



B G S

n e w s l e t t e r

Spring Meeting Cardiff



The 2001 Spring Meeting was held in the Cardiff International Arena, with a full scientific programme led by an impressive line-up of keynote speakers, mostly with some Welsh connection, albeit often tenuous (like their rugby team).

A packed satellite meeting on the Wednesday evening examined the *Implications of the National Service Framework and Guidelines for Stroke Care in the Elderly*. The main event kicked off with a

bilingual welcome from Dwarak Sastry and Rhian Morse. Dr Roger Francis made an excellent start with *A Practical Approach to the Management of Osteoporosis*. He stressed that risk is influenced by skeletal and non-skeletal factors and an holistic approach is essential. The treatment of underlying causes was as effective, if not more so, than the increasing number of proven interventions for osteoporosis. Four short platform presentations of submitted papers on bones and falls followed.



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Plagues new and old

Next was a clinical update on *Plagues New and Old*, beginning with a clear review by Dr Ian Campbell of the special considerations needed in the case of in older people with TB. He reminded us of the increase in numbers, and six or seven times higher mortality rate, and that diagnosis was 20 times more likely to be made post-mortem than in younger people. A high index of suspicion, the right tests, and the correct combination chemotherapy, adequately supervised, was needed. A three-month therapeutic trial was sometimes also justified.

Continued on page 2

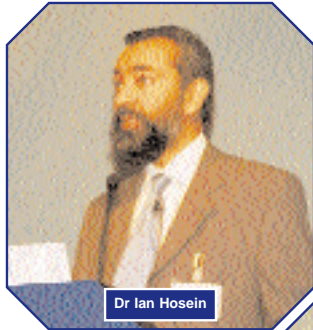
President: Prof Cameron Swift, PhD, FRCP **President Elect:** Prof Robert Stout, FRCP
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specialist medical society for health in old age

Continued from page 1

Dr Ian Hosein discussed infections and antibiotic resistance in the elderly, reminding the audience that bugs are no respecters of organisational or geographical boundaries.



Dr Ian Hosein

There is a great need to focus on prevention rather than merely control.

Prof Sir Leszek Borysiewicz then

challenged complacency about HIV in older patients. Increasing numbers of people



Prof Sir Leszek Borysiewicz

with HIV now survive to middle and older age. Diagnosis was usually late in older people due to public and professional lack of awareness of risk. There was rapid progression

to neoplasm in such patients. Globally, HIV was responsible for 20% of deaths in Africa and an increasing proportion (50-70%) of projected health expenditure (excluding retro-viral drugs.)

Over 160 posters were available for viewing over the two days next to the areas used for both the Pharmaceutical Exhibition and the lunch/refreshments, all of which were of a very high standard.

Parallel meetings

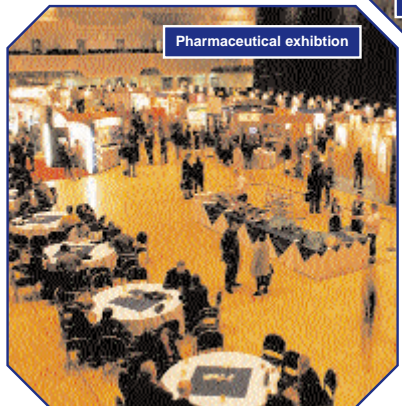
Five Special Interest Groups ran parallel meetings after lunch, i.e. Cerebral Ageing & Mental Health, Falls Prevention & Bone Health,

Gastroenterology & Clinical Nutrition, Medical Ethics, and the newly formed New Technology in Elderly Medicine. A number of them considered the implications of the NSF for the elderly. For further details on the SIG meetings, see page 10.

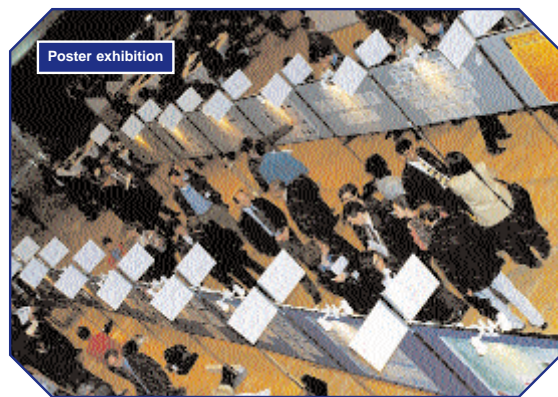
Drugs and prescribing

The last session of the day was devoted to drugs and prescribing. Alastair Breckenridge (Chairman, Committee of Safety of Medicines) gave a review of safety and drug licensing issues affecting older people. He emphasised that drug regulation should follow science and not vice versa. He was concerned about ‘over the counter’ preparations, over 50% of which are used by people over 65. Drug regulation was of lesser importance than appropriate prescribing in improving safety.

Andrea Sutcliffe, a NICE Board member, asked if Clinical Effectiveness provided a fair deal for older people. She outlined the role of NICE and its need to reflect national policy including the NSF for older people, to work closer with relevant agencies and organisations and for more input from clinicians and older people. Among the subsequent six short papers, Dr Gwenno Batty showed that enthusiastic local multifaceted intervention strategies could improve prescribing.



Pharmaceutical exhibition



Poster exhibition

Millennium Stadium reception

The day was rounded off by a memorable reception in the Millennium Stadium. Despite the best efforts of WRU guides to discover hidden talent with Welsh connections, there was little chance that any of the BGS party will be recruited. The Minister of Health & Social

Services (Wales) welcomed the BGS and obviously had a good grasp of priorities for elderly services (and is well advised by local members).



Jane Hutt, Minister for Health & Social Services for Wales

Breakfast symposia

Early birds the next morning had the choice of two well-attended sponsored breakfast symposia on the future of epilepsy and an update on osteoporosis. The first session of the main event

began with Prof Mark Wiles giving a clear review of neurobiology and assessment of swallow, emphasising the value of a simple swallow test and pointing out some of the possible danger zones in dysphagia. He advised against over-reliance on pulse oximetry to detect aspiration.

Prof Sir John Grimley Evans challenged common assumptions about practical aspects of feeding and related ethical issues. More work is needed in defining deficiency diseases and what we should do about them. He urged us not to confuse legality and morality, advising that potential conflict about individual

patient treatments was usually avoided by careful discussion and negotiated agreement with consultants. Local guidelines were required.

Amongst five short papers, Dr Simon Luttrell reported only moderate agreement on decision-



Dr Simon Luttrell



Prof Swift presenting the Hall Cup to Dr Viswan, the winner of the annual Spring Meeting golf tournament

making about life-threatening illness between attorneys and patients - the former were more likely than donors to wish to preserve life than allow to die. Dr Thomas noted lack of consensus about withdrawing PEG feeding within a multidisciplinary team. Most considered that withholding and withdrawing feeding were different considerations.

The morning session was rounded off by a clear and positive keynote lecture from Dame Deirdre Hine, Chairman of the Commission for Health Improvement (CHI). She proposed that the CHI should be a catalyst for quality improvement in geriatric services and should balance performance management in the NHS with concern over quality, emphasising the importance of strong leadership from consultants to develop an appropriate culture for effective clinical governance.

The afternoon session, entitled '*Genes, Brains and Geriatrics*,



Dame Deirdre Hine

included a clear explanation of the implications of The Human Genome Project for old age psychiatry. Prof Michael Owen

thought that gene therapy was not widely applicable, but would aid the development and application of the targeted new treatments particularly for depression and some dementia.

Vascular problems were the focus later. Prof Roger Hall noted the increasing numbers of people over 80 receiving cardiac surgery. Selectivity was needed

but many centres had good results, particularly with aortic valve replacement. Angioplasty was an attractive alternative to CABG but mitral valve surgery results were disappointing. Surgery should be a bonus rather than an onus. Prof Charles Warlow considered if age should influence the investigation and treatment of stroke, 58% of which occur in



Prof Sir John Grimley Evans

those over 75. Differential diagnosis differed but a CT scan within 24 hours was required in the vast majority of cases. The absolute benefits of giving aspirin and of carotid endarterectomy for those with greater than 70% stenosis was greatest in those over 75. The case for stroke units was very strong at all ages.

St David's Hall reception

On the Friday evening, an excellent dinner and reception took place in St. David's Hall, enlivened by a superb after-dinner speech from a local ENT surgeon, Mr Richard Mills, who updated 'Under Milk Wood' to reflect a contemporary medical community. The founding father of Welsh geriatrics, Prof John Pathy, was presented with the BGS Founders Medal.



Mr Richard Mills presenting his after-dinner speech at the St David's Hall reception

Sessions 11 and 12 on Saturday morning were multidisciplinary, focusing on wound healing/care and incontinence respectively. Prof Keith Harding and Joe Grey gave a useful medical prospective, including the pathogenesis of ulcers and the limited evidence for various treatments. Although wounds healed better when kept moist rather than dry it is unclear "how moist is moist". Compliance with Type II compression stockings was only 15% after three months. Topical platelets derived growth factor studies were promising but good basic management was crucial. OT and Clinical Nurse

Specialist colleagues emphasised the need for an holistic, rehabilitative approach, which maintain dignity. This was emphasised in a moving contribution from a patient's perspective.

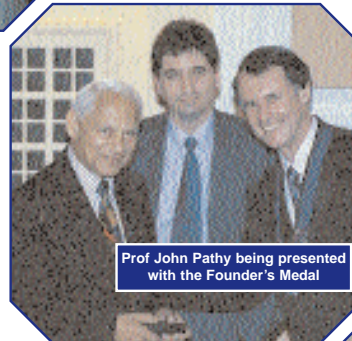
In the final session, Dr Rhian Morse reviewed her experience in assessment and management of urinary incontinence in a Day Hospital. Low dose desmopressin appeared useful in selected patients. Mr Ash Monga, a urogynaecologist, reviewed minimally invasive surgery and, in particular, recent encouraging work on injectable treatment for stress incontinence and of tension free vaginal tapes (TVT) for prolapse. The meeting ended with a reminder of the value of Nurse Specialist input on incontinence management in care homes.

Sincere congratulations to the hosts!

In conclusion, the BGS Spring Meeting in Cardiff was of a very high professional and scientific standard, with a relevant and challenging programme. Excellent hospitality was enjoyed in a relaxed atmosphere. The host team led by Dwarak Sastry and Ken Woodhouse deserve sincere congratulations. No Triple

Crown or Grand Slam this year, but BGS Spring 2001 was a home triumph!

*"Cafodd pawb amser bendigedig
Llongyfarchiadau gwresog
i'n cyd-weithwyr yng
Nghaerdydd!" ("Everyone*



Prof John Pathy being presented with the Founder's Medal

had a wonderful time. Warmest congratulations to our Cardiff colleagues.")



Dr Rhian Morse



Spring Meeting 2001 Organising Committee

Dr Peter Murdoch
BGS Representative
(Scotland)
Falkirk & District
Royal Infirmary

Editorial

page



NHS services will be provided, regardless of age, on the basis of clinical need alone. So begins Standard One of the National Service Framework for Older People (NSF) (Newsletter, May 2001, page 1).

In the rationale, the reader is reminded of the guidance issued last year (HSC 2000/028) which made clear that local resuscitation policies should be based on guidelines issued by the British Medical Association, Royal College of Nursing (RCN) and Resuscitation Council and should be regularly audited. In response to concerns raised by members of the Society about the complex and emotive issue of cardiopulmonary resuscitation (CPR) (Newsletter, July 2000, page 5), the *Compendium* document on CPR has been updated. It is now on the BGS website (www.bgs.org.uk) and, because of the importance of the issue in everyday clinical practice, it is included on page 19 of this Newsletter.

Raising the profile of incontinence

One of the milestones for Standard Two of the NSF, Person-centred care, is that by 2004 all local health and social care systems should have established an integrated continence service which should include, among other things, links to designated medical specialities such as urology and geriatrics.

Therefore, the setting up of a Special Interest Group (SIG) in Bowel and Bladder Problems agreed by Council in May, could not be more timely and means that three of the geriatric giants now have the prominence within the Society that they deserve. Reports from the recent meetings of the SIGs for confusion (Cerebral Ageing and Mental Health) and falls (Falls and Bone Health) are on page 10. Three down and one to go!

Nurse Specialists for Older People

This is the terminology for gerontological nurse specialists used in the NHS Plan. Work with the RCN to produce a joint statement is nearing completion. I am grateful to Christine McAlpine, Donald Farquhar and David Beaumont who responded to my request for members' views of working with gerontological nurses. I thought their experiences should be shared (page 22). I apologise for any mistakes in my summary, but please direct any queries about the work described to the geriatrician concerned.

Pressure ulcer risk assessment and prevention

This is the title of what is intriguingly referred to as Inherited Clinical Guideline B, issued by the National Institute for Clinical Excellence (NICE) in April 2001 and due for review in 2005. Apparently, it is part of work inherited by NICE and so has not been through the full guideline development process used now. Perhaps a case of not so nice!

Mary Bliss and John Young were the consultant geriatricians involved in developing the guideline. It aims to reduce the occurrence of pressure ulcers by providing guidance on early identification of patients at risk and prevention, and by identifying practice that may be harmful or ineffective. It specifically excludes the epidemiology of pressure ulcers, recommendations for wound care and surgical management. It needs to be considered with the guideline of the same name produced for the Department of Health by the RCN and which is on the NICE website (www.nice.org.uk). Together they form the standard against which local practice can be compared and change implemented.

Finally, welcome to Louise Wykes who has joined the BGS staff as Committee Secretary.

Dr Rebecca Dunn
Honorary Secretary

President's column



I hope that overseas BGS members will in spirit feel able to join UK colleagues in celebrating a new milestone for the Society.

Opening of Marjory Warren House

I am delighted that the UK Secretary of State for Health, the Rt Hon Alan Milburn, MP, has accepted my invitation to him to open the Society's newly acquired premises in central London on 26 September. Each UK Branch representative on Council (or her/his nominee) has already been invited, along with other guests to this important event in BGS history, and I do hope the key role which geriatricians play internationally in the health care of older people will be effectively highlighted and publicly acknowledged at this occasion. The building has only just begun to fulfil some of its necessary functions, but its potential both functionally and in terms of profile is enormous, and the event will, I hope, kick-start the next stages.

The BGS Plan and the Regional Branches

In the current climate of devolution it is by no means surprising that the Northern Ireland, Scotland and Wales branches of the BGS have already forged, or are in the process of setting in place, strong representative links to influence decision making within the respective administrations. Along with the English Regions the branch structure and organisation constitute a major strength of the Society and a pivotal mechanism to enable geriatricians in this country to promote and maintain the best standards of clinical practice and service provision. The recent re-shuffle of English NHS Regions threw into sharp relief the difficulties left behind by the considerable reduction in Regional involvement in local services enacted by the previous UK government. Formerly, each region had its own speciality committee (or

subcommittee of medicine) which in geriatric medicine fulfilled an important peer support function for departments – particularly when local district management initiatives threatened standards. This largely disappeared in any formal sense in the early nineties or sooner.

With the recent central policy directives and the rolling out of clinical governance and revalidation, there is now an urgent need to rediscover this function and it is probably the Regional BGS branches who (like Northern Ireland, Scotland and Wales) are best placed to contribute in conjunction with the Regional Service Advisors to the College(s). The agenda will include information gathering (e.g. on the local effects of the National Service Framework), consultation on local service strategy where requested, troubleshooting on behalf of departments and liaison with the relevant Regional office. From recent exchanges, it is clear that these aspects cannot be left to NSF monitoring procedures, the Commission for Health Improvement or the Health Advisory Service.

The work on this is currently being taken forward by the Policy Committee, the Hon Deputy Secretary and Council members themselves, under the BGS 2000-2 Plan. Proposals will be firmed up for the next Council meeting.

Tomorrow's stroke physicians

The Training Committee has been considering proposals presented to the Colleges by the British Association of Stroke Physicians to establish stroke as an accreditable clinical subspecialty. Their response is outlined on page 8 of this Newsletter and follows a similar response to the London College President from the Joint BGS/RCP Committee.

Geriatric medicine has played a major role in the evolution of this discipline and geriatricians are the largest constituency of stroke physicians, both in district hospitals and academic centres.

Clearly, any future training programme should reflect this (alongside those whose interest has originated from neurology, rehabilitation medicine or clinical pharmacology) rather than trying to invent a new training track within general medicine itself - for which there is little or no significant tradition.

Consultants and trainees alike will welcome formal recognition of subspecialty skills in geriatric medicine. It is, however, incumbent on us to ensure that older people (the majority) who suffer from stroke disease are in no way disadvantaged in the future design and delivery of services - and that includes those with complex co-morbidity, recurrent disease, cognitive impairment and long-term care needs.

It is, of course, equally important to deliver just as comprehensively for younger stroke sufferers, and geriatricians specialising in the field already have an excellent track record in this respect as well. For this balance to occur, tomorrow's stroke physicians, if they are to become a distinct entity, will therefore need to be formally and properly trained in geriatric medicine (whatever their speciality origins) - with the possible exception of a subset of research academics,

who may perhaps operate in a more collaborative (but clearly specified) context. Collectively, the Society and the Joint Committee are engaged in the discussions, and I have taken steps to reinforce the respective positions with the College Presidents and the Joint Committee on Higher Medical Training. Geriatricians internationally need to be aware of this and to be planning ahead in a way which ensures that the claims of older people to comprehensive quality stroke care are fully promoted. Feedback from members would be welcomed.

Next steps with the NSF

Our consultation with the National Directorate continues. At the most recent meeting the three themes of ageism, local implementation and workforce were pursued. It has to be said that election uncertainty imposed some limitations on the process, but now we know the outcome, forward momentum can resume. What is clear is that our own monitoring of NSF-driven activity is important not just to geriatricians and their patients, but also to the Department of Health. It's up to us (see BGS Plan above).

Prof Cameron Swift
President

Training in stroke medicine

The British Association of Stroke Physicians (BASP) has recently submitted a proposal for the recognition of stroke medicine as a sub-specialty interest.

This follows discussions with the Director of the JCHMT and the President of the Royal College of Physicians of London.

The proposal is for a one year period of supplementary training, supervised by a sub-commit-

tee of one of the SACs, and open by national competition to trainees in any of the relevant specialties, e.g. general internal medicine (GIM), geriatric medicine, rehabilitation, clinical pharmacology and therapeutics, or neurology.

Three basic modules are to be included: acute stroke; stroke rehabilitation; and stroke prevention. Equal attention is to be paid to each module but will depend on the trainee's previous experience. Full details of the knowledge, skills and experience to be acquired in each module are described within the proposal. The issue of how an extra year of training would be funded is still being explored.

These proposals were discussed at the BGS Training Committee meeting on 17 May, and the views of the committee were as follows.

1 Structured training in stroke medicine is welcomed. A subspecialty focus on stroke would help raise the profile of stroke services, and this would be a step towards attracting the resources required to improve outcomes to the level achieved in Europe, where appropriate investment has already been made.

2 The only SAC with the breadth of knowledge and skills required to oversee this training is Geriatric Medicine. As the majority of stroke sufferers are elderly and as the vast majority of stroke services are presently run by geriatricians, this seems almost inarguable. The GIM SAC will not have the required expertise in rehabilitation or in the planning of stroke services. The same applies to clinical pharmacology, while the SACs in neurology and rehabilitation medicine do not have the required expertise in acute medicine.

3 There was a strong view that training should not be laid down in terms of time, but rather in terms of competences. Many geriatric medicine trainees with an interest in stroke will have most of these by the time of achieving CCST, perhaps only requiring a brief period of extra training, e.g. in imaging or the management of younger stroke patients. There is great enthusiasm to find ways of building all the requirements for stroke training into existing SpR training programmes in geriatric medicine.

4 There is great concern that trainees coming

from other specialties may in fact require significantly longer than a year to achieve the necessary competences to run a comprehensive stroke service. Some allowance is made for this within the proposals, but this needs to be stated more clearly. A trainee coming from pure GIM is unlikely to have any experience in rehabilitation and would require substantially longer than four months to achieve competence in this specialised area. Likewise, trainees in neurology and rehabilitation medicine that are not dually accredited will need a period of acute GIM training if they are to be competent in managing the intercurrent illness and comorbidities so frequently seen in stroke patients.

5 Given that most stroke patients are elderly, it can be argued that a level of competence and thus specific training in geriatric medicine should be included in the Stroke Training Programme.

6 Finally, there are concerns regarding the implications for workforce planning if a significant number of trainees in geriatric medicine decide to spend an extra year in training. This will have to be matched by an equivalent rise in the number of NTN's to avoid a shortfall in the workforce.

A stroke committee of the Royal Colleges of Physicians, with representatives from the relevant specialties, including geriatric medicine, is to meet shortly to discuss the JCHMT's response.

Dr Nicki Colledge

Chair of the BGS Training Committee

PRIZE WINNERS - CARDIFF SPRING MEETING, APRIL 2001

Elizabeth Brown Prize (best paper read)

Winner: A M Qureshi

Abstract: Relationship Between Collagen Type 1 Alpha 1 Gene Alleles and Hip Fracture

Ferguson Anderson Prize (best poster)

Winner: J Ngeh

Abstract: Seroprevalence of Chlamydia Pneumoniae in Elderly Stroke and Medical Patients: A Case-Controlled Study

SPECIAL INTEREST GROUPS

- CARDIFF SPRING MEETING PARALLEL SESSIONS

CEREBRAL AGEING & MENTAL HEALTH

Prof David Jolley introduced the meeting by commenting that the fourth meeting of the SIG tied in nicely with the recent publication of the NSF, both being catalysts for closer working between old age psychiatrists and geriatricians.

NSF and the geriatrician

Duncan Forsyth, speaking about the NSF from a geriatrician's perspective, reminded us about the various factors that lead its inception. A key factor was the HAS 2000 report which resulted in press criticism of elderly care, and the realisation by government that older people were very large consumers of medical and local authority resources.

Combating ageism was a key feature but he felt, as did our other speakers, that the NSF in some aspects could itself be interpreted as ageist. There was also the risk that progress in the management of older people in recent years was being overlooked.

A particular worry was that the success of DGH geriatrics, with its improved acute care of elderly people, was at the cost of more traditional community and long stay aspects of care. Indeed the training of our present SPR's lacked community focus and gave them little experience in long-term care. There is also a danger that the emphasis on inappropriate placement of a small minority of older people stigmatised the care of the rest.

Older patients need wards designed for them, and well-trained staff and experts that can work across traditional boundaries, e.g. liaison psychiatry. One worry about the implementation of the NSF centred on staff recruitment and training, with the attendant resource implications. The initial local assessment of how well the services in Cambridge matched up to the demands in the NSF was also discussed.

NSF and old age psychiatry

Prof Alistair Burns looked at the NSF from the perspective of old age psychiatry, developing the theme that some of the impetus behind the NSF was the realisation by government of resource use in this group. Subdividing old age into early post retirement, transition and frail stages, he proposed the view that the NSF was aimed at the latter group. Disappointment that the NSF could be seen as bland and obvious, without precise cookbook fixes, should be tempered by the realisation that raising overall standards was the aim, rather than leading edge development.

A key element from an old age psychiatrist's perspective is the focus on the support of patients and carers. Treatment and diagnosis are also important and the old age psychiatrist's skills in diagnosis seem to have got a little lost in the NSF algorithm.

A key theme was the opportunity the NSF gives to improve services for older people and this should not be lost sight of in the arguments over detail. Prof Burns

concluded his contribution with the message that implementation was the key.

Dr Rhys Lodwick
New Cross Hospital,
Wolverhampton

FALLS PREVENTION & BONE HEALTH

Launch of a new SIG

The April Spring Meeting provided the forum for the launch of the Falls & Bone Health SIG. Prof Marion McMurdo opened the meeting by welcoming all participants and setting out what is hoped to be achieved by this SIG, both in terms of keeping up-to-date with evidence based practice, service delivery, successful models of care etc, maintaining the research agenda high on the list of priorities, and promoting collaborative working in clinical studies across the UK. She also conveyed her thanks to Prof Cameron Swift who had provided the inspiration to develop this SIG.

NSF and falls

As Chairman of the External Reference Group for the falls section of the recently published NSF, Prof Swift was ideally placed to deliver the opening lecture, providing a broad overview of the development of the NSF for Older People, and then focused on the falls section of the document (Chapter 6). He gave the overall document a cautious welcome but did highlight the potential for geriatricians to take on board the recommendations in Chapter 6 and to

be pro-active, both locally and nationally in developing services that address falls prevention and bone health in our older population. He made it clear that not all the key interventions and recommendations were strongly evidence-based and that there is still a considerable amount of research to be undertaken in this area.

Prof John Campbell from New Zealand spoke next. Those with an interest in the area will be familiar with the contribution he has made to the literature on falls over the years and, more recently, in terms of successful intervention strategies in the form of RCT's to prevent falls. He delivered a pragmatic review of the current evidence base in falls prevention and provided an insight into the work of his own research group in New Zealand which has successfully delivered exercise programmes, leading to a significant and sustained reduction in falls.

Membership* (£25) of the SIG includes, e.g. reduced fees, for future meetings. All those communicating by email will get a falls booklet template (in Word) ready for bespoke local conversion and ongoing distribution of policies, documents of interest etc.

It is hoped that we will see many faces again at the forthcoming one day meeting on Falls and Postural Stability at the RCP (London). With time we hope to develop our own website and set up a forum on email to facilitate the exchange of ideas in the ever expanding world of falls and bone health. In the meantime, here is some useful information on national activity.

1 Launch of the AGS/BGS/AAOS *Guidelines for the Prevention of Falls in Older Persons*. JAGS 2001 49:664-672.

2 Forthcoming meetings:

a The 2nd National Conference on Falls and Postural Stability, 7 September 2001. Royal College of Physicians, London. Organised by the SIG and Nottingham City Hospital. Jayne Mowson: Tel 0115 9627758, fax 0115-6927937 or email jmowson@ncht.trent.nhs.uk

b Providing Falls Services, 26 September 2001. St George's Hospital, Tooting. Organised by Dr J Simpson & E Mosby. Tel 020 8725 5327, fax 020 8682 0926, email: e.mosby@sghms.ac.uk.

3 On-going national activity: RCP (Lond) Clinical Effectiveness and Evaluation Unit are looking at the development of national performance indicators for evaluating falls services nationally (Chaired by Jonathan Potter. SIG representative: Jacqueline Close).

Dr Jacqueline CT Close
Secretary, Falls & Bone Health SIG

*Those interested in joining should contact: Jed Rowe, Hon Treasurer, BGS Falls & Bone Health SIG, Moseley Hall Hospital, Birmingham B13 8JL. Email: jedrowe@geriatrickery.freemove.

MEDICAL ETHICS

Getting past the Ethics Committee

Speakers: Dr Donald Portsmouth, Dr Karen Le Ball, Dr Tony Bayer.

Research governance

Donald Portsmouth explained that research governance is the UK Government's framework for ensuring a systematic approach to quality within NHS research. It establishes that the well-being, rights and safety of volunteers participating in research is paramount. The framework seeks to: (i)

improve quality; (ii) put in place safeguards to protect the public; (iii) enhance ethical and scientific quality; (iv) promote good practice; (v) reduce adverse events; and (vi) prevent poor performance and misconduct. The Government's proposals for research governance can be found on the DoH website at www.doh.gov.uk.

Local Research Ethics Committee

Karen Le Ball outlined the role of the Local Research Ethics Committee (LREC). LRECs are accountable to Local Health Authorities but remain independent bodies without political or financial agendas. Members usually sit for between three and five years. Decisions are reached by consensus and are not necessarily unanimous. LRECs make decisions on the ethical acceptability of research involving human subjects.

In coming to a decision, an LREC will consider both the scientific validity of the research and the welfare and humanity of the individual participants. It will review: (i) the protocol; (ii) potential conflicts of interest; (iii) funding; (iv) benefits v risks; (v) issues relating to confidentiality; (vi) information for participants; and (vii) mechanisms for seeking consent.

LRECs will advise that research should not be undertaken on mentally incapable volunteers if that research could equally well be undertaken with mentally capable participants. Karen explained the various approaches that can be used to assess the ethical quality of a study as: (i) a goal-based approach focusing on outcome; (ii) a duty-based approach focusing on moral principles; and (iii) a rights-based approach focusing on the rights of each individual

participant. She explained that LRECs will commonly use all three approaches when reviewing the ethical quality of applications before them.

Practical problems for researchers

Tony Bayer reviewed the practical problems that researchers face when trying to ensure that their study is ethically acceptable. He indicated that there should not be a conflict between the aims of researchers and those of LRECs. However, there is some evidence that there may be differences of opinion about the responsibilities of the LREC. A 1997 study showed that whilst researchers indicated that they felt an LREC has a duty to ensure that participants are not harmed and that their autonomy is respected, they did not regard an assessment of whether the study will provide any benefit or whether it is scientifically valid and lying within the remit of the LREC.

Tony listed common complaints from researchers about the function of LRECs as including: slow responses; inconsistencies between committees; and challenges to methodology. He indicated that researchers should make timely applications to LRECs, ensure that all the paperwork is completed, ensure that any patient information sheets are of sufficient quality, be prepared to attend the LREC meeting, and adopt a non combative approach.

Elections to office

Drs Portsmouth, Luttrell and Barber have all retired from office at the AGM in Cardiff. They have all been in office since the SIG was formed in 1995. Dr Karen Le Ball, Queen Elizabeth Hospital, Woolwich, is the new Chairman.

The new Secretary/Treasurer is Dr Jane Liddle* of the Northern General Hospital, Sheffield.

Dr Steven Luttrell

*To be included on the correspondence list for the Ethics SIG, email Dr Jane Liddle on: b.j.liddle@sheffield.ac.uk.

NEW TECHNOLOGY IN ELDERLY MEDICINE

This SIG was launched at the Spring Meeting in Cardiff. Prof Bulpitt amicably chaired the well-attended inaugural meeting.

Frank Miskelly provided an introduction to telecare and defined it as the remote provision of care and medical services to people in their own homes using digital information and communication systems. These technological aids and devices are another part of the overall package to enable older patients to manage at home. Their role in supporting both frail older patients and their relatives was emphasised.

Telecare systems

The three components of a telecare system are: (i) vulnerable elderly patients; (ii) electronic aids and devices; and (iii) an appropriate response system to respond to emergencies. The Community Alarm system is a good example where frail elderly are able to press their pendant alarm in an emergency and the warden responds. The major defect of this system is that the patient needs to recognise the emergency and have sufficient mental and physical capacity to press the alarm. Semi-automatic systems which do not require good physical and mental capacity are

currently being tested for pressure mats, health monitors, fall detectors and video-monitoring systems. Some promising early results from this research were presented.

This was followed by a presentation based on the 'CarerNet' model for integrated care delivery telecare by Kevin Doughty (Technology in Healthcare Ltd). This focused on the patient in the home, supported by a 'Ring of Care', provided by formal and informal carers.

Analysis of the requirements of the stake-holders in a healthcare system provides an engineering solution to the information network needed to manage such a system. The addition of constraints, such as minimising intrusion, yields a solution based distributed intelligence and a battery of sensors within the home, i.e. a 'smart' home, referred to as the WISEST Home (Well-being, Information, Security, Enablement, Safety and Telecommunications).

Community alarm services offer simplest telecare, compatible with the CarerNet model. A wide range of smart sensors was described, which included devices to detect emergencies of a social, environmental, personal and physiological nature. The sensors have a built-in self-test capability for reliable operation; they are currently being used in more than a dozen pilot studies across the UK.

The second generation

Second generation telecare involves considerably more data collection and analysis, both in the home and at a remote monitoring centre. It allows lifestyle and vital signs monitoring to be performed and for data to be retrospectively analysed by physicians or other health professionals. It also allows artificial intelligence to be applied to detect problem conditions from an

analysis of trends. MIDAS is an advanced lifestyle monitoring system currently undergoing trials in both community and institutional settings. Similarly, Tunstall's Telemed monitor allows vital signs data to be accepted and processed

by Community Alarm Centres. A number of commercial operations are soon to be launched using this technology.

The SIG's second annual conference will take place at the Charing

Cross Hospital London on 2 October (see page 26 for more details). Amongst the speakers will be the head of NHS Direct.

Dr Frank Miskelly
Charing Cross Hospital, London

Training -

Can specialist registrars organise their own?

Training sessions in geriatric medicine vary greatly between regions, in their format and in their leadership.

In 1999, in Northern Ireland, as formal training sessions were not set up in geriatric medicine, three trainees decided to explore the feasibility of specialist registrars (SpRs) organising their own teaching with consultant involvement.

The three SpRs highlighted topics to be discussed at ten half-day sessions on the last Thursday afternoon of each month. Once accepted the challenge of organising the meetings for one year. Geriatricians across Northern Ireland were approached to chair each session. All of them agreed. The consent of the Regional Speciality Advisory and education supervisor were obtained. The programme for each three-hour session involved a consultant geriatrician, two registrars and guest speakers from other disciplines. Three of the sessions were held outside the Belfast area, involving round trips of 100 miles. Attendance was compulsory for the 11 SpRs and three LATS. Staff grade physicians in geriatric medicine throughout Northern Ireland were later invited to join the group.

Attendance and appraisal

An attendance rate of 84.5% was achieved.

Three of the registrars attended 100% of the meetings, while three attended 90%. As part of an appraisal process, all the registrars rated the meetings as being either excellent or very good. We continue to develop and update our teaching programme and recently a sub group, made up of the educational supervisor, a trainee advisory and an SpR has been set up. They meet every six weeks to monitor the teaching programme and regularly audit the meetings.

Feasible and successful

The setting up of the training group by SpRs proved feasible and successful. The teaching programme in Northern Ireland is under constant review to maintain both the current high level of teaching and the remarkable support of all the consultant geriatricians in the region. Work is now ongoing to set up a four-year programme with SpR input.

We would suggest that trainees in other regions take control of their teaching programme. They will gain valuable experience in organisational skills and will be able to develop a teaching programme suited to the needs of the group as a whole.

[This article is based on an abstract presented at the Cardiff Spring Meeting in April 2001. The authors are: R Kelly, I Steele, C Foy, L Armstrong and A Heaney, of the Elderly Care Units in both Belfast City Hospital and The Royal Victoria Hospital, Belfast. Contact Dr R Kelly on 028 90797387.]

CLINICAL GOVERNANCE

Many thanks to all those consultant members of the Society who filled in the latest clinical governance questionnaire at the recent Spring Meeting in Cardiff.

The results are tabulated below, together with results from the same questions in 1999 and 2000. No doubt members will draw their own conclusions but the only significant difference that we can demonstrate over the last two years is the small increase in the number of people who have actually been appraised and the large number of trusts that aim to introduce an appraisal system. It is perhaps not surprising, as appraisal became compulsory on 1 April.

There is no doubt that there is still considerable enthusiasm among geriatricians to see proper, resourced, comprehensive systems of clinical governance introduced. The reality appears to be that it has slightly slipped down the political agenda, it certainly has not been resourced and it is proving very difficult for most consultants to find the time. We have recently lobbied Sir George Alberti, President of the Royal College of Physicians, with the view geriatricians believe that if the government is serious about clinical governance, they must move it higher up the agenda and, crucially, they must provide the time, the workforce and the resources to make it work.

Dr David Black

Chair, Joint Specialty Committee on Geriatric Medicine

RESULTS OF THE BASELINE CLINICAL GOVERNANCE ASSESSMENT FOR CONSULTANT GERIATRICIANS

	1999 (n=58)		2000 (n=106)		2001 (n=120)	
	Yes	No	Yes	No	Yes	No
1 Appraisal						
a Have you had a job review in the last year?	56	44	51	49	52	48
b Have you been personally appraised in the last year?	30	70	36	64	40	60
c If no appraisal, is your trust currently planning to introduce an appraisal system?	75	25	84	16	96	4
2 Personal Development Plans						
Through appraisal or any other mechanism, have you had the opportunity in the last two years to agree a clinical or non-clinical personal development plan?	36	64	33	67	34	66
3 Departmental Development						
a Is there a nominated lead clinician in your elderly care department responsible for the service quality and developing the service?	54	46	50	50	61	39
b Do you have a recognisable department development plan?	46	54	36	64	36	64
c Would you or your department know how to develop a departmental development plan?	58	42	56	44	72	28
4 Outside Peer Review						
a Do you support the principle of external peer review of the whole department?	98	2	96	4	96	4
b Has your service had a review by the Health Advisory Service in the last two years? [SHAS Scotland]	11	89	10	90	16	84
c Do you have any audit or benchmarking systems in your department which use clinical outcomes of the service?	54	46	45	55	56	44
d Are you confident that a Commission for Health Improvement Visit could find clear audit trails in your department with regard to audit complaints, critical incidents, etc? [CSB Scotland]	38	62	37	63	42	58

Council Study Day

- focussing on intermediate care

The Council Study Day, which took place on 24 May 2001, was the first conference-type meeting to take place in the Society's new premises in London.

The meeting was chaired by Prof Cameron Swift. There followed an interesting discussion on intermediate care, led by four guest speakers, as well as a contribution from the Honorary Treasurer, Dr Ian Sturgess.

By way of introduction, Prof Swift pointed out that intermediate care is central to the NHS Plan and National Service Framework (NSF), so with additional resources there is now an opportunity to rediscover this aspect of the service.

Department of Health

The first speaker was Gareth Jones, Team Leader for Intermediate Care, Department of Health (DoH). He described the lack of intermediate care as a black hole in the range of services available to elderly people; renewed interest developed as a result of both the National Beds Inquiry in early 2000 and the availability of winter pressure money. Important points were highlighted about intermediate care.

- 1 The primary aims are to prevent unnecessary admissions, promote timely discharge from hospital and minimise premature need for residential/continuing nursing care.
- 2 An additional 5000 intermediate care beds are expected to be available by 2004 and £900m is to be pumped into schemes. A concern will be whether the funding actually goes to intermediate care, rather than being 'lost' elsewhere.
- 3 Flexibility is essential; the DoH is not giving directives regarding what specific schemes are established; it is a local issue which requires local solutions. Schemes should, however, allow appropriate care to be closer to peoples' homes.

4 There should be an expectation of improvement, with an emphasis on active therapy and rehabilitation to maximise independence, thus enabling people to live in their own home whenever possible. It is not meant to be a half way house to continuing care.

5 The length of time patients are in a scheme may be as short as one to two weeks, but should generally be no longer than six weeks, although no definite cut-off time is intended.

6 Schemes are meant to be part of a fully integrated service, and not a substitute for others, e.g. respite care or slow stream rehabilitation.

Methods and expectations

1 Schemes are expected to involve cross-professional working, a single assessment framework, single professional records and shared protocols.

2 It is a key test for joint working; partnership building is essential, not only between primary care, secondary care and Social Services, but also with other agencies such as Housing and the Voluntary sector.

3 Building on good practice with innovation is necessary, as is systematic evaluation.

4 The DoH will be looking for evidence of tangible benefits, with reductions proportionally in emergency admissions, delayed discharges and continuing care placements.

We were reassured that intermediate care is not intended to be a device for providing a second class service for elderly people by diverting them away from acute hospitals.

The Ealing experience

Dr Janet Ballard, a GP who is working as a Consultant in Primary Care within the Acute Hospital Trust at Ealing, spoke next. Her brief in Ealing was to set up a primary care link in A&E. The service now provides immediate access to a multidisciplinary team for patients attending A&E who do not need hospital admission. A single assessment occurs by one

member of the team, which may be a nurse, occupational therapist (OT), physiotherapist or social worker. GPs also refer patients who are still at home, and not having to contact the different agencies can save considerable time as access requires one telephone call only. Clinical responsibility remains with the GP and adults of any age are referred, although most are over 65. No charge is made for the service.

The benefits for patients are clear. Timely care packages tailored to their needs enable patients to stay at home. An evaluation of ability on finishing the scheme, which is usually within six weeks and six months later, showed the majority to have either maintained or improved on their gain in independence. Dr Ballard commented that the benefit to the Trust was more uncertain, as it was not always possible to be sure an acute admission had been avoided; it had, however, been estimated that an additional 40 beds would have been necessary to deal with the patients who entered the scheme and would otherwise have been admitted to hospital. GPs benefit from the single point access, the availability of an alternative to acute hospital admission, improved hospital discharge and better co-ordinated health/social care.

To establish intermediate care schemes requires not only a good working relationship between Health and Social Services, but support from senior staff within these organisations.

Dr Ballard also commented that many areas have already established schemes which could be defined as intermediate care.

Intermediate care at Rotherham

Ms Anne Ashby, the third speaker, has an OT background and is a Joint Commissioning Development Manager at Rotherham. She highlighted that increasing hospital admissions are placing greater pressures on rehabilitation services, with a consequent increased use of expensive residential/nursing home care. Less money is therefore available for preventative services. The Audit Commission found that, in the 75 plus age group, 39% of hospital admissions are inappropriate and 56% have an inappropriate length of stay. An aim of intermediate care is to reduce both these percentages, but

one of the difficulties in evaluating schemes is that admissions and discharges are affected by many different factors.

In Rotherham they have developed Community Assessment Rehabilitation and Treatment Services (CARATS), which are nurse led and involve community rehabilitation teams. There is rapid response, hospital at home, residential rehabilitation, day rehabilitation and nursing home recuperation with rehabilitation. Twelve beds are available for rehabilitation in a residential home, with assessment being undertaken in the community by geriatricians. Again, adult patients of any age are accepted for the scheme, although it is important to clarify financial arrangements as budgets for young adults and elderly patients are separate.

Last year, 485 patients were referred to the rapid response/hospital at home scheme; 62% remained at home, 17% died at home and, of those referred for early discharge, 9% returned to hospital. An advantage for the latter group is that arrangements were made for them to be readmitted under the care of the same consultant. It was estimated that the scheme saved up to 14 hospital beds/day.

A total of 104 patients were referred for residential rehabilitation - 80% for falls or reduced mobility. The average length of stay was 19 days and there was an estimated saving of £300-£600,000 per year by diverting admissions from long stay care. The aim is to have six local rehabilitation teams working coterminously with social and nursing services, but recruitment of paramedical staff has been problematic.

The independent sector

Dr Chai Patel, Chief Executive of Westminster Health Care, commented that the independent sector has been involved with intermediate care for a long time and wishes to develop services further. He re-emphasised the use of single assessment plans and the need for active rehabilitation, with the aim of both restoring confidence and recapturing independence. The role of IT was also promoted. There is a need for training in a more generic approach, so, for example, nurses could undertake more OT work and vice versa. The partnership necessary for successful intermediate care heralds the

prospect of narrowing the traditional divides between both public and private sectors and between health and social care.

East Kent

Finally, Ian Sturgess, Nunnery Fields Hospital, Canterbury, gave a geriatrician’s view from his experience establishing intermediate care in East Kent. He emphasised the need for local geriatric departments to be fully involved in intermediate care as part of a comprehensive service for older people, although he believes it should be available for younger adults as well as the elderly. It took time before a firm partnership between primary care, secondary care and Social Services evolved.

Intermediate Rehabilitation Units have been developed in Community Hospitals, where patients are regularly assessed by geriatricians. Patients are also seen in their own home by Community Assessment and Rehabilitation Teams (CARTs) and their cases discussed at weekly meetings with geriatricians. There are A&E support teams, and a Clinical Nurse Specialist Team supporting nursing home practice. The elderly can also be admitted to Local Authority Residential Homes for up to four weeks for recuperative care, supported by CART teams. When necessary, patients spend one or two nights at home before being

discharged from the residential home. A cost-effectiveness project on services is presently being undertaken.

Patients entering any intermediate care scheme should be told the support is not permanent; it is also necessary to review care packages, which at a later date may need to be increased or, just as importantly, decreased.

Conclusion

The Study Day gave members a greater awareness of the aims of intermediate care as well as a more practical insight into what is happening locally in various parts of the country. A particular emphasis was for a comprehensive approach, innovation and evaluation; it was also clear that Departments of Geriatric Medicine need to be proactive locally.

Professor Swift thanked all speakers for their thoughtful contributions, with special thanks going to Ian Sturgess, who manfully managed to complete the task despite suffering from a viral infection, and to the Honorary Deputy Secretary, Chandra Vellodi, for arranging a most successful meeting.

Dr Roger Lewis
 England Representative
 BGS Executive Committee

COUNCIL MEETING, 24 MAY 2001 - SUMMARY OF PROCEEDINGS

President’s report

- 1 Prof Swift congratulated the Cardiff organising committee on the success of the Spring Meeting.
- 2 Members of Council were notified of the date for the official opening and reception of Marjory Warren House, i.e. 26 September, to be held in the Hall of the Order of St John.
- 3 Prof Swift explained his intention to visit as many BGS regional meetings as possible and asked for dates to be given to the office.
- 4 Members were encouraged to attend the IAG meeting in Vancouver (July). The poor UK academic repre-

sentation was highlighted; this will be addressed in future meetings.

- 5 There had been no nominations for the post of Hon Dep Secretary; members were urged to seek appropriate candidates.

6 The Age and Ageing Editorial Board has appointed Prof Gordon Wilcock to succeed Prof Graham Mulley.

Executive Committee

- 1 The agreement with Novartis to provide distance learning via the BGS

website, linked to the Novartis geriatrics syllabus, was noted. It could also eventually serve as a means of supporting revalidation, as and when this was introduced.

- 2 Consideration was being given to providing representation by country within the UK on the BGS standing committees, a matter Prof Stout would examine as part of his review of how devolution would influence the BGS.

- 3 A proposal by Dr N Coni to set up a Retired Members Forum had been

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Continued from page 16

welcomed (see page 22). It was asked that Regional Secretaries should be advised when a retired member moved into a different BGS region.

Training Committee

The 17 May meeting was reported on, including the the BASP's proposals for sub-specialty training in stroke medicine, discussed/responded to, stressing the need to retain stroke training under the SAC for Geriatric Medicine.

Other matters covered

- 1 SpRs and research. The Trainees Group had circulated a questionnaire to all SpRs in the specialty regarding research aspirations and opportunities. The result is awaited with interest.
- 2 Age Concern invited a nomination from the committee to sit on their Training Advisory Committee; Dr Chris Turnbull from Mersey will be the BGS representative.
- 3 SAC issues. A final draft of the new curriculum has been submitted to the JCHMT, but approval by the Specialist Training Authority is unlikely before February 2002. Work on the Assessment of Competence is now ensuing. The SAC Training Day would take place on 6 June in London. SAC visits continue with pilot JCHMT all-specialty visits to Mersey and South East Scotland.
- 4 Training in GIM. The proposals for structuring SHO training beyond General Professional Training are well advanced. A period of geriatric medicine to be mandatory for all SHOs in medicine is being pushed for. There are some concerns as to how GIM training will be separated from specialty training in integrated services.

National Service Framework

- 1 The Executive agreed that the implementation of the NSF plan at national, regional and local levels would be monitored, and that members' support in providing feedback was imperative.
- 2 Dr Knight reported on the discussions with the DoH at which it had been agreed that the funding streams intended to support the care of older

people, the provision of staffing, and ageism would be monitored.

Special Interest Groups (SIGs)

It was agreed that the Cardiology, Health Services Research, and Parkinson's Disease SIGs were eligible to change their designation to Section, subject to providing satisfactory reports on their activities over the last two years. Approval was given for the formation of a Bladder & Bowel SIG.

Annual Report of Council

Council agreed its text for the annual report for the year ending 31 March 2001, as prepared by Richard Lynham.

BGS Plan 2000-2

- 1 Key papers were being completed for the Finance Committee to cost.
- 2 Dr Knight gave an overview on the plans to put into effect a PR strategy meeting the Society's aims, drawing attention to the tensions between the wish to represent members' concerns and promoting the greater good of older people's care in total.
- 3 Progress had been made in developing key contacts and alliances, e.g. with the HAS, RCN, Help the Aged, and Age Concern, but more was still needed. A joint document on the clinical management of falls had been produced in collaboration with the American Geriatrics Society.
- 4 The problem faced by the BGS office in being able to call on BGS opinion leaders for support in dealing with press enquiries was pointed out. The concept of engaging a PR company was discussed, but the conclusion was that the membership would not be happy with the cost this would entail. The Society had been effective in issuing press releases, but needed to be able to react quicker to developments.
- 5 An effective dialogue had been established with the DoH, particularly in the 'celtic fringe', but this needed a more consistent process.

Honorary Secretary's report

- 1 Dr Dunn reported on the interdisciplinary day planned with the Autumn Meeting, and on progress made with the RCN on the development of plans for the nurse specialist for older people; to be finalised 12 June, put on the

BGS website and sent to Trusts and Health Authorities.

- 2 The HAS had introduced a complaints procedure, following a representation by the BGS earlier this year.

Honorary Treasurer's report

Subject to final audited data, Dr Shepherd reported that the year ending 31 March 2001 was expected to break even financially, but a shortfall in income was forecast for the current year, with an uncertainty surrounding future costs in the running of *Age and Ageing*. The need to look at alternative funding sources was pointed out.

Academic Medicine

Prof Swift reported that academic medicine was in crises, with major concerns over its future. Prof Stout headed a BGS working group looking into this and would be reporting on its findings in due course.

Elections - nominations to office

- 1 **Scientific Committee:** Prof Potter; Dr Playfer; and Prof Wilcock. It was noted, however, that if Prof Wilcock were precluded from attending the Scientific Committee, by virtue of his work on *Age and Ageing*, Dr Masud would be the next candidate in line for appointment.
- 2 **Policy Committee:** Prof Young was appointed to fill the vacancy.

Dates of future meetings

26 September 2001.

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Advice on CPR policies

- BGS *Compendium* document

The BGS believes that all hospitals and elderly care units should have a locally agreed policy on cardiopulmonary resuscitation.

The meaning of cardiopulmonary resuscitation (CPR) relating to this document is confined to the medical procedure that involves some or all of the following: the application of closed chest cardiac compressions, cardiac defibrillation, tracheal intubation and ventilation and the administration of medications intended to re-establish a normal circulation. These procedures may be undertaken by non-medical staff in some instances, e.g. specifically trained paramedics or nursing staff. The membership of the resuscitation team, where medical staff are not always available, should form part of the CPR policy.

Note: *Decisions about the application of this medical treatment do not determine decisions about other active medical treatments for the same patient, each of which must be decided on their own merits.*

Such a policy is necessary to:

- 1 enhance clinical care and the dignity of patients;
- 2 ensure that those who will benefit from CPR have rapid and appropriate access to it;
- 3 ensure that those for whom for whom a 'Do Not Resuscitate' (DNR) decision is made are not subjected to inappropriate, undignified and invasive procedures;
- 4 ensure that clinicians have an explicit and open framework for making these difficult and sensitive decisions;
- 5 ensure that there is an explicit planned process for reviewing these decisions; and
- 6 reassure patients, their family and carers, and the wider public that such decisions are made in a transparent and open manner. In particular, there is a need to ensure that decisions are seen to be free from ageism and are

not made in the light of resource constraints on the NHS.

The policy should be locally agreed and adapted, although those drawing it up should pay close attention to the guidelines jointly issued by the BMA, the RCN and the Resuscitation Council (UK)¹. They may also find the suggestions of Doyal and Wilsher² helpful.

The policy should indicate the following.

- 1 The process for arriving at DNR decisions, and which clinical staff of what level of seniority should be involved.
- 2 The rationale for DNR decisions. The BGS is especially anxious that advanced age alone is not regarded or used as a reason for a DNR decision since it has been shown that disease severity is more important than age in being able to benefit from medical treatments. For CPR, selected older patients can benefit as well as selected younger ones³.
- 3 The process for involving patients in decisions. This is a difficult area to address and an experienced doctor should be involved. Policies should indicate the circumstances under which it is especially important for the patient's views to be taken into account. They should also ensure that doctors are made aware that although some patients may want to be involved in decisions, some apparently do not⁴ (see notes).
- 4 The process for discussing decisions with relatives and friends and for recording such discussion. It should be emphasised that relatives should not be asked to act as proxy decision-makers but should be asked to represent the views previously held by the patient. The implications for patient confidentiality should be addressed^{1,2,4} (see notes).
- 5 The circumstances when it may not be appropriate or necessary to discuss decisions with patients and relatives^{3,5}.
- 6 The procedure for documenting decisions. Particular attention should be paid to the need for clear documentation so that the process is

seen to be transparent and open. The documentation should be readily available and recognisable.

7 The legal situation of doctors making or reviewing DNR decisions.

8 The composition and training of the resuscitation team when trained medical staff are not readily available, e.g. on a rehabilitation site remote from the general hospital.

The policy should be audited regularly to check on compliance and ensure adequate education of its content. Regular education sessions for all staff should include the appropriate use of resuscitation, and the ethical aspects of decision-making. Legal advice and consultation with the Medical Defence Organisations can be helpful in formulation of a policy.

Notes

1 Futility

DNR decisions can be made on the basis that CPR is so unlikely to succeed that it can be regarded as futile. Determination of futility is difficult but necessary so as to identify patients

who would not benefit from the treatment. Numerous clinical factors may be apparent before the cardiac arrest indicating that a poor outcome is likely after CPR has been attempted. However, it is not possible to be dogmatic about the stage of illness at

which the outcome of CPR is so likely to be poor that it should be regarded as futile. Patients, whom are identified as inevitably close to death, for example because of advanced cancer, might be one group where this would apply.

2 Involving patients in decisions

Hitherto, doctors have not involved patients sufficiently in these decisions. The Health Service Circular HSC 2000/028 emphasises the rights of patients to be involved in decisions about CPR. The BMA guidance states: “*Where competent patients are at risk of cardiac or respiratory failure, or have a terminal illness, there should be sensitive exploration of their wishes regarding resuscitation*”. Policies should indicate the expectation that discussion with patients should take place unless there is good reason to suppose that a patient does not wish this to occur⁴, or the patient is

regarded as incompetent (see below).

3 Involving relatives and friends

The Health Service Circular HSC 2000/028 generally encourages such discussions and evidence suggests that most next of kin felt that such decisions should be discussed with them. However, the general rules of confidentiality apply and the agreement of a competent patient is necessary for such discussions. For patients without competence (see below), discussion with others close to the patient should take place if practicable. The approach to be taken should reflect the Law Commission’s report of 1995 on mental incapacity as set out in *Making Decisions: the government’s proposals for making decisions on behalf of mentally incapable adults*⁵.

4 Competence

For patients to be involved in decision-making they must be mentally competent to do so. There are studies that suggest that many patients lack mental capacity for such decision making at the time when DNR decisions are most relevant, i.e. soon after hospital admission^{5,6,7}. Patients should, however, be presumed competent unless shown to be otherwise. There are different levels of competence, depending upon the nature and complexity of the decision needing to be made, so a patient may be competent in some areas, but not in others. To be competent, a patient must understand the nature of the decision to be made, the possible benefits and detriments surrounding that decision and must also understand the consequences of his or her decision once made. It is important to remember that simple scores of cognitive function (AMTS, MMSE) may bear little relationship to competence⁸.

For patients without competence, decisions “in their best interests” must be made by the clinical team. To help in making these decisions, relatives and friends may give valuable insights into the beliefs and values of an incompetent patient although they cannot give or withhold consent on the patient’s behalf.

Some patients, even though incompetent, might not wish that relatives or others be involved in discussions or decisions about their care. In practice, whilst care must be taken to respect this position when it is evident, it is reasonable

Compendium documents can be found on the BGS website at: www.bgs.org.uk

to assume that patients would accept such involvement in the absence of clear information to the contrary.

It is hoped that for those practitioners working in Scotland, the detailed guidance of the *Adult Incapacity Scotland (2000) Act* will provide a useful template relating to competence in these situations (see www.scotland.gov.uk/justice/incapacity/intro.asp).

5 Advance Directives (living wills)

Statements refusing treatment made in a valid Advance Directive carry the same force as contemporaneous statements made by a mentally competent adult⁹. As for any decisions made by a competent patient, the patient may change their mind as their thoughts or circumstances change.

6 Quality of life

It is the patient's own view of their quality of life which is important in decision making. Therefore, this has to be known if DNR decisions are made on the basis of poor quality of life and it follows that competent patients should be involved in this process, if they wish. There are studies showing that relatives' perceptions of patients' likely views often differ from patients' own wishes¹⁰. Thus, in the event of patients being unable or unwilling to participate, discussions with relatives or others close to the patient should aim at determining what the patient's view would be, rather than reflecting their own opinions.

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- 4 *Discussing CPR with patients and relatives: in Communication Skills in Medicine* (ed. CR Hind). Stewart K. London: BMJ Publishing Group, 1997.
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- 8 *Assessment of mental capacity: guidance for doctors and lawyers. A report of the British Medical Association and the Law Society*. London: BMA, 1997.
- 9 *Advance Statements about Medical Treatment. Report of the British Medical Association*. London: BMJ Publishing Group, 1995.
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POSTER ASSESSORS FOR BGS MEETINGS

THANKS TO MEMBERS WHO HAVE VOLUNTEERED

<p>The BGS office has had an excellent response to the call for poster assessors in the last issue of the BGS newsletter!</p>	<p>interest(s) when serving as poster assessors at the bi-annual BGS scientific meetings.</p>	<p>but would like to thank all of them very much for their interest, willingness and commitment.</p>
<p>150 members replied and indicated their particular medical</p>	<p>Due to the huge response we have been unable to reply to prospective poster assessors individually,</p>	<p>We hope they find being an assessor is a rewarding and enriching experience for their career.</p>

Retired Members' Group



After a somewhat protracted gestation, the Retired Members' Group held their first meeting in Bath on 9 May.

Some 60 retired members of the BGS had expressed support for the formation of this group, but many were prevented from coming, due to other commitments or their own infirmity or that of a spouse. In the event, 14 members attended, plus 10 spouses, and most stayed one or two nights in the small family hotel where the meeting was held.

Although six members gave short presentations on a rich variety of very loosely medical subjects, which were greatly enjoyed, we agreed that the main purpose of these meetings would

be social, and we had some excellent meals and a tour of this beautiful city. We hope to hold meetings on an annual basis, probably about the same time of year but in different locations, and separate from national BGS meetings. The programme will be broadly along the same lines, but will be flexible, and contributions will be agreed from time-to-time to cover the costs of postage, etc.

We very much hope that new members will join us but clearly cannot undertake to contact everyone on their retirement. We intend to announce future meetings from time to time through the BGS Newsletter, but meanwhile, anyone interested is very welcome to get in touch with Nick Coni or Peter Wilson (contact details to be found in the BGS Handbook).

Dr Nick Coni

Nurse specialists for older people



Thank you to Christine McAlpine, Donald Farquhar and David Beaumont who have sent details of their experience of Nurse Specialists for Older People. Please contact them directly if you wish to know more.

**Christine McAlpine, Consultant Physician,
Stobhill Hospital, 133 Balornock Road,
Glasgow G21 3UW. Tel: 0141 201 3217.**

Clinical Support Nurse (CNS)

In February 2000, a G-grade nurse was appointed to act as an out reach nurse to nursing

homes with the aim of reducing the number of people being admitted and readmitted from nursing homes to hospital for reasons related to nursing care, e.g. dehydration and pressure area care. The CNS follows up inpatients on discharge back to nursing home care and patients discharged from hospital to nursing home as new placements. The follow up is as required for up to four weeks and, for new placements, the CNS participates in placement review at four weeks. She is not employed specifically to provide training for nursing home staff, but is happy to advise about specific problems.

Results

The admission rate from nursing homes has been reduced by 30%. The service has been

well received by local GPs.

Future

Expansion of the area covered is planned. Consideration is also being given to changing the post from a full-time job as CSN into a six month rotation, with six months as CSN followed by six months as a G-grade ward manager. Christine would be interested to know if others have tried similar rotations.

**Donald Farquhar, Consultant Physician,
St John's Hospital, Livingston EH54 6PP.
Tel: 01506 419666.**

Clinical Nurse Specialist Care of the Elderly

Since December 1997, a nurse specialist has led a multidisciplinary team in the acute medical admissions ward to assess the functional needs of older patients and to promote both early discharge and more appropriate transfer of frail older people to rehabilitation areas. The team comprises a clinical nurse specialist in care of the elderly, a senior 2 occupational therapist and a senior 1 physiotherapist.

Results

Over 1000 patients were assessed during the first 16 months. Twenty four percent were discharged directly home, of whom, almost half had some form of ongoing support. The remaining 76% were transferred for ongoing care to other wards in the medical directorate. Of this group, 49% moved to general medicine, 43% to geriatric assessment and 8% to the stroke unit.

Reference

Cameron S et al. *Impact of a nurse led multidisciplinary team on an acute medical admissions unit.* Health Bulletin 2000;60:512-4

**David Beaumont, Consultant
Physician/Geriatrician, Queen Elizabeth
Hospital, Sheriff Hill, Gateshead NE9
6SX. Tel: 0191 482 0000.**

Elderly Care Nurse Practitioner (ECNP)

The post was set up in the mid-90s to help with the assessment, transfer and ongoing ward management of patients referred for rehabilitation in our peripheral rehabilitation unit. There had

been problems with training approval for the SHO posts there and the ECNP posts were set up to develop expertise in assessment of new referrals and to share tasks formerly done by medical staff.

Over the years, the roles have evolved. Basic task sharing with doctors has been devolved to nurses at ward level and two staff grade doctors provide the medical input. The ECNPs now screen all new referrals to the Elderly Care Team from other inpatient departments particularly orthopaedics, surgery and the A&E observation wards. They divide them into those likely to need rehabilitation, which they go and assess, and those with a medical component, which are assessed by a consultant or specialist registrar. After assessment, the ECNPs decide whether transfer to the rehabilitation or, occasionally, the acute ward is necessary, or whether with limited input they can case manage a discharge home. In this event, occupational therapists and physiotherapists attached to the ECNPs to form the Older Persons Liaison Team, will provide the input and with the Discharge Liaison Nurse will manage the discharge home.

The initial pair of ECNPs developed particular expertise, one in orthogeriatric liaison and assessment, and one in Parkinson's Disease (PD). After three or four years, one moved to become coordinator and leader of our Community Resource Team for Older People and undertakes similar assessments in the community, liaising with the consultants, whilst the other became a PD Nurse Specialist in a nearby trust.

Some nurses from the Elderly Care Unit have been seconded to the ECNP posts and acquired expertise in the assessment and rehabilitation of older people. Two have become the current permanent post holders. One is developing an interest in orthogeriatric rehabilitation and working with one of my colleagues to set up an older persons' trauma unit within the orthogeriatric ward. The other is concentrating on general assessment and rehabilitation within the medical and surgical units. The third was appointed to establish a PD Nurse Specialist post and is not involved with ward work, other than with PD patients. She has developed the

role and now receives direct referrals from GPs and hospital doctors, working with me to provide a PD service based around a once-a-month PD clinic. We hope to expand this with further neurological input and paramedical support into a multidisciplinary PD service.

Other nurse specialist posts are planned, e.g. a Stroke Nurse Specialist and a Falls Nurse Specialist who will work with the orthogeriatric lead to establish an integrated falls and osteoporosis service including, eventually, tilt-table and syncope assessment.

Main advantages of the ECNPs

1 They enable us to provide a more flexible and responsive service. Referrals from throughout the hospital are usually responded to the

same day.

2 They take on the more routine assessments and discharge planning, easing the burden on senior medical staff and specialist registrars and promoting earlier discharge.

3 They have become skilled at identifying which patients need medical assessment. I do not feel that people have been denied access to medical assessment.

4 They relate well to patients who are sometimes happier to confide in nurses than doctors.

5 They are ideally placed to extend elderly care services into the community and provide a link across the boundaries of primary, intermediate and secondary care.

Dr Rebecca Dunn
Honorary Secretary

BRITISH CARDIAC SOCIETY/BRITISH GERIATRICS SOCIETY CARDIOLOGY SECTION JOINT PLENARY SESSION

On 23 May, over 300 delegates attended the first joint plenary session between the British Cardiac Society (BGS) and the Society, which took place at the annual BCS meeting in Manchester. The topic was revascularisation in older adults. The agenda included: The Scope of the Problem (Richard Thomson, Professor of Epidemiology and Public Health, Newcastle); Therapeutic Angiogenesis (Dr Armin Helisch, Max-Planck-Institute Bad Nauheim, Germany); Coronary By-pass Surgery in the Elderly (Gianni Angelini, BHF Professor Cardiac Surgery, Bristol); and Thrombolysis in the Elderly (Stephen Ball, BHF Professor of Cardiology, Leeds).

The session was chaired by Prof John Camm, President of the BCS, and Prof Rose Anne Kenny. It was sponsored by the British Heart Foundation.

Summary

Acute myocardial infarction is the leading cause of death in older adults and, in the UK, one third of AMI patients are over 75 years old. This

proportion will undoubtedly increase in tandem with demographic changes. Current revascularisation strategies include thrombolysis, percutaneous transluminal coronary angioplasty, coronary artery by-pass grafting and angiogenesis. The majority of data in older adults is derived from observational and retrospective studies.

Age is cited as a risk factor for adverse events with all revascularisation procedures. However, age *per se* does not cause positive or negative outcomes from revascularisation therapies but is a marker for the underlying pathophysiological factors and comorbid illnesses which influence treatment effects. Recent observational studies suggest that rather than being beneficial, thrombolysis may actually be harmful in those patients over 75 years of age. There is also a gender difference in poor outcomes - women are at higher risk of adverse events from revascularisation procedures than men; reasons for this are speculative.

Tissue growth factors and angiogenesis are evolving and promising experi-

mental therapeutic strategies with particular hypothetical advantages in older adults.

The Bristol cardiothoracic surgery group have a large data base of older adults and presented promising data on normothermic coronary artery by pass procedures which afford significantly better early and one year mortality outcomes in older patients.

It was clear that there are a number of areas of clinical uncertainty about best practice which warrant randomised control trials, particularly in the older old, including what the optimum reperfusion strategies for AMI in older adults are. Relevant outcome measures such as cognitive function, quality of life and functional independence should be incorporated into these future interdisciplinary trials. Although there is circumstantial evidence of a significant unmet need for revascularisation amongst older patients; there is little information of the extent of this need.

Prof Rose Anne Kenny
Chairman, Cardiology Section

FOOD TRIAL SEEKS NEW CENTRES

Dr Martin Dennis provides an update on the FOOD Trial article which appeared in the March 1999 Newsletter (page 21).

Poor nutrition is associated with worse outcomes after stroke, but do our attempts to improve patients' nutritional status lead to greater survival and more complete recovery? The FOOD Trial is a family of three Multicentre International Randomised Trials aiming to answer this fundamental question. It compares three intensive feeding regimes against three more conservative ones.

1 For those who can swallow

Trial 1: routine oral supplements plus normal hospital diet vs normal hospital diet.

2 For patients who are dysphagic

Trial 2: early vs delayed tube feeding.

Trial 3: Percutaneous Endoscopic Gastrostomy vs Nasogastric tube.

The FOOD Collaboration already includes clinicians from 145 hospitals in 18 countries, with over 3,300 patients enrolled. Some of the most successful collaborators are members of the BGS. However, to provide precise estimates of the relative effectiveness of these feeding regimes we need to enroll many more patients.

Your help is sought

We are seeking the help of more BGS members who are uncertain about the best method of feeding stroke patients and who would be willing to enroll their patients into any one of the three comparisons. Participation is relatively straightforward and does not involve a lot of paper work, but does encourage good practice as difficult feeding issues are

inevitably discussed amongst the team and with the patient and/or families. The trial is funded by the NHS Research & Development Health Technology Assessment board, the Stroke Association, the Scottish Chief Scientist Office and Chest Heart & Stroke Scotland.

Dr Martin Dennis

To take part in or receive more information contact: Dr Martin Dennis (Principal Investigator) or Gina Cranswick (Coordinator). FOOD Trial Coordinating Centre, Dept of Clinical Neurosciences, Western General Hospital, Edinburgh EH4 2XU. Tel: 0131 537 3126. Fax: 0131 332 5150. Email: FOOD@skull.dcn.ed.ac.uk. Website: www.dcn.ed.ac.uk/food



CLINICAL PRACTICE EVALUATION GROUP (CPEG)

Enthusiastic individuals sought to join committee

The BGS has as its main charitable aim *"the relief of suffering and distress amongst the aged and infirm by the improvements of standards of medical care for such people ..."*.

The Government quality agenda is placing increasing reliance on clinical effectiveness and the benchmarking of services.

In order to address these issues, the BGS Executive has approved the establishment of a Clinical Practice Evaluation Group (CPEG) as a sub-committee of the Scientific Committee. The group will address matters relating to clinical effectiveness, i.e. critical appraisal, guideline assessment and development, development of clinical datasets, benchmarking, audit, etc. The subgroup has been formed

comprising four members of the Scientific Committee. Co-opted members from the Society are sought from those who have a strong interest in this aspect of practice. This is seen as an opportunity to bring specific enthusiasm and expertise to bear on behalf of the Society as a whole.

At present, it is planned to transact the bulk of business by email with two to three meetings per year. The group will report to the Scientific Committee.

Those interested should contact: Dr Jonathan Potter, Chairman CPEG, via the BGS office (see page 27) or by email (jonathan.potter@ekh-tr.sthames.nhs.uk) with details of their experience with regard to clinical effectiveness.

NEW ABSTRACT INSTRUCTIONS

A big thank you to all those who took note of the new instructions (see BGS website for further details) when submitting abstracts for the BGS Autumn Meeting. The majority of abstracts we received followed the new instructions and only a few had to be informed to reformat their abstracts accordingly.

MEMBERS ON EMAIL

We know you are out there. We just don't know your email addresses! The BGS office would be grateful if you could send an email to the BGS Membership Secretary: recia.atkins@virgin.net, so she can add you to the email address book/future Handbooks. Thanks to those who have already done so.

AGE AND AGEING ONLINE: <http://ageing.oupjournals.org>

As a member of the BGS in 2001, you can access all articles published in *Age and Ageing* since 1999, and search through tables of contents and abstracts going back as far as 1974. As well as searchability, you can also join the e-mail table of contents alerting service, to be sent the very latest table of contents of each issue, in advance of publication.

To register for personal online access simply go to the *Age and Ageing* Online website (<http://ageing.oupjournals.org>), click on the "Subscriptions" button, then on the "Manage Your Online Access" link, and follow the simple instructions. You will need your *Age and Ageing* subscriber number to obtain your own username and password - you

will find this on the address label of your printed copies of *Age and Ageing*.

If you have lost your subscriber number there is a facility to contact OUP who can provide it for you (contact: Paula Thompson, OUP 01865 267 985). If after you have registered once you lose your username or password please contact OUP.

MODERNISING SERVICES

"Modernising Services for Older People"

10 July 2001

Manchester Dental Education Centre

Topics include: impact of NHS Plan; NSF; collaborative care; intermediate care; and mental health.

Fees: £225 (reduced for BGS)

Contact: Email Jo Amos on: jo.amos@informa.com. Website: www.healthcare-info.co.uk/LH119.

STROKE BEACON

**Wirral Stroke Beacon Event
3rd Art & Science of Stroke
Management Course**

14 September 2001

**Arrowe Park Hospital &
Clatterbridge General Hospital**

Fee: free.

Contact: Stroke Co-ordinator, c/o Ward 23, Arrowe Park Hospital, Arrowe Park Road, Upton, Wirral CH49 5PE. Tel: 0151 604 7397. Email: Stroke.Co-ordinator@CCMAIL.wirralh-tr.nwest.nhs.uk.

NEW TECHNOLOGY IN ELDERLY CARE

2 October 2001

Charing Cross Hospital, London

This conference is organised by Dr Frank Miskelly, New Technology of Elderly Care SIG. Topics include: role of NHS Direct in elderly care; Government policy; the NTEC project; and latest research in intelligent homes.

Fee: £30/£20 (consultants/juniors)

Contact: Sue Evans, tel: 020 8846 7197/email: smevans@hhnt.org.

EUGMS CONGRESS

1st Congress of European Union of Geriatric Medicine Society

29-31 August/1 September 2001

Palais des Congrès, Paris

Topics include: heart failure; adherence to clinical guidelines and inappropriate prescribing; harmonising geriatrics across Europe; cancers; and quality geriatric medical care.

Fees: FF 1500 - 2100.

Contact: M Bia, MF Congrès, 8 rue Tronchet, 75008 Paris, France. Tel: 33 (0) 1 40.07.11.21. Email: mbia@wanadoo.fr.

FALLS SERVICE

"Providing falls services"

26 September 2001

St George's Hospital, London

To provide information and share ideas about setting up seamless services for the elderly who fall.

Fee: £75.00

Contact: Sandra Jago, Marketing Services Unit, Faculty of Health and Social Care Sciences, St George's Hospital Medical School, Cranmer Terrace, London SW17 0RE. Tel: 020 8725 0196. Fax: 020 8725 0201. Email: sjago@hcs.sghms.ac.uk.

ETHICS

"Ethical dilemmas at the beginning and end of life: the clinicians' perspective"

15 October 2001

RSM London

Topics include: alleviating suffering v hastening death; and is rationing healthcare inevitable?

Fees: £20 - £105 - £165 (RSM students - RSM Fellows - Others)

Contact: V Boswell, Academic Conference Dept, Royal Society of Medicine, 1 Wimpole Street, London W1G 0AE. Email: events@rsm.ac.uk.

**AUTUMN MEETING
2001 - LONDON**

Preliminary programme

17 to 19 October 2001

Novotel Hotel, London

Wednesday 17 October

- ◆ Interdisciplinary day on implementing the NSF (CME 5h25m)
- ◆ Symposia on osteoporosis and on dementia (CME 2h)

Thursday 18 October (CME 9h)

- ◆ Clinical practice, audit, health services research, respiratory, and special senses update.
- ◆ SIG/Section parallel sessions.
- ◆ Spring Meeting 2002 information: Prof Peter Crome.
- ◆ Update on CPD: Prof Mark Castleden.
- ◆ Marjory Warren Lecture: Prof Rose Ann Kenny on "Ruled by our heart or by our head?"
- ◆ Symposia on the NSF and hypertension, and epilepsy.
- ◆ Annual dinner.

Friday 19 October (CME 4.5h)

- ◆ Palliative care update, health services research, stroke, locomotor/falls, clinical practice - psychiatry, and CNS update.
- ◆ Trevor Howell lecture - Prof Sir Stewart Ross Sutherland
- ◆ The Society's AGM

Contact: BGS Autumn Meeting Secretariat, 1 Arun House, River Way, Uckfield TN22 1SL. Tel: 01825 769337. Email: bgs@bhm.co.uk.

USE OF TECHNOLOGY

"The use of technology to help older people"

23 October 2001

West Hall, RSM London

Topics: telemedicine and links for older people; IT and communications; the ordinary home as a smart aid; assistive technology; and ethics.

Fees: (£16 for supper)

Contact: D Johns, Academic Dept, Royal Society of Medicine, 1 Wimpole St, London W1G 0AE. Tel: 020 7290 2984. Fax: 020 7290 2989. Email: Geriatrics@rsm.ac.uk.

**STROKE
MANAGEMENT**

"Therapeutics of stroke management"

28 November 2001

RCP London

Topics include: stroke care; mechanisms of underlying stroke damage; use of imaging; emerging treatments for stroke; and white matter injury in stroke.

Contact: Conference Office, Royal College of Physicians London, 11 St Andrew's Place, Regent's Park, London NW1 4LE. Tel: 020 7935 1174 x 300/436/252. Email: conferences@rcplondon.ac.uk.

**SAILING FOR THE
DISABLED**

Prof Mark Castleden, the BGS Director of CME/CPD, has also become Yachtmaster Instructor and Principal of the Devon Sailing School, centred in Dartmouth.

The school offers able-bodied as well as disabled people the opportunity to obtain the RYA certificates of competence, from competent crew to yachtmaster. It offers cruising weekends/weekend tasters for those wishing to try out or broaden their sailing experience. Trips include the southwest coast of England, the Channel Islands, France and The Scilly Isles.

Contact: Prof Mark Castleden, Devon Sailing School, 11 Smith Street, Dartmouth TQ6 9QR. Tel: 01803 833399. Email: post@dartmouthsailing.com.

**RELATED SITES OF
INTEREST**

Members may be interested in the following two websites.

www.rheumatology.oupjournals.org - relates to the journal *Rheumatology*.

www.qjmed.oupjournals.org relates to *QJM: Monthly Journal of the Association of Physicians*.

Includes free email table of contents alerting service.

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