of doctors reported being trained in the use of at least one of the three NICE recommended approaches to end of life care (Gold Standards Framework, Liverpool Care Pathway or Preferred Priorities for Care). For palliative care specialists, 91 per cent of nurses and 95 per cent of doctors had received such training. These approaches are well regarded by a range of users and both doctors and nurses reported that their use had improved their confidence in delivering end of life care. There has been little measurement of the benefits for patients of using these approaches and the direct benefit to patient

care associated with their use has yet to be fully demonstrated. What research has been done has shown that their use can reduce unnecessary hospital utilisation and increase the likelihood of people dying in their preferred place of care.

The End of Life care strategy includes advice on workforce development, broken down into a development aspect for each step of the pathway. To begin to address this, staff have been categorised into three groups within the EoLCS: 1) staff working in specialist palliative care and hospices; 2) staff who frequently care for those at the end of life and 3) staff who infrequently care for those at the end of life.

Staff caring for older people are likely to fall into the second category so will be entitled to training in communication, assessment, advance care planning and symptom control. SHAs will lead on workforce development, "Skills for Health" and "Skills for Care" are developing competences and "E-learning for Healthcare is developing a package".

Service commissioning needs to improve

The expenditure by PCTs on specialist palliative care services does not reflect the pattern of need. The PCT census in the report and data collected by the DH found large variations in the average amount spent on specialist palliative care services for

individuals approaching the end of their life (£154 to £1,684 per death). There is also variation in the availability of palliative care beds, and in the number of staff within hospital and community specialist palliative care teams. The provision of care home places and hospice services is also, in many cases, not proportional to need.

The DH has not yet implemented a national tariff to underpin commissioning of palliative care for NHS and voluntary sector providers. In 2004, in response to the House of Commons Committee's report on palliative care (HM Government, 2004) the DH stated that it was on course to implement a national tariff which would allow full cost recovery by all palliative care providers by 2008-09). There is no specific timetable currently for such implementation.

Multiple Conditions: Multiple Challenges

To a geriatrician, it is stating the obvious to say older people don't fit into a neat diagnostic box, generally experiencing several co-existing conditions and possibly frailty, as they move towards the end of life. The NCPC with key partners – Age Concern, Help the Aged and the British Geriatrics Society - have been considering ways of adapting the generic principles of the strategy to this issue. It may be that you can help your local EoLC leads and commissioners to consider this, so NCPC have produced guidance to help (Multiple Conditions: Multiple Challenges). The NCPC expects to hold an event in 2009 leading to the publication of an information leaflet for patients and carers (produced jointly with the British Geriatrics Society). Further information will be available at www.ncpc.org.uk.

Dementia

29% of people, 85 years old and over, with other conditions such as cancer, will also have dementia. NCPC has a specific project looking at the palliative and end of life care needs of people with dementia and 3 key publications have been developed. For more info see www.ncpc.org.uk. A successful conference launching guidance in this area was held in February this year.

NCPC has worked very closely with the Department of Health on the development of the EoLCS and has therefore been in a good position over the last two years to develop work to help services implement the policy. To receive information, subscribe to NCPC, otherwise details of publications and events are available at www.ncpc.org.uk.

Implementing the End of Life Care Strategy at local level

The strategy is to be supported by the recent NHS Next Stage Review where a key theme was end of life care. This means that in the implementation of a national EoLCS, each local area has to develop its own strategy and EoLC lead across the Strategic Health Authority (SHA), Local Authority and Primary Care Trust (PCT), with processes covering local health, social care, voluntary and independent sector providers. These local initiatives should ensure that EoLC is high on the agenda and therefore

something that all staff caring for older people are aware of.

Geriatricians need to be aware of the respective EoLC plans of their PCT with a view to linking into it and gaining access to the resources available. Each PCT will have collected baseline data around EoLC and this may help in service and workforce planning and development for geriatric services.

Martin Curtice (Consultant Old Age Psychiatrist)
Lucy Dutton (NCPC)

Geriatricians and the EoLC Strategy

The NHS next steps review (The Darzi review) also focussed on end of life care which was one of the eight workstreams. Each Strategic health authority in England reviewed its local arrangement for end of life care.

What is the relevance of this emphasis to geriatricians? As mentioned in the article above, very few people say they would like to die in hospital and yet a significant number do. The group least likely to die in hospices or at home are older people dying of conditions other than cancer; even older people with cancer are less likely than younger patients to end their days in a hospice.

Geriatricians working in hospital settings need to be aware of the End of Life Care Strategy and its parallel policies in Scotland, Wales and Northern Ireland. Most people die of long term conditions (only 5% of people die unexpectedly) so many deaths could be anticipated, and if services are redesigned to be proactive rather than reactive better end of life care could be offered to many.

Geriatricians deal with death frequently and in most departments end of life care pathways, such as the "Liverpool Care Pathway", are in use. This has been demonstrated to improve the process of end of life care. Nevertheless it is acknowledged that recognition that a patient is reaching the end of their life can be difficult and diagnosis of dying is not always easy, especially by less experienced staff. Thus some patients are subjected to inappropriate invasive investigations or treatments at a time when the emphasis could have been more appropriately on comfort and dignity.

Most geriatricians will have had the distressing experience of caring for a severely ill, very dependent patient who has been inappropriately admitted from a care home to end their days on the acute admissions unit rather than in their own bed in their care home. The End of Life care strategy provides an additional stimulus to the work which has begun in some areas to enhance anticipatory care planning for care home residents, as well as others, so that patients and their relatives can consider end of life care before an emergency situation arises. They can therefore identify where they would like to be cared for at the end of their life and GPs, community nurses, and care home staff can plan in a timely way to avoid inappropriate emergency

admissions. In some cases support from community geriatricians will be needed to assist in this work and stimulate its development. The strategy flags up the need for improved support from specialist palliative care where specialist palliative care needs are identified. Often (perhaps more commonly) frail older people will benefit from the support of a geriatrician working with primary care if the patient's needs are complex (for example where there are issues around medication use, swallowing and feeding issues and indeed, the recognition of the dying phase).

Some geriatricians have expressed concerns that patients will need substantial support to make informed decisions for themselves. Others have rightly expressed concerns that patients who have potentially reversible conditions may mistakenly be diagnosed as coming to the end of their life if they are denied comprehensive assessment by a specialist geriatric team.

Geriatricians will welcome the improvement in quality of care that the End of Life care strategy demands for all people who are dying. Within the hospital environment we will need to continue to make careful assessments of the potential for improvement in our patients and to recognise when the focus needs to move from curative measures to comfort. We need to listen carefully to other members of the multidisciplinary teams and to what patients and their families are telling us about their wishes. The responsibility for clear communication will be even more important, both with patients and their carers, and also with colleagues, in primary, intermediate and social care. Within a community setting we need to ensure that PCTs and practice based commissioners are aware that this change in location of work will enhance the need for community geriatricians to ensure that by avoiding hospital admission, patients are not being denied access to specialist assessment or care when this has the potential to benefit that patient.

A change in the responsiveness of many community services will be needed if the promise of the end of life care strategy is to be delivered. Such improved services would not only benefit those patients at the very end of their life but also help many frail older people to fulfil the aspiration of the "Gold Standards for Care Homes" initiative- to help older people to "live well until they die"

E Burns
Consultant Geriatrician

Trainees



column

Knowledge Based Assessment (now known as Speciality Certificate Exam)

The first sitting of the exam will take place in this month. Despite the best efforts of Dr Corrado, and the presentation of a petition signed by trainees to the Federation of Royal Colleges, no progress has been made on either securing free re-sits or combining the exam fee with college membership to make it tax deductible. It will be interesting to see how many candidates take the exam this year.

Dual Accreditation in Geriatrics and General Internal Medicine (G(IM))

Late last year we became aware of a discrepancy in that those people starting as ST3s in August 2007 & 2008 will, on completion of their training, receive a CCT (Certificate of Completion of Training) in Geriatric Medicine, and a Level 2 Accreditation in Acute Medicine. This is in contrast to SpRs on the old training scheme, and STs starting their training from August 2009, who will be dual accredited in both Geriatrics and G(IM). This applies to all medical speciality trainees between these times.

This has been of great concern to many, as this is the cohort who were caught up in the chaos of MMC, are the first group for whom the SCE is

compulsory now, they will be disadvantaged when applying for consultant appointments if competing against those who started their specialist training at an earlier or later date. The initial solution proposed was for the affected group to apply via the article 14 route to enrol on the Specialist Register for G(IM) but we felt this was unacceptable because it is not held in equal standing as a full CCT.

We have had substantial support from consultant colleagues and the various committees within the BGS, with many letters being written to PMETB and the JRCPTB. The topic has also been raised on our behalf at College meetings. I have been interviewed by the 'Newshound' section of BMJ careers, and an article was published.

As I write, there are rumours that a joint statement is being prepared by PMETB and JRCPTB to outline the process by which this group can obtain two CCTs without incurring extra cost. I will update via the email cascade and the BGS website as more information becomes available.

Zoe Wyrko
Chair

Trainees Committee

UK Clinical Research Network – Age and Ageing Specialty Group chair



Professor Marion McMurdo from the University of Dundee has been appointed to chair the Age and Ageing specialty group of the UK Clinical Research Network (UK CRN).

This newly formed specialty group will bring together researchers from throughout the United Kingdom to improve the delivery of UK CRN portfolio of research. It is the first clinical ageing

network with full UK coverage and offers collaborative research organisation and working in a way which has been lacking to date.

The Age and Ageing group's first task will be to obtain an overview of ageing research in the UK via the CRN portfolio and then to work with researchers to reduce barriers to successful trial recruitment. The group can use evidence of research activity to justify the allocation of additional resource to ageing research via NHS support costs. Staff involved in trials featured on the portfolio have free access to national training and education programmes run via the UK CRN.

In the first instance, Clinical Leads from the Comprehensive Local Research Networks in England, together with research leaders from Scotland and Wales will form the core specialty group. The intention is to expand membership to include researchers from non-medical disciplines as well as lay representation.

A NEW exercise video with a difference!

Patients at Addenbrooke's Hospital, Cambridge are the first in the country to have exercise classes broadcast straight to their bedside.

A 45-minute video exercise programme has been developed to help patients maintain muscle strength, avoid deep vein thrombosis and other complications associated with being immobile.



Duncan Forsyth, consultant geriatrician at Addenbrooke's came up with the innovation while on a long-haul flight with his family. Whilst watching the in-flight video demonstrating exercises for the neck, shoulders and legs, it occurred to

Duncan that providing a simple exercise routine direct to the patient bedside, that could be viewed free of charge, might possibly help reduce muscle deconditioning, venous thromboembolic disease, chest infections, and perhaps lead to a quicker recovery by improving the patient's general sense of well-being. There might also be additional benefits in helping maintain muscle strength and in reducing in-hospital falls. Duncan enlisted the help of **Caroline Stoneham**, a senior physiotherapist at Addenbrooke's, to develop a set of bed and chair based exercises that would be reasonable to recommend to any adult in-patient. The exercises are designed so that they can be carried out by anyone, although staff do ensure that patients are working within their means and also advise if any exercises are inappropriate, e.g. shoulder exercises after shoulder joint reconstructive surgery! The video includes routines to

help breathing, and exercises for legs, arms, neck, feet, and hands.

Before making the video, Caroline and Duncan undertook a pilot to determine the acceptability of the concept and the actual exercises across a range of medical and surgical wards in Addenbrooke's, and included old and young adults. They were pleased with the enthusiasm with which patients greeted the project. The video was made in-house by Addenbrooke's Medical Photography Department and will be aired on a loop throughout each day, allowing patients to exercise at their leisure. Each set of exercises has a voice-over introduction, whilst the exercise is demonstrated on the video, to explain the exercise and how many times to do them. Patients are also offered a printed handout of the exercises by ward staff.

The project, funded by Addenbrooke's Charitable Trust, was officially launched on Wednesday 19 November 2008. Duncan and Caroline hope that other hospitals might consider adopting their exercise programme. Anyone wishing further information about the video exercise programme should contact Duncan Forsyth at duncan.forsyth@addenbrookes.nhs.uk

As a postscript, we should report that while at first, Duncan declared that he would NOT be releasing any pictures of himself wearing lycra, he has now relented and will be available, on request for private viewings, wearing lycra. He assures readers that full resuscitation facilities for those of delicate sensibilities will be on standby.

Fallers' clinics - You say tomatoes, I say...

As part of the 9th wave in October 2003, the subject of "Fallers' Clinics" was referred to NICE for a "multiple technology appraisal".

A draft scope was issued for consultation following the NICE's normal process in April 2004. The responses to the consultation showed there was no accepted definition of a "faller's clinic". Following discussion with the Department of Health, the appraisal was suspended. In addition, a piece of research was commissioned via the NHS Service Delivery and Organisation R&D programme, to undertake a detailed scoping exercise for fallers' clinics.

The research was conducted by the University of Warwick and is now published (www.sdo.nihr.ac.uk/rsummevaluate.html). The

research shows that fallers' clinics vary greatly in their organisation, the skills mix of their staff, the procedures used, and how clients are managed. It concludes that the ability to assess this will be constrained by the variability in their organisation and limited outcome data. There is limited information available and therefore the effectiveness of various models cannot be confidently assessed and economic modelling is not recommended.

NICE have published a clinical guideline on 'The assessment and prevention of falls in older people' (CG21).

In light of the published research and the existing NICE guidance, the Department of Health have recently advised NICE that Ministers have removed faller's clinics from the technology appraisal work programme.

BGS Falls and Bone Health Section

from strength to strength

The Falls and Bone Health section was founded in 2001. A handful of interested practitioners and researchers were there, myself included.

Prof Marion McMurdo was elected as the first chair that day and served for 3 years before Finbarr Martin took over – handing the role over to Opinder Sahota and myself (as joint chairs) in 2008. We are now the biggest section of the society with close to 300 members and our annual conference on falls and postural instability attracts very multidisciplinary audiences of 500 or so (close to the attendance for the main BGS conferences) and a number of high quality scientific submissions and state of the art lectures. At the outset we offered life membership of the Section for £20, and at the time of writing this has yet to change. During the lifetime of the section, the highest number of submissions to Age and Ageing have been in the falls and bone health category and many of our members have been active in the research presented, or in peer review and commentary.

During its existence, the section or its members have also contributed to major national audits of falls and bone health, (e.g RCP audits, hip fracture database and Scottish hip fracture audit) evidence-based guidelines, (e.g NICE consultations, Orthopaedic “blue book” on hip fracture management, AGS/BGS guidelines) government consultations, and alliances with other societies such as the American Geriatrics Society, Association of Orthopaedic Surgeons or Age Anaesthesia Association, Help the Aged and National Osteoporosis Society. We have also been behind the BGS good practice guides on falls and osteoporosis, as well as campaigns like the (so far unsuccessful) initiative to have falls and bone health included in the Quality and Outcomes Framework

for the GP contract, although some components have been included in the DES (Direct Enhanced Services) framework for PCTs. In addition to our main annual conference we have also put on a number of specialist sessions at the main BGS conference and have contributed to numerous other educational events such as the recent RSM/Swedish Society of Medicine Berzelius Symposium on falls.

Perhaps most importantly, we have provided a forum for the sharing of ideas, information and good practice examples and a resource to answer the questions and concerns of our members and we have provided a clear example to the wider BGS in terms of our interdisciplinarity. For instance, 60% of the delegates and many of our speakers and scientific contributors at our annual conference are non-doctors – reflecting the range of professionals who deliver falls and bone health services. These events are considerably cheaper than those organised by rival “for-profit” companies and the anonymous feedback is uniformly excellent.



We plan to continue this range of activities. For the future, we want to ensure our current membership list is up-to-date, we want to recruit new members with relevant clinical backgrounds and we intend to establish a website and regular e-newsletter as well as an online forum and message board as a resource for members. We also hope to link

these developments to the continuing existence of PROFANE (Prevention of Falls Network Europe).

If any readers are interested in joining, please contact the membership secretary, Dr Jane Youde at Derby Foundation Hospital
(Jane.Youde@derbyhospitals.nhs.uk)

David Oliver
Opinder Sahota
(Joint Section Chairs)

Ageing and Academic Geriatric Medicine



quo vadis? -

In 2002, Professor Stout described the challenges facing academic geriatric medicine in the UK.

He described how the funding processes for research, the broad nature of the topic, the relative youth of the specialty, and the requirement for academic geriatricians also to be clinicians, all conspired to render academic geriatric medicine a small and vulnerable specialty. He made suggestions for actions the British Geriatrics Society could take in terms of communication and lobbying, developing a research strategy, improving education in the topic, supporting academics in job planning, and the formation of strategic alliances with organisations and bodies with similar goals.

Below, we have published the views of several

academics on the state and the future of academic geriatric medicine. The writers approach the subject from different perspectives, reflecting to some extent, their personal *weltanschauung!* We have the military commanders - "the system is broken, let's fix it" (John Gladman and Graham Mulley); the resolute optimist - "the system is under strain, but the solution is already underway" (Tash Masud); the pragmatists at the coal face (Roger Jay, David Oliver) and, showing a touch of the comic genius, James Frith; the young Turk and educationalist (Adam Gordon), and the "blue sky thinker" who would have academic geriatrics triumph by the back door (Simon Conroy).

What do you think? Having scanned the contributions below, we would invite readers to go to the BGS website and log on to our online poll. The views of "jobbing geriatricians" are particularly welcome.

- Is academic geriatric medicine sufficiently strong?*
- Is there enough geriatrics in undergraduate and postgraduate curricula?*
- Is there a good enough evidence base for what we currently do?*
- Does the quality/volume of research in geriatric medicine match that in the organ specialities?*
- Is high quality geriatric research not sufficiently recognised/rewarded or funded?*
- Is the balance between basic science and "research for patient benefit" right?*
- How well are we doing at translating the evidence for practice into real improvements in patient care? (See for instance the RCP continence or falls and bone health audit) ?*
- Do current government policies and research frameworks/medical training pathways incentivise/enable or deter/obstruct potential researchers in geriatric medicine?*
- Should chairs in geriatric medicine be trained and accredited in the speciality or is ability to generate research income more important?*

Online poll on www.bgs.org.uk

Academic Geriatric Medicine - it's broken. Let's fix it!

Facing the challenge of ageing

Since Professor Stout's report, the research community has shown increasing recognition of the fact that ageing is one of the greatest challenges facing the world. Here, we are talking not only about geriatric medicine, but everything to do with ageing. It is not a cliché to say that demographic change and the effects of conditions such as Alzheimer's disease will change and potentially threaten society as we know it. Ageing research has been recognised as an overlooked orphan: it did not belong to any one research council or charity, and so received no clear or directed support. On the contrary, it was recognised that the challenges faced by ageing would potentially require biomedical, social, and technological responses. Using this thinking, initiatives such as SPARC and joint funding collaborations between research councils have developed. The research funding bodies have therefore become more evidently interested in ageing research. It is to be hoped that increased and co-ordinated funding for ageing research will eventually create a change in the way universities organise themselves. But ultimately this will also require the university research assessment processes to value such work. In the Research Assessment Exercise in 2008, there was no unit of assessment for ageing. A simple poll of academic geriatricians in the BGS illustrated this: BGS researchers in some Universities were assessed as part of groups in social policy, or as allied health professions, or as psychiatry or as hospital based subjects or as community based subjects.

Professor Stout's report particularly mentioned the major change in the way doctors are trained, which has led to a welcome greater focus on the quality of clinical training, but which has also potentially reduced attention upon academic training. These concerns were not unique to geriatric medicine. Since his report, a new process for the training of clinical academics has been established. This offers the chance for academic training to be better and more structured than ever before.

The two positive changes (new funding streams for ageing research, new academic medical training pathways) offer opportunities for academic geriatric medicine. To grasp these opportunities however, two major points need to be understood:

1. An increased interest in ageing research is not the same as an increased interest in academic geriatric medicine. Ageing research includes research into the meaning of ageing, demography, pensions, social policy (sociogerontology). Ageing research includes research into the biological processes underlying ageing organisms, and is interested in preventing the consequences of ageing (biogerontology). Recently the field of gerotechnology has emerged, recognising the need to put new technologies to use to overcome issues that arise as a consequence of ageing. Of course, ageing research also includes dealing with the clinical consequences of ageing (geriatric

medicine). The increased funding in ageing research does not automatically mean increased support for academic geriatric medicine.

2. Academic training pathways are generic and not specifically for geriatric medicine. Bigger and more established specialities will be better placed to exploit these opportunities. If these pathways become the dominant way to develop academic medicine, and if geriatric medicine does not have a foot on the ladder, it is possible that academic geriatric medicine could fare even worse than before.

It follows from these two points that the British Geriatrics Society should recognise that it is likely that the best strategy to develop and sustain academic geriatric medicine will be through collaboration with other researchers in the wider field of ageing, rather than as a stand-alone discipline. Not only will this give better access for academic geriatricians to research funding, but it will also enable there to be sufficient critical research mass to encourage new academic training posts to be in geriatric medicine.

As a first step towards this, the British Geriatrics Society will work with its sister organisations the British Society for Gerontology and British Society for Research into Ageing, through the British Council of Ageing. Together, these bodies could help to facilitate regional ageing research networks, populate the BGS website "Research Centres of Good Practice" to reflect all ageing research in the UK, not only that done by geriatricians, and continue to explore opportunities for collaboration (such as seeking educational and research contributions from BSG and BSRA members at BGS meetings).

Other steps include

- ◆ exploration of further opportunities along the lines of the existing BGS / Research into Ageing Research Fellowship for trainees in geriatric medicine
- ◆ increased inclusion of socio-gerontology, bio-gerontology and gerontechnology in the BGS's educational programme
- ◆ encouraging trainees in geriatric medicine to consider ageing research and not just clinical geriatric medicine research during the two academic half days per week (that together make up the equivalent of a year of full time study over the training period)
- ◆ co-hosting the IAGG meeting (or putting forward a bid to do so) for 2015 in London, subject to the financial viability of doing so.

John Gladman
on demitting from the Chair
of the BGS Academic and Research Committee

Academic Geriatric Medicine - from the desk of Professor and BGS President

I applaud John Gladman's assessment of the current situation and his proposals for improving Ageing research by linking with others and facilitating the expansion of a research culture in geriatrics and gerontology.

The British Council of Ageing (BCA) started in 1975. Prompted by the House of Lords Science and Technology Committee into Scientific Aspects of Ageing, it was re-vitalised in 2006. The idea was that this body would act as a platform to lobby for greater support for ageing research and be a contact point for government policy makers. The three constituent societies (British Geriatrics Society, British Society of Gerontology and British Society for Research on Ageing) would provide informed opinions on social, biological, technological and medical aspects of ageing and stimulate much needed research. The proposals for extending the influence of this umbrella organisation make a lot of sense

The opportunities for meaningful research are enormous - for example, prevention and health promotion (a theme that is politically sweet following Lord Darzi's reports); basic science (particularly in arthritis, vascular disease, degenerative neurological conditions and cancer); ways of postponing and mitigating disability and handicap; designing and de-stigmatising enabling equipment and environmental aids; improving transport and buildings to make them more suitable for older people

It is now time to build on Bob Stout's excellent assessment of the challenges to UK academic geriatrics. Perhaps I could offer some comments and proposals:-

◆ We should encourage our colleagues in nursing, therapy, pharmacy as well as orthotists, social workers, clinical psychologists and others to be part of the research

enterprise. It is encouraging that so many are already doing Master's degrees and Doctorates and some are heads of academic units

◆ Links could be formed with other academic university departments - engineering, philosophy, geography, transport studies, economics for example

◆ Closer collaboration between UK academic departments is vital. We are updating the database of all the Chairs in geriatrics and related specialties so that departments might link with others working in similar fields and plan large - scale studies

◆ With so many front-line clinicians in our specialty, there are great opportunities to collect clinical information nationwide (and ultimately do RCT's to match the size and quality of those done in cardiology and other specialties)

◆ Clinicians who may not have the time, training or interest in doing research themselves could feed into fora for the development of research ideas. This would ensure that academics are constantly reminded of clinical priorities and can be made aware of potentially important clinical observations (the central importance of which has been de-emphasised in recent years).

◆ Key research papers in all aspects of gerontology and geriatrics should be publicised - not least to the lay press. This could be an important part of the BGS plan to improve public relations, with particular emphasis on informing the media of important "ageing" stories.

◆ How about brief presentations at our scientific meetings on the most important research publications from the past year?

◆ We should consider campaigning for a major grant-giving body, which would heighten awareness, raise funds and promote high quality age-related research

These are exciting times and the opportunities for improving the lives of old people and those who care for them are immense. Let's do it!

Graham Mulley

Academic Geriatric Medicine - Chairs are therapeutic tools ...but how to convince trainees of this

When Prof Robert Stout first reported on the crisis in academic geriatric medicine in 2002, he identified deficiencies in postgraduate training for academics as a major contributor. A much heralded solution to this problem, academic clinical fellowships (ACFs), are the future of academic training under Modernising Medical Careers and are designed to recruit medical trainees as dedicated academics much earlier in their careers, as they complete their Foundation Programme.

The rationale is that it takes a long time to produce

a clinical academic, so it's best to start early and to provide highly structured, specific training. Yet we know the seed of "geriatricianly" enthusiasm is often slow to germinate – previous work has suggested that the majority of consultant geriatricians in practice today decided on the speciality late in their career, often having worked in other specialties first. The worry is, therefore, that ACFs will exclude exactly the sort of "late bloomer" who traditionally has migrated to a career in academic geriatric medicine after time spent at the clinical coalface. In fact, from the

There...are anecdotes of just how disengaged our medical colleagues are (“It would be better to gas them all”, one colleague is alleged to have said).

ACFs in ageing so far advertised, it is proving difficult to recruit candidates from a geriatrics background, with the posts going unfilled and therefore being lost (personal communication, Julia Newton). It has now been made possible to recruit non-geriatricians to ACFs in ageing. Such training will, undoubtedly, produce high quality researchers in ageing, but possibly not the academic geriatricians of the future.

Do we need academic geriatricians?

Is it possible that academics from other disciplines will provide us with the evidence upon which to base our practice – letting us get on with the critical job of providing care and services? I think not. I spend my days at the moment, gathering data from Care Home residents about their health care needs. As part of my preamble, I sometimes suggest that doctors in general (and researchers in particular) have so far failed to engage adequately with care home residents. Usually there is emphatic agreement, sometimes supported by anecdotes of just how disengaged some of our medical colleagues are (“It would be better to gas them all!” one colleague is alleged to have said). Occasionally there is just resignation. Nobody ever disagrees.

To research these types of issues properly, a geriatrician perspective is required. So, how do we produce academic geriatricians? If we are to encourage geriatrician ACFs then we’ll have to plant the slow-germinating seed of geriatrician enthusiasm at an earlier stage. Undergraduates are increasingly required to participate in Bachelors’ or Masters’ degree research during their undergraduate programme. Existing research programmes in Geriatric Medicine need to engage with these students and show them, early in their careers, that research in our specialty is a truly academic, highly rewarding and worthwhile pursuit, with the possibility of having an impact on some of the big issues affecting the delivery of health care in the 21st century. We need to think, during the design stage of research, how undergraduate projects can be incorporated. We also need to look at ways of funding prizes and travel awards in geriatric medicine for undergraduates – something for them to put on their CV, whilst at the same time planting the seed that geriatric medicine is a

desirable career path for high-achievers.

Later, during foundation training, we have to sell our specialty, not just as the “last bastion of true general medicine” and “common sense solutions for common problems” (quotes from recent StR recruitment interviews), but also as one in which huge academic challenges and rewards exist by grappling with the big issues facing medicine today.

Holding open doors for late entrants

We must also ensure that routes for late entrants into academic geriatric medicine are maintained. The Dhole, Warren and Dunhill fellowships are important in this, as are the numerous fellowships available from MRC and Wellcome. We need to lobby as a speciality to protect late entry into academic training and ensure that any attempt to close down such opportunities is fiercely opposed. Every trainee should have an academic mentor who understands the opportunities available. Whilst not everyone will want to do a PhD, we need to ensure that academic time, which is obligatory for all trainees, is spent fruitfully. A recent survey of higher medical trainees by the BGS Trainees’ Committee revealed taught Masters’ to be the most popular postgraduate degree amongst those surveyed (poster to be presented at BGS Spring Scientific Meeting, Bournemouth). Masters degrees in Gerontology and Education were particularly popular. The body of literature and academic thought generated by these doctors is a potential asset to our specialty and we need to ensure that they are supported and directed in their studies. One current failing, across all specialties, is a lack of funding for colleagues undertaking these taught postgraduate degrees. We need, as a specialty, to consider how to remedy this for geriatricians.

There is also a wider battle for the hearts and minds of trainees to consider. In many areas, geriatricians do not see themselves as belonging to an academic specialty, in contrast with colleagues in respiratory medicine or cardiology, for example. We have to understand that this influences our trainees’ aspirations. We need to encourage Specialty Trainees to aim above “the occasional poster at the BGS” (as important as this is) and groom them for higher academic success from early in their Higher Medical Training. Five years as an StR is a short time and often, by the time that trainees are aware of the opportunities available, they find themselves under-prepared to apply for

them. We need to ensure that high profile academic geriatricians are regularly lauded as role-models through BGS publications (and more widely) and that their every success arrives to a fanfare of publicity.

Whilst Googling “academic geriatric medicine”, I stumbled across the phrase “a chair should be a therapeutic tool”. I got very excited, before realising that the article referred, of course, to chairs of the four-legged variety and their role in physiotherapy! However, *an academic chair, too, is a potent therapeutic tool.* Only a

geriatrician could engage with the issues of my care home residents, for example. The prevailing paucity of academic chairs in geriatric medicine, has left our specialty somewhat disarmed against the many challenges we face in dealing with our patients. Considering carefully how to educate and support the academic geriatricians of the future is one of the most important steps to dealing with the current crisis.

Adam Gordon

Clinical Lecturer in Medicine of Older People
University of Nottingham

The view from the “coalface”

Our registrars in the north of England just love weaving a bit of variety into their training programmes. Not content with working in a diverse region that stretches from coast to coast and from the Scottish border to south of the Tees, and which includes urban teaching hospitals and rural outreach, they have developed a taste for anything to get out of the day job! And our consultants are delighted to see them go – it demonstrates their magnanimity as trainers as well as their ability to cope without junior support. Well, perhaps – until this year.

The region has always been fortunate in having both academics and NHS consultants with excellent track records of supervising out of programme research leading to an MD or PhD. Areas of study include falls and syncope, movement disorders, osteoporosis and stroke. The regional training committee has sometimes bent the rules to ensure that prestigious grants and fellowships are not lost and often granted extended time to complete research running behind schedule.

Several hospitals have developed ‘teaching and research fellow’ posts. These are Trust posts, usually for a year, in which the doctor undertakes a manageable research project, oversees medical student teaching in the department and takes part in the on-call rota; trainees usually obtain a good quality presentation with published abstract and a qualification in medical education.

The northern region was also at the forefront of obtaining Academic Clinical Fellow and Academic Clinical Lecturer posts following the Walport report – we have so far had one of each at registrar grade, with others undertaking research on a theme of ‘ageing medicine’ at Core Training level. Our ACF has obtained a research fellowship and is now undertaking a PhD, while the ACL has gone on to a senior academic post.

So far, so good, but for the past two years, other ‘out of programme’ activities have burgeoned. Two trainees are currently undertaking a year’s stroke training. One is taking the Liverpool Diploma in Tropical Medicine and Hygiene before working for *Médecins Sans Frontières*. Two, encouraged to do so for fear of a shortage of ST3 posts for

run through, arranged their own out of programme year following completion of core training. We have also forged a valuable link with a centre in Australia, which has taken one trainee for a year and is about to host a second. Finally, our trainees have a reproductive track record second to none – I won’t bore readers with statistics on maternity leave and flexible training.

Such variety comes at a price which, in 2008, led us to reconsider our position regarding out of programme activity and protected academic time. Despite overfilling our 42 places with 3 additional NTN, we have been left with 11 unfilled registrar posts in the region. Only two LATs were in post at the start of August, and both have subsequently obtained substantive posts elsewhere.

This inevitably reduces goodwill amongst trainers, some of whom have already been generous in releasing trainees to start or extend research at inconvenient times. It puts an extra strain on the remaining registrars in geriatrics, as well as those in other specialties taking part in on-call rotas, and reduces subspecialty training opportunities due to pressure of service work.

As a result of the current pressures, our regional training committee (which includes four trainee representatives) reluctantly decided to disallow further out of programme activities that do not count towards training. We have also reduced the weekly protected academic time from 2 sessions to the minimum 4 hours stipulated in the new curriculum. Trainees can apply for an additional session if they can justify it and produce tangible results. We remain fully supportive of those undertaking research leading to a doctorate and of other training that is recognised as counting towards their CCT.

The forecast for next year looks better, as a number of wanderers return to the fold. We want to keep a degree of flexibility that allows our trainees to develop into well-rounded individuals with the enthusiasm and skills that are developed through academic work, experience overseas and other forms of out of programme activity. We do not want to be a mere production line for adequately trained NHS doctors.

Roger Jay

Newcastle upon Tyne

Academic Geriatric Medicine and Visiting Professorships - a new type of partnership

Whilst there has been a justifiable concern over the fate of many academic Geriatric Medicine units, particularly in relation to the traditional type of Medical School chairs, one welcome development over the past few years has been a new type of partnership between research and academia-orientated clinicians and several universities.

Different models have developed including "Special Professorships" (e.g. Professor Rowan

...particularly suitable for NHS consultants with a proven track record of research publications

Harwood, University of Nottingham), Honorary Professorships (e.g. Professor Tim Hendra, Sheffield Hallam University), and Visiting Professorships (e.g.

Professor Stephen Allen, University of Bournemouth; Professor Paul Baker, University of Salford, Prof Tash Masud, University of Derby). This type of development is particularly suitable for NHS consultants with a proven track record of research, publications and other academic activities. One common theme with these Professorships is a robust appointments process used by the universities, including external peer reviewers.

Professor Allen's Visiting Professorship in Clinical Gerontology at the Centre for Postgraduate Medical Research and Education, University of Bournemouth, was awarded to acknowledge his contribution to research, teaching and the

Masters programme. This has led to an encouraging result in the recent RAE, and there has been very positive and flexible support from the University for his research programme. Steve supervises two MSc and three PhD students and the university compensates the Trust for 1 PA . Professor Hendra's Honorary Professorship at Sheffield Hallam University, in contrast, is not associated with any remuneration or time allocation in the job plan. It has allowed him currently, to supervise two PhD students and the University has

a developing profile in relation to postgraduate medical education and in the training of AHPs and nursing staff. Professor Baker's Visiting Professorship at the Faculty of Healthcare Studies, Salford University, is also not remunerated, and is in recognition of the Master's Programme in Geriatric Medicine which he founded and runs with colleagues.

In my own case, several years of collaboration in research and in teaching AHPs in the fields of osteoporosis and falls with the University of Derby led to my appointment as Visiting Professor in Musculoskeletal Gerontology. I have had the opportunity to write and develop modules for the diploma courses for AHPs and I also supervise PhD, MSc and Diploma students in their research projects. There is no remuneration and the university does not compensate the Trust for my time; however both the University and the Trust benefit from the association, particularly in terms of developing the research profile of both institutions, and in gaining substantial research grants.

I believe that such associations can not only open doors for academically minded geriatricians, but

Both the university and the Trust benefit from the association, particularly in terms of developing the research profile of both institutions

can play an important role in preserving and developing academic geriatric medicine in addition to the more traditional academic chairs at medical schools, and the potential to increase collaboration is obvious. Time commitment is needed to make the roles successful and support is needed from the Clinical Directors at the Hospital

Trusts, but the rewards are great. Like my colleagues in such positions, I have certainly found the role extremely fulfilling.

Tash Masud

Consultant Geriatrician, Nottingham University Hospitals NHS Trust
Visiting Professor of Musculoskeletal Gerontology, University of Derby

I am the only academic in the village - changing the view of the “poor man’s choice”

One in four British citizens believe that Churchill never existed'. This statistic is worrying enough but 'one in five geriatricians believe that no one wants to be a geriatrician' and 'one in two geriatricians believe that academic geriatricians want to work in another specialty'².

Unfortunately I have discovered the second statistic to be untrue. Hoping to be the only candidate to apply for an ST3 post in geriatrics, my heart sank when I heard the actual number of applicants. In Newcastle, geriatrics is one of the most popular specialties; following the introduction of MMC, the number of applicants applying for geriatrics rivalled and superseded the numbers of applicants applying for those glamorous and heroic specialties (cardiology, respiratory, neurology).

Given that the 'seed of geriatricianly enthusiasm is often slow to germinate'³ something up here in the far north must be fertilising the little seedlings. I need to get my hands on some weed killer to improve my chances at interview. Or, maybe I don't need weed killer. Perhaps the air of despondency and self-pity which occasionally infects those 'accidental geriatricians' will be enough to dampen the spirits of the hardiest of seedling, thus improving my chances.

If I am the only person in the UK who wants to be an academic geriatrician, it will have its advantages; it will make me feel special, I'll have less competition for grants/funding and I'll be invited to speak at exotic conferences. There'll be disadvantages too. I may feel misunderstood, be considered cavalier or be invited to speak at a BGS conference.

One of the key figures that inspired me into the so-called lonely world of academic geriatrics once tried out the academic world, completing a PhD. However he no longer has an interest in academia, but this is inconsequential; we do not necessarily need academics to inspire academia, we just need inspirational figures. Let's encourage the BGS to hold a competition for trainees to nominate inspirational figures and invite the nominees to the BGS conference to share their inspirational magic; not just with the trainees but also with those 'rooted' consultants who have become despondent.

In the same vein, it is also not necessary to have academics specifically in geriatrics to inspire academia. For six months or for one year of their training, trainees could be appointed an academic mentor (from any discipline). This would not be to impose the trainee with

tedious research tasks just to get their name on a paper, but to foster an environment in which trainees could develop an interest in research without committing to it.

'General medicine has ceased to exist, therefore chose geriatrics. It wouldn't be your first choice, but go for the next best thing.'⁴ We should stop encouraging young doctors to choose geriatrics for this reason. There are so many reasons to opt for geriatrics as a career, let's stop selling it as leftovers. Evidence base is often lacking for older people's care; we therefore have an exciting opportunity to build a unique, evidence based specialty upon its already robust, holistic and multidimensional foundations. Choose geriatrics not because it is generalist leftovers but because it is specifically an exciting, academically-developing field, within which are stimulating sub-specialities. Maybe then more academics will choose and stay in geriatrics.

If these reasons/suggestions are not enough to encourage more academic geriatricians, then we could go for a different approach. Sex sells⁵. I volunteer to be the BGS's first salaried actor. I could inspire thousands by playing myself in *Holby City*. Being a junior academic gives me the required, exclusive skills; I once attended a public speaking course, taught by the Royal Shakespeare Company and held by the University. I am yet to convince my supervisor of its significance and this is my chance.

Leaving my inspirational sex-appeal to one side, one in five geriatricians will be surprised that more and more junior doctors are choosing geriatrics as a specialty. This is fantastic. All geriatricians in the future will be motivated, inspirational and accept change. The BGS conference will not have to be mandatory for trainees, because it will be oversubscribed. The 'Inspirational Figure Award' will be envied by other specialties and I will no longer be the only person in the UK who wants to be an academic geriatrician.

James Frith
Clinical Research Associate
Newcastle University



I am the only
academic in the
village ...

1 UKTV Gold. 2008.

2 Hearsay. 2009.

3 Gordon A. *Chairs are therapeutic tools...but we need to convince trainees of this.* BGS Newsletter 2009.

4 *Uninspired geriatricians.* 1965-2009.

5 Channel 4.

Academic geriatrics is dead - long live ageing research

There is concern amongst some geriatricians that conventional academic geriatric posts are withering on the vine¹ and that opportunities for funding geriatric research, as opposed to ageing research, are inadequate (see John Gladman's contribution above).

This view is fuelled by concerns that many chairs in geriatric medicine have been 'lost' or remain unfilled. Together with concerns about

undergraduate geriatric education^{2,4}, one might be inclined to some despondency about the future of any would be academic geriatricians.

Geriatrics however, is very much alive and kicking, and the UK should be rightly proud of the fact that geriatric medicine is the largest medical speciality. There are, in fact, around 50 geriatricians holding professorial chairs throughout England and Wales, and many geriatricians hold important roles in undergraduate education throughout the country, albeit not necessarily university based posts. Now, more than ever before, geriatrics is the mainstream speciality and this should mean that the UK is well positioned to engage with the forthcoming silver tsunami⁵. So, why then all the pessimism? Part of this is perhaps related to the inherent humility of the geriatrician, but perhaps also a certain unwillingness to stray too far from the beaten track, as laid down by Marjory Warren some 50 years ago.

Geriatricians are no longer seen as second class physicians, but are becoming increasingly valued for their generalist approach and ability to manage complex patients, whether in acute care settings, rehabilitation settings, in end of life care and other scenarios both in primary and secondary care. Few other specialities can bring such breadth of knowledge and skills to their patients. How many specialties can quote multiple RCTs and a series of meta-analyses^{6,7} in support of their raison d'être (comprehensive geriatric assessment)? Teaching of the geriatric giants is now commonplace on most medical school curricula. Several geriatricians have leading roles in the Royal College of Physicians and the Department of Health as well as other august bodies. In terms of research, ageing is now one of the top three priority areas for the Medical Research Council, and the rationalisation of NHS funding should lead to a greater focus of research on priority areas for the NHS – of which ageing and frailty is surely one.

Humble geriatricians

So perhaps it is a glass half-full/half-empty scenario? Geriatricians remain, on the whole, inherently humble and down to earth, and are not by nature egoistical and glory seeking, which are some of the hallmarks of the more vociferous 'successful' academics. So whilst we do not shout about the speciality from the rooftops, academic

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I suspect that the role of the forefathers of geriatric medicine has been fulfilled. Geriatrics is now mainstream

and clinical agendas are being subtly influenced for the good of frail older people.

inclination for collaborative and interdisciplinary working.

So what then of the academic geriatricians of old?

Well, I suspect that the role of the forefathers of geriatric medicine has been fulfilled. Geriatrics is now mainstream. The academic geriatrician of today needs to find his or her niche elsewhere. And there are plenty of challenges – care home medicine⁸, community geriatrics⁹, acute care¹⁰, end of life care¹¹ and frailty¹² are just a few of the many areas ripe for exploitation by academic geriatricians. Geriatricians are well placed to lead or support such research, because of their broad and multi-dimensional knowledge, and their natural

So maybe the labels are different, and the landscape is changing, but the role for a researcher in areas relevant to geriatric medicine is great. Geriatricians just need to have confidence to embrace new ways of branding the speciality. This does not mean changing name – one of which we should be proud given the heritage, but being prepared to work with different groups in different ways. Stroke medicine is a good example of what can be achieved – massive service improvement driven by research.

Why does any of this matter to the ‘jobbing geriatrician’? After all, academic geriatricians are few and far between, and most people are just getting on with the job in hand. Well in my view, one of the key roles of the academic is to enhance the reputation of a department, whether through service development, teaching, research – or better still, all three. We need to make geriatrics appealing, such that it attracts junior doctors at an early stage, rather than later on in their training once they realise that medicine is about people and not procedures, as has traditionally been the case¹³. That is about role models, and the role of geriatricians to speak up for the speciality and all the challenges – and opportunities, that it brings. The academic geriatrician – all geriatricians - should be leading role models, expounding the virtues of a career in geriatric medicine, ensuring that the brightest and best trainees are attracted to a stimulating and vibrant speciality. Part of this is related to the academic esteem of a speciality, the impetus that research brings to clinical service delivery and this is why academic geriatrics should be supported.

Yes but...

While I agree with a good deal of what you have said:

a) The fact that we are the largest physicianly speciality and are a strong clinical presence in many hospitals, not only delivering a high proportion of inpatient care, but often occupying clinical/ medical/ educational director roles, and also being in the vanguard of full engagement with PCTs around alternative models of care is most welcome and a mark of our success as a discipline. However, this doesn't negate the fact that several medical schools have decided not to invest in academic departments of geriatric medicine

b) The BGS' own survey of teaching of geriatric medicine in undergraduate curriculae showed that it was extremely patchy and the BGS had to push hard to have more than a page or so about geriatrics in the Core Medical Training Curriculum. In turn, geriatrics may be mainstream in terms of its presence in general hospitals but we know (e.g. from audits of falls, delirium, incontinence, stroke, etc.) that even the most common geriatric syndromes still often get a very raw deal

c) We may very well be equipped as a speciality with the skills to provide an evidence base for our craft but if we compare the amount of research funding (or impact factor points) to be gained researching service delivery for patients with common conditions of old age against, for instance, cancer research/genetics/molecular biology there is still a gross mismatch.

d) Compared to other specialities, relatively few trained geriatricians have formal research training and the new career structures and tighter job plans in place will make it harder for "late starters" to get into research. We will be more reliant on a small cohort of researchers chosen at an earlier stage.

David Oliver

Simon Conroy
Senior Lecturer and
Geriatrician
Leicester Medical School

Geriatricians

not old (hat) and certainly not useless

In a recent JRSM editorial¹, a non-geriatrician specialist internist consultant physician from Colchester, wrote that “geriatric practice in hospital appears to follow two different models...”

In **Model A**: the geriatrician is a passive member of the specialist team and oversees the ongoing management of those patients whose conditions prevent a speedy return to the community. **Model B**: the geriatrician takes control of the patient’s management on arrival at the hospital.” before going on to suggest a role reappraisal whereby geriatricians are absorbed by “the four major acute specialties – cardiology, chest medicine, gastroenterology and endocrinology”.

I think the writer’s opinion serves as an excellent guide to the perception of geriatrics in certain quarters, and the challenges geriatricians face in service provision and advocacy for older people.

One of my most rewarding experiences to date was when I diagnosed polymyalgia rheumatica in a 90 year-old man who had been caring for his frail wife of over 60 years. Watching him, over a period of days, regain the strength and confidence to go back to independent living and resume his role as his wife’s carer, had a profound effect on me. I do not know how the health economics of this transformation add up, but two places in long term care were spared and something human, and incredibly affecting, happened in the process. It had not been a readily apparent diagnosis and had been



overlooked in previous weeks during the usual transfers around the modern hospital.

The development of geriatrics as a specialty predated the management considerations supposed erroneously by the JRSM author, to have created and helped burgeon the specialty. One of the underpinning principles of early geriatrics was seeing the infirm elderly as having different needs to the usual medical patient and attempting to address these needs. Older people deserve equality of choice and experience within healthcare but I do not believe that 48 hours on an admissions unit with 30 other acutely ill adults, after 3 hours 59 minutes and 59 seconds spent on an A&E trolley, constitutes either “choice” or an ideal of “equality”.

The dichotomisation of geriatric practice into “passive” and “active” leads me to want to add something about leadership and team dynamics, where many more subtle “faces” of the leader may be apparent under the surface. Moreover, the JRSM editorial ignores the roles of the geriatrician in providing outpatient services, day hospitals, liaison within a hospital, systems development, and community liaison (in the form of domiciliary visits or other, perhaps proactive, outreach services) are ignored.

The author’s supposition that patients would choose to have a passive geriatrician only managing

those for whom a speedy (convenient, uncomplicated health economics model) return to the community is problematic, ignores the fact that this particular “difficult” population is invariably ill, frail, comorbid and/or demented (and therefore unable, in many instances, to choose without some advocacy)³.

With regard to health economics in the care of older people, the author would do better to consider the difference between the situations he compares. It is not easy to quantify the benefits of geriatric care, unlike “hard” outcomes like myocardial infarction, door to needle time, or outpatient waiting times. A moot example would be the management of faecal or urinary incontinence – a common reason for families and carers failing to cope and often leading to admission to a care setting⁴. Managers and clinicians would do well to remember who the client is in the health equation.

As regards the question of GPs or geriatricians caring for elders, and my following statement is not intended to denigrate the care GPs provide, there is a difference between the two. The number of referrals to a geriatric service from primary care and the work done within an average department are only the tip of the iceberg in terms of need.

Some of the domains within the GP Quality and Outcomes framework (QOF) that are a driver to both payment and “quality” measurement, are potentially at odds with reasonable geriatric management. An example would be the blood pressure targets for the older and oldest old where a degree of common sense is required when looking at the measured blood pressure. While the Hypertension in the Very Elderly Trial (HYVET) data, recently published, strongly support antihypertensive therapy in the 80+ age group⁵, targets are less clear. Hence, adhering to QOF targets might cause an unacceptable burden of iatrogenic disease. The risk to benefit ratio in treating elderly hypertensives is not a straightforward proposition – one would not like to withhold a potentially beneficial treatment, but would equally not like to have a fractured neck of femur defining the “maximally tolerated treatment” to create an exception in terms of the QOF.

An example (of geriatric benefits) would be the management of faecal or urinary incontinence – a common reason for families and carers failing to cope and often leading to admission to a care setting⁴.

The early results from the TIME-CHF trial⁶ presented to the European Society of Cardiology Conference in Munich in 2008⁷ support this point of view as elderly patients treated relatively aggressively by a BNP-directed strategy were found to have similar death and hospitalisation rates to those treated in a standard, non-BNP-directed fashion, but had worse quality of life (presumably iatrogenic or drug-related?) than those on standard treatment.

Indeed, a recently published study of General Practice use of a comprehensive geriatric assessment tool⁸, showed that even amongst the GPs with long (>8 years) relationships with patients, 14% of patients had new problems identified by the use of a simple 32 item tool. It is also of interest to note the perceived relevance of new diagnoses to patient and/or doctor – with some perhaps unsurprising results. For example, problems with the teeth were more likely to be of perceived relevance to the patient than the GP, whereas for hypertension, the situation was the reverse. Constipation and incontinence were important problems for patients (and their geriatricians where they have one) but not so much for GPs. It is also of note that 45/220 (20.5%) of GPs originally enrolled responded to follow-up concerning the tool at 1 year.

It is a matter of pride within the geriatric departments where I have worked (but nothing to do with “the kudos of empire” which the JRSM author employs perjoratively against

geriatrics and geriatricians) that those people not choosing geriatrics or medicine as careers will take away something from their experience in terms of attitude, clinical acumen, team working and management of the complex, problems of older people. Considering the age of clients admitted under the average medical and surgical acute take, any experience of geriatrics after medical school (many of which fail to offer dedicated geriatrics training at undergraduate level), has to be a *sine qua non* of medical training in the 21st century.

I would add another option to the argument of who cares for the majority of medical inpatients – a legion of geriatrics-trained specialist physicians who

occasionally consult the “internists” for their views on the organ-specific problem troubling the complex elder. The internists could then be freed to run admissions units, while the geriatricians run outpatient and outreach services, develop strategies for inappropriate admission avoidance and facilitate advance care planning, inpatient care for geriatric problems as judged by needs, not age based criteria, and develop better policy for the multi-disciplinary management of complex, multi-faceted, problems such as delirium and falls. This argument sees the non-geriatrician specialist internist as a geriatrician-manqué rather than vice-versa.

This brings me to the technologies of the gastroenterologist (the endoscope) or the respiratory physician (the bronchoscope) being immediately obvious to anyone – perhaps because they are more easily “waved around”, as opposed to a tilt table which is a little more difficult to “wave around”. The technologies of the geriatrician are overlooked, such as, taking the time to think about the cause of a fall before (over?) expeditious discharge, or managing delirium

and dementia (or, at least, advocating on behalf of the demented person and their carers). This may have something to do with both the natural humility of geriatricians and the narrow prejudices of those looking on?

It seems an unassailable fact that dependent, fragile children are managed by paediatricians and their specialist teams. What is it about geriatrics or geriatricians which makes the specialty a target in some quarters? Is it the often-repeated “ageing

demographic timebomb”, so eloquently debunked at the recent conference in Birmingham; is it a reflection of the value placed on the elder; is geriatrics just “old (hat) and useless”?

If client views were canvassed on ideal place and type of care, I believe we would see Day Hospitals, domiciliary visits and specialist

geriatric services described in detail, possibly with the return of the cottage hospital with tertiary services, one way (of a few) in which I think Lord Darzi has it right. Maybe some of us have to re-invent (or, rather, market) ourselves as “frail-ologists”, as one non-geriatrician colleague recently referred to us, or to define more clearly for non-geriatricians the “geriatroscope” that one geriatrician colleague uses in order to reach his diagnoses.

We are only beginning to understand delirium, dementia, frailty and sarcopaenia. The new generation of geriatricians, and trainees, in this challenging specialty have the dynamism and drive that their ever-increasing client group demands.

In the depth of verbiage, a clear message can be lost; I am, as in reading the recent BMJ argument regarding Geriatrics as a specialty⁹, lost, at times, as to the position that the author is arguing. I would add that most arguments can be sustained with more or less elegance. A pattern of working for elders, not despite them, has been shown to work well, and I risk hubris, – obviously not everywhere¹⁰. Yet.

Ian Thompson
SpR Darent Valley Hospital
Dartford

The technologies of the geriatrician are overlooked, such as taking the time to think about the cause of a fall before (over?) expeditious discharge, or managing delirium and dementia (or, at least, advocating on behalf of the demented person and their carers).

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Letter from Europe

from the President of EUGMS

I have just reached the midpoint of my two year term as President of the European Geriatric Medicine Society (EUGMS).

The EUGMS is an umbrella organisation which brings together the national societies of all the European Union and EFTA (Iceland, Norway and Switzerland) countries and has observers from Israel, Turkey, aspirant nations to the EU and the IAGG, UEMS and EAMA. EUGMS is a veritable alphabet soup which aims to be inclusive but is strongly focused on the needs of speciality practice in geriatric medicine.

The Society works hard to influence the European Commission and its offshoots through its policy committee and during the last 12 months we have had some fruitful dialogue with the European Medicines Agency (EMA). We have launched a campaign to combat the poor representation of older people in clinical trials on the back of recent European legislation governing medicines in children. Our aim is to mirror the developments in paediatric medicine and create a geriatric medicine committee within EMA.

One of the main aims of EUGMS is to foster the development of the speciality of geriatric medicine across Europe. The specialty has developed in a very heterogeneous style, or not at all, in Europe. EUGMS promotes geriatric medicine, by bringing the benefits of the specialty to the attention of policy makers in Europe, helping local clinicians develop their services and offering high quality education events. The European Silver Paper on the future of geriatric medicine, created from a meeting in Wroclaw in Poland in September 2008, is an example of the first and can be found on the EUGMS website (www.eugms.org). In 2008 EUGMS participated in a training course for geriatricians in Estonia. Similarly we are investigating the possibility of providing educational courses for primary care practitioners in Greece and

Poland in the near future.

Our major Congress in Copenhagen in 2008 attracted nearly 1000 participants and seemed to indicate that we had turned a corner in the provision of professional development for the specialty in Europe. The hubbub at the breaks between sessions and around the poster displays was testament to how much European geriatricians had in common and how much they could learn from each other.

Despite the fact that Paris will host the world congress of the IAGG, where EUGMS will be participating with 3 symposia, there will be a separate EUGMS meeting run jointly with the Royal College of Physicians and Surgeons of Glasgow, 17-18 September, on the topic of Palliative Medicine and End of Life Care Issues, including the launch of new WHO guidance on Palliative Care (www.rcpsg.ac.uk or www.eugms.org). 2010 will be the tenth anniversary of the founding of the EUGMS and our major congress will be hosted by my successor Prof. Des O'Neil in Dublin, September 29th – 1st October (www.eugms2010.org). 2011 will see what will now be an annual congress hosted in Malaga by the Spanish Geriatrics Society.

British geriatricians have a lot to offer, and to learn from, their European counterparts and I would encourage you to participate fully in the Glasgow and Dublin meetings. It is vital that EUGMS engages successfully with its national partners, one of the reasons that I instituted a European Presidents' meeting in Copenhagen. We take this engagement so seriously that we have already appeared at the German Society Meeting in December 2008 and will be holding our Academic, Executive and Full Board meetings at the BGS meeting in Bournemouth where we will be co-hosting the symposium on dementia on 1st April. So come and talk to us if you would like more information about forthcoming meetings or the work of the EUGMS in general.

Paul Knight
President, EUGMS

Alcohol and Older People



Age Concern and Institute of Alcohol Studies Seminar

Last December a seminar of stakeholders was arranged by Age Concern and the Institute of Alcohol Studies to discuss the development of national policy on alcohol and older people.

I attended the meeting as a representative of the BGS Policy Committee. It was chaired by Professor Ian Gilmore and included participants from the Department of Health, Royal Pharmaceutical Society, Age Concern and Institute of Alcohol Studies.

Alcohol abuse has attracted government and media attention in recent years, but the spotlight is dominated by younger people and associated binge drinking, public order and criminal justice issues. There is a large but under-detected group of older people with chronic physical and mental health problems misusing alcohol. This is a neglected area in research, policy and practice.

The size of the problem

22% of men and 11% of women over the age of 65 in the UK exceed government recommended "sensible limits" for regular alcohol consumption and these proportions are steadily rising.¹ There is a

question whether these limits are appropriate for older people, as they are based on evidence for younger age groups. There is no consensus as to what are the safe levels of alcohol intake for older drinkers, who have increased risk of depression, dementia, falls and physical illness.

Current and future generations of older people may be relatively heavier drinkers than previous generations, perhaps with a larger proportion of problems related to long term moderate drinking.

Geriatricians are trained to recognise and treat physical illness and cognitive problems but receive little formal training in detecting and managing the alcohol problems that may underlie them.



Screening

Healthcare professionals caring for older people need to screen for alcohol misuse.

The "SMAST-G" screening tool is the most validated in the elderly population.²

However, to avoid confusion it is best to use one consistent tool for professionals targeting mixed groups of all ages; with the "AUDIT" tool most widely recommended.³

Specialists dealing with older people can then, if needed, use more specific tools.

When to screen?

It is difficult to target older people misusing alcohol as they present to many different services. Screening should be part of standard primary care review of older people but opportunistic screening

References:

1. General Household Survey 2006, Office of National Statistics.
2. Short Michigan Alcoholism Screening Test- Geriatric Version, University of Michigan Alcohol Research Centre 1991
3. The Alcohol Use Disorders Identification Test, World Health Organisation
4. Carrington Reid M et al. Physician awareness of alcohol use disorders among older patients. *J Gen Intern Med* 1998; 13(11):729-734.
5. Kominski G et al. UPBEAT: The impact of a psychogeriatric intervention in VA medical centers. *Medical Care* 2001; 39(5):500-512.

should take place too, e.g. on admission to hospital. There is evidence that geriatricians are less likely to screen for alcohol abuse than general physicians.⁴ Other points in life that may represent a higher risk period where screening could occur include the transition from work to retirement, and after bereavement.

Evidence that alcohol screening alters the outcome for older people is limited, however this should not be used as an excuse that it is not effective. The few studies that have been done show that older people benefit from intervention and follow up to the same extent or better than younger people. There is some evidence that managing older people with alcohol problems can reduce length of stay, and improve physical and mental health.⁵

Outcomes

Participants developed a greater awareness of the difficulties facing healthcare professionals, not only in recognising and managing alcohol misuse in older people, but in promoting the issues at a national level.

Specifically for geriatricians there is a need to work

more closely with old age psychiatrists and alcohol support workers.

Core components of a National strategy on alcohol use in older age:

- i) Improving detection. Training and educating all care professionals working with older people; including community matrons, social workers, pharmacists, GPs, geriatricians and A+E staff.
- ii) Promoting multi-disciplinary care. To involve psychiatrists, geriatricians, alcohol support workers, social workers and pharmacists; requiring collaboration between health, social care and the voluntary sector. This could include development of "local" champions with good clinical leadership promoting screening, brief intervention and follow up, and may not require a lot of additional resources.
- iii) Research. There needs to be more extensive research into the effects of alcohol in older age.

Alison Cracknell

Alison.Cracknell@leedsth.nhs.uk

A political appetite for wellness in older people?



The Institute for Public Policy Research (IPPR) describes itself as the UK's leading progressive think tank producing cutting-edge research and innovative policy ideas for a just, democratic and sustainable world (no pressure then!)

Using independent research and analysis it seeks to develop agendas for change and provide practical solutions to challenges across the full range of public policy issues.

In July 2008 the IPPR produced its report entitled 'Older People and Wellbeing' (Allen, 2008). This report is the first in a series on older people

and their well being as part of a programme exploring the 'Politics of Ageing.'

The report highlights the lack of political interest in the welfare of older people. Although there are government and quasi-government departments dealing with some aspects of older people's issues (e.g. Department for Work and Pensions), there is nothing comparable to the Department for Children, Schools and Families, which has widespread and overarching responsibility for young people. With care needs in the over 65 year old cohort expected to increase by over 80% in the next 50 years, the report suggests that discussions need to begin as to how the UK will cope with the increase in demand.

Demographics

Despite the well-documented improvement in

health and increasing wealth leading to the longer life expectancy (although the report notes crucially, that not all the years gained are healthy years), there has not been a comparable improvement in levels of 'life satisfaction'.

A general health survey produced by the ONS (2008) revealed that over a quarter of the over 75 year olds reported 'poor health'. It is estimated there will be a 67% increase in the numbers of people with disability in the UK over the next 20 years, particularly because it is the over 75 year old that exhibits a significant decline in physical health, often with its attendant depression and other mental health problems. Interestingly, the overall proportion of disabled people in the UK has not altered over the past 10 years, which indicates that the expanding older population will not necessarily bring a proportionate increased health burden.

Wellbeing and Mental Health

The Easterlin paradox (developed in 1974) is the concept that people with higher incomes are more likely to report being happy. However, in recent times there has been a drive to use a range of indicators to measure life satisfaction and over the past 50 years in the UK, levels of wellbeing have remained fairly constant despite a noticeable increase in GDP/capita (PMSU, 2007).

When looking specifically at the wellbeing of older people (aged 65 and over) it is generally believed that overall life satisfaction is at its highest (Oswald, 2007). However, recent studies have shown that the prevalence of depression increases with increasing age and approximately 25% of older people will suffer from depression that 'impacts significantly on their quality of life' (Lee, 2006). With only a third of older people suffering with depression visiting their GP to discuss their symptoms, these statistics are likely to be gross underestimates of the true picture (Chew-Graham & Burroughs,

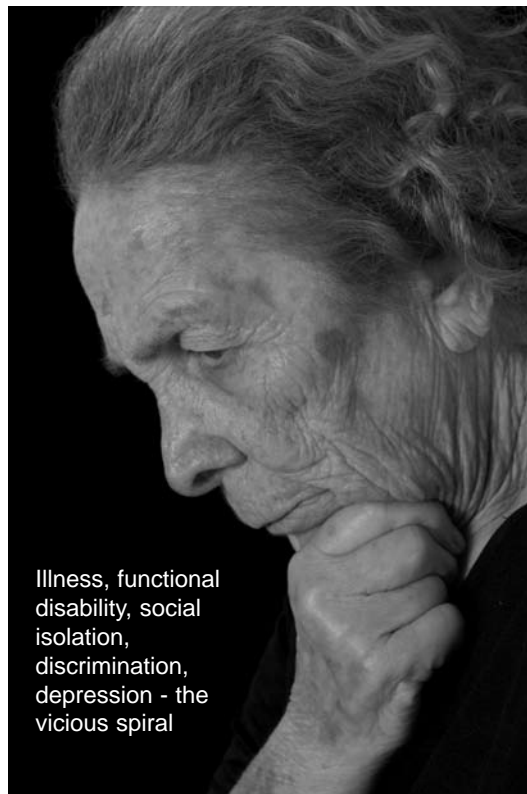
2004).

It would be preaching to the converted to say that older people should not be classed as one homogenous group and the problems faced by the 'older old' will be significantly different from those faced by 'younger old people'. Predictably dementia, which is thought to affect 25% of 85 years and over, also has a significant impact on levels of wellbeing, for both sufferers and their carers.

Financial inequality

Financial inequality is an important stressor with an established detrimental impact on mental health and wellbeing. This places limits on the social participation, the quality of the housing and level of care available. Whilst the net disposable household income per head of population has risen by approximately 60% in the last twenty years, so the gap between rich and poor has widened. In just 12 years the share of this wealth in the hands of the richest 1% of the population has jumped from 17% to 21%. Whilst it might be expected that pensioners would have fared poorly compared to the working population, this is not so. Rises in occupational pensions, investments and state benefits has seen an

average increase in income of 37% for the over 65s, compared to a 17% increase in average earnings for the working population. This has left the majority of pensioners better off today than their counterparts thirty years ago. However there is a stratification of wealth across the elderly population. A recent annual increase of 0.3 million pensioners in relative poverty identifies a worrying trend. The figure now stands at 2.1 million, a dismal number compared to the EU average. One of the ways financial difficulty may manifest is through the quality of housing available. Despite the total number of 'non-decent' houses falling in the UK from 9.1 to 6 million in 9 years, 2.2 million households with a person over 60 are still classified as unfit to live in (ONS, 2008).



Illness, functional disability, social isolation, discrimination, depression - the vicious spiral

The IPPR report advocates that many disadvantages faced in old age are part of a wider picture of financial and societal inequality present throughout life. Government initiatives to reduce these life-time inequalities have focused on the youngest in the population, to the detriment of older people. Reduction in child poverty will hopefully prove fruitful in eventually reducing poverty in all age groups, but will not rectify poverty in older people anytime soon.

Illness and Disability

A staggering 70% of new presentations of depression in older people relate to ill health or disability (ONS, 2003). The vicious downward spiral of chronic illness, leading to disability, decreasing physical activities of daily living, leading to social isolation, leading to loneliness and depression is well known (Prince et al., 1998).

Emotional support: the role of friends, family and religion

One of the most important protective factors for mental health discussed by the report is that of social and emotional support through friends or family. It often mitigates the detrimental effects of ill health on wellbeing (Prince et al., 1998). Other protective factors advocated include a sense of value within a community and strongly held religious beliefs. A third of men and nearly two thirds of women over 75 currently live alone, and of these 17% rate themselves as often or always lonely. This number is set to rise as more adults choose to live alone and more couples opt not to have children. There are an estimated one million socially isolated older people in the UK, a figure set to more than double in the next 15 years.

Care receivers and providers

Depression amongst elderly residents in nursing or residential care is rife, with one recent survey finding 40% of residents to be suffering from depression. This is double that found in the community (Godfrey & Denby, 2004). This may be because many elderly are transferred to care due to mental health concerns. However, the report found little evidence to support or refute this, and there are calls for further research into the reasons for so many in care suffering depression.

A crucial yet often overlooked element of nursing

care for the elderly is the care provided by a loved one. Older people are more likely than any other age group to be informal carers, and provide hours of care equivalent to £15.2 billion a year. This comes at a personal price, with 28 - 55% of carers for those with dementia reporting high levels of depressive symptoms. The health service is financially reliant upon their work and dedication, and yet they are failing to receive sufficient emotional, financial and respite support from the government.

One of the main conclusions of the IPPR report is the need for a reappraisal of residential and community care. A stronger focus is required on the emotional support for the carers and those cared for, not just the provision of resources.

Age discrimination

The prospect of growing numbers of older people suffering mental health problems is made worse by widespread age discrimination exhibited by healthcare services, as highlighted by this report. Only half of older people who present to their GP with depressive symptoms receive any form of intervention, mostly in the form of pharmacological medication. More expensive services offered to younger patients such as talking therapy are often not provided to older people (Godfrey et al 2004, McCrone et al., 2006). This discrimination is also present at a public health level, with recent government initiatives on improving the provision of mental health services targeting resources on younger rather than older people. Those suffering from mental illness already face widespread prejudice by society due to misconceptions about these illnesses. Ageism by healthcare services is likely to act as a further barrier to obtaining help.

Unhappiness in old age is not inevitable, even for those with poor physical health and limited mobility.

Age discrimination is not limited to health care, but transcends many aspects of society, such as the provision of leisure activities, employment, and the perceived value of the older person in society. These can impact significantly on the ability of older people to fulfil personally rewarding activities, on the financial income or self-esteem of older people, further decreasing wellbeing. The Department of Work and Pensions has acknowledged the presence of age discrimination in society, and has set out a strategy to address issues of wellbeing of older people. However the IPPR report concludes that sufficiently ambitious action

has yet to be taken.

Unhappiness in old age is not inevitable, even for those with poor physical health and limited mobility. This report highlights the significance of support in fostering wellbeing and social and community participation for older people, particularly for those most at risk of isolation and exclusion.

Political appetite?

The report concludes that a number of recent and well-intentioned policy documents from central government have set out ways of improving levels of wellbeing among older people (e.g. Department for Work and Pensions 2005, ODPM 2006, Department of Health 2004). The report further notes that the overall focus of national policy continues to be children and young people to the detriment of the older population. Furthermore, it

opines that sadly some of these documents have languished after launch and the proposals have not been acted upon. The report makes a very pertinent observation that the political appetite to drive through proposals sometimes appears to be lacking. We can only hope that this and similar future in-depth, well written and delivered reports serve to whet the appetite of those in relevant governmental departments for change in policies affecting the older person and hence improve their future wellbeing as a whole.

Michael Roach

4th Year Medical Student, University of
Birmingham Medical School

Poonam Jain

FY 1, Hollyhill Unit, Birmingham.

Martin Curtice

Consultant in old age psychiatry, Hollyhill Unit,
Birmingham

Letters to the editor

Dear David

Following your request for information on how geriatricians are treating the name "geriatrics" at a local level, our department in Gloucestershire has taken the term "Old Age Medicine".

There seem to be mixed views about reference to "elderly" by clinicians, while the public and official bodies have indicated that this term is not really acceptable to them. There seems no debate about "geriatric", as this term is not liked by anyone, as far as I can find.

When we were debating our new name for the department, views polarised between those who wished some reference to a specialty for older people, and those who preferred to think of our specialty as general medicine with rehabilitation. I think that at least half of our members have moved on from the debate, as they have attached themselves to stroke services, falls services, or acute assessment units. I believe we need a specialty to cater for the rapidly growing band of frail "fourth age" people during their latter years of life where the benefits from specialist medicine are much less predictable. Our specialty is the study of what happens in those latter years, measuring the benefits and risks of treatments, and understanding the complex biological, psychological and social interactions. I am comfortable that we should refer to our specialty in terms of what we study rather than who we study - hence terms like old age medicine and geratology.

Dr Ian Donald

Dear David

My idea for an alternative name for the British Geriatrics Society: "British Society for Ageing Health" (? Healthy Ageing) or "British Society for Age and Health" is a good idea!

Kind regards

Dr Jonathan Bayly

Dear Sir

I am very concerned with the manner in which the BGS Newsletter is being used to campaign to change the BGS policy from being opposed to Physician Assisted Suicide (PAS), to being in favour of it.

I am not opposed to informed debate, but I am opposed to my subscription being used to subsidise a campaign which I do not support and which is contrary to current BGS policy.

The BGS Newsletter of October 2008 contained an article by a pro-PAS organisation. This was followed in the December issue by a fairly neutral article. Are there plans to publish an article opposing physician assisted suicide?

Dr Peter Gibson

Editor's reply: *You will have received a personal letter from the President advising that there is no BGS policy in favour of Physician Assisted Suicide and that we depend on volunteers to provide material for the newsletter. If you or some of your colleagues would like to provide an article which is less neutral, we will be happy to publish it.*

*The article "written by a pro-PAS organisation" was not, in fact written by that organisation, although they were certainly the source of **some** of the data mentioned. It was written at the request of two people (not BGS members) because the media was, and still is, being lit up by stories of euthanasia and yes, by the fact that that organisation was holding a well-publicised event promoting PAS. The media and television has continued to publicise this subject for nearly a year now. A Google search today on "euthanasia" in the UK media turned up no less than 149 articles, including an article in the Times, entitled "A slow, private death, an urgent public issue". This embodies the public's perception of dementia, and an urgent desire for the authorities to address the public will to be able to choose one's time of death while one has the mental capacity to do so.*

The BGS's policy on assisted dying is embodied in our response to Lord Joffe's bill http://www.bgsnet.org.uk/Nov04NL/03_Assisted%20Dying.htm. The public campaign goes on however, and publishing those recent articles is our attempt to recognise the pressures upon the law makers. The implications of a successful pro-euthanasia campaign on our members would be profound. Ignoring that such a campaign is steaming ahead is not going to change that, or, I hasten to assure you, the BGS's official stance.

Dear David

Assisted Suicide

This topic is being given much publicity and open discussion is advocated by prominent people such as Dame Joan Bakewell and Margo McDonald MSP. Should assisted suicide become legal in the UK., many more people with long-term conditions may well be tempted to end their lives sooner than later.

This will result in smaller numbers of sufferers being available for drug trials and research into these conditions will gradually fade away. Millions of pounds will be saved and could be put by for the next credit crunch or an invasion somewhere to effect a regime change.

An alternative to assisted suicide is to what I used to advise, until I reached a certain age, periodic culls of the older generations.

Viva Geriatric!

Dr C Cohen

Editor's reply: *For those readers who have not spotted the bulge of a tongue in the cheek, let me assure you, it's there.*

AGE AND AGEING ONLINE

Are you aware that as a subscriber to *Age and Ageing* you have free access to the journal online? In fact every issue of *Age and Ageing* has been archived on our website and you can access any article or supplement we have published since 1972.

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Katy Ladbrooke
Editorial Manager
Age and Ageing Journal

Age and Ageing is the official journal of the British Geriatrics Society

STAFF GRADE AND ASSOCIATE SPECIALISTS

Notice of Spring Meeting

A meeting of the non-career grade members will be held on Thursday at the Bournemouth BGS Spring Meeting. Please make your way to the venue after you have eaten your lunch. Coffee will be available and updates on the issues affecting SAS doctors at the moment will be given. This is an opportunity to network and meet others in a similar situation to your own.

SAS FREE Educational day - 5th June 2009 for those working in the London Region.

I am organising this free CPD day with funding from the London Deanery and academic input from the Deanery and the BGS. The only expense you will have to reclaim is your travel. It will cover topics on epilepsy and therapeutics in the elderly with small group working in the afternoon on issues of specific concern to SAS doctors such as job planning for the new contract. If you feel able to contribute to the day or are interested in receiving further information, please contact me as below. The day is being funded for your benefit. This is the time to get active and seize the opportunities now being offered. Book your study leave now.

London Deanery Initiative

Exciting news for the personal development and CPD opportunities for SAS doctors. Funding for SAS doctors to undertake various CPD courses or even funding for secondments, MSc or other further qualifications is now on offer. The London Deanery has been leading the way. Take the opportunity to look at their website to see what opportunities may be available to you. Check in your region how this money is being allocated. It may be directly from your trust or your Regional Deanery.

Look at the Deanery's website for further information:
<http://frontier.londondeanery.ac.uk/>

Membership is open to all members of the British Geriatrics Society but also it shall be open to non-members of the BGS by invitation of the Committee. The latter is very important if we wish to be an inclusive group trying to attract all SAS doctors working within elderly care medicine. Hopefully if we can gain their involvement this will in turn lead to a wider and more representative BGS membership.

Please let us have your comments. You can contact us by:

E-mail: suemorgan@doctors.org.uk

Text: 07796 535733

Phone: 07763 463992

Snail mail: British Geriatrics Society 31 St John's Square
London EC1M 4DN

Sue Morgan
Chair, SAS Group

NEW YEAR HONOURS

Congratulations to **Nadia Chambers OBE** and **Tom Kirkwood CBE** who were recognised in the New Year Honours

New educational resource on ageing

We are now happy to announce that the 'Educational Resource on Ageing' set up from the Section of Ageing & Health, University of Dundee is open and running after a successful initial trial phase. We are working towards increasing the question bank in order to improve the resource.

This has been funded by the National Initiative for the Care of the Elderly, Canada - an international network of researchers, practitioners and students dedicated to improving the care of older adults.

The website can be accessed through the following web address:

<http://caa-02.dundee.ac.uk/q4/perception.dll>

Please use the following login details:

Username: era

Password: dundee

System requirements for this are:

Platform: Windows 2000, XP, Vista or MacOSX

Hardware: Minimum 512 MB of RAM, 1 G of free disk space

Browser: Internet Explorer 6.0 and above (recommended) - JavaScript &

Cookies must be enabled.

Network: Broadband (Good) or Local Area Network (Best)

We trust the resource will be of use. Feedback about the website is welcome.

Deepa Sumukadas

VACANCY BGS FINANCE

Expressions of interest are invited from BGS members based in England to serve on the BGS Finance Committee as England representative.

Issues falling under the remit of the Finance Committee include:

- ◆ Setting the annual membership subscription
- ◆ Deciding on the ringfencing of funds for the BGS grants programme and other ad hoc projects, e.g. the advance care planning guidelines, the role of the CME journal etc.
- ◆ Reporting to the UKMC and the membership on the Society's investments.

The Finance Committee meets three times per annum (one of the meetings being held at the BGS Scientific Autumn Conference.

Please email sarah.allport@bgs.org.uk with expressions of interest by 15 April.

FALLS PREVENTION

Falls Prevention in Older People

1 April 2009
76 Portland Place, London

The conference provides an important update on maximising the contribution of frontline staff to preventing falls in older people, with a focus on a positive and preventative approach.

Contact: For more information please call Hanisha on 020 8541 1399, email hanisha@healthcare-events.co.uk or visit <http://www.healthcare-events.co.uk>

VACANCY CLINICAL PRACTICE EFFECTIVENESS COMMITTEE

Expressions of interest are invited to fill vacancies on the Clinical Practice Effectiveness Committee (CPEC) from members who are active in the following special interest groups:

Falls and Bone Section
Gastroenterology Special Interest Group
Primary and Continuing Special Interest Group

CPEC meets four times a year, including sessions for adjudicating abstracts submitted for the Autumn and Spring Scientific meetings.

For more information, or to express an interest please contact Mrs Joanna Gough at scientificofficer@bgs.org.uk by 15 April 2009.

VACANCY GERIATRICIANS - THE NETHERLANDS

"De Tjongerschans" Hospital in Heerenveen (the Netherlands) is about to open a geriatric ward. We therefore invite applications from enthusiastic Geriatricians (0.8-1.0 fte) with good communications skills, a talent for improvisation and innovation and good team spirit. You will, of course, need to learn the Dutch language!!

The hospital has all the basic medical specialties and a number of other functions.

De Tjongerschans aims to provide care in an effective way, taking account of patients' wishes and dignity. Caring for the elderly (as well as sports medicine) are particular areas of development.

We are operating in cooperation with our partners in the region (for instance the mental healthcare facility). The intention is that, in cooperation with these external partners, we can develop an unrivalled centre of excellence.

For more information please contact Mr. P.E. van Walderveen, geriatrician (phone 0031582866846) by 15 April 2009.

If you are interested in reading our policy papers (Dutch language), please send an e-mail: Heine.Brondijk@Tjongerschans.nl

You can also look at our website: www.Tjongerschans.nl

HEALTHCARE EVENTS - UPCOMING CONFERENCES

Consultant Job Planning - 31 March Good Practice in Consent - 6 May

Enhanced Appraisal and Revalidation - 14 May

[Download brochure from the BGS website \(Notices / Non BGS meetings\)](#)

STROKE

8th Welsh Stroke Conference

19 June 2009

Riverfront Centre, Newport,
Gwent

Programme includes: Stem Cell Transplantation: Sci Fi or Clinical Reality?; Treating Acute Strokes: the state of the art; Translation of stroke rehabilitation evidence into practice – experiences of the Canadian Stroke Network

See BGS website for more details: (www.bgs.org.uk Select Notices and Non-BGS meetings

See BGS website for more details: (www.bgs.org.uk Select Notices and Non-BGS meetings or email: lizzie_williams21@hotmail.com

CARE OF THE ELDERLY

Care of the Elderly: "Old Problems...New Ideas"

4 June 2009

Edinburgh, Scotland

The College symposium on Medicine for the Elderly has become an annual event in recent years, with high quality speakers covering a wide range of topics, reflecting the breadth of the speciality and the range of illnesses seen in older people. This year's symposium is no exception and will be of interest to geriatricians, general physicians, general practitioners, and medical trainees at all stages of their post-graduate education.

See BGS website for more details: (www.bgs.org.uk Select Notices and Non-BGS meetings

AUSTRALIA CONFERENCES

Transitional Care for Older People: making the difference (registrations open)

26-27 March 2009, Sydney, NSW

Treading Softly: Reducing the Carbon Footprint in Healthcare

(call for abstracts open), 18-19 June 2009, Sanctuary Cove, QLD

Inaugural Advance Care Planning Symposium (in partnership with Austin Health, VIC

(call for abstracts open), 13-15 August 2009, Melbourne, VIC

Managing Challenging Behaviours In Older People With Cognitive Impairment

(call for abstracts open), 6-7 August 2009, Melbourne, VIC

Outpatients – Beating the Waiting Game

(call for abstracts open), 17-18 September 2009, Cairns, Far North Queensland

4th Healthcare Without Walls:

Hospital Avoidance, 28-29 October 2009, Sydney, NSW

Investing in the Healthcare Team: Aligning Strategy, Leadership and the Team to Deliver Better Outcomes for Patients,

6-7 November 2009, Sydney, NSW

www.changechampions.com.au/

CALCIFIED TISSUES

36th European Symposium on Calcified Tissues

23 - 27 May 2009

Vienna, Austria

The 37th symposium in 2010 will be held in Glasgow, Scotland on 26 - 30 June.

See BGS website for more details: (www.bgs.org.uk Select Notices and Non-BGS meetings

GASTRO-INTESTINAL

Food and Function 2009

12 June 2009

Zilinia, Slovakia

The symposium will focus on the role of probiotics in the maintenance of intestinal health and prevention of intestinal diseases. It is a networking event; a unique opportunity to meet all those who influenced the past, influence the present and most importantly will enable the future of probiotics in gastro-intestinal health management. Initiation of cross-boarder co-operations between scientists and institutions will be also facilitated during the symposium.

Abstract submission deadline March 31, 2009

See BGS website for more details: (www.bgs.org.uk Select Notices and Non-BGS meetings

NEUROLOGY

Association of British Neurologists

22 - 26 June 2009
Liverpool

The ABN wishes to announce its inaugural annual conference which will be held jointly with the Spanish Society of Neurology. The programme will include scientific symposia, teaching courses, communications and poster sessions.

See **BGS website** (Notices / Non BGS Meetings)

The BGS regrets that owing to restrictions on space, we are not always able to publish all events we have been asked to publicise. Please visit the Notices section of www.bgs.org.uk for details of more events, courses related to geriatric medicine and for downloadable programmes and registration material

CARE OF THE ELDERLY**Fifteenth Conference in Medicine for the Elderly"****10 June 2009****Leicester, England**

- ◆ Diabetes
- ◆ PD and other movement disorders
- ◆ Developments in dementia
- ◆ Mental Capacity Act
- ◆ Management of Chronic Leg Ulceration
- ◆ NICE Guidelines for the management of osteo-arthritis
- ◆ Maximising ITU and HDU Outcomes
- ◆ Urogynaecology in the elderly

See **BGS website** (Notices / Non BGS Meetings) for more details

EPILEPSY**12th ILAE SpR Teaching Weekend in Epilepsy****18 - 20 Sept 2009****Oxford, England**

The teaching weekend comprises of a series of lectures, video sessions and informal seminars covering the most important areas of clinical epilepsy practice in 2009

The number of attendees at this meeting is limited to 230. If you would like to attend this meeting please register by completing the application on-line at:

www.genesisadoration.com/epilepsy.html you should then fill the form in fully and submit by pressing, "Register".

See **BGS website** (Notices / Non BGS Meetings)

EUGMS

**EUGMS
Glasgow Congress
Palliative Care Medicine and
End of Life Issues in Older
Adults**

17 - 18 Sept 2009**Glasgow, Scotland**

Download brochure from BGS website (Notices / Non BGS Meetings)

IAGG

**Longevity, Health and Wealth
19th IAGG World Congress of
Gerontology and Geriatrics**

5 - 9 July 2009**Paris**

Held only every 4 years, the IAGG World Congress of Gerontology & Geriatrics brings together experts from around the world to discuss the latest findings in the field of ageing.

<http://www.gerontologyparis2009.com/site/view8.php>

**BGS Cardiovascular Section and 10th
Annual General Meeting in association
with the British Association of Stroke
Physicians**

2 - 3 July 2009, Birmingham

For further details about this meeting and a registration form please contact Tamara Lloyd at the BGS CV Section Secretariat either by email: tamara.lloyd@lamedica.com or telephone: 01249 700 065

OSTEOPOROSIS

**Osteoporosis Conference 2009
organised by the National
Osteoporosis Society**

28 June - 1 July**Manchester**

Educational Update: Key advances Plenary Invited Lectures - Vitamin D, Osteoporosis in Children, Male Osteoporosis, and Hormonal treatment of Osteoporosis

Abstracts to be submitted by 16 Jan 2009

See **BGS website** (Notices / Non BGS Meetings) for more details

BGS REGIONAL AND SIG MEETINGS**BGS Trent Branch**

17 March 2009, Dakota Hotel (Junction 27 off M1) Directions and programme available on the BGS website

BGS South East Thames Branch

19 March 2009, Brighton Hospital. Contact: beth.downes@qms.nhs.uk

BGS Joint Scotland/Northern Ireland Meeting

14 - 15 May 2009, AECC, Aberdeen. Call for Abstracts

East Midlands & Trent Falls Symposium

13 July 2009, Nottingham
Joint organisers: Professor Tahir Masud and Dr Rob Morris
A multidisciplinary day aiming to learn more about evidence-based intervention with regard to falls prevention and to understand more about the aetiology of falls.
Contact: sue.pinkett@nuh.nhs.uk or jane.turner@nuh.nhs.uk

More details on: www.bgs.org.uk/Notices/regional_sig_meetings.htm

Regional Officers, please contact editor@bgsnet.org.uk to publicise your region's meetings.

In memoriam

Dr J A Campbell Ball (1924-2008)

Dr Campbell Ball, formerly Consultant in Geriatric Medicine in Belfast City, Musgrave Park and Lagan Valley Hospitals was born on 18 January 1924.

Leaving school, the Royal Belfast Academical Institution, during the Second World War, he took a degree in engineering in Queen's University, Belfast before joining the Royal Air Force as a commissioned officer and was posted to the Far East. Later, using the opportunities available to ex-service people, he returned to Queen's to study medicine. He qualified in 1953, and undertook postgraduate training in medicine, obtaining his doctorate in 1958 and his MRCP(Edinburgh) in 1962. He was elected FRCP(Edinburgh) in 1971. He decided on a career in geriatric medicine and in 1964 was appointed consultant in the Belfast City Hospital, also having beds in Musgrave Park Hospital, Belfast and Lagan Valley Hospital, Lisburn.

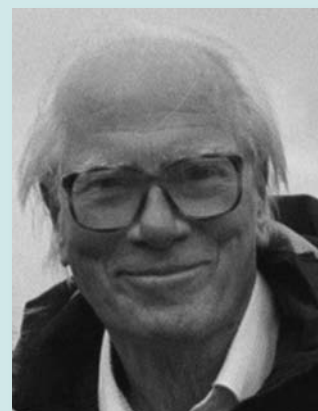
During his time in Musgrave Park, Campbell was able to replace Nissan hutted wards with a purpose built unit, and in Lagan Valley he also opened a new unit, replacing a Victorian hospital. In the clinical system that operated then, he was responsible for the care of older patients, including home assessment visits, in a catchment area which covered West Belfast and which included some of the most troubled parts of Northern Ireland.

Campbell Ball was a warm and friendly person who was popular with colleagues and patients. He was a careful and conscientious physician and also undertook medical management duties as both Chairman of the Division of Medicine and Chairman of the Medical Executive Committee of the Belfast City Hospital. He gave valuable support to the new University Department of Geriatric

Medicine and regularly taught students in his wards. He retired in 1984.

Campbell was multi-talented. He had an interest in all things mechanical, and there were few devices that he did not think he could improve. In one of his wards, he constructed a bath that could be filled very rapidly to avoid patients having to wait in the cold. He was deeply interested in the arts and in his retirement he took piano lessons. He was a keen sailor and developed a passion for astronomy. Of all his interests, he spoke most fondly of the home he built on Inishbofin, a small island seven miles off the west coast of county Galway, one of the most westerly parts of Europe. Built on high ground it has wonderful views of the harbour, Cromwell's Castle and, across the sea, Connemara. His staff remember some Monday mornings when a message would be received from the local Post Office that Dr Ball would be delayed until the storm had abated and he could get off the island.

Campbell Ball died on 22 December 2008. He is survived by his wife, Hilda, his sons Barnaby and Jonathan and his grandson Christopher.



Bob Stout

We regret to report the passing of Dr Frank Robertson, formerly of Bishop Auckland in County Durham, who also passed away in late 2008.

Erratum

We misspelt Dr David Levy's name in the obituary published in December 2008, where it should have been spelt Dr DAVID WILFRIED LEVY



Good reasons to come to Bournemouth

BGS Spring Scientific Meeting 2009

The Spring 2009 BGS Meeting in Bournemouth is fast approaching. For those of you wavering as to whether to come or not, here are some good reasons not to miss out.

1. A European flavour to the meeting. The Clinical section of the European region of the IAGG and the European Union Geriatric Medicine Society are organising a symposium on dementia. Several prominent European speakers will be presenting.
2. Professors Chakravarthi Rajkumar, John Gladman and Stuart Parker will be updating us on their work in the "Meet the Professors session".
3. The meeting has clinical updates on the Older surgical patient, Gastroenterology, Cardiology and Orthogeriatrics
4. Professor Allan McLean from Notre Dame University, Australia will be speaking about the ageing process.
5. Baroness Young of Old Scone, shadow chair of the Care Quality Commission will be speaking about "Maintaining Quality in the NHS"

PUBLICATIONS INFORMATION

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6. The meeting concludes with a symposium on "increasing treatment opportunities for elderly diabetic patients". Well known speakers including David Kerr, Alan Sinclair, Simon Croxson and Gillian Hawthorne will speak about various aspects of managing elderly diabetic patients.

7. The BGS fellowships are a recent development led by the society. Work stemming from these fellowships will be presented in a dedicated session. This is in addition to the usual scientific presentations

8. We are organising three workshops. The Mental Capacity Act 2 years on will be discussed and illustrated with a number of case discussions. Developing Re-enablement services at home is another topic and the Nurses Special Interest Group will also be organising a workshop.

9. Two of the most popular Special Interest Groups i.e. Ethics and Cardiovascular will be presenting a programme. The ethics SIG will be discussing the use of restraint in falls prevention.

10. Participate in a debate with the motion "Complementary medicine should be used more widely in the NHS".

11. David Gunson is the after dinner speaker at the conference dinner. David is a previous winner of the American Express speaker of the year award and a retired air traffic controller, having worked in Birmingham airport for 22 years. Certainly not to be missed.

12. Have a break! Bournemouth is a lovely town and the conference centre is set by the sea, ideal for a leisurely stroll or, weather permitting, a boat trip from the pier. Alternatively consider visiting some of the beauty spots surrounding Bournemouth. Christchurch is a small historic town bordering Bournemouth with a priory and gardens. If you feel like a country walk visit Old Harry Rocks which marks the eastern end of England's world heritage "Jurassic Coast line"

On behalf of the organising committee I hope that you will be able to make it and look forward to welcoming you at the 2009 BGS Spring meeting.

Michael Vassallo
Chairman - Local Organising Committee