



Editor: Rebecca Dunn

# BGS

n e w s l e t t e r

## A delegate's personal view of the BGS Autumn Meeting 1999

The last conference of the millennium should have served to remind me, at the half century myself, why I got interested in elderly care medicine in the first place. It succeeded, and abundantly.

The mark of a good conference is the number of changes one will make in practice as a result. Here's one. I now know that, for at least 60% of patients with that awful chronic, isolating, painful and expensive condition (£600 million per year to the NHS) varicose ulceration, cure is available. Nick London, professor in vascular surgery at Leicester,

earned the longest ovation of the conference with his inspiring account of how he found that deep vein incompetence can be excluded in at least 60% of sufferers by colour flow doppler scanning. These fortunates (if they live in or near Leicester) Nick cures by superficial vein ties, a day case procedure. In his first 122 cases thus treated ulcers healed in 90%.



*A cartoonist injects a lighter note into the Autumn Meeting*

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My next favourite moment was provided by Danielle Harari. I had always suspected that there was more to diagnosis and treatment of constipation than simply spotting it then using some

**continued on page 5**

**President:** Dr Brian O Williams, MD, FRCP (Glas, Lond, Ed) **President Elect:** Prof Cameron Swift, PhD, FRCP  
**Honorary Secretaries:** Dr Rebecca B Dunn and Dr Chandi Vellodi **Meetings Secretary:** Dr Margot A Gosney  
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specialist medical society for health in old age

# Editorial

page 

**H**appy New Year and welcome to a bumper edition of the Newsletter!

The usual pattern is a Newsletter every two months starting in January. Early last year it was decided to amalgamate the first two editions of 2000 and publish in February (instead of January and March) in order to include a report of the Autumn Meeting which, as a one-off, was being held in December, and to avoid any electronic problems associated with the year 2000. The next edition will be in May and every two months thereafter.

### Royal Commission

The turn of a year is a time for reflection. Looking back to 1999, perhaps the main item of unfinished business is the Government's failure to respond to the recommendations for funding long term care made by the Royal Commission which it set up. The crux being that nursing and personal care should be available after assessment, according to need and paid for from general taxation. The cynics among us are wondering whether the response will keep being delayed until there is no time before the next general election. It is surprising that a government so adept at marketing and sensitive to public opinion has apparently failed to grasp the vote winning potential of implementing the recommendations. Given the demography of our population I think the future of New Labour as the party of government in this country would have been secured for the foreseeable future. It would also have been a more worthwhile millennium project for a supposedly civilised country, than the tented theme park at Greenwich. I think there has been a serious misjudgement of what the British public values. The other main recommendation namely that a National Care Commission be set up, has been accepted, but this will not happen until 2002.

### CEPOD

Last year's Report of the National Confidential

Enquiry into Perioperative Deaths concentrated on those under 16 years and those 90 and over. The sections concerned with the elderly are so important that the relevant parts of the executive summary are reproduced in this Newsletter. We need to discuss these with our surgical and anaesthetic colleagues and encourage action in their directorates.

Looking forward, the National Service Framework for Older People, which is due to be published this year, will be an important milestone for our specialty. Its implementation should remove the much-publicised inequalities in care for elderly people and correct the substandard provision highlighted last year by Age Concern and Help the Aged \* (see below for details of the documents concerned).

A New Year offers an opportunity for speculation. On page 21 Dr. Huw Williams suggests that geriatricians should become primary care based, a move which I suspect would fit in with the views of Dr Norman Vetter who favours a widening of our specialty to the general care of complex problems in all age groups (page 22). Dr Jacqueline Close, from her viewpoint as a trainee (page 24), provides a timely reminder of the need to improve our image and get our research act together. This latter point echoes the theme of the 1999 Marjory Warren Lecture (page 19).

Finally, as an 01 01 01 person, all that remains for me to do is wish you the very best for what is left of the 20th century!

**Rebecca Dunn**

\* *Turning Your Back on Us: Older People and the NHS*. Available from: Age Concern Mail Order Department, 1268 London Road, London SW16 4ER, telephone 0171 765 7203, £5.00.

*Dignity on the Ward: Promoting Excellence in Care of Older Patients*. Available from: Help the Aged, St James's Walk, Clerkenwell Green, London EC1R 0BE, £10.00

# President's column



If nothing else, the problems associated with ageing certainly stimulate would-be lexicographers to coin new words.

Thirty years ago the psychiatrist Butler introduced the word 'ageism' to represent prejudice against older people. More recently Paul Wallace, an economist, coined the term 'agequake' to encapsulate the seismic changes in the age profile of the world's populations due to the greying effect. Perhaps I could invent a new word 'agephobia' that could be defined as an irrational fear, dislike or antipathy of older people and their health needs. An extreme form of ageism, this might explain the desire of some clinicians and health service managers to exclude ill or disabled older people from acute hospital beds and give priority to younger patients. The healthspeak term for this growing trend is 'hospital diversion' and usually means poorer care for vulnerable old people.

## Euthanasia

We were all concerned by banner headlines in the national press in early December, 'Elderly abandoned to starve by the NHS'. I understand that statements made by a London academic psycho-geriatrician may well have been misinterpreted by the media watchdogs. The allegation that elderly patients are being allowed to die through an unwritten policy of euthanasia to free hospital beds was widely publicised. We did make a reasoned comment to one of the broadsheet newspapers but, unfortunately, it was not deemed appropriate for publication or perhaps it was not polemical enough. The BGS views are clear. We do not support or encourage euthanasia, which is an illegal act. We abhor the concept of withdrawal of normal nutrition from any patient who can manage physiological swallowing and digestion. However we recognise that it is very difficult to make tidy soundbites about the role

of artificial nutrition in individual cases without an informed discussion.

## Distinction Awards

The 1999 awards cycle is now complete and the 2000 cycle has already started. Geriatricians received 4 A+, 2 A and 16 B level awards within the UK. The national process for deciding awards is slightly different in the three constituencies of England and Wales, Northern Ireland and Scotland. The principles are the same, however, and you should consult your local guide, which is available by contacting your human resource department for advice. You should be able to access the 'Guide to the NHS Consultants' Distinction Awards Scheme' on the appropriate website.

In broad terms the process is as follows: Consultants are nominated for A or B awards by a variety of organisations including the Royal Colleges, the BGS and individuals. From 1999, consultants can also nominate themselves for an award. In England and Wales, Regional Awards Committees consider nominations from all sources, together with the views of the employing body. This also allows for a systematic consideration of all consultants in their area of responsibility to ensure that deserving cases are not overlooked. Nominations are then prioritised and submitted to the Chairman and Medical Director of the Advisory Committee on Distinction Awards (ACDA) and they, in turn, submit the final list to ACDA for final deliberation. The systems for processing nominations are different in Northern Ireland and Scotland but equally painstaking.

In the last year or two and largely because of Government influence there have been major moves to make the Awards system more open or 'transparent'. ACDA has attempted to pay more attention to what have been described by mandarins as 'The dark corners of the NHS'. Proper consideration must now be given to less acute specialties, non-teaching institutions and non-academic consultants who make major contributions to the work of the NHS.

The current BGS system is as follows: In October a letter is sent to Father Figures asking them to take soundings about potential nominees for A and B awards for the coming year. In late November or early December ACDA sends the BGS the new nominal roll. Copies are sent to Father Figures. In December the BGS awards advisory group (President, President-Elect and Immediate Past-President) reviews the success and lack of success of the previous years' BGS nominations and prioritises the new regional nominations provided by the Father Figures. The BGS then submits between 20 and 30 nominations to ACDA. The awards advisory group consults with the Father Figures in

Northern Ireland and Scotland and submits nominations to the appropriate authorities. The BGS system pays particular attention to contributions made by consultants to the specialty of geriatric medicine, to the NHS and to the work of our own specialist society.

To those of you who are numerate, and perhaps a little less neophilic than the current trend, I wish you a wonderful New Year in this the last year of the century and the millennium. For the others I have the same sentiments, but I reckon you will manage two great parties instead of one!

**Brian Williams**

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**'Autumn Meeting' continued from page 1**

stepwise laxative protocol. In fact, I now understand, different causes require different treatments. Constipation due to slow transit, for example, responds best to lactulose then senna (magnesium sulphate if hypotonic) whereas rectal impaction demands glycerine then bisacodyl by suppository. Colonic faecal impaction requires arachis oil enemata and daily tap water enemata thereafter followed by senna (3) and lactulose (30cc bd). It was also good to be given permission to Xray the abdomen now and then to make these distinctions. You know it makes sense.

**Common things occur often**

Better care of common things provides the maximum health care benefit. Michael Whitelaw, in his lucid and revealing account of the National Diet and Nutrition Survey, brought us back to basics again by reminding us that dietary deficits are terribly common among the frail old, even in this land of plenty. Poor mouth and tooth condition is a major factor in this. Full dietary assessment should be routine in hospitals.

Diet too probably has the major aetiological role in prostate cancer, which explains its rising incidence in the third world, where unhealthy Western dietary habits are creeping in. Orchidectomy, losing favour here as LHRH analogue treatment takes over, will be the treatment of choice once more in the poorer countries as the expected epidemic develops, said Malcolm

Coptcoat, in his informative and humane overview of this common cancer. Remember too that one-off PSA measurements mean little, trends up are the real marker for cancer growth, (exercise bike riding apart).

**The debate on funding**

Professor Bob Stout, a member of the Royal Commission on Long Term Care told us about it on Thursday. Its conclusions are sensible. The provision of proper care for the very frail can be made by our society without ruinous taxation. So why does our government not go ahead and accept the recommendations in full? Is Prof Stout right to suspect that a Royal Commission is partly designed to defuse anger on a matter of public outrage? My only quibble with the Commission is on the issue of the split responsibility for funding. The way to avoid the twin curses of inappropriate provision (including bed blocking) and budget protectionism, is to unify health and social service budgets for elderly non acute care under one umbrella. Why was the opportunity not taken to advise this?

I can hardly wait for my next cases of varicose ulceration and constipation!

**Andrew Whitehouse**  
**Consultant Physician**  
**George Eliot Hospital, Nuneaton**

*We are sorry to learn of the sudden death of Mr Malcolm Coptcoat.*

# Reports on non-BGS meetings



## 'MEDICINE IN AN AGEING SOCIETY'

This meeting was organised by the BMJ and held at BMA House on 23 November 1999. The meeting began with David Hall, Professor of Community Paediatrics at Sheffield, considering the consequences of an ageing society upon young people, including the fear of diversion of resources from child health services, which Primary Care Groups don't see as a problem area, the implications of reduced contact with grandparents (as childbearing is postponed later and later) and the care of severely handicapped people surviving into middle age, looked after by aged parents. While these are interesting points, methought the professor did protest too much: these seem small problems compared to those that old people face, and I hadn't noticed that children were losing their fund-pulling power.

### Demographic projections

Professor Kay-Tee Khaw then presented the demographic projections of a 50% increase in the number of elderly people in Britain, reaching a plateau in the middle of the next century - but also the more hopeful fact that the percentage of elderly men dependent in four chosen activities of daily living have halved in the last 20 years. Projections for population are much more robust than those for incidence of disease or prevalence of disability: the likely numbers of patients with fractured femoral neck could vary by a factor of two, depending on the base year chosen for projection. This variability itself however suggests that there may be room for intervention - though the proportion of young women dieting, smoking and drinking doesn't make me optimistic for my successors.

### Ageism in the NHS

Professor Ann Bowling of University College London discussed Ageism in the NHS, in particular looking at cardiology. Ageism and discrimination were decried, but I didn't feel that the ethical complexities of rationing, or indeed the clinical issues in frail old people, were adequately addressed: we have to accept that, other things being equal, a 45 year old is likely to gain more life-years than an 85 year old from some interventions. Plainly, other things usually aren't equal, and it will probably do more good to thrombolysed the 74 year old on his first infarct than revascularise the 45 year old on his fifth.

Professor Elaine Murphy, Old Age Psychiatrist turned Health Authority Chairman, explored the implications of population change for hospital use, with increasing admission rates, shorter stays and declining bed numbers, in a typically robust fashion.

Professor Shah Ibrahim ended the morning by exploring the implications for training, as (nearly) all doctors will need to understand old peoples' needs. He recorded the pressures on the undergraduate curriculum and the hostile environment in post-graduate training. He called for six months geriatrics for all aspiring physicians - as should we all - but wouldn't all specialists say the same for their own field? He also suggested that all doctors should be accustomed to the idea of career changes - evidently setting an example himself.

### In favour of virtue

In the afternoon the conference divided into groups discussing training, primary care, hospital care, long-

term care, ageism and medical institutions. In my experience, whatever the merits of the discussions, the conclusions of such exercises come out as in favour of virtue, and none came out with ideas of the radicalism that might be necessary to meet future needs. The Ageism group thought that specific services for old people were ageist; I confess I am - positively ageist.

In conclusion Professor Sir John Grimley Evans emphasised the need for local, not global, solutions, adequate funding, intergenerational equity, decent data and collaborative research networks. He stressed the dilemma of individual versus collective needs in rationing decisions, but more controversially questioned the need for geriatric input into primary care - and claimed that he'd 'rescued' three relatives from geriatric departments.

When I saw that most of the papers had already been published in the BMJ, I wasn't sure whether it would be worth getting up early in order to go. I'm glad I did, because there were some good ideas (as well as old friends). However, I didn't feel that we could really see much beyond the next few years, or far outside the boundaries of existing services. Sadly, some people still need to be persuaded that frail old people are likely to do better when looked after by doctors interested in them!

**Dr Edmund Dunstan**  
Consultant geriatrician  
Birmingham

**‘SHARING BEST PRACTICE FROM EUROPE AND THE UNITED STATES  
IN THE CARE OF OLDER PEOPLE’**

This conference, organised by the Department of Health and held in December 1999 at the end of the UN Year of Older Persons, achieved its aim of being a celebration. It was attended by about 100 delegates invited from health and social services, the voluntary sector, government departments and other organisations such as the BGS, which have been part of the reference group for the International Year in the UK.

The event was ably and enthusiastically chaired by Professor Ian Philp, the geriatrician who co-chairs the External Reference Group of the National Service Framework for Older People.

John Hutton MP, Minister of State for Health, gave the keynote address. Unfortunately he did not apologise to us for his late arrival which had delayed the start of the conference. ‘What arrogance’, muttered my neighbour, a general practice manager. ‘Patient charter standards obviously don’t apply to ministers’, I whispered back. His speech was predictably upbeat, itemising what this government has done for the elderly. Looking to the future, assessment and rehabilitation seemed to be firmly in his vocabulary but it was unclear what these would mean in practice. I sensed a more social services rather than medical/health emphasis. There will be new guidance on eligibility criteria for long-term care in 2000, taking into account the High Court ruling in the Coughlan case. There will be no decision on the funding of long term care until the summer.

**Tailored care**

The rest of the morning was occupied by four presentations which showed how care can be tailored to the needs of frail and fit elderly by involving the elderly themselves. Dr Monika White talked about the Center for Healthy Aging, a private, non-profit organi-

sation in California, which since 1976 has used professionals and volunteers to provide a range of health and community-based services designed to keep older adults healthy and independent. Assessments are carried out by professionals, but many of the services such as ‘the senior peer counseling program’, are delivered by appropriately trained and closely supervised elderly volunteers. This model has been replicated widely including by some of the voluntary agencies in the UK.

**Intensive home care**

From closer to home, Geraldine Coyle described how intensive home care has been provided to older people in Belfast for almost eight years. People so disabled that they would otherwise be in institutional care, (the example given was a tetraplegic woman with a Barthel score of 0), are maintained in their own homes by hybrid Care Workers, each client being carefully matched to their named Care Worker. The notes are multidisciplinary. The goals in the care plan are the client’s. The user standards for the scheme have been developed with and agreed by the clients. District nurses are involved in training the Care Workers and because of the care provided by the Care Workers, are themselves released to provide acute care in the homes of others as part of a rapid response team. There are fewer call-outs to GPs from clients on the scheme than from nursing homes. Most of the clients live alone and in the future it is hoped to use closed circuit television and video links so that clients can be monitored and also see and talk to somebody if problems arise between Care Worker visits. It wasn’t surprising to hear that the clients rated the service highly. One comment was, ‘not just looked after but really cared for by the Team’. It is not a cheap option; 40 hours of care a week cost £480.

**Senior Citizens Council**

Kristian Riis, Secretary General of the Danish Association for the Welfare of the Elderly, explained how in 1997 it became a legal requirement for every local authority in Denmark to have an elected Senior Citizens Council. The members, who are elected by citizens over 60, have a right to comment on all matters concerning the elderly in their area and with training they have been empowered to provide consumer opinions on matters such as home care, nursing homes, housing and meals on wheels.

**Consumer satisfaction**

The final presentation of the morning was by Dr Scott Geron who gave a fascinating description of his work in the United States developing an instrument to measure consumer satisfaction for home care services such as meals on wheels, based on the views of the users of those services. The Home Care Satisfaction Measure is being used as a performance measure for home care services in four states in the US. He acknowledged however that the relationship between consumer satisfaction and quality of services was not straightforward.

The lunch break was concluded with a poetry reading by the playwright Gabriel Gbadamosi. I had a sense of déjà vu as the work of some of the Irish poets encountered in April in Cork was included and seemed as depressing as it had then! The quotes from Jenny Joseph and Dylan Thomas helped redress the balance by providing humorous and defiant views of ageing.

In the afternoon session there were four workshops run concurrently which built on the themes of the morning, namely:

- ◆ Assessment and care management for older people led by

Professor David Challis, Director of the Personal Social Services Research Unit at the University of Manchester and GP Dr Chris Dunstan (see Newsletter May 1999 page 19);

- ◆ Effective community-based services for older people led by Naina Patel, Director of the Policy Research Institute on Ageing & Ethnicity at the University of Bradford and Janice Robinson, Director of the Community Care Programme at the King's Fund;
- ◆ Involving and empowering older service users led by Andrew Dunning, Advocacy and Engagement Officer at Better Government for Older People; and
- ◆ Evaluating and monitoring the

quality of services for older people led by Gillian Crosby, Deputy Director of the Centre for Policy on Ageing and Trish Davies of the Department of Health's Social Care Group.

I joined the first group and made sure I raised the importance of making a medical diagnosis as part of assessment and having specialist geriatric input when needed.

At the final plenary session each group fed back one action point. The wish list was as follows:

- ◆ A method of self-assessment for older people to identify their needs;

- ◆ Help for communities /elected members/ professionals to manage change, implement directives;
- ◆ Older people must own the problem and call in the professionals, not the other way round; and
- ◆ National standardised methods to measure outcomes for service users.

If a conference is judged by the feel-good factor produced, then this was a great success. I came away feeling better for having attended and optimistic that person-centred care can be achieved.

**Rebecca Dunn**

## MEASURING THE QUALITY OF CARE FOR OLDER PEOPLE

A packed audience of clinicians, academics and managers gathered to discuss the issues around setting, implementing and measuring high quality standards of care for older people. The meeting, held at the Royal College of Physicians of London on 10 November 1999, was organised by the Centre for Clinical Effectiveness and Evaluation (CEEu) and the National Centre for Health Outcomes Development (NCHOD).

### The National Agenda

Serious concerns exist over the quality of care for older people. Dr Sheila Adams, Director of Health Services at the Department of Health, identified examples such as poor treatment of older people in acute hospitals, denial of treatment on the grounds of age, premature discharge from hospital, and variations in the quality of care around the country. She outlined the national strategy for enhancing quality:

- ◆ central standard setting (NSFs, NICE)
- ◆ local delivery of quality care (Clinical Governance)
- ◆ effective monitoring (Centre for

Health Improvement, Performance Assessment Frameworks, Patients Councils).

Prof Ian Philp, Co-chair of the External Review Group for the National Service Framework for Older People, and Prof Peter Littlejohns, Clinical Director of NICE, developed the theme of central standard setting. The NSF for Older People has a challenging remit, embracing 50% of NHS activity and ranging from health promotion to palliative care. Expert working groups have been formed which, working to set principles (e.g. fair access to services, dignity, carer consideration etc) and utilising the evidence base, would be producing clear principles on which services should be based.

NICE equally and unashamedly is promoting high standards. The standards are determined by thorough and 'transparent' review of the evidence base. Work focuses on technology assessments, clinical guidelines, audit and the dissemination of clinical effectiveness. Input into the process includes a broad church of professions, industry and patient and carer

groups.

Mr Jim Coles, Director of CASPE (Clinical Accountability Service Planning and Evaluation), turned to the issue of measuring the quality of care. He identified the importance of producing measures that reflected the needs of clinicians rather than drawing on readily collectable central data. He outlined the methodology being used in developing health outcome indicators such as those used in the studies presented below.

### Measuring the Quality of Care Fractured Femur

Dr Alistair Mason of NCHOD, presented data from the Oxford record linkage dataset - a dataset of some 17,684 records from 10 hospitals in the Oxford area. The data demonstrated wide variations in case fatality rates between hospitals. The strength of this centrally derived data collection lies in the large number of records, the ease of access to such data across the country and relative reliability of the data collected. Problems were identified, however, in that case mix variables can not be determined, which may well impact

on the primary outcomes (case fatality rates). Furthermore other important outcome measures such as functional independence and length of stay cannot be determined from such databases.

**Stroke**

Dr Tony Rudd, Associate Director of CEEu, presented details of the National Sentinel Audit of Stroke. These data were obtained at a hospital level from case note review and from questionnaires filled in by locally based staff. The results for both outcome measures (length of stay, mortality, institutionalisation) and for process measures showed great variation around the country and generally reflected a poor level of care. Quality of care was greater when stroke unit care had been included. The large number of contributing Trusts gave the data great importance. Methodological problems included the risk of subjective bias in data obtained from case notes, however inter-rater reliability had shown a fair to good correlation. Process measures were useful in measuring the quality of care.

**Incontinence**

Dr Jonathan Potter, Associate Director of CEEu, presented data from a cross-sectional pilot study initiated by Professor John Brocklehurst evaluating outcome indicators in long term care settings. Data were gathered at the ward level from careplans, notes and from care staff. The data demonstrated great variation between settings in outcome measures (prevalence of incontinence, prevalence of indwelling urethral catheters) and process measures.

However it was clear that results were influenced by case-mix differences and by differing criteria for admission to different settings. While such data were useful within units for monitoring care, comparison between units would be unreliable.

**Summary of Discussion Evidence Base**

Many sought reassurance with regard to the methodologies and evidence base that would be used in setting quality standards. Some of the questions asked included: Would the standards set by NICE be scientifically backed? With regard to the evidence base 'is NICE going to look at older people as a specific group in any of the guidelines?' Would details of the evidence base and the methodologies be readily available? Would cost effectiveness be included?

**Implementation**

Many expressed concerns with regard to matching laudable policy objectives with resources. These included: How can local groups implement and take responsibility for quality without the resources to do it? How in practice can we get 'the right staff in the right place doing the right things'? How can cost neutral changes be achieved? Will the NSFs identify 'something which is clear and understandable about how the NHS is actually going to deliver ...?'. The standards are too broad so that local people have to make their own interpretation (like the eligibility criteria). How will the changes required reach to non-NHS parts of the service i.e. private nursing and residential homes? Should processes of care that reflect quality be imposed rather than infused?

**Measurement of Process**

Process measures can be used to reflect the quality of care. Measures used must be clearly defined and reliably recorded. Selected process measures can be used to identify the major part of differences between good performance and poor performance. Issues raised included: Do standardised processes lead to standardised outcomes? How do standardised processes allow for professional freedom? How do national requirements fit with local resources?

**Measurement of Outcome**

How are outcomes to be measured? Are we going to count proper people rather than FCEs? Dr Jonathan Mant pointed out that outcome is determined by chance, quality of care and case mix. In many situations case mix variables will obscure any possibility of measuring variations in the quality of care. Dr Iain Carpenter saw the way forward in the use of standardised assessment tools which do allow the collection of reliable, consistent data which can be used for comparisons within and between settings.

**Conclusion**

The day generated much discussion and raised more questions than answers. In so doing the aim of the day was met in exploring and informing the national debate about setting standards for, achieving and measuring quality care in older people.

**Dr Jonathan Potter**

**SURVEY INTO LONG TERM CARE - AN APOLOGY AND EXPLANATION**

With the November newsletter you received an A5 sized card with a short questionnaire about decisions and provision for nursing home care arrangements in your patch. This was

prepared by Martin Severs and me and I apologise that it was not accompanied by a note of explanation.

We were prompted by the events of

the Coughlan case in North and East Devon, and the subsequent appeal in the High Court (see Newsletter, Sept 1999). As reported then, we are

**continued on page 13**

**'EXTREMES OF AGE'**

To follow is a summary of the 1999 report of the National Confidential Enquiry into Perioperative Deaths entitled *'Extremes of Age'*.

**Background**

The National Confidential Enquiry into Perioperative Deaths (NCEPOD) is a registered charity whose aim is to review clinical practice and identify potentially remediable factors in the practice of anaesthesia, surgery and other invasive medical procedures. The aim is to look at the quality of the delivery of care and not specifically the causation of death. The commentary and recommendations made in the annual reports are based on peer review of the data, questionnaires and other records submitted to them. NCEPOD is not a research study based on differences against a control population and does not produce any kind of comparison between clinicians or hospitals. NCEPOD is an independent body to which a commitment has been made by the Royal Colleges, Faculties and Associations related to its activity. Since April 1999, NCEPOD has come under the aegis of the National Institute for Clinical Excellence (NICE), which provides the majority of the organisation's funding.

NCEPOD does not cover Scotland, where a separate enquiry is conducted, the Scottish Audit of Surgical Mortality (SASM).

NCEPOD collects basic details on all deaths occurring in hospital within 30 days of a surgical procedure. This data is submitted to the Enquiry by a designated Local Reporter within each hospital. A surgical procedure is defined by NCEPOD as *'any procedure carried out by a surgeon or gynaecologist, with or without an anaesthetist, involving local, regional or general anaesthesia or sedation'*.

**The elderly**

Life expectancy is increasing and society understandably demands and

expects successful outcomes after surgical intervention for this elderly population. It is, therefore, pleasing to report that there was a high level of consultant input into decision-making in the care of these elderly patients. The greatest problem seen in this group concerned the management of fluid balance and the lack of multidisciplinary care despite a high level of coexisting medical conditions. The report highlights the need for a full diagnosis, evaluation and rigorous preoperative high dependency approach to stabilising the physiological state of the patients before surgical intervention. This should help reduce postoperative complications. Issues surrounding emergency admissions throughout the week, and the availability both of emergency theatre time and of sufficiently senior clinicians, are factors behind the delays in treatment of some elderly patients that still need to be addressed. The lack of high dependency beds has been recognised but the problem of providing suitably trained nursing staff is an even greater resource issue. Unless this is addressed, it is difficult to envisage significant improvements in the care of this group of patients.

NCEPOD was concerned at the low post-mortem rates. It is highly desirable that clinicians should be present at post-mortems, yet this seems not to occur, presumably due to other commitments. This results in an even greater need for post-mortem reports to be communicated to the clinicians involved, which does not occur sufficiently frequently.

**Findings and recommendations**  
**General issues**

- ◆ A large number of patients in the sample were hypotensive during surgery although the precise incidence was difficult to quantify. It may be indicative that hypotension was reported as a perioperative adverse event in 17% of cases. Hypovolaemia should be corrected before operation

whenever possible and particular care is required when general anaesthesia combined with epidural analgesia is used during emergency abdominal surgery, especially when there may be sepsis.

- ◆ Fluid balance charts were reviewed and indicated that fluid imbalance can contribute to serious postoperative morbidity and mortality in the elderly, who may have renal impairment or other coexisting medical disorders. Accurate monitoring, early recognition and appropriate treatment of fluid balance are essential. Fluid management should be accorded the same status as drug prescription.
- ◆ The documentation on fluid charts was often poor. Doctors and nurses of all grades need to understand the clinical importance, and ensure the accurate recording, of fluid intake and output. Multi-disciplinary review of the problem and development of good local working practices is required. Fluid charts are important documents that need to be retained and appropriately filed for future reference.

**Specific issues**  
**Anaesthesia**

- ◆ There has been expansion in the number of non-consultant career grade (NCCG) anaesthetists. Their requirements for personal development, continuing medical education and supervision need to be recognised.
- ◆ The majority (81%) of patients were treated in a hospital with an acute pain service but a minority of patients had a pain assessment chart, the use of which is recommended.
- ◆ Non-steroidal anti-inflammatory drugs should be prescribed with particular caution in elderly patients in the postoperative period. They can contribute to postoperative renal failure in patients with renal impairment and those receiving ACE inhibitors, potassium-sparing diuretics or beta-adrenergic blockade.
- ◆ Postoperative respiratory com-

plications were more serious when patients were anaesthetised by less experienced anaesthetists. The dose of opioid or sedative drug needs to be titrated to effect. Elderly patients most at risk of complications are those with concomitant medical disorders, metabolic disorders or electrolyte disturbance.

### Orthopaedic surgery

- ◆ Orthopaedic surgeons need to establish whether there is sufficient expertise available within their team to manage the complex medical problems of these patients, or whether local guidelines for shared care should be developed.
- ◆ Pressure sores remain a problem in orthopaedic patients. Constant vigilance is required in this high risk group of patients.
- ◆ There is a wide variation in the experience and qualifications of non-consultant staff undertaking emergency orthopaedic surgery.
- ◆ Studies need to be undertaken to establish the relative advantages and disadvantages of using urinary catheters in orthopaedic trauma patients.
- ◆ Whilst infrequent cement reactions are often lethal in the elderly, guidelines should be available for the management of cement related complications.
- ◆ Studies are still required to determine the place of thrombo-embolic prophylaxis in orthopaedic patients.

### General surgery

- ◆ The decision whether or not to operate on these elderly patients is frequently difficult and should be made at consultant level. More careful investigation might prevent futile major surgery in patients with disseminated malignancy.
- ◆ An accurate method of assessing the risk of surgery is required. P-POSSUM is suggested as a possibility.

### Urology

- ◆ 66% of patients were operated on by a consultant, but in only half of these cases were trainees present in theatre. Is this a missed training

opportunity?

- ◆ General anaesthesia was used for a number of simple procedures where local anaesthesia might have been preferable in these frail patients.
- ◆ Guidelines on check cystoscopy should take into account the risks due to the high incidence of comorbidity in the elderly.

### Neurosurgery

- ◆ In elderly patients with confusion, if the diagnosis is unclear, a CT or MRI scan of the head should be performed promptly, so that surgically remediable intracranial conditions can be identified.

### Vascular surgery

- ◆ The decision whether or not to operate on these elderly patients is frequently difficult and should be made at consultant level. It is questionable whether any patient of 90 years or over should have a ruptured aortic aneurysm repaired.
- ◆ It is important for an anaesthetist of suitable experience to be present during embolectomy under local anaesthetic, for appropriate sedation, monitoring and resuscitation. Embolectomy should be performed by surgeons who have sufficient vascular experience and expertise to be able to perform an arterial bypass operation if required.

### Pathology

- ◆ Systems need to be established to ensure that clinicians always receive copies of coroner's or hospital post-mortem reports.
- ◆ The Royal College of Pathologists' guidelines may now need expansion and updating, with inclusion of guidance on OPCS formatting for cause of death and examination of the locomotor system.

### Clinical

- ◆ Fluid management in the elderly is often poor; it should be accorded the same status as drug prescription. Multidisciplinary reviews to develop good working practices are required.
- ◆ A team of senior surgeons,

anaesthetists and physicians needs to be closely involved in the care of elderly patients who have poor physical status and high operative risk.

- ◆ The experience of the surgeon and anaesthetist need to be matched to the physical status of the elderly patients, as well as to the technical demands of the procedure.
- ◆ Elderly patients need their pain management to be provided by those with appropriate specialised experience in order that they receive safe and effective pain relief.
- ◆ Surgeons need to be more aware that, in the elderly, clinically unsuspected gastrointestinal complications are commonly found at post-mortem to be the cause, or contribute to the cause, of death following surgery.

### Organisational

- ◆ If a decision is made to operate on an elderly patient then that must include a decision to provide appropriate postoperative care, which may include high dependency or intensive care support.
- ◆ There should be sufficient, fully-staffed, daytime theatre and recovery facilities to ensure that no elderly patient requiring an urgent operation waits for more than 24 hours once fit for surgery. This includes weekends.
- ◆ Clinicians are still unable to return data to NCEPOD as a result of missing patient records. Action is required to improve hospital record systems; this is within the remit of clinical governance.
- ◆ NHS Trusts must take responsibility for ensuring that all relevant deaths are reported and questionnaires returned to NCEPOD as part of their clinical governance duties.

**Rebecca Dunn**

*With thanks to NCEPOD who kindly permitted us to reproduce parts of their report. The 1999 report is available for downloading from the NCEPOD website at [www.ncepod.org.uk](http://www.ncepod.org.uk). Alternatively copies can be obtained by sending a cheque for £15 to NCEPOD, 35-43 Lincoln's Inn Fields, London WC2A 3PN.*

## Standards of care in homes for older people - Government plans national standards



The BGS is joining with other organisations in responding to the Department of Health consultation document entitled – ‘Fit for the Future? National Required Standards for Residential and Nursing Homes for Older People’.

Last year, in its White Paper ‘*Modernising Social Services*’ the Government set out its intentions to modernise various aspects of social care including the regulation and inspection arrangements for residential and nursing home provision for older people (see BGS Newsletter, March 1999). The Government then commissioned the Centre for Policy on Ageing (CPA) to provide a document setting out suggested national standards for care in homes. The intention is to overcome a number of problems.

- ◆ The lack of independence whereby local and health authorities have to commission, sometimes provide and also inspect services.
- ◆ The unsatisfactory split of responsibilities resulting in a lack of coherence in monitoring the various aspects of provision - environment, social care and health care.
- ◆ Lack of consistency between local authorities and between health authorities. This has created problems for providers, particularly the large chains, and also resulted in uncertainty for the residents as to what standards they can expect. It was recognised that the Registered Homes Act of 1984 does not set out in sufficient detail the standards that care homes should meet.

The purpose therefore of the CPA’s work was to set up nationally required standards of a minimum nature rather than best practice, and to assess the likely impact of their introduction on the care homes sector.

The CPA involved many individuals on their advisory groups including Professor Tom Airie

(representing the Royal College of Psychiatrists, retired professor of health care of the elderly at Nottingham), Dr Michael Denham (representing the BGS and Royal College of Physicians and past president of BGS) along with representatives from nursing, pharmacy, providers, regulation and inspectorates and voluntary organisations. Methods of working also included listening to the views of residents using a number of techniques including personal questionnaires, discussion groups in several homes and interviews with individual residents. As the issues emerged, a number of specialist groups was established to concentrate on specific issues e.g. health and personal care, staffing and so on. The document has now been issued for consultation, and the BGS has responded.

The report was split into sections, each associated with some specific standards. It is important to emphasise that these standards are regarded as obtainable within a few years and are not aspirational i.e. there would still be plenty of room for improvement. The sections covered include:

- ◆ Information given to prospective residents in the brochure and prospectus
- ◆ The rights of individual residents
- ◆ Complaints
- ◆ Policies and procedures
- ◆ Health and personal care
- ◆ Social activities
- ◆ Food and meal times
- ◆ Death and dying
- ◆ Physical environment (e.g. room sizes)
- ◆ Management and administration
- ◆ Staffing

There is then a series of glossaries covering details of nutritional guidelines and other sources of detailed information that can be used by both the regulation bodies and the homes themselves.

The intention of the Government is that these

standards will be set at three levels. Some will be enshrined in law and therefore a legal requirement on the providers. Some will be strongly recommended though not enforceable in law, but will be monitored by the regional Commissions of Care Standards (the new regulatory bodies) and may be required from homes as a condition of block contracts etc. Others will be purely advisory.

As far as the detailed content is concerned, there is much that we can support and little from which we would dissent. There is clearly an intention that all residents should have access to a single room but this would not be obligatory in terms of regulations. On the other hand, it might force care home providers to dispense with double rooms which many of our members feel have some benefit for some residents, particularly couples and close friends etc. As far as room size is concerned, specification is laid down and this specification will of course contribute to the overall cost of the home. Possibly, residents with severe disability will gain less from having a larger room than they might gain from the available space being used in a communal way. Thus the response from the BGS (along with others) is that the room sizes should be adequate for the care to be provided but not be too prescriptive about the size.

Following consultation with the Care Home Medicine Special Interest Group and others in the Society we have responded independently and also in collaboration with other organisations. Our main concern was that the detailed standards of care, particularly health care, were inadequately covered. We have drawn attention to the need for:

- ◆ Clarity about the availability of cardiopulmonary resuscitation
- ◆ Guidance about the response to advance directives
- ◆ The need to record information relevant to

judgements about the capacity of residents in their clinical and other decision making

- ◆ The need for adequate documentation to accompany residents on attendance at hospitals and other such places
- ◆ Greater emphasis on the need for clinical guidelines about urinary continence, restraints, risk of falling, development of pressure sores
- ◆ A requirement for individual care plans which cover the above issues and also issues such as medication use, detection and management of depression and reducing disability
- ◆ The need for each home to develop clear written agreements with its local elderly care specialist providers and community health services about provision of specialist assessment, treatment and rehabilitation and similar arrangements for specialist palliative care where appropriate.

The CPA, having delivered this Report to the Department of Health, is keen that the momentum is not lost. To that end it has created a 'Coalition for Quality in Care' with a number of organisations including the BGS. This seeks to put pressure on the department to implement these care standards at the earliest opportunity and ensure that the Commission for Care Standards is set up with adequate representation from relevant clinical disciplines so that it is competent to regulate and monitor them adequately. We would hope very much that the BGS would be involved in at least an advisory capacity in setting up these regional bodies.

Anyone wanting further detailed information about the document or the consultation can contact Indra Sikdar Esq, DoH, Room 625, Wellington House, 135-155 Waterloo Road, London, SE1 8UG. Tel: 020 7972 2000.

**Finbarr Martin**  
BGS Policy Committee

**'Long term care survey' continued from page 9**

working with the RCN, Alzheimer's Disease Society and others to apply pressure on the DoH for them to clarify the issues of eligibility for NHS-funded continuing care and get

rid of the current lottery. We wanted to know how a specific case would be judged locally so as to identify national variation, and to find out the degree of involvement of geriatricians in these decisions. This will help us in following up discus-

sions we have had at the DoH. Thank you for the over 200 responses we have received. This a very good and useful response and the results will be reported in the next Newsletter.

**Finbarr Martin**

# Purchase of a BGS office

a report by Ian Sturges, Honorary Deputy Treasurer



At the Extraordinary General Meeting in December, I promised an article explaining the outline business case for the Society to purchase a property in London and to provide some thoughts on the timing of that purchase.

## Why do we need an office at all and why can't we stay as we are?

The Society's operations have grown increasingly in volume and complexity over the past 10 years. To function effectively requires regular meetings of Council, the Executive and the craft Committees.

## St Andrew's Place no longer an option

We have no security of tenure; the present lease expires on 25 December 2000 and the College from whom we rent will only offer a 3-5 year lease thereafter, to provide flexibility should they need the space themselves. The British Thoracic Society has already had to move out to allow RCP expansion. Others, e.g. the Paediatricians moved of their own accord but their space was immediately taken up by the College.

We cannot accommodate the Society's Council, Age & Ageing Board and full Training Committee meetings. The layout of the current BGS premises is also unsatisfactory with the offices on the 3rd floor divorced from the ground floor meeting room.

## Paying rent an unsatisfactory option

The Society will have spent £192,000 in rent alone over 10 years, in addition to £15,000 in refurbishment, as well as substantial sums in hiring outside facilities for Council, Age & Ageing and other large committee meetings. The Society has no asset to show at the end of this.

Future rental charges in St Andrew's Place are expected to increase. We spent £41,000 pa in rent, rates and service charges prior to 1995 when the charges were reduced to a total £35,000 pa to reflect the downturn in the market rate for rented property. The College needs money to fund, e.g. its increasing role in the Government's quality agenda, its development of regional offices etc. The increase in Fellowship fees bear witness to this. It is logical to assume that future rental charges to their tenants will therefore be increased to reflect the upturn in market rates. The rent pro rata to each tenant and house also has to cover the upkeep of the Georgian facade.

## Purchase versus renting - the principle

The underlying principle is that it is cheaper to buy than rent in the long term. The Abbey National Survey reported by Sunday Times in April 1999 compared purchase cost against rent paid on a 4 bed house in the South East. Assuming 4% growth pa in property prices and mortgage interest rates of 6.85%, the purchase cost over 25 years was £338,000 against rental costs of £664,000. There are many factors to be considered in this comparison - varying interest rates, terms and length of mortgage etc, but as a general principle the tenet espoused by the Sunday Times applies to the BGS purchasing a property. The Society needs to take a long term view. The eventual savings for the BGS on rent can be put to training and research grants or even reducing subscriptions.

Initially the cost of a mortgage may be higher than the rent on hired premises, but over the term of the mortgage, the capital base on which the mortgage is calculated will go down and the cost of servicing and

repaying the loan will reduce. At the end the Society will have a capital asset, which over time will accrue in value and be cheaper to run than a rented equivalent. The savings eventually achieved in operational costs will go to support research and training grants.

## Why London?

The issue of an alternative to London has been debated many times over many years, invariably with the same conclusion - members from across the length and breadth of the UK (e.g. Aberdeen, Belfast, Aberystwyth, Norwich, Truro) can get to London for a meeting and back home again in one day. This is not yet possible in respect of other cities.

There is also the factor of increasing co-operation with the London College and UK associations based there. The BGS Training Committee is composed of members from each region in the UK. It always meets on the same day as the SAC for Geriatric Medicine in the RCP-L on account of the linkage between the two. Many BGS members have individual associations with the College for which they try to combine visits to the College with visits to the RCP.

The Society needs a place for officers to foregather to prepare for meetings with Government ministers prior to seeing them - if not in our own premises, then in a hired venue. From our discussions at the DoH, it is apparent that senior Civil Servants still spend as much time in London as they do in their putatively main office in Leeds. Some even have two offices - one in Leeds and one in London. It is also worth noting that while Age Concern chose to have their main office in Morden, they keep premises in Central London opposite Euston Station. There is increasing

contact with European Societies and institutions e.g.

European Geriatricians' meeting. London remains a

major centre of access for European countries.

### Comparing the costs of rent and purchase

Members should be aware that financial assessments are always in a fluid state as the market varies. Outlined here is the most up to date information we have to hand, and allows for the fact that property prices have risen since early 1999. Obviously, the Finance Committee will review the assessments as often as is practicable. Time lags between information received and fully disseminated to the membership will result in some of the information being out of date. Please bear with us, our aim is to maintain the Society's best interests and that of its members at heart.

Presently our expenditure is approximately £11,000 less than the lowest of these two figures i.e. £35,000 per year due to a mid lease rent review

when the rent market was at a low point. We therefore feel that the best case scenario is probably the absolute minimum the College will require, although there is the distinct possibility that the College may take a more market-

orientated approach. The higher figure is what we have been quoted for a comparable property within the same area of London to cater for the likely contingency that we will need to leave the Precinct in the foreseeable future.

If we have to move from 1 St Andrews Place there

will be an estimated £42,000 Capital Cost needed to adapt the property to meet our needs, which will apply also to the adaptation of purchased premises. This is clearly an estimate and wherever possible this would be kept to a minimum.

#### Anticipated future rental costs

Best case scenario		Worst case (market rates)	
Rent	£30,000	Rent	£70,000
Services	£11,500*	Services	£11,500
Rates	£1,500*	Rates	£ 1,500
Power	£3,000*	Power	£3,000
<b>Total</b>	<b>£ 46,000</b>	<b>Total</b>	<b>£86,000</b>

\* Current Expenditure.

### Purchasing a property - 2000 sq ft

#### Assumptions

Purchase price £1 million  
 BGS deposit £400,000  
 Mortgage £600,000  
 Term 20 years

#### Annual costs

Mortgage £63,000  
 Services £ 6,000  
 Rates £ 5,000  
 Sinking fund £ 3,000

**Totals £77,000 pa**

#### Capital costs

Partitioning £15,000  
 Redecorating £ 2,500  
 Cabling, phones £ 3,500  
 Legal, bank, registration fees £21,300

**£42,300**

This scenario does place us at the mercy of the vagaries of interest rates, but there is the potential for income generation (as long as this does not contravene our charitable status) and the property will be an appreciating asset.

**How would this purchase be funded?**

	Purchase price of £1m in 2000	Financial status as at 15 December 1999
<b>Funded by:</b>		
RBS mortgage of Reserves	£600,000	-
Meetings & 98/9 surplus	£244,000	£244,000
Individuals & Regions	£ 70,000	£ 70,000
Subs levies	£ 51,000	£ 13,438
	£ 25,000	£ 20,000
<b>Total</b>	<b>£990,000</b>	<b>£347,438</b>
<b>Shortfall</b>	<b>£ 10,000</b>	<b>£ 52,562 (excluding mortgage)</b>

These figures are significantly different from those in Dr Jonathan Potter's (the immediate past Treasurer) original fundraising strategy conceived in January 1999 since we are now one year further down the line and not only has the property market changed significantly so, fortunately, has our financial situation. Both of these are highly likely

to change again because of the continued upsurge in property prices, and because of fundraising and the superb efforts of Dr Margot Gosney at the highly successful Autumn meeting in 1999, the final financial figures for which we have not received prior to going to press.

Our options are, therefore, either  
 a) to consider immediate purchase and then build up reserves to pay off significant chunks of the capital to reduce our mortgage repayments; or  
 b) to wait until we have built up the capital reserve and then move into the property market at that time, approximately in 2003/2004.

**Arguments in favour of purchasing now :**

- ◆ Highly competitive terms being offered to us by the Royal Bank of Scotland which would allow us to borrow a higher amount initially at very competitive interest rates.
- ◆ Potentially beating the predicted rapid rise in London property prices and thus limiting our borrowing and avoiding the possibility of not being able to afford the move due to price

rises.

- ◆ Through fundraising we would be able to pay off parts of the capital loan reducing our expenditure.

**Arguments against purchasing before we have built up a capital reserve**

- ◆ If we fail to raise a significant amount of capital we would be left with a significant mortgage to service.
- ◆ Property prices do have a habit of falling as well as rising in the short term.

Second guessing the market is not something even the experts get right. However, entering the property market if you can sustain the vagaries of interest rates is a sound investment in the long term,

and the general feedback at the EGM was to proceed with the early purchase of a property. This is what we are preparing to do and will seek final ratification from the Executive and Council as a means of ensuring democratic accountability. Trying to share rapidly changing information with the membership to seek their formal approval would seriously impede our ability to take advantage of market opportunities. However, as far as is possible we will keep everyone informed as to the situation regarding the purchase.

If any member would like further information, the office or I will gladly answer your questions as rapidly as possible.

**Ian Sturgess  
 Honorary Deputy Treasurer**

**BGS HANDBOOK 2000 - WE NEED YOUR HELP!**

We are hoping to produce a new BGS handbook in the near future. To help us with this task we would greatly appreciate it if you could complete the details on the card at the front of this Newsletter and return it to us as soon as possible. Thank you.

# BGS Autumn Meeting 1999



**D**r Rebecca Dunn and Dr Chris Dyer report on the BGS Autumn Meeting of the British Geriatrics Society, which was held in London from December 15 to 17 last year.

This was the first time it had been held at the Novotel, Hammersmith, and turned out to be the best attended scientific meeting ever held by the Society, with a final tally of 676. The venue was large enough to accommodate the entire conference including ancillary meetings (one of which was the Association of Professors of Geriatric Medicine), the pharmaceutical companies' displays, and the Annual Dinner, as well as providing hotel accommodation for many delegates. Everything on one site was a big improvement on previous London meetings and attracted many from out of town. Delegates came from all corners of the UK including the Isle of Man and Channel Islands, as well as the Republic of Ireland, Australia, New Zealand, Hong Kong, Malaysia, Egypt, Malta, Germany, Denmark, the Netherlands and the USA. The numbers and plain, almost clinical, décor of the conference centre, did not prevent the meeting from having an intimate feel and we were soon reacquainted with friends and colleagues.

The conference facilities were first rate. Glass doors led from the hotel lobby into the spacious entrance hall of the conference centre, which made the perfect setting for the International Year of Older Persons photographic exhibition. There was a check-in for coats and double doors led to the registration desk and the two main meeting rooms which had good acoustics and high-tech visual aids. Escalators went down to the hall on the ground floor where in the centre the pharmaceutical companies had their stands, and in avenues around three walls the posters were displayed, providing an excellent forum for lively debate. Coffee and lunches were served

here making it easy to visit the drug company booths and view the posters while fortifying the inner (wo)man. The posters were fewer in number but of higher quality than usual, owing to the selective culling of abstracts by the Scientific Committee.

Novotel's French connection was evident in various ways, such as the meeting rooms being named after the wine growing regions of France, the selection of gateaux at lunch and a shout from behind the scenes of 'Fermez la porte!' There was however something forever English about the marmite next to the toaster at the breakfast buffet.

## Cartoons and calligraphy

The International Showjumping Championships were being held just along the road at Olympia, which explained the presence of jodhpur-clad people in the hotel evoking memories of Thelwell. On the theme of cartoons, one of the drug companies had provided an artist to draw caricatures of passing delegates which became a source of much hilarity for them and the representatives at adjacent stands. Another

enterprising company, making the most of its origins, had a Japanese calligrapher in kimono. Delegates were invited to write down their name which was translated



phonetically into Japanese characters, which were written onto one side of coloured card similar to a bookmark and on the other was written the English translation of the Japanese. We are still pondering 'Clear Area Summer'(Rebecca).

### Evening symposia

On the Wednesday evening there were two satellite symposia run in parallel: ‘*Respiratory Disease in the Elderly in the New Millennium*’, chaired by Dr Martin Connolly and, ‘*The Treatment of Osteoarthritis – an Update*’, chaired by Prof Cameron Swift. Both were well attended, 218 and 116 respectively. The chest symposium reviewed pneumonia (Dr Mark Woodhead), bronchodilator therapy (Dr John Pounsford) and outcome measures in COPD (Dr Wisia Wedzicha). All the talks provided useful nuggets. For example, macrolide antibiotics are rarely needed in pneumonia in elderly people as ‘atypical’ pathogens are so unusual in this age group. Prof George Nuki spoke on, ‘*Osteoarthritis in Late Life – a Rationale for Treatment?*’ Apparently the BGS logo on the programme reminded him of a beer can. Perhaps we reach the parts other professional bodies don’t! He spoke at length and there was whispered speculation that perhaps he thought he had an hour’s slot instead of the half-hour allocated. It was useful to be reminded of the concept of osteoarthritis as ‘joint failure’ analogous to heart failure or renal failure, the end result of a variety of causes. Dr Alison Carr spoke eloquently on, ‘*The Track Record of NSAIDs – an Epidemiological and Economic Perspective*’. Side effects of NSAIDs are common and can be costly. The risk is immediate and constant and persists for months after stopping the NSAID. But all drugs have side effects and in one study paracetamol caused more abdominal pain and dyspepsia than ibuprofen! Prof Ken Brandt from the USA gave a talk to warm a geriatrician’s heart. He used the results of research on patients with osteoarthritis (OA) of the knees to support his belief that the mainstay of treatment should be non-pharmacological. Drugs should be used as an adjunct to physical measures such as muscle strengthening exercises and weight loss, and psychological support. The vivid imagery evoked by his reference to the patient with advanced OA of the knees, as, ‘walking on parentheses’, persists. The final talk was, ‘*Advances in the Selectivity and Specificity of Drugs*’, given by Prof Rod Flower. It was a masterly exposition and at the end, just as we thought we had come to terms with Cox 1 and Cox 2, he raised the intriguing possibility of there being others and even a paracetamol-sensitive Cox 2. Watch this fascinating space!

### A full programme

Thursday was a long day (almost 10 hours of CME) and despite interesting sessions and sustaining victuals, many of us were flagging by 7.15pm when the last session ended. The Champagne Suite was large enough for everyone to gather for the Opening Address by the President, Dr Brian Williams. Then there was a choice between staying put for a Clinical Management Update or moving to the smaller Bordeaux Suite for the first session of the Submitted Oral Papers on Cardiology. Those who stayed put heard about cancer of the prostate, chronic constipation and pain from non-malignant disease. Mr Malcolm Coptcoat reviewed prostate cancer, warning us that in spite of widespread misperceptions, there is no difference in disease severity between the ages of 50 and 80 years. Dr Danielle Harari provided a helpful schema to categorise and manage chronic constipation, which could usefully be turned into written guidelines. Dr Chris Wells showed that most currently available analgesia for non-malignant pain was around 4000 years ago. He suggested that there was little point in using codeine as it is converted to its active metabolite morphine in 90% of patients, while 10% of patients lack the necessary converting enzyme which therefore renders it utterly useless! While many may balk at prescribing more morphine, there remains a persuasive logic to the argument.

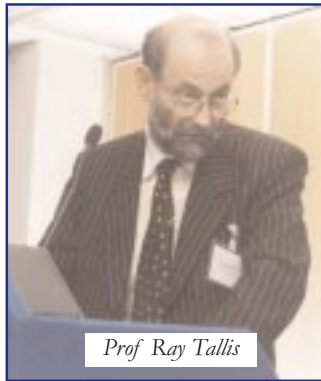
Coffee was followed by the first poster viewing session. There was a total of 56 in the following categories: Cardiology; Falls, Fractures & Trauma; Health Service Research; Law & Ethics; Neurology & Neurosciences; Parkinson’s Disease; Pharmacology; and Respiratory.

### Royal Commission

The International Year of Older Persons was celebrated by the Society in the form of a lecture entitled, ‘*The British Geriatrician and the Future of Long-Term Care*’, given with authority and conviction by Prof Bob Stout. He was the geriatrician on the Royal Commission on Long-Term Care and he talked us through the background to the Commission, its membership and how it worked, its Report and the subsequent loss of political pressure to act on it. He provided a strong rationale for the conclusion that personal care could be provided free in insti-

tutions without breaking the public purse. More importantly perhaps, were the recommendations to coordinate greater pooling of health, social service and housing budgets. He rebutted the suggestion that not enough emphasis was placed on the value of rehabilitation in the Report.

After lunch there was again a choice. In the Champagne Suite there was a Nutrition Symposium as part of which Dr Anita Thomas successfully made her maiden voyage in PowerPoint, followed by a Keynote Lecture on, *'Skin Ageing: Hope and Hype'*, by Prof Christopher Griffiths. In the Bordeaux Suite was the second session of Submitted Oral Papers on Falls, Fractures & Trauma; Stroke; and Psychiatry. Take home messages from the latter included the finding that falls prevention programmes are probably cost neutral, and that stroke progression was more likely in the presence of potentially modifiable factors such as pyrexia and haemodynamic instability. A break was scheduled in the course of the platform presentations to enable people to move from red to sparkling, if they wished to attend the lecture.



Prof Ray Tallis

Tea (an Earl Grey tea bag in hot water) was followed by the Selected Poster Platform Presentations. Six posters selected earlier in the day by the Poster Assessors were presented by the authors.

### Marjory Warren Lecture

Then with his usual panache, Professor Sir John Grimley Evans gave the Marjory Warren Lecture on, *'Service and Research for an Ageing Population'*. He described the threats to innovation and research in the NHS, explained how a strategy for R&D relevant to older people had been constructed and called for a National Research Advisory Group to be set up to ensure that such a programme could be delivered. He issued a clarion call to the BGS to drive the evidence base for the specialty.

Those of us still eager to learn went either to a symposium entitled, *'See Stroke in a Different Light'*, or one on, *'Deep Brain Stimulation in Movement Disorders'*. Dr Anil Sharma talked about the Acute Stroke Intervention Study (ASIST) which had looked at the infrastructure in DGHs

admitting acute strokes. Dr Gregory J Del Zoppa spoke on, *'The American Experience of Acute Stroke'*. He advised caution and by reminding us that thrombolysis is suitable for only a tiny minority of stroke patients put its use into perspective.

### Acronyms for the uninitiated

Then it was up in the lift, a quick change into our glad rags and back down for fizz before dinner in the Champagne Terrace. The Master of Ceremonies was magnificent in his red tail-coat. The meal was good and rounded off by chocolates borne in on vapour-shrouded platters. The after dinner speech given by Professor Ray

Tallis was hilarious. His insights into TLAs, three letter acronyms to the uninitiated, brought new meaning to many favourites such as CME.

The following awards were made: The Medal for relief or suffering amongst the aged to Lady Sally Greengross of Age Concern and Michael Lake of Help the Aged; The Founder's Medal to Sir John Grimley Evans; The E Woodford Williams Prize to Mrs Jane Mickleborough.

### Medical education update

Friday started with a Medical Education Update held in parallel with the third session of Submitted Oral Papers (Health Service Research, Neurology, Pharmacology). Dr Peter Langhorne kicked off in the 'red eye slot' by describing the Cochrane Database and demonstrating its use. He succeeded in his aim of pitching it at the novice. Dr Carol Jagger talked us through critical appraisal. The idea of research clinics to which novices can take their study design problems, and the suggestion that statistics are like a lamppost, there to illuminate research and not to prop it up, appealed. Mrs Joan Williams' presentation on, *'Effective Interviewing Skills'*, seemed stronger on theory than practice. Did she really believe that all interviews were level playing fields?

Coffee was followed by the second poster viewing session with 53 posters in the following categories: Stroke; Clinical Practice; Diabetes; Bone, Muscle & Rheumatology; Epidemiology; Gastroenterology; and Psychiatry.

### Medico-legal litigation

The slot before lunch had a medico-legal theme. Dr Christopher Evans talked on, '*Medico-legal aspects of practice in Geriatric Medicine*' and Clive



Rawlings, a barrister, gave us, '*The Lawyer's View of Medico-legal Litigation*'. As geriatricians we are relatively safe from litigation, but beware of fractures and dislocations, adverse drug reac-

tions and systemic embolisation in association with atrial fibrillation, and for those doing general medicine add myocardial infarction, pulmonary embolus and subarachnoid haemorrhage to the list. There was some comfort in hearing how hard it is for a claimant to prove a case, apparently the greatest hurdle that has to be overcome is causation, in other words that the doctor's breach of duty to the plaintiff caused injury. Perhaps on another occasion the medico-legal aspects of end of life issues such as cardiopulmonary resuscitation and feeding could be covered.

### Best session of the meeting

After lunch The Trevor Howell Lecture was given by Professor Nick London. His, '*Evidence Based Practice for the Surgical Management of Varicose Ulceration*', must be in the running for best teaching session of the entire meeting. Is it a sign of ageing when professors of surgery look young? This dynamic and practical lad from Leicester used audio as well as visual aids which prevented any post-prandial nodding off. He explained the workings of the 'venous heart' in our legs and showed convincingly that the vast majority of venous ulcers could be healed as a result of surgery for varicose veins in the presence of normal deep veins, and four layer compression bandaging for the rest. It was a presentation that brought new insights into an old condition and left the audience optimistic about a common and often demoralising (for patients and staff) affliction.

Delegates then divided up either to attend the

Cardiovascular Symposium on, '*Evidence Based Medicine versus Clinical Practice in the Treatment of Heart Failure in the Elderly*', or to be updated on the National Service Framework for NHS Care of Older People. Prof Ian Philp, Denise Platt and Prof Cameron Swift described the aims of the National Service Framework (NSF), the work of the external reference group and the implications of the NSF for the elderly and the BGS. The overall aim is a levelling up of practice. Geriatricians will be able to use the NSF to support them in developing and improving their services locally. The session was a great morale booster and by the end the audience seemed convinced that at last there would be watertight principles for geriatric services nationally. On this high point I headed for home pausing on the way out to pick up a photo calendar for the Year 2000. It contains a selection of photographs from the exhibition and will remind me of the excellent Autumn meeting of 1999 which coincidentally was held at the end of the International Year of Older Persons.

After tea was the second Selected Poster Platform Presentations. The best poster prize went to Dr S L Dawson and the best oral paper prize went to Dr S Dhoat. The President closed the meeting at 5pm.

The meeting was an outstanding success, and the organisers are to be commended for delivering a well-balanced high quality programme of which the Society can be justly proud. Special thanks to Margot Gosney, Meetings Secretary, Cecilia Ingram and all the staff of Buckham Hill Meetings, and the BGS office staff, namely: Richard Lynham; Recia Atkins; and Caroline Houston (not forgetting Rawia Habiby now working from home in Oxfordshire).

See you at the same place October 19 & 20 2000.

**Rebecca Dunn, Honorary Secretary**  
**Christopher Dyer, Poster Assessor**

*We are sorry to learn of the sudden death of Mr Malcolm Coptcoat, who presented a paper at the meeting.*

# Future for the care of the elderly - where do geriatricians fit in?



**T**he internal market has come and gone. Competition has been replaced by co-operation and 'the new kid on the block' is the Primary Care Group (PCG) - soon to be the Primary Care Trust (PCT).

Health Authorities are being 'actively encouraged' to ensure this process of evolution takes place, and so it is appropriate to speculate on the kind of future this will bring to the care of the elderly and the potential changes that could be brought about.

### Ensuring local services

PCGs are about ensuring local services. The Chairman of the PCG is directly responsible to the Chief Executive of the Health Authority to deliver the Health Improvement Plan agenda and Clinical Governance. With the evolution to PCTs the whole unit is more independent, with the opportunity to be more imaginative to ensure services meet the needs of the local population. What will be needed is flexibility and fleetness of foot - not how most of us would describe our local services!

Primary Care is currently dominated by general practitioners who are generalists. There are some specialists within the profession, but this is an informal arrangement. No system of health needs assessment is applied when appointments to general practice are made and the system is mainly characterised by 'like attracting like', not necessarily resulting in what the local population needs. You end up with a rigid system of both primary and secondary care attempting to provide a service for a population in an individual, opportunistic way, rather than a population based way. The type and quality of care the patients receive is, to some extent, down to chance. The patient may be lucky and find that his or her local general practitioner has an interest in medicine for the elderly. Access to

geriatric services vary and quality within that is not standardised. At best, the service works well with optimal care offered on a local basis. At worst it is substandard.

### Change required

PCTs can offer a new way, but for this to be really successful I feel a fundamental change is required. GPs may well need to give up their monopoly of primary care and specialists may need to leave hospitals and get out into primary care. I should like geriatricians working alongside me in primary care. I should like a clear policy on managing the very old and I want to be part of a strategy that involves sensible, evidence based screening of the elderly. Working alongside specialists may well result in a 'passive improvement' in quality and could see a diminution in hospital admissions, the ultimate disaster for the elderly.

### A new breed of geriatrician

Likewise within the hospital environment, I would envisage geriatricians working alongside other specialists to ensure a holistic approach to patient care. What I am arguing for is a new breed of geriatrician; someone who is primary care based, offering population and individual care working in a primary health care team alongside GPs, community nurses and other professionals allied to medicine, in order to achieve the health needs of the local population. Appointments will vary according to local needs. A clear definition as to what is meant by rehabilitation is required and not an assumption that this is a service best led by geriatricians.

A willingness to change and actively embrace the process is a characteristic we would like to be ascribed to ourselves, yet if we are completely honest, most of us would prefer it to happen to someone else, preferably some way removed. The change that PCTs will inevitably produce will redefine the service that we need to provide

continued on page 31

# The future of geriatrics

## A public health perspective



**F**or at least 200 years, the emphasis on single organ systems in medicine has increasingly failed various groups of people.

The largest group being the elderly, who were summarily dismissed from the infirmaries from their inception, as ‘vagabond beggars, incurables and elderly’. After 1948, when the NHS diverted attention from people’s cheque books and onto their illnesses, the vagabonds at least were welcomed. Other groups however have continued to suffer from the tyranny of single organ care, notably the ‘incurables’; young chronically sick people and those who were not capable of ‘getting better’ immediately. Moreover this suffering has not been mitigated by unqualified success in single organ care, as has been demonstrated by the lack of good consistent post myocardial infarction advice, despite excellent research findings and a lack of rapid admission, and full rehabilitation services for stroke victims.

### Is geriatrics the right model for elderly people?

According to the BGS, ‘*geriatric medicine (geriatrics) is that branch of general medicine concerned with the clinical, preventive, remedial and social aspects of illness in older people. Their high morbidity rates, different patterns of disease presentation, slower response to treatment and requirements for social support call for special medical skills. The purpose is to restore an ill and disabled person to a level of maximum ability and wherever possible return the person to an independent life at home.*

General rules for deciding upon effective services have been put together by a large number of people. Those that appear to have stood the test of time were put together by Maxwell. These should be borne in mind, as well as the quality

of the direct care provided by a doctor or nurse for patients.

The rules are:

- ◆ Access to services
- ◆ Relevance to the needs of the whole community
- ◆ Effectiveness for individual patients
- ◆ Equity
- ◆ Social acceptability
- ◆ Efficiency and economy

### Access to services

Services given to people in or near home are likely to be more accessible to patients than those given for a large population at a single site. Over the past 20 years or so, smaller geriatric hospitals have been largely closed down in preference to a district general hospital site. Where the geriatric department has remained separate it has, usually, been in poorer premises with poorer physical access. Patients often have another type of problem with access to services when they try to find their way through the complex appointment systems to see a consultant. Geriatric care has been good at not developing waiting lists but this is a function of the fact that most admissions are emergencies.

Geriatricians still occasionally do domiciliary visits and a few work out of health centres, but this has not been common. In terms of access such approaches are to be desired. Access to services can mean other things. One is whether people or the professionals know about the service in question. There is little point in having a special clinic for a particular group of people if the publicity for it is bad. In the past such innovative schemes as night-sitter services and incontinence laundry services have foundered because of a perceived lack of demand when lack of publicity was the culprit.

### Relevance to the needs of the whole community

Primary care practitioners on Primary Care

Groups (PCGs) have the advantage of being aware of the social background and pressures on at least some of the areas in which they work. Geriatricians, with their holistic approach to medicine, may find that they have some insights in common with the PCG members which were missing from the health authority personnel.

UK general practitioners, as gatekeepers for the service, have been particularly effective in keeping down the demand for services, compared with countries where patients have open access to hospital care. Sometimes however there appears to be an inherent ageism in this parsimoniousness which geriatricians could try to overcome through advising the local PCG.

### Effectiveness for individual patients

Scientific testing of the effectiveness of care for elderly people still lags some way behind that for the middle aged due to ageism among researchers. There is an increasingly expanding body of knowledge in this area, especially about the effectiveness of 'high tech' medicine in older people and in the area of rehabilitation which until quite recently lacked good scientific research.

### Equity

Equity is a central concept for geriatricians because, as recent studies have shown, ageism is rife within the health service. Such ageism may be subtle, for example the failure of a GP to refer for specialist care an elderly patient with renal failure, or perhaps more commonly, to wait until the disease is at a more severe stage than for younger people. PCGs will have to be kept straight on such matters.

### Social acceptability

Geriatricians should be aware of the social acceptability of the treatment that they give or purchase for their patients. However they are not always as aware of their patients' views on the acceptability of treatment or, for that matter their social conditions, as might be wished.

### Efficiency and economy

The specialty of geriatrics is not perceived as a pricey specialty. In fact high staffing ratios are important in geriatric care, which balance

somewhat the faster turnover in non-geriatric wards. Overall, as far as it can be measured, they probably cost about the same per patient.

In as far as some geriatric departments are involved with cold orthopaedics, they must share some of the responsibility for the ridiculously long waiting lists for assessment, operation and rehabilitation for total hip replacement which, in terms of cost per QUALY, is one of the most efficient and effective treatments in medicine.

### The Future

One of the problems within geriatrics is that the roles of geriatricians are often not clear. There are a number of models which may cross over. A commissioner on a PCG, keen to get the best value might want to know more precisely what he or she is getting for their money. There appear to be five models, some of which overlap:

- ◆ General physician for older people
- ◆ Expert in complex pathology
- ◆ Specialist in holistic medicine for older people
- ◆ Expert at rehabilitation
- ◆ Expert at assessment for community care

Geriatrics has put on the agenda the differences between elderly people and younger in relation to acute inpatient care. I think geriatrics needs to make clear its preferred sphere of influence before purchasers, especially the new PCGs, can decide how it fits into the treatment of ill people. Geriatricians may say that they are expert in all of the fields I have mentioned, but there are two dichotomies to be faced; the specialist vs the generalist and the care of the aged vs the care of complex problems at all ages. I do not think every geriatric service can perform all of these functions.

My personal preference would be for geriatrics to take over the general care of complex problems in all age groups.

**Norman Vetter**  
**Reader in Public Health**  
**University of Wales College of Medicine**

## BGS INTO THE NEW MILLENNIUM - A TRAINEE'S VIEWPOINT

The last five years have seen the introduction of the Calman training scheme which has reconfigured and reshaped training in medicine. As we enter the 'New Millennium' we will start to see the results.

The change has been accompanied by the inevitable introduction of new jargon; RITAs and OOPes, CCSTs, FTAs, LATs and LASs to name but a few. The profile of educationalist has risen and woe betide the innocent who fail to distinguish education from training or appraisal from assessment.

### Training

Will the Calman era lead to better trained (and educated!) geriatricians with a wide variety of interests and areas of expertise? Is five years of training sufficient to produce people of consultant calibre, able to develop and deliver quality services for older people? I have my doubts, but only time will tell.

We have certainly not reached a status quo with respect to training, and the ongoing machinations of the Royal College of Physicians would suggest that further changes are afoot. Let's hope a review of that dreadful log book is one of them.

The creation of a framework for training has undoubtedly focused the minds of trainers and trainees alike on the role of the geriatrician. People are now making a positive decision in the early stages of their career (perhaps too early for some) to pursue a career in geriatric medicine. With this change should come the end of the perception that geriatric medicine is for failed physicians. But beware! Whilst other specialties are disappearing up, down and into their various orifices, geriatricians are at risk of being overwhelmed by the general medical workload at the expense of their own speciality. Scrutinise a consultant job description when applying for a new post!

### Research

Research is a major area of concern that requires a radical review. The current structure for training has led to fewer people taking time out to undertake a decent period of research. This could impact significantly on the academic standing of the speciality and society. Already there is a marked disparity in the number of academics in geriatric medicine when compared to other medical sub-specialties. The gap may widen as we enter the new millennium unless there is an increase

in the number of academic posts and the research profile moved up the training agenda.

### Positive image required

Out with the old image and in with the new. We must promote a positive image for the speciality and alter the misguided public perception that geriatric medicine signifies the end of life. A move to a 'geriatric' ward or referral to a geriatrician should be viewed as a positive step in one's journey through the secondary health care setting. Fostering links with other relevant societies will serve to strengthen our position whilst our role in the community must be clearly redefined with geriatricians taking a lead in the care of older people in institutional care.

The last century has seen the birth and growth of one of the biggest medical specialities. However the work is far from over, and this century should be one of consolidation and promulgation of existing knowledge and expertise, in conjunction with an expansion of the research agenda, to bring geriatric medicine in line with other medical specialities.

Jacqueline Close

## APPOINTMENT TO OFFICE IN THE SOCIETY IN OCTOBER 2000

Regional secretaries have been notified that the following posts will fall vacant on the retirement of the current office holders in October 2000.

### Appointments made by the Regions

Scottish representative on the Executive Committee.  
Council representatives for Scotland (3 vacancies), Wales, Mersey, NE Thames, NW Thames and Oxford.

### Standing committees

Vacancies will occur on the Finance

and Policy committees.

### National BGS posts

President Elect.  
Deputy Meetings Secretary.

Nominations for national posts must be sent with the appropriate documentation to the BGS by 1 May 2000. The consolidated list of nominations will be sent to regional secretaries a week later to allow discussion at regional meetings and for the respective regions' council representatives to be

advised of the regional preference. Council will then nominate candidates from the list in July. The full membership of the Society will be asked to endorse these nominations at the Society's AGM in October 2000.

The procedure for appointing representatives to posts filled by the regions is a matter for each region; the names of the appointees are then notified to the BGS in September 2000, in order that they can be announced at the AGM.

# The geriatric service in the heart of England

**S**outh Warwickshire is blessed with beautiful, semi-rural countryside with narrow winding roads although recently dissected by the M40.

Warwick Hospital celebrated its 150th anniversary in 1998. Medical services in Warwickshire have a long history related to Victorian benefactors with the beginning of rehabilitation in Stratford in 1884 and a hospital in 1898.

## Pioneers

The two early pioneers of geriatric medicine were Dr A G Stephenson, after whom the day hospital at the main rehabilitation hospital is named, and Dr W L Sanders who wrote some of the early articles on Jakob Creutzfeldt disease. Dr Stephenson used to do his domiciliary visits on foot or bicycle and Dr Sanders was a keen teacher to senior registrars in the West Midlands General and Geriatric Medicine rotation scheme based at Birmingham. Later Dr A K Viswan joined Dr Sanders in 1978. They worked in a large area which contained hospitals at Warwick, Royal Leamington Spa, Stratford-upon-Avon and Alcester. The King Edward VII Memorial Hospital in Hatton, Warwick was renowned for its open heart surgery, its treatment of tuberculosis and especially for the Heaf test. General practitioners also had beds for the elderly in Stratford and at Ellen Badger Hospital in Shipston-on-Stour.

By 1988 the District General Hospital (DGH) was shifted from Stratford to Warwick and the service was run by three different directly managed units: one for mental health, one for community rehabilitation and one for acute medicine. Within a few years the service was organised into three Trusts and by 1994 the Geriatric department and the Department of Medicine were integrated into a single service.

Today the three geriatricians work on equal par with the other six consultant physicians in a 1:9 rota managing 150 beds in seven medical wards.

## Rehabilitation

Geriatric rehabilitation is done in the community trust hospital based at Royal Leamington Spa Rehabilitation Hospital (RLSRH) and Alcester Hospital. The former has 72 beds of which 56

are designated geriatric beds and the remaining 16 are used for an extended



*Rehabilitation ward at RLSRH*

care unit. Alcester Hospital, 17 miles away from the DGH, has 22 beds. Both sites have day hospitals. A unique feature of the service is a mobile hospital which goes on a weekly basis to Kenilworth so that patients do not have to travel a great distance. The wheelchair, limb-fitting and incontinence service is based at RLSRH.

Dr Viswan was the first Medical Director of the community rehabilitation hospital. From 1988 with the appointment of Dr H N Desai, the custodial service at Royal Leamington Spa came to an end and within a few years and, especially with the appointment of a further consultant, Dr Francis Vaz in 1989, the throughput increased through a smaller number of beds. There is a high referral rate from the acute hospital for rehabilitation. To avoid bed blocking and to make maximum use of PAM staff, an extended care unit or halfway home was created in 1996 with the assistance of Warwickshire Health, Social Services and the Combined Trust. The unique feature here is that it is a nurse-led unit where GPs from a nearby practice run the day to day service and see to the nursing and social needs of the patient. Within six weeks patients are

either returned to their home or resettled in a residential home or nursing institution. This has saved the Acute Hospital 6,576 occupied bed days per annum for the last three years.

### The Warwick team

The three consultants are Dr Kumaran Viswan, Dr Harsadroy Desai and Dr Francis Vaz. Since 1997 Dr Vaz has been the Clinical Director of the whole Medical

Directorate and has also taken a lead in the stroke strategy, is helping to set up the stroke unit and runs a syncope clinic. Dr Desai has an interest in Parkinson's Disease and runs the PD clinic. He is also an Honorary Senior

Clinical Lecturer at the University of Warwick. In 1991 and 1996 he was a visiting lecturer to medical schools in South Africa and promoted the care of the elderly. He was also a BGS regional representative (1991-93) and served on the Training Committee under the chairmanship of Professor Grimley Evans as a SR representative. It was his proposal to initiate the Nuffield Fellowships which have resulted in one professor and two senior lecturers. Dr Viswan is the current president of the West Midlands branch of the BGS.

South Warwickshire has been divided into three areas so that the three consultants can serve the GPs personally and have continuity of care of the patients in the community. The nine physicians are divided into three teams and one geriatrician works in a team. One staff grade doctor helps to run the rehabilitation service at RLSRH. Two clinical assistants provide added help on a sessional basis. At the DGH on average 20-25 patients are admitted each day in an integrated non-age related take. Two post-take rounds are done daily. The Geriatric Unit receives approximately 800 rehabilitation referrals annually. A close liaison has existed with the orthopaedic surgeons for over 15 years helping them increase their throughput and decrease their waiting times for elective operations. Once it is clear that there are no orthopaedic problems and that the patient needs rehabilitation, the patient is transferred to the rehabilitation hospital. The Department is

involved in the National RCP Stroke and Drug Prescribing Audits. One of the Geriatric Ward sisters, Verna Pritchard, an expert in tissue viability, devised the Douglas Score, Douglas referring to the name of the ward of which she was in charge.

The department operates multi-disciplinary assessment, working with Social Services as a

gateway to long stay in the community. A district wide discharge planning policy is already in operation and this is being revised by Dr Vaz. Two liaison nursing

sisters in the hospital work together with the district nurses to provide close community links.



Warwick Hospital

### New medical school

From Spring 2000, Warwick Hospital will have medical students from the new joint Warwick University - Leicester University Medical School. In 1997, the Department had its first Specialist Registrar, Dr Helen Brooksbank, who is one of 34 senior registrars in the West Midlands General and Geriatric Rotation Scheme. To improve the profile of the elderly and to counteract ageism, two nurse co-ordinators were appointed in 1999. To celebrate the International Year of Older Persons a special meeting was organised in September 1999 at the University of Warwick on 'Active Ageing', in which Professors John Grimley Evans, Alan Sinclair, Marion McMurdo and others including two lay speakers took part. The meeting was organised by Dr Desai jointly with the World Health Organisation and the University of Warwick. To ensure that the millennium does not go unnoticed the BGS 2000 Spring Meeting will be held at the University of Warwick and this together with the development of the Medical School will play a vital part in developing geriatrics in the heart of England. It is our wish that from here we will produce doctors who are well trained and have excellent attitudes towards the elderly, no matter which discipline they adopt in the future.

**Dr A K Viswan**  
**Dr HN Desai**

**DR A K VISWAN - YOUR HOST AT THE WARWICK SPRING MEETING**

Known affectionately as Vis to his colleagues, Dr Viswan is a model ‘working geriatrician’. His diffident manner and soft speech belie his outstanding record of achievements and his great personal dedication to the infirm and the disabled.

**Geriatric medicine**

Dr Viswan developed the geriatric service in Warwick, doing first or second on-call duties every day for the first ten years before being joined by two colleagues. With a little chuckle he recalls, ‘we had no long range bleeps then, my wife (a nurse) provided the message service!’

**Adult rehabilitation**

Dr Viswan was also responsible for establishing a sub-regional rehabilitation unit for young disabled people with neurological problems – indeed he contributed to getting rehabilitation recognised nationally as a specialty. The work was achieved at the Royal Midland Counties Home for Incurables, originally built in 1874, the emphasis being on incurable, that is until Dr Viswan took a hand. It took five years to get the first patient out and

working – previous to this, patients stayed all their lives. For his pains Dr Viswan was reported for cruelty ‘for making people walk’ – fortunately his superiors were more foresighted. ‘The conditions were like something out of David Copperfield or Great Expectations’, Dr Viswan recalls. Happily a consultant in rehabilitation medicine is now in charge.



In the voluntary sector Dr Viswan was one of the founders in 1984 of the Stratford upon Avon branch of the Cross Road Care Attendant Scheme, providing help for the disabled and their carers in the community. He is closely involved in the local branch of the Parkinson’s Disease Society and has been commended for his contribution to

the Very Sheltered Scheme for the Elderly in Stratford.

In the medical profession his work has included services as Vice Chairman for the Regional Geriatrics Committee since 1990, Medical Director and Clinical Director; he acts as chairman of the Panel of Assessors of the RCP London for General Professional Training and joined the Warwickshire Health Authority Executive Strategy Board in 1996. In the BGS he is currently Chairman of the West Midlands regional branch, having represented it on Council from 1985 to 1988, and for the last two years has chaired the committee organising the BGS Millennium Spring Meeting.

When asked to what he attributed much of his success in co-ordinating projects, Dr Viswan, a self-proclaimed ‘fanatic’, replied, ‘You must know your colleagues in a team!’ He still works up to 12 hours a day on Mondays, but ‘only’ to 7.30pm Tuesday to Friday.

**Richard Lynham**

**LORD LEYCESTER HOSPITAL, WARWICK  
CARING FOR THE OLD AND DISABLED SINCE 1571**

Members will not find this hospital in the NHS list, but they may care to visit this historic group of buildings at the West Gate of Warwick, dominated by the ancient Chantry Chapel of St James built in the 14 century. Acquired by Robert Dudley Earl of Leicester, the buildings were converted under a charter



from Queen Elizabeth I to a hospital for aged or disabled soldiers; after modernisation in 1966 the premises were opened by Queen Elizabeth the Queen Mother and now house eight ex-servicemen and their wives. The medieval Courtyard, Great Hall, Guild Hall, Brethren’s Kitchen and the garden are open to the public and are well worth a visit.

# BGS Spring Meeting 2000

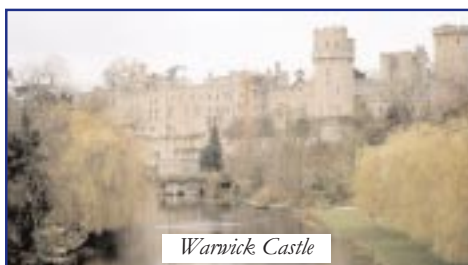


**S**hakespeare country - your base for the BGS Spring Meeting. Explore historic Warwick, Royal Leamington Spa and Stratford-upon-Avon or lesser known but equally lovely towns such as Kenilworth, Alcester or Shipston-on-Stour.

Warwickshire, forming a boundary between the West Midlands to the north and the rolling countryside of Oxfordshire and Gloucestershire to the south, offers a number of historic towns and attractions for delegates attending the Spring Meeting.

## Warwick

The county town with its famous castle and a clutch of medieval and Georgian buildings. The



*Warwick Castle*

imposing castle is sited above the River Avon in 74 acres of gardens. One of the 'tableaux' in the underground chambers evocatively

portrays scenes of preparation for a 15th century battle, peopled by waxwork figures (made by Mme Tussauds) and boasting authentic smells! Nearby **Kenilworth** is also noted for its own impressive castle.

Architectural treasures dating from medieval times to the modern day can be found during a stroll in the town. Highlights include the 15th century Guildhall, the 18th century mansion Abbotsford, the fine Georgian houses on Northgate Street and the 14th century St Mary's Church, from whose tower a superb view of the town and castle can be obtained.

## Stratford upon Avon

Dominated by all things Shakespeare, Stratford caters for the year-round tourist trade. Aside from Shakespeare, it also provides plenty of

opportunity to relax, strolling along the streets of timber framed houses or even taking a trip on the river.

## Coventry

One of Coventry's main attractions is its cathedral. Built next to the shell of the old cathedral, destroyed along with the much of the city centre in a German air raid in 1940, the new cathedral was completed in 1962. Unconventional in design, it has attracted both controversy and approval. The cathedral is packed with artworks including a vast tapestry of Christ in Glory and spectacular abstract stained glass windows.



*Cathedral window*

Despite the destruction caused by the wartime bombings, there still exist a number of examples of older architecture including Holy Trinity, the city's only complete medieval church, the 14th century St Mary's Guildhall and Ford's Hospital, a timber-framed building with decorative carving.

Car lovers will enjoy the Museum of British Road Transport which contains hundreds of cars, bicycles, motorbikes and other vehicles aptly commemorating Coventry's role as the birthplace of the British car industry.

## University of Warwick



*Part of the 'Sculpture Trail'*

For those of you who can't tear yourselves away from the BGS Scientific programme at the Spring meeting, Warwick University's self-contained campus offers a parkland setting, an unusual sculpture trail and a range of sports facilities for those spare moments between sessions.

In  
Memoriam 

**DR JOSEPH MELLOR GREENWOOD**

We have been informed that Dr Greenwood died in December 1999.

Joseph Mellor Greenwood was born at Bolton on 20th November 1905, the son of a draper. He was educated at Ashton-under-Lyne Grammar School and Manchester University, qualifying MB B Chir. in 1929 and proceeding MD in 1934. He took the DPH in 1937.

After house appointments at Manchester Royal Infirmary he joined the Manchester Principal Hospital Service working as a medical officer first at Cumpsall and then at Mansall Hospital. In 1934 he was appointed deputy medical superintendent at Withington Hospital in South Manchester and became medical superintendent in 1939, a post he held through the year.

At Withington he took a special

interest in the ‘chronic sick’ and in 1949 wrote a report about this for the Regional Hospital Branch, which was used in the establishment of geriatric units throughout the Manchester Region. The first was in the new hospital at Withington; he was appointed as consultant physician to run it, later joined by J M Leaming. He had a charismatic personality and great administrative skill and became the chairman of the hospital’s medical division. He was an indefatigable advocate for the elderly and took every opportunity in committees, in advising meetings and in talks to the press to market the cause of geriatric medicine.

He was one of the first to see that the subject should be taught to students and was able to arrange for students from the Manchester Medical School to visit his department. This brought him increasingly into contact with the

Ministry which was planning to convert Withington, which adjoins the Ministry Campus, into a University Hospital. He conceived the idea that there should be a choice of geriatric medicine in the new hospital and, such was the success of his levels of persuasion, he was able to get the idea accepted. He had the satisfaction of seeing the chair, the first in England, filled by the appointment of Professor J C Brocklehurst in 1970, the year of his retirement.

He served on the Council of the BGS in its earliest days and was the first chairman and secretary of the North West Regional branch of the Society.

He married Janet Bowden, an obstetrician. Their son became director of an MRC unit in Gambia, West Africa.

**DR GEORGE KENNETH LAXTON**

George Kenneth Laxton was born on 24 January 1919 in Dewsbury, West Yorkshire and studied at Leeds University, obtaining his MB ChB in 1942. He started his career at various hospitals in Yorkshire, then Northern Ireland and in 1951 set off for Kenya, serving with HM Colonial Service for nine years.

After returning to Britain in 1960 he went on to become consultant geriatrician first in Reading, then Coventry, Hull and Peterborough.

In 1976 he emigrated to Australia, where he was appointed geriatrician to Gippsland in Victoria with responsibilities in 16 hospitals spread over an area of 400km. A serious car accident five years later meant Dr Laxton could only serve in three of the hospitals. In spite of this setback, he continued his active involvement in geriatric medicine, becoming chairman of a multi-disciplinary assessment team and maintaining his interest well into retirement.

George Laxton was a Rotarian and enjoyed meeting people. He also greatly enjoyed walking, playing golf and maintained an interest in poetry, literature, music and natural history, throughout his life. He was known locally as ‘the gentle physician’ and for his sense of humour.

Dr Laxton was predeceased by his first wife, Sydney. He leaves his second wife Josephine, a daughter and two sons as well as six grandchildren.

## DHOLE BURSARY - INCREASE IN AWARD

The Society is pleased to announce an increase in the amount available under the terms of the Dhole Bursary. The maximum amount has been doubled to £20,000 and is intended to support a small project grant submitted by any member of the BGS.

Applications will be considered for support at any level up to the maximum amount to cover personnel, equipment or consumables. Priority will be given to projects concerned with medical aspects of ageing of direct relevance to the address of the BGS, but research in the biological and basic sciences of

ageing is not excluded. The principal criterion governing the award will be the originality and quality of the scientific content and method.

Applications are reviewed by a central grants panel comprising the Chairman, Vice-Chairman and immediate Past-Chairman of the BGS Scientific Committee, who will make use of peer review where necessary. Routinely, the deadline for consideration of applications will be 14 December each year, but calls for grant proposals may take place at other times depending on demand and the amounts awarded.

Audit projects will not normally be supported unless there is clear evidence of originality of general relevance and closure of the audit loop. The final decision on the award of any grant under the Dhole Bequest will rest with the grants panel.

Grant holders will be required to provide progress summaries mid-way through each project and at its conclusion, and to acknowledge the bursary in any publication. They may also be requested to present their findings to the BGS in an appropriate form and context.

**Deadline for applications: 14 December 2000**

## EXTRAORDINARY MEETING - MINUTES

### **BGS Extraordinary Meeting Held in the Novotel, Hammersmith, London 16 December 1999**

The President, Dr Williams, chaired the meeting and 51 members were present.

1. Apologies for absence had been sent by Dr Colin Powell and Dr Roger Smith.
2. The minutes of the Annual General Meeting held in October 1999, previously published in the November BGS Newsletter, were approved.
3. The following nominations to office made by Council in Oct 1999 were unanimously approved: Dr Rebecca Barton Dunn as Honorary Secretary; Dr Robert John Shepherd as Honorary Treasurer; Dr Sheilaigh Baillie to be a member of the Finance Committee; and Dr Thomas Keith Smith to be a member of the

Finance Committee.

4. The nomination by the England representatives on Council of Dr Roger R Lewis as England representative on the Executive Committee was unanimously endorsed.
5. The meeting was given a presentation by Dr Ian Sturgess on the reasons and the financial background underlying Council's decision to raise funds to enable the Society to acquire its own premises as distinct from renting third party accommodation. This is to be reproduced in the February BGS Newsletter. A key decision for Council would be whether to abandon the plan to save up to buy premises at a date some five years hence or whether to opt for a larger mortgage now to allow an early purchase with the purpose of avoiding a situation where inflation in the property market risked to outstrip the Society's ability to save sufficient amounts; i.e. the use of an early mortgage would enable the Society

to fix the price of its purchase now and the Royal Bank of Scotland had indicated a willingness to support the Society with a longer term mortgage package commensurate with the Society's financial ability.

Dr Sturgess responded to a number of questions on the potential availability of property, the comparison of costs for purchasing with the aid of a mortgage compared to renting, the scope for fundraising within and outside the Society, and the reason why London was still the most logical location to site the office.

Dr Williams summed up saying members should raise any concerns with Council through their regional Council representative; members would be kept informed of developments through the BGS Newsletter.

6. The revised date for the next AGM was agreed as 20 October 2000.

**ELDERLY PATIENTS LEFT STARVING TO DEATH IN THE NHS**

Whilst not ignoring the serious issues at stake - poor care due to lack of resources, the ethical issues of artificial feeding, the debate over euthanasia - one has to say that the sensationalist headlines of The Daily Telegraph in

December did not provide the best framework within which to review these issues.

The Society responded in a letter to the paper, as follows:

<p>8th December 1999</p> <p>Dear Sir</p> <p><b>NHS and the Elderly</b></p> <p>Whilst appreciating the Telegraph's support for older people in hospital, I regret that the many organisations you contacted did not include the British Geriatrics Society, the professional association of consultant and trainee geriatricians and a charity dedicated to improving the medical care of older people.</p> <p>The Society has been actively campaigning against ageism in the NHS, for better training of medical staff in respect of how much can be done in the treatment of older people and, for equity of access to diagnostic and treatment facilities for older people.</p> <p>The Society is one of the partners that took over the Health Advisory Service from the Department of Health. Now renamed HAS 2000, it carried out the independent inquiry into care of older people in acute hospital wards. The results were recorded in the report <i>'Not Because They Are Old'</i> issued earlier this year, re-</p>	<p>flecting a lack of resources in staff, materials and equipment, a situation the Government have pledged themselves to rectify.</p> <p>Whilst accepting that there have been cases of unsatisfactory care, it is important to stress that this is the exception rather than the rule. Our members, mostly all practising hospital physicians, are dedicated to providing a high standard of care and to this end are constantly working to obtain the resources they need.</p> <p>There appears to be a common misconception that to be placed in a geriatric or general medical ward is to be abandoned by the system. This is quite wrong. Geriatricians are consultants specialising in the diagnosis and treatment of older patients who frequently present with complex multiple symptoms and who cannot neatly be placed in e.g. a cardiology ward or an orthopaedic ward which deal with single symptoms. The geriatrician will call in other specialists to assist with different components of an acute illness, whilst co-ordinating the overall treatment programme.</p>	<p>Geriatric medicine has its origins in the 1940s when the potential for rehabilitating older patients was first realised; the aim of the specialty today remains the same, namely to treat acute conditions and to rehabilitate the patient to his or her maximum potential.</p> <p>Against this background it is inconceivable that a geriatrician would countenance the withdrawal of nutrition from a patient whatever the pressures on the department. There may be cases where the issue of artificial feeding has to be considered, but such cases have to be considered individually and in consultation with the patient's relatives or legal representatives.</p> <p>Whilst therefore supportive of your aims to highlight the effects the lack of resources can have in individual cases in the NHS, it is important to stress that the majority of older people can expect effective medical treatment and proficient nursing care in the geriatric or general medical ward of most hospitals.</p> <p style="text-align: right;"><b>Brian Williams</b> President</p>
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**'Primary care group' article continued from page 21**

for our elderly patients. There are enormous opportunities here to provide better care, utilise resources more wisely and offer a better career structure for many of us. It is always unsettling to give up what we are familiar with even if, perversely, we spend most of our time criticising

it. The opportunity is coming. I would seriously suggest getting in at the beginning.

**Dr Huw Williams**  
GP, Trowbridge  
Vice Chairman, Wiltshire Health Authority

## LETTERS

## November 1999

Peter Crome's views on the recommendations of the Royal Commission on Long Term Care are close to those of the members of the Commission who signed the Note of Dissent, and who were also concerned that the recommendations would tend to favour better off people. There is some truth in this view but of course it would apply to any publicly funded services, including health and education. This is a special example of a general debate on whether public expenditure should provide comprehensive services or only a safety net. I make the following points:

At present everybody who has assets of £16,000 and over (including the value of their house) has to pay the full cost of long term care. This includes a very large number of people who by any criterion could not be described as 'well off'. It also penalises those who have been careful throughout their lives and who have accumulated savings, whereas those who have not, receive public support. It is particularly hard on

home owners; an increasing proportion of the older population will be home owners in future years.

The Royal Commission recommended that personal care should be funded from taxation because Income Tax is progressive and applies to all income, including pensions. Thus the better-off pay more, and in some cases may pay more in tax than any benefits they may receive. Funding from taxation has an additional benefit in that it is flexible and if, for example, an effective drug for Alzheimer's Disease becomes available, it is easy for the Government to switch funding from the long term care budget to the drug budget.

The main recommendation of the Royal Commission, that personal care should be free following assessment of need, was not based on economics but on equity. Older people require long term care, not because they are old, but because they are ill or have the residual effects of an illness. Certain illnesses e.g. Alzheimer's Disease or stroke, tend to lead to the need for long term care, which under current arrangements has to be paid

for by the sufferer or their family, whereas other illnesses e.g. heart disease or cancer, cause different problems and the sufferers receive hospital care which is free. The Royal Commission believed that this distinction is indefensible.

The Royal Commission discussed its proposals at considerable length and took advice from a wide variety of experts. There is no perfect solution but we believe that our proposals are a good attempt at resolving the problem and complying with the values set out at the beginning of our report. An equally important proposal is to set up a National Care Commission which would monitor the impact of Government policies and make recommendations for change as necessary. It is very disappointing that the Government continues to offer no response to the recommendations of the Royal Commission.'

**Professor Robert Stout**  
Member, Royal Commission on  
Long Term Care

## November 1999

I am writing to all Presidents or Chairmen of Medical Specialist Societies in an attempt to enlist their support for the work of the Royal Medical Benevolent Fund (RMBF). This exercise is needed, rather sadly, because the work of this Fund is still unknown to many doctors.

It seems that a belief is prevalent, especially amongst younger doctors, that there is little place for such charitable organisations in society today. If things go wrong somehow the NHS or the State will provide the necessary help. A single visit to a meeting of our Case Committee,

which considers requests for support, would show how wrong this view is. A few facts may help to put our work into perspective.

In 1998 we gave out almost £900,000 in grants to disadvantaged doctors or their dependants. At the end of that year 623 beneficiaries were receiving help from us. The demands made on our resources grow year by year and as they do so the average age of applicants is falling. In 1998 of 65 new beneficiaries, 35 were doctors and their average age was 44 years. The corresponding figure for 1999 to date is 42 years, while at a recent meeting of the Case Committee the average age of 12 new applicants for help was under

31 years. It is widely believed that doctors are affluent and well able to look after themselves and their dependants. Yet of our beneficiaries 54% are in receipt of Income Support or Housing Benefit, both means-tested indications of poverty.

Against this backdrop I would make two requests. Firstly it would be most helpful if you would publicise our work and our need for more resources amongst your members. Reference to us in any newsletter or commentary your specialty produces would be appreciated. Your members could help by joining the local guild of the RMBF and paying the modest annual subscription (minimum £10). Alter-

natively a donation could be made directly to the Fund. Even better, one of your members, or their spouse, could join the local guild and help in fundraising. Although there are 120 guilds the whole country is not

covered and we are working on this.

Thank you for your time and attention.

**Dr Norman Jones**  
Treasurer, RMBF

*For more information or to make a donation, contact: RMBF, 24 King's Road, Wimbledon, London SW19 8QN. Tel: 0208 540 9194. Email: [rm.bg@virgin.net](mailto:rm.bg@virgin.net)*

## DUNDEE SCOOPS AGEING RESEARCH FELLOWSHIPS

The University of Dundee's growing reputation for research on ageing received a twin boost when it beat off rival bids from throughout the country for two prestigious research fellowships.

The Ageing Research Fellowships were awarded for the first time by the Royal Society of Edinburgh and Lloyds TSB Foundation for Scotland, whose chief executive Mr Andrew Muirhead described the result as 'a

remarkable double success for Dundee. The University's projects are both exciting and challenging, and show the rich range of work that can be done to tackle different aspects of old age'.

Winner of the major three-year award is post-doctoral researcher Ms Jacqueline Paterson for a project entitled, 'Diet, Ageing and Immunomodulatory Effects on the Colonic Microflora'. She will join the research

groups of Professor Marion McMurdo (Ageing and Health) and Dr George Macfarlane (Department of Molecular and Cellular Pathology) at Dundee University. The one-year support fellowship goes to Dr Norman Alm in the Department of Applied Computing to explore the potential for information and communications technology to alleviate problems associated with dementia.

**Prof Marian McMurdo**

## STROKE ASSOCIATION RESEARCH PROJECT AWARDS

To follow are details of the BGS members and their projects which recently gained funding from the Stroke Association's Research and Development Committee.

**Dr J Gladman**, University Hospital, Nottingham. 'Characterisation of carotid stenosis: the relevance of high signal material within the

carotid artery detected by MRI in patients with cerebral ischaemia'. £92,821 for two years.

**Prof L Kalra and Dr A Rudd**, Institute of Psychiatry. 'South London ethnicity and stroke study'. £253,613 for five years.

**Prof D Barer**, Freeman Hospital,

Newcastle. 'The role of cervical auscultation in the prediction of aspiration'. £51,268 for two years.

**Dr R Shinton**, University of Birmingham. 'Impairments of everyday life tasks after stroke: diagnosing and rehabilitating'. £61,432 for two years.

## INTERNATIONAL PSYCHOGERIATRIC ASSOCIATION AWARDS

The International Psychogeriatric Association honored six distinguished leaders in the field of psychogeriatrics as part of its prestigious 1999 Field and Service Awards. BGS member **Prof Tom Arie** was amongst the group who was recognised for his long history of significant contributions and

leadership in the field of mental health of the elderly.

The Association stated 'Tom Arie can be rightly credited with establishing the foundation principles and practices of a comprehensive, integrated, multidisciplinary service system of

psychogeriatric care. Through the many students and disciples he trained at Nottingham, particularly in the intensive residential Arie Courses, his precepts have been translated into policy and action in many countries, with inestimable benefits to the elderly with mental disorders.'

## DRUGS & PRESCRIBING SECTION

**DPS SpR training afternoon**

**Belfry Hotel, Warwickshire**

**10 March 2000**

Topics to include: basic sciences, clinical genetics and therapeutic management of dementia.

**Fee:** £50 members (residential);  
£40 members (non-residential);  
£70 non-members (residential);  
£60 non-members (non-residential)

**Registration:** Cal  
Communications. Tel: 01273  
623630.

## DIPLOMA IN GERIATRIC MEDICINE

**Cardiff 30th Diploma Course in Geriatric Medicine**

**University Hospital of Wales**

**15 to 17 March 2000**

This intensive course will be of particular interest to candidates in the forthcoming Diploma in Geriatric Medicine exam. PGEA approved.

**Fee:** £200 (incl. meals)

**Registration closes:** 10 March 2000

**Contact:** Julianne Bartlett, Ward B6, University Hospital Wales, Heath Park, Cardiff CF4 4XW. Tel: 01222 743646

## CARDIOVASCULAR CONFERENCE

**Cardiovascular Disease Prevention V**

**Kensington Town Hall  
London**

**4 to 7 April 2000**

**Contact:** The Secretariat, Hampton Medical Conferences Ltd, 127 High Street, Teddington, Middlesex, TW11 8HH. Tel: +44 (0)208 977 0011. Fax: +44 (0) 208 977 0055. Email: hmc@hamptonmedical.com

## BGS NORTH WEST

**Forthcoming meetings**

**15 March 2000**

**Ormskirk**

*Business meeting; masterclass on 'District stroke services'*

**20 April 2000\***

**Bolton**

*Joint study day with all GIM SpRs. \*  
Please note date change.*

**17 May 2000**

**Stockport**

*Gastroenterology masterclass*

**21 June 2000**

**Haydock Thistle Hotel**

*Joint meeting with Mersey Region.  
Incorporates business meeting*

**Future meeting dates:** 19 July, 16 August, 20 September, 18 October, 15 November 2000.

**Contact:** Dr Paul Baker, Royal Bolton Hospital, Minerva Road, Bolton BL4 0JR. Tel: 01204 390991. Email: paulbaker@drivehard.demon.co.uk

## AGE CONCERN CYMRU

**Age Concern Cymru Lecture**

**'Time of Our Lives - the Science of Human Ageing'**

**Cardiff Marriott Hotel**

**23 March 2000, 7pm**

**Guest speaker:** Tom Kirkwood, Professor of Medicine and Head of Department of Gerontology, University of Newcastle.

**Contact:** Age Concern Cymru, 1 Cathedral Road, Cardiff CF11 9SD. Tel: 02920 371 566. Email: enquiries@accymru.org.uk

## NEW EDITION

**'Principles and Practice of Geriatric Medicine'**

**Edited by Prof M. S. John Pathy**

**3rd Edition now available**

## MENTAL HEALTH

**Innovations in Mental Health of the Elderly**

**Westminster Central Hall  
London**

**6-7 April 2000**

During the 6th World Congress on Innovations in Psychiatry 2000, there will be a series of multidisciplinary symposia on current developments in mental health care of the elderly.

**Contact:** 6th World Congress Secretariat, PO Box B135, Huddersfield, HD1 1YG. Tel: 01484 532102. Fax: 01484 425699. Email: worldforum@aol.com. Website: www.worldforum.co.uk

## CONTINENCE COURSE

**Leicester continence training course for Specialist Registrars**

**Leicester General Hospital**

**6-8 November 2000**

**Contact:** Dr N Lo. Tel: 0116 258 4048

**DEMENTIA CARE**

**'Dementia Care: the future assessment and beyond'**

**Manchester**

**10 April 2000**

A conference aimed at a multi-disciplinary audience focussing on communicating good practice, demonstrating person-centred attitudes and the development of effective models of service in the care of patients with dementia.

**Contact:** Pavilion Publishing Ltd.  
Tel: 01273 623222.  
Email: pavpub@pavilion.co.uk

**MEDICAL ETHICS SIG**

**Medical Ethics SIG meeting**

**Northern General Hospital,  
Sheffield**

**afternoon of 8 June 2000**

Topics to include: advance directives and the relationship between patient autonomy and professional paternalism; and ethical dilemmas of gerontological research and discussion of other topical ethical issues.

**Contact:** Dr Jane Liddle, Northern General Hospital, Herries Road, Sheffield, S5 7AU. Tel: 0114 271 4970. Fax: 0114 256 0472.  
Email: b.j.liddle@sheffield.ac.uk

**BIOGERONTOLOGY**

**2nd European Congress  
on Biogerontology**

**Saint Petersburg, Russia**

**25-28 August 2000**

Organised by the Gerontological Society of the Russian Academy of Sciences in collaboration with the European Biological Section of the International Association of Gerontology.

**Contact:** Congress Secretariat, c/o Olga Mikhailova, St Petersburg Institute of Bioregulation and Gerontology of the North Western Department of the Russian Academy of Medical Sciences, 3 Dynamo Pr, 197110, St Petersburg, Russia. Tel: +7 (812) 235 1832. Fax: +7 (812) 230 0049. Email: igb@medport.ru

**PARKINSON'S DISEASE  
SIG**

**Parkinson's Disease and  
Parkinsonism -  
from Science to Practice**

**RCP, Regent's Park, London**

**20 July 2000**

A 1day multidisciplinary conference

**Contact:** Helen O'Donnell at

continued in next column

Medical Education Partnership,  
PO Box 22096, London SW2  
1GD. Tel: 07775 643500.  
Email: odonnellph@aol.com

**HEALTHCARE FOR  
OLDER PEOPLE**

**Healthcare for Older People:  
The UK Experience**

**The Royal College of Physicians  
of Edinburgh**

**2-15 September 2000**

A two week course presenting the British viewpoint and experience in the fields of geriatric medicine and psychiatry with a careful balance between theory and practice. The most important topics will be selected and dealt with by eminent UK experts chosen for their special knowledge and experience. Specially developed for overseas physicians who are involved in health care for their ageing populations, this course provides the opportunity of learning about the unique nature of British Geriatric Medicine, which has expanded rapidly in recent years and evolved to produce several models of geriatric service.

**Contact:** Christina Gray, International Medicine Department, Royal College of Physicians of Edinburgh, 9 Queen Street, Edinburgh, EH2 1JQ. Tel: +44 (0) 131 225 7324. Fax: +44 (0) 131 220 4393. Email: c.gray@rcpe.ac.uk

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