



# B G S

n e w s l e t t e r

## GPs and Geriatricians in partnership

The publication of the NSF for older people and the relentless pressure on acute hospital beds continue to increase the pressures on all services for older people, both in hospitals and in the community.

BGS policy is quite clear that this should not mean a move away from our standard: all older people who are ill are entitled to appropriate specialist care irrespective of whether this is provided in a district general hospital, a rehabilitation setting or in their own home. This is to ensure that reversible medical conditions can be identified and treated, and the patient's

optimum function restored.

This has led to ongoing work by the BGS Policy Committee in conjunction with the British Association of Emergency Medicine to develop a statement proposing the presence of older people's specialists in emergency departments, to support decisions about admission or transfer to intermediate care. Indeed our recent updated statement, **Developing Intermediate Care** (*BGS Policy Committee 2003*), about intermediate care itself applies. The recent report from the **Federation of Royal Colleges of Physicians** (*Working Party on Medical Aspects of Intermediate Care. Royal College of Physicians, London 2003*), explores in detail the need to ensure the appropriateness of medical cover for intermediate care, particularly for older people.

However there is an increasing tension for all specialists in older people's services, who face growing demands for specialist expertise outside the traditional hospital setting, whilst also trying to ensure that the standards in acute hospitals continue to improve.

### The GP's Perspective

From a General Practitioner's (GP's) point of view, initiatives to devolve the care of older people may be perceived as an ill-considered transfer of clinical responsibilities from hospitals out to the 'community', with little or no resource to support them. GP's, who provide the bulk of

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specialist medical society for health in old age



Dr Gill Turner, Chairman of the BGS Policy Committee

services for older people in such circumstances, find themselves increasingly bereft of time, money and support staff which they need to do it well.

### General Practitioners with Special Interest

We may now have a new opportunity to address some of these issues. One of the strategic 'thrusters' of a primary care led NHS (through PCT's in England) is the concept of general practitioners with a special interest (GPwSIs). A far cry from the established 'clinical assistant', these GP's will have developed appropriate professional portfolios demonstrating their competence in the clinical care of older people and, where relevant, in allied skills such as service development or education. Crucially, whereas the work of clinical assistants is subordinate to consultants, GPwSIs will work as independent clinicians.

The RCGP and BGS, in consultation with the DoH, have agreed a professional framework for a GP with Special Interest in Older People's services (GPwSI-OP). These will be active and experienced GPs who may work as principals or

in salaried posts. They may be expected to have a strong local knowledge and local ties. They will be able to work in a complementary manner with existing geriatric and old age psychiatry services, to augment and develop the services locally. Many will be primarily involved in the non-hospital or community aspects of the service (for example intermediate care) – but they will be no less specialist for that.

The framework – some of which is printed here - can be downloaded in full from [www.bgsnet.org.uk](http://www.bgsnet.org.uk). Its provisions include:

- ◆ The GPwSI-OP should work cohesively with local consultant led services
- ◆ Most should work closely with their local Department of Geriatric Medicine
- ◆ Clinical governance, appraisal and other professional development, may be shared between GPwSIs and consultant led services.

Although they will be independent practitioners in their own right, they will be providing services which form part of the overall district wide specialist service for older people. Care needs to be taken to ensure that these services integrate effectively (see below).



For new GP's, an attractive way to prove competency to take on the role of a GPwSI-OP will be by a **diploma of geriatric medicine**. This has already been recognised by the RCP in London, who are discussing an extensive review of their exam in partnership with the RCGP, and the relaunch of a joint diploma, better suited to the needs of GPwSIs should follow. The Royal College of

Physicians and Surgeons in Glasgow are also concerned to ensure that their Diploma remains relevant to GPwSI roles.

Diploma exams are by no means the only route into the system, as many older GPs have established skills developed through clinical assistantships, or by independently developed

innovative community roles. Whatever evidence is advanced for initial accreditation, GPwSIs will have to demonstrate ongoing competency in the care of older people through appraisal, as they will for all other aspects of their practice.

### Links with the new GP contract

The new GP contract may also offer opportunities for improving standards for services for older people. For the first time, this contract offers incentives for all practices to provide evidence of quality in the care they provide for their older patients.

### Enhanced Services

**National Enhanced Services** are to be defined for a range of community services considered to be beyond the normal remit of general practice, and will be offered by some practices only. One of these will define standards of care for care home residents. Resources will be attached to these standards, hopefully at a level commensurate with the work involved.

Finally, primary care organisations (PCT's in England) will have the option of specifying Locally Enhanced Services. These will enable service specifications to be drawn up to meet the particular needs of local communities. Like National Enhanced Services, these will be provided by GPs under the terms of extended practice contracts, usually to patients on their registered practice list.

There will inevitably be some cross over between services provided by Departments of Geriatric Medicine, the GPwSI-OP, and National or Locally Enhanced Services under the new GP contract. Such diversity could lead to confusion, which in the worst case could threaten the integrity of existing services, rather than improving care through the introduction of new services. Handled well, however, there may be a real opportunity here for GPs, consultant geriatricians and primary care organisations to review their services and to define a blueprint for comprehensive services for older people.

### Who will employ GPwSIs?

GPwSI's-OP will be employed largely by the primary care organisations (PCT's in England).

Typically they will work two to three sessions a week and will also work regularly in general practice under their practice contracts. Some PCTs are employing salaried GP's to work in a practice and to work part time as GPwSIs.

Currently there is no absolute requirement on PCTs to ensure that the GPs they employ as GPwSI's-OP are appropriately trained to work with older people. Given the complex demands that could be placed on GPwSIs working in newly developed services, and the lack of a formal professional qualification, this could lead to risks for patients, practitioners and PCTs alike.

Concern has been raised on this matter by the BGS, and is being relayed by the RCGP to senior levels of government, though as yet without any firm reassurance that our concerns are being addressed. While further formal guidance is awaited, any PCT which is considering employing GPwSIs who are not appropriately trained using the framework described, would be advised to read the CHI report into the Gosport War Memorial Hospital.

The remuneration and terms and conditions of employment for GPwSIs are all still under consideration. However, the sessional salary for GP's is likely to be considerably in excess of the clinical assistant sessional commitment. Typical rates being paid currently, are around £7,500 per annum for doing weekly sessions, comparing favourably with consultant sessional rates.

### Responsibilities of Departments of Geriatric Medicine

Although PCT's exist in England only, all UK Departments of Geriatric Medicine will find the concept of the GPwSI framework of interest and of potential value in considering ways to provide a comprehensive service for older people.

Geriatricians will be aware that the best service for older people is likely to be provided when the component parts 'match up'. Geriatricians are advised therefore, to involve themselves with PCT's and be receptive to discussions about GPwSIs. They should try to ensure that the

PCT's problems being addressed are clearly defined, that GPwSI led services are an appropriate solution, and that effective evaluation forms an integral part of the service specification.

Geriatricians may be approached to provide or organise training placements or appraisal sessions. Integrating these new specialist services with acute specialist departments, and recognising the unique contribution they can make, has the potential to provide benefits for older people. GPs who take on these roles will be valuable allies, supporting the clinical care of older people, and acting as local champions for old age services – nurture them!!

For further information see the NatPact website [www.gpws.org/subindex.shtml](http://www.gpws.org/subindex.shtml)

The full framework may be downloaded from either [www.bgsnet.org.uk](http://www.bgsnet.org.uk) or the RCGP site [www.gpws.org](http://www.gpws.org)

We would welcome comments and reports of experiences by both our geriatrician and GP members in the implementation of this new stream of service.

**Gill Turner**

Chairman : BGS Policy Committee

**Joe Neary**

representing the RCGP

## Editorial page

The editorial team welcomes our new Chief Executive, Alex Mair. He joins us in late September and will be hoping to meet as many members as possible at the autumn meeting and over the coming months.

Whilst on the subject of autumn meetings, the Society is obliged to wean itself off London as a venue for the Autumn Scientific Meeting (page 8). I would urge members to support the new venue. Harrogate has a great deal to offer, not least of which, a considerable saving on the venue costs that we pay to have our autumn meeting in London.

### Beyond geriatricians

By pure coincidence, this issue of the Newsletter focuses on the growing links with our “non-geriatrician” colleagues - medical and other health professionals. With the framework for GPwSI's-OP now being approved, it is important that we as geriatricians engage with our local PCTs to ensure that the benefits offered by

integrating the GPwSI-OP initiative are fully exploited. The alternative to good communication and effective co-ordination is yet more fragmentation.



Still on the subject of our non-geriatrician colleagues, Dr Playfer and Dr MacMahon update us on the initiatives underway, to support the Society's policy of fostering multi-disciplinary practice, as well as links with other professionals involved in the care of older people.

With all this activity around a cohesive, multi-strand approach to providing better services for our patients, I thought it appropriate to re-print a thought-provoking letter written in 1996 by Dr Keith Thompson, one of our most long-standing GP members, and sadly, no longer with us. It was again, pure coincidence, that the members whose letters re-open the Newsletter's “Letters Page” are both GPs. I would encourage our GP members to write to me and become actively

involved in contributing to the Newsletter. I would particularly ask them to let us know what issues they would like to be covered, not only in our publications but also, of course, at our scientific meetings.

### Trainees

I have welcomed the greater contribution of trainees to recent issues of the Newsletter. Cath Church, current Chairman of the Trainees Group, is moving on to pastures new and I hope the trainees who take the reins from her and her Vice Chairman, Jugdeep, will continue to make the trainees' voice heard in our Newsletter.

### BGS cyberworld

The four national councils of the BGS now have their own websites. Each of the websites has adopted its own emphasis and I would ask you to check these websites regularly for updates and news on current issues. I would also ask members to use the sites to publicise meetings and training events in their locality. Vibrant websites are always attractive and it was interesting to hear at the interviews for our new chief executive, how much useful information candidates gleaned from the BGS sites in their preparation for the interviews.

### BGS compendium documents

The BGS Policy Committee has been busy. A number of new compendium documents and one clinical guideline have been either published

or are in the pipeline. We hope to publish an outline of these in our next issue, so watch this space!

### Advance Directives

The matter of "living wills" seems to be enjoying renewed attention in the minds of both the public and politicians, with particular reference to artificial nutrition. It is my understanding that one of our members is about to undertake research into policies among the various geriatric services on the issue. Assuming she has secured the funding to carry out the survey, we hope to publish her results in the near future. In the mean time, I have summarised one of the current debates, as it appeared in the June issue of "Care Directions".

In conclusion, I look forward to seeing you all at the Autumn meeting in London.

Kevin Kelleher  
Editor

### Apology

We apologise for failing to acknowledge Finbarr Martin as author of the foreword and editor of the article on the Single Assessment Process, published in the July issue of the BGS Newsletter.

Thanks for your understanding, Finbarr!

The Editor



### Spring Meeting Venue

In the eternal quest for The Perfect Venue, Dr Janice O'Connell, supported by a quartet of administrators from the BGS office and Hampton Medical Conferences, braved the building site that will be the Sage Conference Centre in Gateshead, Newcastle, with a view to determining its suitability as a venue for the 2006 Spring Scientific Meeting.

From left to right: Annette Guerda-Fischer (BGS office), Jacinta Scannell (Hamptons), Janice O'Connell (Meetings Secretary), Juliet Brereton (Hamptons) and Sophie Moseley (Hamptons) sporting designer building site apparel.

# President's column

**W**hile writing an obituary on Prof Desmond Montgomery, it occurred to me what a huge debt we owe the generation of doctors who qualified just before or in the early years of the Second World War.

They served in the armed forces medical services, and then came back to start both the National Health Service and the specialties which we now recognise. They probably contributed more to the health of the population and to health care in general than any other generation of doctors before or since. The effect of contributions they made to the health of the community can be seen in the huge increase in the number of older people, most of whom have spent the greater part of their lives in good health. It may be that medical historians will see the second half of the twentieth century as a golden age of medicine when huge advances in prevention and treatment were not only developed, but were widely available, and when modern systems of health care were devised.

## Training

The other thought I had is that, while these doctors of course undertook postgraduate training, there were no NTN's, CCST's, SAC's, JCHMT's or STAs. Training was less formal and less structured and much more based on gaining wide experience. Many established the specialties in which they worked, training themselves. They then set up training schemes for their successors. While it is certainly better to be trained than untrained, (as a former Chairman of the SAC in Geriatric Medicine I have to say this!), I am concerned that training is becoming so bureaucratic and rigid that we may be disadvantaging our speciality as well as others. Health care of older people has benefited greatly by the arrival into our speciality, of doctors who

have trained first in other medical specialties. Such movement should be encouraged and should continue, and we must ensure that we do not create unnecessary

barriers which will disadvantage our speciality and our patients. Similarly, we must welcome those who have spent a significant amount of time in high quality research or who have worked in other countries. They all add to the wide experience which is necessary for a general and rapidly developing speciality such as ours.

## Tough decisions

A recent special issue of the British Medical Journal dealt with the relationship between doctors and the pharmaceutical industry. While nobody doubts the huge contribution that the pharmaceutical industry makes to health care, and the need for the industry to make reasonable profits in order to pay for research and development, the journal suggested that in some cases the relationship between the medical profession and the pharmaceutical industry is too close and too cosy. It cannot be healthy that so much postgraduate medical training depends on funding from the pharmaceutical industry. As a Society we need to take these points seriously and consider our own position. When you receive your copy of the annual accounts for 2002/3, you will see that the income from our bi-annual conferences and sponsorship is a very important source of funding for the Society; 59% of total income. This income largely arises from the pharmaceutical exhibitions which are such a prominent part of our spring and autumn meetings. You will also be aware that this source of income is far from secure. Mergers in the pharmaceutical industry have resulted in a reduction in the number of companies, and hence in the number of exhibition spaces that are taken at our meetings. Sponsorship for a



number of activities is becoming more difficult to obtain. As part of its strategic thinking, I believe that the Society needs to consider whether it ought to be so dependent on the pharmaceutical industry to balance its books, or whether it would be both financially healthier and ethically sounder if we covered our core activities from the income from the membership. **In 1989/90 subscriptions accounted for 56% of income, compared to just 24% now.** To move back in this direction might require some tough decisions about our subscription levels, but geriatricians are well used to making tough decisions.

### Beyond our shores

The Society quite rightly spends much of its time and effort in considering the care of older people within the United Kingdom, the policies, both of the UK Government and of the

devolved Administrations, and its own business. It is important that we also look beyond our own needs and problems. Ageing is a worldwide phenomenon and in the next few decades will probably have most impact in the developing world. Some of the problems are similar to ours but some are different. Unlike sub-Saharan Africa, in this country we are not faced with the 'missing generation' in which younger adults, particularly those who are parents, have succumbed to HIV/AIDs and the older generation find themselves bringing up their grandchildren. I hope that at one of our Spring or Autumn meetings in the near future, we might devote a session to ageing in the developing world.

**Prof Robert Stout**  
President



## Society of Pharmaceutical Medicine

The Society of Pharmaceutical Medicine was founded in 1987 with the specific remit to be a multidisciplinary organisation covering all facets of drug discovery and development - both within the pharmaceutical industry and also outside.

The Society aims to promote a closer relationship between physicians and scientists in the fields of pharmacology, toxicology, drug metabolism, clinical research, clinical pharmacology, therapeutics and drug development.

### Working parties

Guidelines in drug development and new findings have been produced by individual working parties in the areas of: Developing Anti-Asthma Agents, Pharmacovigilance, Developing Anti-Viral Agents (in collaboration with the British Society for Antimicrobial Chemotherapy) and Pharmacogenetics.

### Scientific meetings

The Society organises regular meetings in many different

areas of pharmaceutical medicine. Details of forthcoming meetings and past reports are on the website [www.socpharmed.org](http://www.socpharmed.org), with favourable rates available to academics.

### Journal

The Society's journal, the *International Journal of Pharmaceutical Medicine*, is published 6 times a year and includes editorials, news items, commentaries, meeting reports, original articles on all aspects of pharmaceutical medicine and associated disciplines. Subscription to the journal is included with the Society membership fee.

### Membership

Membership is open to those with medical or scientific training who are actively engaged in the evaluation of medicinal agents. Applications are welcome also from persons who, though lacking formal medical or scientific training, are nevertheless interested in furthering the aims and objectives of the Society. We are actively seeking to increase the Society's academic membership.

For further details visit: [www.socpharmed.org](http://www.socpharmed.org)

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# BGS Autumn Meeting

## Harrogate 1 : London 0 - a change of venue

**M**ay this serve as advanced warning that the Autumn Scientific Meeting will, next year in 2004, be held in Harrogate and not, as was traditionally the case, in London.

### Why change? Why Harrogate?

The UKMC in considering the question of whether to break with an almost hallowed tradition of holding the Autumn meeting in London were ultimately persuaded that change was inevitable on the grounds of cost; the Society will save £24,000 a year in the cost of running the meeting by switching to Harrogate, more than £70,000 on room hire over three years. There are only three venues in London capable of accommodating the BGS meetings and events of a similar scale; in consequence the venues use their monopoly position to charge very high prices, prices which have been increasing year by year to a point where the Society felt compelled to examine alternatives, and Harrogate offered the most convenient and cost effective alternative.

### Facilities in Harrogate

The Harrogate International Centre is regularly ranked amongst the top three in the annual league table of the most successful venues in the UK and probably all readers will be aware of reports in the media of the various high profile conferences held there.

The main auditorium seats 2000, and there are additional rooms that seat 100, 250 and 300 to accommodate parallel sessions, as well as a hall of 1,120 square meters for the commercial exhibition and catering, in addition to myriad other rooms for the many activities that go with the our

meetings.

In addition to the Moat House Hotel, which is linked directly to the Conference Centre, there is a wide range of accommodation on offer. The formal Dinner will be held in the Majestic Hotel, an impressive 19<sup>th</sup> century hotel set in 12 acres of award winning landscaped gardens, only 5 minutes walk from the Conference Centre.

### The joys of Harrogate

Medicinal springs were discovered in 1571, leading to the development of Harrogate as a spa resort in the 19<sup>th</sup> century. It remains a very genteel town surrounded by extensive gardens – The Valley Gardens (comprising many acres of floral displays, the Royal Horticultural Society Garden (68 landscaped acres), the Montpelier gardens in the centre, the dramatic Plumpton Rocks, and 200 acres of lawns in the Stray. There are smart shops in Oxford Street and Cambridge Street; and the Royal Pump Room Museum is well worth a visit.

### Betty's Tea Shop

Betty's is something of an institution in Harrogate (though there are also branches in York, Ilkley and Northallerton). It was started by a Swiss émigré who brought his mouth-watering recipes to the spa town. It is probably the best tea-shop in the North. Specialities include "fat rascals", a rich cake containing currants, almonds and spices, which is best eaten warm with cholesterol-restoring butter; Yorkshire curd cake; a range of scones; Sachertorte; chocolate fancies - the choice of mouth-watering treats is infinite.

Betty's also serves excellent meals and snacks. It sells some of the finest coffees and teas available. In the early evening, a pianist adds to the timeless atmosphere of this wonderfully unspoilt café.

The provision of such fine fare does not come

**Autumn Meeting 2003  
15-17 October**

**A farewell to London.  
Don't miss this historic  
occasion and a superb  
scientific programme!**

cheap: however, no visit to Harrogate is complete without an hour or two spent sampling Betty's wares. It is not uncommon to see leading politicians enjoying a life-enhancing fat rascal when they are here for the conference season. Top stars appearing at the International Concert Centre also invariably take tea at Betty's.\* (The Society declines all responsibility for the effect of a visit on your waistline!)

### A touch of the self-indulgence

*'Exhilaration, euphoria, total relaxation and absolute cleanliness'* (but no CME points!) are promised at the Turkish Baths, with their Moorish design and splendid arches dating from 1897. (Allow 2½ hours for maximum benefit.)

### The surrounding area

This also has much to offer the visitor, reflecting the importance of the region in history –Aldborough Roman Museum, Fountains Abbey, the castles at Knaresborough, Ripley and Spofforth, whilst an obelisk commemorates the site of the last Civil War battle at Marston Moor. Before turning to prayer in the cathedral in Ripon, you may wish to visit the Prison & Police Museum, the Workhouse Museum of Poor Law and the Courthouse Museum (used for the TV series Heartbeat) in Ripon.



### Access? It's a doddle!

By air - the expanding Leeds/Bradford airport is just 20 minutes drive away and provides direct links to e.g. Amsterdam, Belfast, Brussels, Cork, Dublin, Edinburgh, Glasgow, London, and Southampton. Manchester airport is a 75 minute drive away.

By train - train connections are well developed with regular services from Leeds (every half hour) and York (every hour) to Harrogate. In turn, York has direct rail connections to Bristol and

Penzance, Birmingham, Liverpool and Manchester, in addition to being on the excellent GNER line between London, Newcastle, Edinburgh and Glasgow. Total travelling time from London to Harrogate can be as little as 2 hours 35 minutes. Sadly the Welsh have been a bit neglected in our industrial heritage and would need to change in Manchester coming from Cardiff; likewise changes en route are necessary coming from North Wales.

By car - there are good north/south and east/west motorway connections (details will be provided in due course) giving easy access to the UK motorway grid which, depending on traffic, provides potential for happy motoring. Harrogate has 6000 parking spaces, some at the Conference Centre itself.

### Your support is sought

This is a dramatic move for the Society, forced on us by economic circumstances. The change may be

welcomed by many, but equally may seem daunting to others like me - resident south of Watford. However the key ingredients of the Autumn Scientific Meeting, the clinical

excellence of the programme and the opportunity to commune with your colleagues will remain unchanged. Please therefore, be bold and support the move; we need you there!

### But all that is next year, don't forget this Autumn meeting!

*\*Mention of Betty's was ecstatically insisted upon by the two Meetings Secretaries and this authoritative recommendation was supplied by Prof Graham Mulley (quintessential Yorkshireman).*

**Richard Lynham**  
Administrative Director

# The 'Living Will'

## Care Directions Update

In 1995, the issue of "advance directives" received an airing in the context of a House of Commons debate on the subject.

At the time, Prof Peter Millard, then President of the BGS, wrote to every MP warning against the dangers of advance directives which provide an established legal right by a competent, informed adult, to refuse medical procedures in advance.

In June, Care Directions ([www.caredirections.co.uk](http://www.caredirections.co.uk)) published an article on the current status of the "Living Will". Aimed at the person contemplating having a living will drawn up, Maxine Trowbridge, Solicitor of Clifford Cowling in Fleet, Hampshire, wrote\*: "The Living Will can deal with what medical treatment you wish to receive or not - should your health become so poor that you are in a persistent vegetative state. This covers such conditions as terminal physical illness, permanent mental disability, and permanent unconsciousness.

A person can appoint somebody else to help the doctor consider what their views would have been. Such a person is a proxy. However, one must consider very carefully who should be the proxy.

Any person making a Living Will would be well advised to provide their doctor and, perhaps, their legal adviser with a copy of the document. The document should be executed and completed correctly to ensure it is of legal status. Recent case law has proved beyond doubt that when an informed and competent patient makes an advance decision to refuse specific treatments which would otherwise be given later, such refusal will be legally binding on doctors. Legislation will, in time, enforce the case law and draft legislation may actually become enacted.

### Draft legislation

It is envisaged that the most common condition for which a Living Will would be appropriate

would be where a person suffered from senile dementia - such as Alzheimer's disease at its most severe, coupled with serious physical illness. Another example may be where there are Living Wills drawn up by Jehovah's Witnesses declining blood in all circumstances.

The Law Commission's draft legislation now published is aimed at clarifying the position. It proposes that patients should not be able to refuse 'basic care' and hygiene through a Living Will - but they can legally refuse specific medical procedures. It has been made clear through the courts that patients can authorise or refuse treatments - but are unable to make legally-enforceable demands about specific treatments they wish to receive.

The British Medical Association makes it clear there is an important difference between intentionally killing and the withdrawal of treatment in a way that will ultimately result in the patient's death. Medical treatment can be legally and ethically withdrawn when it is unable to accomplish any improvement and it would not be in the patient's best interest to continue treatment - or, alternatively when the patient has refused further treatment.

### Artificial Nutrition

The Living Will is a subject of delicate current affairs debate. One will recall the case of Tony Bland - who, following the awful Hillsborough football stadium tragedy, was left in a persistent vegetative state. Tony had no awareness of the world and no possible hope of recovery. He was not terminally ill, but the withdrawal of artificial nutrition resulted in his life coming to an end. It was confirmed in this case that artificial nutrition **does** constitute a medical treatment, which in turn meant the Lords agreed that this could be withdrawn. In this case, Lord Browne-Wilkinson summed up the legal complexity saying:

'How can it be lawful to allow a patient to die slowly, although painlessly over a period of weeks from lack of food, but unlawful to produce his

immediate death by a lethal injection?’

He went on to say this was a difficult moral question to answer, but agreed it represented current law and that the legal boundaries must be maintained. Thus, the British Medical Association is of the opinion that, under certain strictly-defined circumstances, it is ethically acceptable to withdraw artificial nutrition and hydration from patients.

Also, the British Medical Association has made no distinction between euthanasia and physician-assisted suicide. In summary, specialist legal advice

should be sought before considering the whole concept of Living Will construction and implementation.’

**Kevin Kelleher**  
Editor

\*(Ms Trowbridge’s article is intended as guidance for readers. The text can be no substitute for considered advice on specific problems. Consequently, the writer cannot accept responsibility for this information, errors, or matters affected by subsequent legislation.)

# BGS New Chief Executive

## Alexander Mair

**A**lex Mair joins the staff of the BGS in September and will succeed Richard Lynham as administrative head of the Society when Richard retires at the end of the month.

**Alex is a qualified company secretary, a member of the Institute of Chartered Secretaries and Administrators** and also has an HND in Business Studies. For the last twelve years he has been Company Secretary and Executive Secretary (Chief Executive) of the British Institute of Professional Photography.

Alex is well qualified for the post, coming to the Society as he does from a similar organisation, i.e. a professional organisation, with a membership of 3,500, a turnover of £600,000, governed by a Council of 14, and with a mixture of nine permanent and part time staff.

Married to Sheila (a business systems consultant) and living in Woodford Green, Essex, Alex enjoys a game of chess, travel and astronomy.



Alex was appointed following his selection from a shortlist of five, by an interview panel comprising three officers – Jerry Playfer, Margot Gosney and myself – and two national representatives – David Kennie for Scotland and Ed Wilkins for Wales, chaired by Mike Sillitoe, Director of Human Resources at Queen Mary’s Hospital, Sidcup, generously loaned to the Society for the day.

He demonstrated a good understanding of the health needs of older people and the current issues affecting geriatric medicine and the Society. Members will have an opportunity to meet him at the Autumn Meeting in Hammersmith on 15-17 October. In the meantime, I am sure readers will want me to wish him well in his career with the Society.

Says Alex; “I am looking forward to the early opportunity of meeting as many members as possible at the Autumn Meeting, and to making a positive and long term contribution to both the Society and geriatric care”.

**Kevin Kelleher**  
Hon Secretary

# Trainees' Page

## European Academy for Medicine of Ageing

For trainees with an interest in research, the European Academy for Medicine of Ageing (EAMA) offers an international course, currently held twice yearly in Switzerland.

The duration of the course is four weeks in total. It aims to:

- ◆ improve knowledge and skills in geriatric medicine for junior faculty members or promising candidates for future teachers in geriatrics.
- ◆ harmonise the attitudes and goals of future opinion leaders in geriatric medicine throughout Europe.
- ◆ establish a network among medical doctors responsible for the care of older people and those responsible for student instruction, as well as general physicians caring for the aged.
- ◆ stimulate scientific interest in geriatric medicine.
- ◆ to develop future leaders in the field of geriatric medicine.

The format consists of intensive student participation in working groups, giving short presentations and leading discussions, as well as state-of-the-art lectures by experts in the field of geriatrics from all over the world.

The course was established seven years ago by a self-co-opted ad-hoc group of the European Professors of Medical

Gerontology (*Age & Ageing* 1994; 23: 179-81) and is now based in the **Institut Kurt Bösch**, Sion, Valais, Switzerland. The current executive board members are: Prof R Bernabei (Rome, Italy), Prof B Vellas (Toulouse, France), Prof N Thorsten (Ulm, Germany), Prof J-P Michel

(Geneva, Switzerland), Prof H Stähelin (Basel, Switzerland), and Prof C Swine (Yvoir, Belgium). Participants come from all over Europe as well as a few from the USA and Brazil. Thus far there have only been two UK participants.

### Work hard, play hard

Having now attended two sessions, I can thoroughly recommend the course. There is a strong academic bias. The working atmosphere is relaxed but the workload is heavy – ‘work hard, play hard’ would sum up the course well. There are excellent opportunities to share experiences between European colleagues, which can provide for a rich source of discussion at times!

### Young geriatricians of Europe

At the most recent meeting, the ‘young geriatricians of Europe’ (not chronologically-speaking, but rather, reflecting our training status) was crystallised. A collective of trainees have formed with the idea of promoting collaborative projects on a Europe wide basis. Our initial project is looking at the definition of

a dying patient and comparing definitions trans-culturally.

We are devising a database which should record the backgrounds and research interests of individual trainees, allowing us to develop networks. Any members interested in

#### Topics covered in recent sessions of EAMA include:

- ◆ Healthy Ageing: Usual or Successful? (January 1999)
- ◆ Frailty in Old Age : Diseases and Functional Consequences (June 1999)
- ◆ Drugs in the elderly : Clinical Approaches to Daily Problems (January 2000)
- ◆ Evidence based geriatrics versus individual based geriatrics (January, 2003)
- ◆ Prevention of age related disorders - from genes to new drug and technological interventions (June 2003)

subscribing to the ‘young geriatricians of Europe’ should contact Simon Conroy – [spcon@doctors.org.uk](mailto:spcon@doctors.org.uk)

Finally, anyone interested in attending the EAMA

should contact the course administrator – Verena Montani - [vmontani@vtx.ch](mailto:vmontani@vtx.ch). Successful applicants will need to have demonstrated an interest in research and academic medicine as well as having the backing of their national body (i.e. the BGS) and will need to be able to provide funding (currently £1000 per session). Places on the course are awarded on merit.

Simon Conroy  
Addenbrookes Hospital



### A Happy Event

On behalf of the BGS Trainees, congratulations and best wishes to the Vice Chairman of the Trainees' Committee, Jugdeep Dhesi and to Richard van den Berg, on the birth of their daughter. Amber Kaur van den Berg was born on 16 July at 5.21 am, weighing 7lb 3oz (or 3 kilos 280 grams for the metricians among you).

# All change at top table

Trainees meeting - October 2003

Our next Trainees meeting will be held during Friday lunchtime of the Autumn BGS meeting in London in October 2003. I hope that many of you will be able to attend.



Among the issues to be discussed are those of the SpR training curriculum/assessment; stroke training; working hours/shifts and research.

It will also be a very important meeting as we need to vote for a new Trainees' Committee. I can hardly believe that it is almost 2 years since I volunteered to be the Chair of the committee and was subsequently voted in! I have thoroughly enjoyed my time as Chair and I am certain that my colleagues on the rest of the committee feel the same about their posts. I would encourage you to consider standing for one of the following posts in the Autumn:

◆ **Chair** – representing trainees on the **BGS UK Management Committee** (which is concerned with the running of the Society,

and determines strategy for influencing UK-wide developments in policy affecting older people's medical care);

◆ **BGS Training Committee** (which deals with training in geriatric medicine);

◆ **SAC for Geriatric Medicine** (a JCHMT body that discusses issues related to training in geriatric medicine)

◆ **Vice-Chair** – representing trainees on the **BGS Scientific Committee** (which adjudicates abstracts for BGS meetings and promotes the role of research in geriatrics)

◆ **Joint BGS/RCP Committee**

◆ **Second Training Committee Rep** – representing trainees, additional to the Chairman on the **BGS Training Committee**

◆ **Finance Rep** – representing trainees on the **BGS Finance Committee**

◆ **Policy Rep** – representing trainees on the **BGS Policy Committee**

◆ **English Council Reps (2)**

◆ **Scottish Council Reps (2)**

◆ **Irish Council Rep (1)**

◆ **Welsh Council Rep (1)**

### New constitution

We voted in a new Trainees Constitution (details on the website - [www.bgstraining.org.uk](http://www.bgstraining.org.uk)) at the Trainees meeting in Aberdeen in April. This allows more flexibility in the above posts and

gives details of how the elections will take place in October. The English Council reps are new positions and at present are unfilled. I am aware that there are already probably representatives for the other councils and, if this is the case, we need to formally recognise them, by vote, at the meeting.

So finally, my time as Chair of the Trainees Group has been a satisfying and an invaluable experience, which I'm sure will stand me in good stead in future. I would strongly encourage my

colleagues to consider standing for one of the above posts.

If you feel moved to stand for election, or would like to contact me for any further information, please do email me at [c.j.church@ncl.ac.uk](mailto:c.j.church@ncl.ac.uk).

I look forward to seeing you in October.

**Cath Church**  
Chair, Trainees Group

## The Outside Clinic

### Domiciliary Eyecare For The Housebound

The report, "**Unseen & Forgotten**", produced by the RNIB in October 2000, highlighted the chronic under provision of domiciliary eye testing - this despite an increasing ageing population. It has now been over 2 years since the publication of this report and sadly the current statistics do not make better reading.

Recent Government figures show a further drop of 8% for last year with only 255,000 domiciliary eye examinations taking place in 2001-2002. The RNIB's report in October 2000 identified that there were collectively nearly one million people who would be entitled to a domiciliary eye examination due to their age and/or infirmity. Clearly a vast number of these are slipping through the net, and as a result find themselves at risk from falls and a reduced quality of life.

The Outside Clinic has been providing a specialist domiciliary eye testing service for the housebound over the last fifteen years. However we have clearly failed as so many

people appear to be unaware of the service and their entitlements. The purpose of this article is to try and redress the balance and to increase the awareness of the services of The Outside Clinic not just to the housebound, but perhaps more importantly to those who care and are advocates for them.

The Outside Clinic has optometrists readily available to cater for the needs of the housebound. The service is free of charge to the over 60's with a minimal charge for those housebound who do not qualify by other means. If The Outside Clinic can be of any assistance to your housebound patients, please do not hesitate to call as our representatives are waiting to help.

Finally, I hope that together we can increase the awareness of this much needed and under utilised service.

**John McKimm**  
Patient Care Services

For further information please call our Freephone number on 0500-295245

# Prof Desmond Montgomery

Founder member of the BGS

**O**n 7th July, Prof Desmond Montgomery CBE MD FRCP FRCPI FRCOG, Honorary Professor of Endocrinology at Queen's University, Belfast, and founder member of the BGS passed away.

Desmond Montgomery qualified with first class honours in Queen's University in 1940, following a distinguished undergraduate career in which he won many medals and prizes. After a house officer year he enlisted in the Royal Army Medical Corps, being posted to the India/Burma theatre of war where he served with distinction and was awarded a military MBE in 1943.

Returning to civilian life he joined the training schemes that were arranged for ex-service registrars, rapidly obtaining the MRCP and MD. In 1947 while at Hammersmith Hospital for further training, he and another Belfast ex-service registrar, George Adams, who had been a naval medical officer serving in destroyers in the North Atlantic, attended a lecture in the Royal College of Physicians. At the question time they recognised an Ulster accent which they traced to Dr Tom Wilson, a contemporary of Desmond Montgomery's, who was working with Dr Trevor Howell in Battersea Hospital, studying the value of cystometry in the management of incontinence. On his invitation they visited Battersea. At the end of their visit he invited them to have tea which would be served at a meeting taking place in the hospital. It thus came about that three graduates of Queen's University attended the meeting at which it was decided to form the Medical Society for the Care of the Elderly (the original name of the British Geriatrics Society). At the meeting Tom Wilson was elected Treasurer and immediately took a subscription of ten shillings each from those who were present. He went on to become a consultant in geriatric medicine in Redruth in Cornwall, the first consultant in geriatric medicine appointed in the United Kingdom. George Adams and Desmond Montgomery returned to Belfast, George starting his work on the care of older people in which he

achieved such eminence, and in due course became the second President of the BGS. Desmond Montgomery continued his membership of the Medical Society for the Care of the Elderly for a number of years and attended several meetings, but his professional career

took him in a different direction. He first worked in cardiology, and then became the pioneer of endocrinology in Northern Ireland. He had a most distinguished career with particular expertise in the management of diabetes in pregnancy, for which he was awarded an honorary FRCOG. Together with Richard Welbourn, then in the Department of Surgery in Queen's University, but later Head of the Department of Surgery in Hammersmith Hospital, he wrote a successful textbook on medical and surgical endocrinology. He chaired most of the important medical committees in Northern Ireland. Most notably, in 1960 he and a fellow endocrinologist from Dublin, Professor Ivo Drury, founded the Corrigan Club, an all-Ireland society of physicians which has continued to meet annually, alternatively in the North and South of Ireland, for over 40 years despite the civil unrest in Northern Ireland. He was awarded the CBE in 1981 and honorary doctorates from both the National University of Ireland and Queen's University, Belfast. The Northern Ireland region of the British Geriatrics Society was delighted to honour Desmond Montgomery at the time of the Society's Jubilee in 1997. He and his wife attended the commemoration dinner and the President of the Society, Dr Arup Banerjee, presented him with a medal in honour of his association with the Society. Professor Montgomery was a highly skilled physician and a successful teacher, researcher and administrator, who was held in enormous respect by all who knew him.



**Prof Bob Stout**

## PREVENTING CARDIOVASCULAR DISEASE IN THE OLDER ADULT

12 September 2003

Royal College of Physicians,  
Glasgow

**Contact:** Kirsty Paterson  
Event Co-ordinator, RCP  
(Glasgow), 232-242 St Vincent St,  
Glasgow G2 5RJ  
Tel: 0141 221 6072  
Email:  
kirsty.paterson@rcpsglasg.ac.uk  
Web: www.rcpsglasg.ac.uk

## DEMENTIA WITH LEWY BODIES AND PARKINSON'S DISEASE

17-20 September 2003

Newcastle upon Tyne

A key meeting aiming to consolidate international opinion about the status of Dewy Lewy Bodies and Parkinson's Disease and the relationship between them.

An excellent networking opportunity between dementia experts and movement disorders specialists as well as scientists who are working on a common understanding of alpha-synuclein-related disorders

**Contact:** DLB/PDD Conference Office, Benchmark Communications Ltd, 63 Westgate Rd, Newcastle upon Tyne NE1 1SG. Tel: +44 (0) 191 241 4523

## MEETINGS/JOBS

Visit [www.bgsnet.org.uk](http://www.bgsnet.org.uk)

for details of

- ◆ conferences
- ◆ jobs in sunny places

## GERONTOLOGY

Irish Gerontological Society

51st Annual Conference

26-27 September 2003

Dublin, Ireland

**Contact:**  
IGS Secretariat  
William Stokes Unit  
Adelaide & Meath Hospital  
Dublin 24  
Ireland  
+353 1 414 3215  
Email: igs2003@amnch.ie  
Web: <http://indigo.ie>

## RESPONDING TO CHANGING NEEDS OF OLDER PEOPLE

4th International Symposium on  
Chinese Elderly People

13-15 October 2003

Beijing, PR China

**Contact:**  
Fax: + 86 10 625 15213  
Email: ageing@mail.ruc.edu.cn

## GASTROENTEROLOGY & CLINICAL NUTRITION A BGS AUTUMN MEETING PARALLEL SESSION

Thursday, 16 October 2003

Novotel Hotel, Hammersmith,  
London

Includes the following presentations:

- ◆ Fatty liver
- ◆ Refeeding syndrome
- ◆ Non-Cardiac Chest Pain

**Contact:** See registration details for the British Geriatrics Society Autumn meeting

## BGS AUTUMN MEETING

16-17 October 2003

Novotel, Hammersmith, London

**Contact:** Hampton Medical Conferences Ltd, 127 High St Teddington, Middlesex TW11 8HH  
Tel: 020 8977 0011  
Fax: 020 8977 0055  
Email: [hmc@hamptonmedical.com](mailto:hmc@hamptonmedical.com)  
Web: [www.hamptonmedical.com](http://www.hamptonmedical.com)

## CLINICAL NUTRITION

Annual Meeting of the British Association for Parenteral and Enteral Nutrition

19 - 20 November 2003

Telford

CME approved  
Initial announcement enclosed with this newsletter

**Contact:** Sovereign Conference Secure Hold Business Centre, Studley Road, Redditch, Worcestershire B98 7LG. Tel: 01527 518777. Fax: 01527 518718  
Website: [www.bapen.org.uk](http://www.bapen.org.uk)

## SYNCOPE

International Conference

20-22 November 2003

Newcastle upon Tyne

**Contact:** Nicola Railton, Conference and Events Manager, Syncope Conference, Benchmark Communications Ltd., 63 Westgate Road, Newcastle upon Tyne NE1 1SG. Tel: 0191 241 4523. Email: [syncope@benchcom.co.uk](mailto:syncope@benchcom.co.uk)  
Website: [www.syncope-conference.co.uk](http://www.syncope-conference.co.uk)

## STROKE

2nd All-Wales Stroke Conference

28 November 2003

County Hall, Cwmbran, Gwent

A multi-disciplinary event

CME and PGEA applied for

Registration is free of charge

**Contact:** Dr E A Freeman  
St Woolos Hospital  
Stow Hill  
Newport  
South Wales NP20 4SZ

## GERIATRICIANS AS TRAINERS

28 November 2003

University of Warwick  
Coventry

Consultants with a training responsibility welcome. Also 20 places reserved for senior SpRs with an interest in medical education

**Contact:** Pamela Bayne, Dept of Medicine, Warwick Hosp, Lakin Rd, Warwick CV34 5BW. Tel: 01926 495 321 x 4341. Email: pamelabayne@swh.nhs.uk

## INTEGRATING SOCIAL AND HEALTH CARE

Managing New Realities -  
Integrating the Care Landscape  
across Health, Housing and  
Social Care

10-11 March 2004

Birmingham

**Contact:** Managing New Realities,  
Cheapside, Brighton, BN1 4GD  
Email: info@pavpub.com  
Web: www.pavpub.com

## Talk to the Older People's Champions online

Feedback from the **Shaping our Future** conference in March indicated that you would appreciate the chance to talk further with the Older People's Tsar and other champions.

An online discussion with Ian Philp was scheduled on 24 July (it remains to be seen whether further similar opportunities will be arranged).

Also, don't forget there is a champions' discussion board on the website which operates all the time - you can interact with other champions by visiting [www.doh.gov.uk/nsf/olderpeople/index.htm](http://www.doh.gov.uk/nsf/olderpeople/index.htm)

*Partially quoted from "Championing Change for Older People" (June 2003)*



**FindCE.com** is a new web site (it went live on 1 July), designed to help you locate continuing education opportunities in literally hundreds of disciplines.

Over 900 speakers have registered. **FindCE.com** does not accept commissions as speakers bureaus do.

There are more than 9,000 meetings listed, and meeting planners visit the site to register their own meetings, and to look for speakers.

The list of educational media (cds, tapes, etc.) and online educational sites is also growing.

**FindCE.com** does not offer the education. It merely leads you to it. You are never expected to pay anything, as this is a resource built for the professional looking to find the educational source that best fits his or her needs.

**FindCE.com** also has the following:

- ◆ An interdisciplinary forum for health practitioners to discuss topics with those in other fields which are common to multiple disciplines.
- ◆ Email alerts when something or someone you are looking for registers on the site
- ◆ Much more!

So, you really should head over to [www.FindCE.com](http://www.FindCE.com) right now and "Register with FindCE" as a member (free) to take advantage of the many benefits, but if you don't have time, at least bookmark it for later use!

# BGS Councils

## Update



Dr David Black

## England

At its earliest meetings, the new England Council members expressed a willingness to take on more work than is traditional of Council members. To this end, we have written to the Department of Health in the hope of creating the necessary network of linkages whereby the England Council can influence government health policy in its early phase.

The Council was using those members who were involved in **Evercare** at a local level to monitor its progress

The **Single Assessment Process** continues to

be confusing and complex. The England Council is promoting the idea of holding a meeting, either as a study day or as a session at one of the scientific meetings, when the process can be discussed and clarified (hopefully!).

The implementation of **reimbursement for late discharge** is a complex and bureaucratic process. The England Council is making representations, and will monitor progress.

The England Council now has a **website** where minutes of its meetings are posted. It is hoped that the site will evolve as an effective communications tool for the England membership, while learning from and forming useful links with the other Councils.

**David Black**  
Chairman, England Council

## Wales



The Wales Council congratulates Dr Gladys

Tinker for being awarded an OBE in the Royal Honours List; Dr Ikram Shah who has been appointed as Deputy High Sheriff for the county of Clwyd; and Dr Bim Bowmick who has been recognised for his outstanding contribution to medical training in Wales.

The Wales Council met in May and June and will be holding its first AGM in Newport under the new structure, which will be attended by the President.

### Concerns of the day

The process is underway for appointing **new RCP Regional Specialty Advisers**.

In the interests of **preserving the unity of the UK BGS**, the Wales Council is seeking to establish a formal administrative function in the BGS London office.

The Wales Council is considering options regarding its **links with the Royal Colleges**, debating whether it should take advantage of England's already strong links with the Royal Colleges or work to establish its own.

With regard to the Council's relationship with the Welsh Assembly, there is concern that the development of a **National Standards Framework** for Wales is lagging behind that of England. It is also felt that the Assembly's newly established **National Partnership Forum for Older People** does not have adequate representation from geriatricians.

**Ed Wilkins**  
Chairman, Wales Council

# What resources should I have?

## a policy guide



The BGS Office regularly receives telephone calls from consultants and other bodies asking for advice on BGS standards related to resources needed for geriatric departments.

One definitive statement the BGS has made on the issue of resources was the article by Peter Horrocks in 1986, in “Age and Ageing”, which then became one of the earliest BGS compendium articles.<sup>1</sup> Such statements on the structure of a comprehensive health service no longer work in the current NHS environment. The reasons for this are numerous but include:

- ◆ Different models of care
- ◆ Difference in resources between those with comprehensive community services and those without
- ◆ Differences in services between those that are entirely DGH based and those that have community hospitals and considerable Intermediate Care type services

### References:

1. Horrocks P. **The Components of a Comprehensive District Health Service for Elderly People – A Personal View.** Age and Ageing. 1986; 15 (6): 321-42.
2. **Consultant Physicians Working for Patients. The Duties, Responsibilities and Practice of Physicians.** 2<sup>nd</sup> Edition. Royal College of Physicians London 2001
3. **Medical Aspects of Intermediate Care.** Federation of the Medical Royal Colleges The Royal Colleges of Physicians of London, Glasgow and Edinburgh 2002.
4. **The National Service Framework for Older People.** Department of Health London 2001.
5. Document A3 **Standards of Medical Care for Older People – Expectations and Recommendations.** BGS Compendium of Guidelines, Policy Statements and Statements of Good Practice at: [www.bgs.org.uk](http://www.bgs.org.uk)
6. **User guide for Modelshire.** HSC 2001/003 : LAC (2001)4

- ◆ Massive variation in the way that different health and social care communities manage to deal with older people, in part due to historical patterns of working rather than resource differences.

So is there anything the BGS can offer to advise?

### Consultant numbers

There is information on consultant numbers. The document “**Consultant Physicians Working for Patients**”<sup>2</sup> clearly states that 6 whole time equivalent consultants are required in geriatric medicine per 250,000 of the population. This is very similar to statements made before by the British Geriatrics Society that 1 consultant per 4,000 of the population aged over 75 is a minimum requirement to start achieving comprehensive services. The latter figure is sometimes of more use to those parts of the country with high proportions of older people. A statement has also been made recently by the Federation of the Medical Royal Colleges in the document, “**Medical Aspects of Intermediate Care**”, that five fixed sessions of consultant time should be available in any locality per 200,000 of the population.<sup>3</sup>

### Bed advice

Bed advice may be obtained by asking the local Director of Public Health in your main PCT to ask for the resources predicted locally, using ‘**Modelshire**’.<sup>6</sup> This program was designed to help Health Authorities estimate future requirements for general, acute services and intermediate care facilities for 2003/4.

The most important document arguing for adequate resources is the **National Service Framework for Older People**<sup>4</sup> which sets out the standards of care that need to be provided and indeed, the structures and processes that need to be in place. If for example, there is no falls service nor any service to provide adequate input to geriatric/orthopaedic rehabilitation, then there should be strong arguments for new resources needed to meet the standards set out in the National Service Framework.

### Standards of care

The Policy Committee of the British Geriatrics Society have recently revised the **Standards of Medical Care for Older People**<sup>5</sup> compendium document A3 to take into account the National Service Framework. This clearly sets out the key elements of specialist services for older people, as well as quality indicators to act as prompts and ideas for monitoring performance. Using this

document in conjunction with the National Service Framework is the way to move forward when considering improving services and when putting forward arguments of resource allocation.

**Dr David Black**

Chair England Council

**Dr Gill Turner**

Chair of the BGS Policy Committee

# The holistic perspective

## Fostering interdisciplinary collaboration

The Society through its governing bodies, has for many years expressed its support for a closer working relationship with our colleagues in the allied health professions.

This policy formed part of the last Strategic Plan. Essentially there are three ways forward, encouraging non-medical staff to join the Society, providing a more diverse programme as part of the Society's scientific meetings and, collaborating on research projects. Whilst good progress has been made, we are still a long way off getting the formula right.

### Membership

In the mid-nineties, the Society opened its membership to non-medical staff, starting with scientists and then encompassing allied health professionals. Today, the Society is pleased to have representation from therapists, nurses and even a pharmacist, but hopes that their presence will grow still further.

### Interdisciplinary meetings

The Glasgow Spring Scientific Meeting in 1993 initiated the inclusion of the first interdisciplinary component into the BGS programme. The Warwick Spring Meeting in 2000 included an interdisciplinary day run as a parallel option to

the main scientific programme, causing grief to many doctors who wanted to attend both. Since 2001 we have added on an interdisciplinary day to the Autumn Scientific Meetings, not always satisfactory as it extends the number of days that doctors are away from their hospitals and surgeries. The Birmingham Spring Meeting in 2005 intends to overcome these problems by having an integrated interdisciplinary programme throughout.

In the past it also proved difficult to get a consensus agreement on what an interdisciplinary programme should encompass (if you want to see a human representation of Vesuvius erupting, ask Margot Gosney - former Meetings Secretary-about this!). Birmingham have allied health professionals on the planning team, thus avoiding any 'eruptions', and Doug MacMahon is consulting widely in respect of the United in Care conference referred to below.

### Interdisciplinary collaborative group

Pursuant to the Strategic plan 2000-2002, Rebecca Dunn initiated a collaborative group, encompassing the allied health professions, to identify ways to improve interdisciplinary collaboration; this was subsequently developed further by Chandi Vellodi and has now been taken on by Doug MacMahon, assisted by Kevin Kelleher. Its terms of reference, approved by the Executive Committee as it was then, defined the

group as being “formed by representatives of professions providing health care for older people.” It presently includes the Chartered Physiotherapists, the Occupational Therapists, the RCN, the Royal College of Speech and

Language Therapists, the City University London and St Bartholomew School of Nursing and Midwifery, the NE London Workforce Development Confederation, and the Nutritional Advisory Group for Elderly People, and a general practitioner. Other professions/associations with an interest in caring for older people would be welcome.

### The Interdisciplinary Group

The aim/objective of the Group is to facilitate joint working between the professions through the development of a shared approach to improving the delivery of health care for older people. The key areas for collaborative working will revolve around education, research, clinical collaboration and service development/delivery.

The Group is tasked to:

#### Education:

- ◆ Identify shortcomings in professional education and propose methods of improving this
- ◆ Develop and implement a programme of annual multi-professional conferences
- ◆ Develop a pool of speakers and subjects to support scientific meetings organised by the member societies
- ◆ Propose measures to encourage cross-attendance at each others' meetings

#### Research:

- ◆ Develop and oversee collaborative research and audit projects involving the professions

#### Clinical:

- ◆ Encourage the development of skill mixes, and make representation to the respective accreditation authorities
- ◆ Develop multi-professional input into care pathways
- ◆ Develop multi-professional clinical guidelines

#### Service Development/Delivery:

- ◆ Co-ordinate projects supporting the implementation of the National Service Framework in England and any future plans of this nature in the UK
- ◆ Seek to encourage a co-ordinated UK wide multi-professional approach to healthcare provision
- ◆ Co-ordinate projects that will serve to monitor and/or support health authority initiatives such as intermediate care
- ◆ Encourage multi-disciplinary working amongst professions
- ◆ Develop and publish guidelines and recommendations on multi-professional working
- ◆ Develop and produce occasional papers on multi-disciplinary team work

### United in Care - Conference 2004

The Interdisciplinary Collaborative Group is exploring the scope for interdisciplinary research leading to joint publications, but more immediately it has focused on a free standing interdisciplinary conference – **United in Care**, in the summer of 2004.

Our allied health colleagues have always been adamant that what they really want is a stand alone conference, not just a programme ‘tacked on’ to another scientific meeting, and the UKMC on behalf of the Society gave approval for Doug MacMahon to take this forward for the summer of 2004.

We will therefore be commissioning the Medical Education Partnership, professional conference organisers, who have run the very successful BGS Parkinson Disease Section's multidisciplinary conferences. A deciding factor in choosing MEP is that they underwrite the financing of the conference so that there is no financial risk to the Society or its allied health professional partners. However we have had to compromise on the structure of the programme to secure this benefit, in that the programme will have a clinical base to attract commercial sponsorship whilst retaining a strong interdisciplinary focus.

It is planned that the morning of the conference will be a vehicle to celebrate areas of British practice of which we can be proud, and the role of older people health teams in providing these innovations. It will also provide the opportunity to update the multidisciplinary team members on



Multi-disciplinary team - Oxford

‘state of the art care’.

We hope to attract a keynote speaker in the middle of the conference, and it is anticipated that the afternoon will provide an opportunity to examine two key issues that concern the whole multidisciplinary team, but from different of perspectives.

The afternoon will close with a rapid fire facilitated discussion between audience and an expert panel. It is hoped that a publication and

other activities (as in box) will follow.

We will be circulating details to members in due course. We hope that not only will BGS members support this initiative, but we would also encourage their local colleagues to attend what should be an important step on the route towards achieving a long-held aspiration for our Society.

**Jeremy Playfer**  
**Doug MacMahon**

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# Congress of Gerontology

## 5th European Congress

It was a great pleasure to represent the BGS when I attended the 5<sup>th</sup> European Congress of Gerontology at the spectacular Congress Palace of Montjuïc in Barcelona during July.

The scientific programme was structured over seven special lectures, 58 official symposia and 9 submitted symposia. More than 800 selected abstracts were presented both orally and in poster form.

### European Perspective

More than 50 countries had contributed to the proceedings, which was held over four days in the beautiful city of Barcelona nestling in the Mediterranean. The conference covered all pertinent issues in both geriatrics and gerontology from an interdisciplinary point of view.

**Dr Kalache**, Director of the Ageing and Health Programme of the World Health Organisation in Geneva presented a slightly downbeat appraisal, I thought, of the current situation, particularly in relation to the developing world. Later in the day **Prof John Pathy** of the College of Medicine, University of Wales, Cardiff, delivered the

opening lecture which was an historical overview of the quality of life for older people. It was a pleasure to hear one of the UK's distinguished geriatricians give an historical insight into the development of his own service over decades at the University of Wales. It was quite clear that a single minded and resourceful geriatrician can succeed in developing a superb service for his older patients. Prof Pathy achieved his objective by focusing on the job in hand, by applying strong negotiating techniques, and through team building. It was quite clear from his delivery that he has been a formidable operator in these areas over many years in Wales. It was also clear, from the warmth of the reception he received from the audience, that he had made many friends and contacts in the world and European geriatrics arena.

### The basics of Dementia

On Thursday I attended a session on the pathophysiology and mechanisms underlying the development of Alzheimer Dementia. It was nice to be reminded of the basic pathological mechanisms underlying this challenging disease at cellular level. The complexity of the condition is slowly being unravelled and with that comes the promise of more targeted pharmacological products in the near future, which will fundamentally alter the progress of this condition, rather than as now, ameliorating some

of its consequences.

In the afternoon I attended a symposium on health and social protection systems for older people, which again gave a fascinating pan-European perspective. There was a particularly interesting paper delivered by **Dr Pacolet** of the Higher Institute of Labour Studies Catholic University of Leuven on “Social Protection for Older Persons with Dependency in the European Union”.

An elegant presentation outlined how individual countries were coping with the challenges of the current demographic picture of an ageing population. Overall it was clear from this paper that an optimistic view should be taken on the ability of the various systems throughout Europe to cope with the challenge of both social and medical care for older patients over the next 20-30 years.

My Thursday afternoon finished with an

Interdisciplinary Symposium on Intermediate Care, when **Prof Cameron Swift** and myself delivered papers on the “Definition and Controversies of Intermediate Care” and the issues of predicting future needs around intermediate care. These two lectures were delivered again in the splendid main lecture theatre. It was an interesting, and not entirely pleasant experience to be blinded by the television lights as one delivered papers to an unseen audience whilst one’s head and shoulders were projected 20-30 feet high on a television screen behind the stage.

Prof Swift gave an elegant review of the issues around the intermediate care developments in the UK, particularly in the context of the National Service Framework. Again there were many positives of course, but the issue of fragmentation and loss of focus is always a

concern.

### Time out

Friday morning saw me taking a couple of hours off to take the tourist bus tour of Barcelona, keeping an eye open for the sights to do with the Olympics in the early 90’s and of course, the famous Sagrada Familia, which is the unmistakable symbol of Barcelona across the world. It is the achievement of Antonio Gaudi who never saw his work completed, but has fascinating works of architecture all over this city. For those who have an interest in architecture and history one could spend a week exploring Barcelona from this perspective alone.

Back at the conference I dipped into another

Clinical Symposium, again featuring Prof Swift under the rubric of “The Role of Geriatrics”. From other presenters, the audience heard about the development of acute geriatric care in general hospitals in our neighbouring

European countries. A paper was delivered by a colleague **Dr Swine** from the Department of Geriatrics at the University Hospital of Mont-Godinne in Belgium. Cameron Swift spoke about geriatrics and long-term care from the UK perspective.

I dipped into many of the oral paper presentation sessions. Again, there were a number of papers delivered by our colleagues here in the UK, from Sheffield, London, Liverpool, Newcastle, Bristol, Reading and others.

Later that evening delegates were received in the ancient governmental buildings in the centre of Old Barcelona by the Lord Mayor and distinguished colleagues of the city and congress.

There was some scepticism that the gentleman



Congress Palace of Montjuïc

who delivered the welcome was in fact the Lord Mayor as, unlike his be-suited neighbours, he was dressed in a light linen jacket, open neck shirt and sported a head of flowing locks. He delivered an address in both Catalan, Spanish and English, but discussion with him following his welcome revealed that he was indeed the Lord Mayor and also a member of the Green Party, which is strongly represented on local government in Barcelona. A walk back to the hotel, of a couple of miles through the bustling streets of Barcelona gave a flavour of the vibrancy of life here in the late afternoon and into the night.

### Quality of Life

I managed to take in a little of the Saturday morning programme. The closing plenary session was on the "Quality of Life, Multidimensional

Aspects and Implications". Our President, **Prof Bob Stout** delivered a paper on, "Quality of Life and Geriatric Care, A State of the Art." Bob had also chaired a fascinating session, which touched on aspects of training medical specialists throughout Europe.

I flew out of Barcelona, my flight being delayed only 1 hour, having spent a concentrated 3½ - 4 days dipping into multifarious aspects of geriatrics and gerontology from a world and in particular, a European perspective.

The World congress is planned for Brazil on 26-30 June 2005. In the mean time, don't forget the Irish Gerontological Society's Annal Conference later this month (see page 16).

**Kevin Kelleher**

# A drive for quality

## Continuing professional development

**C**ontinuing Professional Development (CPD) is one of the responsibilities of the RCP London.

As Director of CPD I work with the Education Department to identify, develop and promote educational resources and activity appropriate for CPD, and to ensure continued improvement in the quality standards of the activities approved for CPD. I provide professional advice within the RCP on CPD policy and activity, on the quality and content of CPD events, and on the methods of ensuring participation in CPD for all practising physicians.

### Federation of Royal Colleges

The Director of the London College works closely with the Director of CPD for the Federation of Royal Colleges of Physicians and

the Scottish College Directors of CPD. The Directors of CPD of all the Medical Royal Colleges (the Academy) meet regularly to develop a common approach to CPD within the UK, and to provide representation of this approach within the European Association for Continuing Medical Education.

CPD forms an essential element in the annual appraisal process, and CPD objectives for each doctor should be agreed at that time. The degree to which the doctor has achieved those objectives will be reviewed at the next appraisal, and satisfactory completion over a five-year period is one element required for revalidation.

I work with a network of RCP Regional CPD Advisers, and with a CPD representative from each medical specialty. Key elements in our work are to ensure that high quality CPD is available regionally, that the range of events does provide for the changing needs of physicians at every stage in their careers, and that all physicians are enabled and encouraged to participate in CPD.

### On line Diary

The establishment of the **Federation On-line Diary** has made it easier for physicians to plan and record their CPD activity, and the need to provide feedback on the event is a key element in our drive to ensure quality in the events we approve. Towards the end of this year we will be carrying out a random audit of individual records, and also an audit of the feedback we have been receiving.

### New initiatives

We are currently involved in three major initiatives – firstly, we are developing an on-line system for approval of CPD events, which will mean that we can tighten up on the quality criteria we use, and we will also be able to scrutinise many more regional events. The Regional Advisers and Specialty Representatives will play a key role in this process. Secondly, through the College Education Department, we are developing a formal development programme for newer Consultants, recognising that, with shorter SpR training programmes, there are many additional skills that



RCP London

have to be learned within a short time of appointment. Finally, all SpRs will be allocated an access code for the **On-line Diary** from October this year, to enable them to plan and record their CPD activities as soon as they receive their CCST.

I hope that you will continue to find CPD a rewarding experience, and that the RCP London is

helpful to you in this area throughout your professional career. The CPD helpline at the College, your specialty CPD Director, or I are always happy to respond to queries or suggestions, so please feel free to maintain a dialogue.

**Ian Starke**

Director of CPD

Royal College of Physicians of London

## *BGS to adopt Geriatric Medicine CME Journal*



At its meeting in July, the UK Management Committee of the BGS approved a proposal that the Society adopt the **Geriatric Medicine CME Journal** as a medium for its CME programme. This enables the CME Director to ensure rolling coverage of the CME curriculum and to assure its quality. There will also be the opportunity to co-ordinate publication of articles with other scheduled CME events.



The journal is published by RILA Publications in London. Publication started in 1998 and the editor for the first year was Dr David Lubel who was succeeded by Dr Steve Allen in 1999. The journal is published three times a year and is available on-line to subscribers. It is the most successful of Rila's

medical CME series with a subscription which has risen rapidly over the last two years, to 5,510 world wide, 80% of whom are consultants or other senior medical staff. A great deal of work has been invested in improving the quality of the publication, and it now receives a substantial number of unsolicited papers for publication. However, most of the main reviews are still commissioned. The primary purpose of the journal is to publish in-depth reviews on topics pertinent to the speciality of geriatric medicine. It is abstracted in Embase/Excerpta Medica.

**Steve Allen**

Editor

Geriatric Medicine CME Journal

# Letters page



## **The GP's Lament (*reproduced from BGS Newsletter, Sept 1996*)**

We must challenge the concept of geriatric medicine as a hospital-based specialty when it is the broadest of disciplines in which General Practitioners play an important role by practising in real and formative communities where the functional capacity and living conditions of people can be observed. There we become acquainted with the genetic background, ethnicity, and educational level of those on the practice list as well as their previous occupations and the *modus vivendi* which is lost, when admitted elsewhere.

I recall vividly one of my Trainees, after some years in hospital practice where he had passed the MRCP, laughing to see many healthy octogenarians, in contrast to the stroke and failing hearts he had come to regard as the norm for old age. While hospital doctors concentrate on the functional assessment and rehabilitation, GPs are not unacquainted with assessment procedures such as the Barthel Index, mobility grading scales etc. Nor are rehabilitation facilities confined to hospital practice.

There are a number of GPs who have made notable contributions to the study of eldercare - Idris Williams, Alastair Tulloch, Denis Pereira Gray, Ian MacIntosh, to name but a few. We cannot ignore the work of these thinkers. When I came into practice many years ago, the hallmark of good practice was the care of children, while the elderly were treated with elegant neglect, and my special interest was treated as a joke. Today, childbirth is a social event not, as then, a pathological landmark.

The BGS's aim of 'obtaining feedback on possible future directions and activities' must involve the recruitment of enthusiastic and able GPs.

**M Keith Thompson FRCGP (Deceased)**

*What a long way we have come since Dr Thompson wrote this letter, and what a pity he isn't around to comment on current developments!*

*The Editor*

**Ann Homer  
Exeter**

Dear Editor

This article about the Evercare Health Group (*BGS Newsletter July 2003*) is a bit odd. The GP press had a report a few weeks ago about millions being spent on flying in experts from the USA to train up PCTs to look after their elderly. It must be the same outfit? I cannot believe that the BGS thinks this is desirable or necessary. Surely we have the expertise to do this in house - here in the UK, where geriatrics started. There are probably lots of good projects already going on around the country, involving existing staff (i.e. district nurses and practice nurses). Why doesn't the BGS find out? We have been doing high risk identification and active management in Mid Devon PCT for years. I bet there are others. Sorry to rant, it just seems such a waste of money.

**Ann Homer**

**The Editor welcomes letters from readers, covering topics published in any issue of the Newsletter, or current affairs in the area of medical and social care for older people.**

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# British Geriatrics Society

## Cyberworld Update



The British Geriatrics Society has never shied away from embracing new technology as a means to communicating with the membership and health professionals worldwide, as is demonstrated by the Society's growing presence on the world wide web.

### The site today

The Society's first website, [www.bgs.org.uk](http://www.bgs.org.uk) was launched onto the world wide web in 1996, and from humble fluorescent green beginnings went on to receive a commendation from the British Medical Journal for the quality of its content, its clarity and ease of navigation. Today it is a large site carrying the Society's compendium of guidelines and policy statements, links through to on-line registration for meetings, details of grants and more.

### Members only

The latest development is a members' only area. The purpose of this section is to enable members to have access to information which would be inappropriate or illegal (Data Protection Act) to publish for wider access. The site will host **the up-to-date Handbook**. The Handbook serves as a useful source of information on e.g. the Society's history, details of officeholders, SIGs/Sections, committee and council membership, and grants and prizes. Most importantly, the Handbook serves as a register of members, which by being in electronic form will in future be updated every quarter. It will enable members to look up the contact details of their colleagues and it may be downloaded by those who prefer a written record. Please note, however, that the information is confidential in that members may disclose their private addresses, which may not otherwise be available even in the Medical Index..

**Documents for discussion** at UK level will also be posted to the site for members to download and comment. The site will be operational as of 15 September 2003 and can only be accessed using a unique username and password.

Members wishing to access the site should send an e-mail to [annette-guerda-fischer@bgs.org.uk](mailto:annette-guerda-fischer@bgs.org.uk) requesting access to the new members' only area on the BGS website. Upon receipt of this e-mail a unique username and password will be issued.

## BGS National Websites

In the wake of devolution, the national branches of the BGS have established their own websites covering issues relevant to their respective memberships. These have been developed and are maintained independently of the main UK site, although the visitor can link through to a national site from the UK site. The format and emphasis on each national website may differ slightly, but the intention is that they will carry reports, publications of relevance to the local membership, dates and programmes of meetings, and details of the representatives on the respective national councils.

### www.bgs-england.org.uk



The England site, still under construction, currently publishes minutes of all its meetings. At the moment this is accessible by all, but in time these may be moved to a secure password protected area on the site. Under "current issues", the site carries reports or links to reports being debated at both English and UK level. Subject to demand, there may be a discussion forum where the local membership can post their views.

### www.nibgs.org.uk

The Northern Ireland site, along with a Trainees' section, specialises in an exhaustive and useful list of links to on-line journals and electronic books and texts, including evidence-based guidelines. Most of these will have UK-wide (and even international) relevance for health care professionals.



### www.bgs-scotland.org.uk



The Scotland site, also under construction, publishes copies of the BGS Scotland Newsletter which began life long before devolution. It incorporates comprehensive sections on the academic centres in Scotland, job vacancies and also a Trainees Section. It too will have a discussion forum.

### www.eldermedcymru.org.uk

While the Wales site also has training and events sections, it has a sophisticated search facility to cater for visitors wishing to trawl its extensive list of services guidelines and reports on issues of topical interest, again, having both local, UK-wide and, in some cases, international relevance.



### On line newsletter www.bgsnet.org.uk

There is a discussion forum available to both the membership and health professionals. In the interests of keeping the site free of Internet vandals who are inclined to post vacuous rubbish on discussion forums, participants need to register on the forum. We would urge members to register and post their views. It has been very quiet to date, but provides a useful vehicle for debate and communication among members.

**Recia Atkins and Annette Guerda-Fischer**  
BGS Office

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