



Behind closed doors the BGS launches its dignity campaign

We all take going to the toilet in private for granted - it is a marker of a civilised society. So why, in care settings should our expectations change?

As reported in the November 2006 issue of the Newsletter), a multi-agency campaign led by the BGS and including Age Concern England, the Department of Geriatric Medicine at Cardiff University, Carers UK, Continence Foundation, Help the Aged, Incontact and the Royal College of Nursing, has chosen toilet access and use behind closed doors as a marker of human rights and dignity. The campaign, launched at the House of Lords on 18 April, aims to empower and inform older people about their human rights in this area while educating and influencing care providers and policy

Autumn meeting abstracts

Abstracts for the Autumn meeting are now invited. If you submitted your abstract before 23 May, please go to www.bgs.org.uk immediately

makers. By focusing on a taboo subject, we will enable older people to have a better experience in hospitals and care homes. The WASH YOUR HANDS campaign has already demonstrated that there is

potential to improve clinical practice with a simple message.

The NHS has changed dramatically over the last few years and older people have seen the benefits and advantages, as well as the disadvantages and weaknesses of provision. The need to meet targets such as the waiting list initiative and four hour trolley waits, while helping older people, has meant that statistics rather than quality of care has driven the NHS. Despite the recognition of their importance in the NHS Plan and the NHS National Service Framework for Older People, processing older patients fast often results in being careless of their dignity and humanity.

Two thirds of people admitted to hospital are aged over 65, many of whom may suffer from physical and cognitive impairment as well as other co-morbidities. The numbers of older people aged over 80, those most likely to be frail and require hospital admission, is predicted to increase by two thirds by 2026. The dependency of older people in hospitals and care homes requires and will



increasingly require staff with appropriate

Any road to reaching one's maximum potential must be built on a bedrock of granting others dignity, a commitment to excellence, and a rejection of mediocrity
Buck Rodgers

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skills and behaviours to provide personal care in a sensitive and respectful manner. Yet The Royal College of Physicians National Continence Audit 2 found that few hospitals had identified that they need to do better in privacy and dignity during toileting.

Respecting rights together

The need to provide services in hospital and care homes, which respect and promote older people's human rights and dignity, is fundamental and has been recognised by the Department of Health's publication, 'A New Ambition for Old Age'. This described how some staff still demonstrate deep-rooted negative attitudes and behaviour towards older people.

In our Behind Closed Doors campaign, we aim to achieve a change of culture at every level by not only making older people and their carers aware of their rights, but by ensuring that designers and architects are aware of the importance of sensitive design. Hospital and care home staff will be encouraged to adopt the Behind Closed Doors standard through review of practice and the implementation of change. Hospital and care home managers need to understand that dignity and human rights should be part of the organisational culture and integrate the standards into appraisals. Training programmes should highlight these issues and the views of patients and carers should be sought. Policy makers and regulators will be encouraged to adopt and promote our standards. Our campaign aims to make both the public and patients aware of their rights, to use the audit tools and to lobby for improvements.

The campaign leaflet highlights bad practice such as:

- ◆ Ignoring request for assistance to go to the toilet
- ◆ Telling people to wait

- ◆ Telling people to use incontinence pads
- ◆ Insisting people use commodes or bed pans when they could be taken to the toilet
- ◆ Not offering choice
- ◆ Scolding or humiliating incontinent patients
- ◆ Entering closed curtains without ensuring that the patient is not engaged in toileting
- ◆ Leaving people on bed pans and commodes for unnecessarily long periods
- ◆ Not offering hand washing facilities
- ◆ Leaving people in full view when using the toilet
- ◆ leaving people on commodes during meal times
- ◆ Using safety as a reason to deny choice.

Best practice should ensure that toilets are adjacent to patient areas and easily accessible as well as being clean and well sign posted, with doors that close. Assessment of toileting needs must include a record of personal choice and preference. Hoists must protect modesty. Staff should respond to requests for assistance promptly and politely and toileting facilities should be proactively offered. If a patient has to go to the toilet behind a curtain or next to a hospital bed, curtains must be fully closed and a notice should be used explaining that personal care is in progress and must not be disturbed.

Following standards

Our standards document states that all people, whatever their age and physical ability should be able to use the toilet in private and that there should be sufficient toilets and equipment to achieve this. People should not be left on bedpans or commodes for longer than necessary. Suitable equipment for transferring should be available and should be used respecting dignity, privacy and modesty.

Lavatories must be clean and patients should be able to wash their hands as well as their bottoms. Language should be respectful and courteous especially in regards to episodes of incontinence.

Our decision aid will enable staff to work with patients in a more thoughtful manner to ensure that their toileting needs are met according to their level of impairment and illness and that their dignity, modesty and privacy are met at all times. Lay people are to be encouraged to use our environmental audit which includes: the width of the door, whether the door can be opened, shut or locked, how well the toilet flushes, the accessibility

of toilet paper, washing facilities and general hygiene and cleanliness.

We hope to influence older people's fora, older people's champions, community health councils (Wales), educators in all education and training programmes, advocacy and patient support groups, carers' groups, Royal Colleges and Patients' Associations. Wide dissemination of our educational leaflets, decision aides, standards and check lists to voluntary groups, patient and carer groups as well as to care staff, will make older people in hospitals and care homes aware of what they should expect. Giving people back control over their most private of functions should enhance their independence and rehabilitation and thus reduce lengths of stay and promote continence. The campaign emphasises the importance of the environment, as well as care practices and will help in the future commissioning of facilities. It will provide commissioners, chief executives and inspectors a measure of good practice and clinical governance.

The primary focus of the campaign is on people receiving care but it must be emphasised that if care staff are to be able to respond to others in a dignified manner, then they too must be treated with dignity. The campaign has produced the following to inform people (all available on the BGS website or in hard copy, from the BGS office):

- (a) The Behind Closed Doors leaflet
- (b) Decision aid
- (c) Lay person's tool to perform an environmental audit of the toilets in a care setting
- (d) Behind Closed Doors standards
- (e) Action Plan.

It is hoped that the campaign will help present and future generations of frail and vulnerable older people to be aware of their rights. It is part of a continuing battle to make the public and the professionals aware that sensitive and humane care is a part of effective care and can never be sacrificed in the name of efficiency and safety.

Jacky Morris

Chairman

BGS Policy Committee

As a naive 18 year old student nurse I was unsure that nursing was the right career choice for me. Working on my first clinical placement I witnessed some of the most degrading care of older women. The sight of people queuing for the 2 hourly toilet round hauled on and off commodes within sight of others was appalling. Worst still was the segregation of three women in an isolated day room. It was only with hindsight that I realised that one was terminally ill, one had severe depression and was starving to death and the other had dementia. Coincidentally all were called Catherine but known collectively as the three C's. The affecting images and experiences of "care" for those women have remained with me throughout my career.

We have come a long way across the speciality since 1981 but have some way to go before we can really celebrate our success. Regardless of the debate about why we need to focus on dignity 25 years later, the fact is we do

The Dignity in Care Campaign is an important initiative launched in 2006 and sets in place a clear direction for all those working across Health and Social Care settings, and most importantly, for those receiving care. The underpinning work of this campaign through use of clinical benchmarking, Better Metrics, Environmental Audits make an important contribution in measuring and improving care. Ensuring privacy in consultation and privacy in personal care should be the minimal acceptable standards of patients' fundamental experience. However, what we really need to see is a shift in the attitudes of all those involved in care, From the sluice to the boardroom and everything in between, it is the responsibility of us all to challenge unacceptable practice

I am encouraged that we have seen a swell of interest from across health, social care, the third sector, independent sector and professional colleges who have come together to make a difference. The launch of the BGS "Behind Closed Doors" campaign will, I have no doubt, make a significant contribution to the work and will be further enhanced if everyone uses opportunities at a local level to promote the importance of the work. It will help to promote a change in care experiences so that 25 years from now we will talk about a historic perspective of undignified care which will have no place in our futures.

Deborah Sturdy RN MSc (Econ)
Nurse Advisor Older People Department of Health

Editorial

endorsements again

This month's letters page features a letter from David Griffith regarding an item in the November issue in response to NICE guidance on Cholinesterase inhibitors in Alzheimers disease.

This letter was written in December but somehow failed to reach us and it was only when David contacted the office, requesting a declaration of the Authors interests that we realised the original had gone missing. Now, one reason for featuring this letter is that I wish immediately to quash the notion that any item is censored or not available for discussion in these columns because it is uncomfortable or "off message". I hope I have made it clear over the last couple of years we welcome all contributions and comment from members and we are not afraid to allow controversial discussions to take place, so read on.

Without breaching confidences, I think it is fair to say that among some members of UKMC the content of the BGS response, drafted by the Cerebral Ageing and Mental health SIG and colleagues from the Royal College of Psychiatrists, did raise a few eyebrows. In fact, it probably led directly to our President and Chief Executive drafting some new guidance regarding Endorsements by the UKMC of Policies, responses and Guidance issued in the name of the Society. My experience has been that official responses have been hitherto factual, analytical and objective but this one was different in tone, bordering on a campaign statement, which a quick visit to the website will quickly confirm

We are still ambivalent about the notion of positioning ourselves as a campaigning organisation

(www.bgs.org.uk - select Publications/Positions Statements).

In my view David Griffith is right. We have to ensure that our educational partnerships with the pharmaceutical industry both as a Society and individuals do not allow us to become a medium for vested interests to exert influence. We are still ambivalent about the notion of positioning ourselves as a campaigning organisation, a topic

we will have chance to discuss at the members' session in Harrogate. The issue of continuing GMC registration has no place in a Society position statement of this type and to encourage non adherence to NICE guidance challenges the right of elected

Government to manage the National Health Service in England and decide which areas represent value for money. That's not to say we necessarily agree with the recommendations but we have to accept that NICE has the right to make them. Clinical freedom died some years ago.

Devolution revisited

Debate continues around the Society about how local policy issues dealt with by the four national councils are best shared and discussed. Indeed as I write this column shortly after elections to the Scottish Parliament and the prospect of a Scottish Prime minister at Westminster becomes a reality, it seems that Society life starts to reflect the country as a whole. The places where this is mostly keenly felt are at the Policy Committee



and UKMC where sometimes it is heard that English issues dominate the agenda. My plea therefore, is for national representatives to continue to raise the big issues from their patch at these meetings and for analysis to be full in order for the Society to remain strong, authoritative and inclusive.

Reflections on Brighton

Elsewhere in this issue we feature our customary reports on the Spring Conference. Congratulations to Prof Rajkumar and his team on organising an enjoyable and extremely successful meeting. There were two really interesting innovations I thought. Firstly, well done to the 15 or so members including a large number of trainees who appeared at 6.30 the morning after the



An issue of gender : Tina C in full voice at the BGS Scientific conference dinner in Brighton

dinner to take part in a 5km fun run along the sea front. David Stott and John Young set a cracking pace but everyone seemed to enjoy it and we hope it will be repeated. The second was the appearance of the Country and Western singing star Tina C after the Society Dinner. Certainly a contrast to Alex Mair's after dinner contributions, it was a relief to know that John Young also struggled with gender identification issues. Having clarified the position in my own mind, I became a bit uncomfortable when Tina launched into the old Foreigner number, "I want to know where Dave is".

Jed Rowe

I am sure that readers would wish to join me in wishing Jed, who recently received the President's Medal (page 24) all the best.

Final word - Egobusters

I am grateful to Duncan Forsyth for his supportive comments and on the occasional inadvertent insults that may find their way into the final paragraph of this column and for proposing the collective title of Egobusters. Here are the latest examples:

- ◆ Ward nurse to Duncan Forsyth when he mentioned that in his pre-consultant days, ward sisters presented consultant physicians with a boutonniere before launching ward rounds, "Well, perhaps you don't get buttonhole because you don't *deserve* a buttonhole."
- ◆ Retired seamstress to BGS officer; "Call that a jacket? I've seen better cloth wrapped round a cheese."

Final, final word-Geordie Lassies

I couldn't resist recounting a new version of an old story I heard last week. Working late one evening I heard our usual boisterous domestics approaching the office door.

"Eee, wor sister's copied the Beckhams and caalled the baby after where it was, ye know, conceived like....Paris Hilton Ferris". "Why if that's the rule, I should have called wor lad Wrekenton Co-op Carpark."

David Beaumont

President's column



It is time to start thinking of applying for a Clinical Excellence Award in the 2008 round. Details of the relevant dates for the BGS nominations are detailed on page 20.

As always we will require completed CVQs before the result of the 2007 round are announced. One expected change for 2008 is that the personal statements of successful applicants will be posted on the ACCEA website so that your colleagues and patients can see what you have written.

President's Medals

Jed Rowe was unable to attend the Brighton meeting to receive his medal. Instead it was presented to him at a garden party kindly hosted by Jill and Alistair Main (page 24). It was a gloriously sunny day and I am pleased to report that Jed was in fine form. I hope it will be



Roger Lewis : My first boss.

possible for him to participate in the Birmingham meeting which I know he was looking forward to organising.

The second recipient was **Roger Lewis** who has been a stalwart of the specialty and the Society in the South East for many years. I first came into contact with Roger almost 50 years ago (we were at the same secondary school) and subsequently he recruited me into the specialty, becoming my first boss. His commitment to older people was unswerving and his example led me to stay in the specialty.

Knowledge Based Assessments (KBA)

Further discussions are going on between the Confederation of Royal Colleges of Physicians and the Medical Specialty Society about the development of KBA and their role in the assessment of Registrars and in recertification. No definite news, so all I can say is, watch this space.

Recertification and MTAS

On this issue too I have no more news. I imagine the Department of Health and the profession have been more pre-occupied by MTAS and the whole issue of Modernising Medical Careers. Clearly many trainees have felt let down and betrayed by the failures of MTAS but all is not as it seems. Some of the senior agitators have personal rather than professional axes to grind and less popular specialties have fared better than previously. The inability of senior members of the profession to choose who should work for them directly is clearly a shock to the system.

Launch of Dignity Campaign: Behind Closed Doors

I am very grateful to Sally Greengross for hosting the launch of this campaign in the House of Lords. We had a good attendance including the Minister for Care Services (Ivan Lewis) and several members of the House of Lords. Baroness Hales spoke first

and said that it was quite clear that the abuses described in the document were breaches of Human Rights! We have heard that the institutional audit has now been taken up by local services. I was invited to give evidence to the Parliamentary Select Committee on Human Rights and will report on this in the next issue (see p8).

Brighton

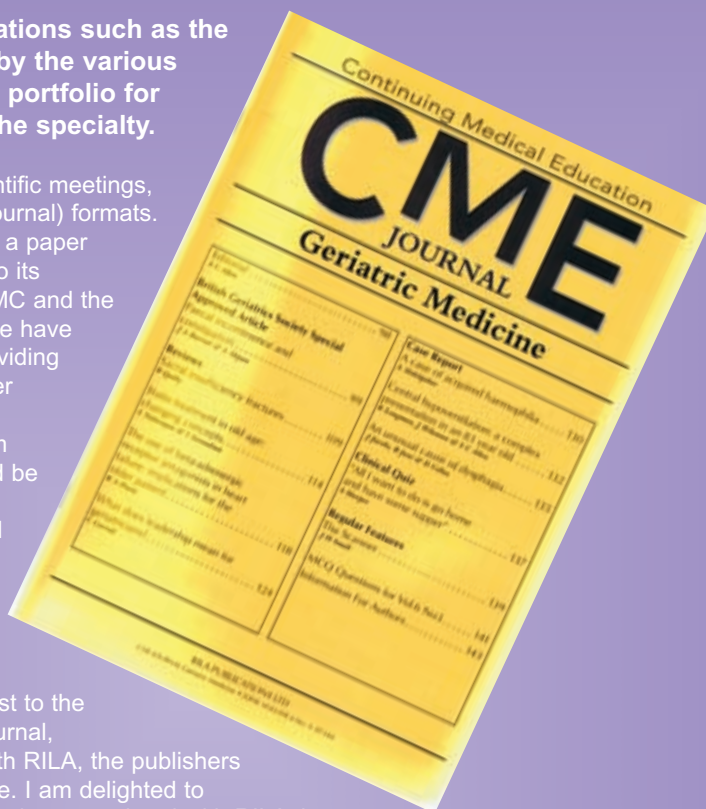
The Spring conference was a great success thanks Raj and team. Plans are now finalised for Harrogate in November and for Glasgow next April. I look forward to seeing you there.

Peter Crome

BGS strengthens links with CME Journal Geriatric Medicine

Individual specialty organisations such as the BGS are being encouraged by the various Royal Colleges to develop a portfolio for delivering CME relevant to the specialty.

This portfolio should include scientific meetings, web-based learning and paper (journal) formats. Currently the BGS does not have a paper based mode for delivering CME to its members. Over the last year UKMC and the Education and Training Committee have debated the relative merits of providing the BGS membership with a paper based CME journal, with UKMC accepting a recommendation from E&T Committee that a trial should be undertaken. To embark upon producing this from scratch would be no small undertaking for the Society and is not something that *Age & Ageing* wish to develop. As the BGS already has links with CME Journal Geriatric Medicine by sponsoring (at no cost to the Society) the lead article in that journal, negotiations were entered into with RILA, the publishers of CME Journal Geriatric Medicine. I am delighted to announce that our Chief Executive has negotiated with RILA that CME Journal Geriatric Medicine will be made available (at no cost to individual members) for a trial period of 18 months. During this trial period our new Director of CPD, Alan Sinclair, will be liaising with the membership to determine the added value of receiving this journal in terms of meeting their CME needs.



Each review article in CME Journal Geriatric Medicine is peer reviewed and provides best of five format MCQs to test the reader's learning. CME Journal Geriatric Medicine is published 3 times a year and will be mailed to you with the Newsletter. You should receive your first free copy in the summer of 2007. As editor of the journal I will welcome your feedback on the educational content of the journal and recommendations for future topics to be reviewed.

Duncan R Forsyth
Editor

CME Journal Geriatric Medicine

Trainees

page

As a committee, we take leave of David Hargroves (no longer a trainee) and Shakeel Ahmed (due to other commitments).

I would like to express our gratitude for their valuable contribution as trainee representatives in the Education and Training Committee and the Policy Committee.

We are lucky to find an enthusiastic newcomer to the committee in Jonathan Birns (new Trainees' representative on the Policy Committee) who was elected at the Trainees meeting in Brighton.

A lot of changes have occurred recently at various levels. The immediate concerns for all of us are the trend towards reducing numbers of new consultant appointments, the uncertainty surrounding MMC and the MTAS problems. We must however, actively engage with every change imposed on us to try and get the best result from often difficult circumstances.

As a committee, we were recently able to contribute in many areas which are relevant to future trainees. David and I had opportunity to get involved with the

new curriculum for higher trainees which will be published soon.

Recognising the different specialties' potential contribution, the BMA Junior Doctors Committee on Education and Training subcommittee invited specialty representatives to attend a meeting on 23rd March, which I attended. The meeting was mutually beneficial and we produced a joint statement on MTAS. For details please check the website. <http://www.bma.org.uk/ap.nsf/Content/MTASmultisp ecgroupmeeting>.

I do hope this statement reflects our views. Subsequently we were invited to attend the JDC Executive meeting held on 2 April as guests. From these experiences, I can assure you all that BMA JDC really is working hard to get the best deal out of the disaster surrounding MTAS.

On a more positive note, we have seen growing numbers of stroke training (NTN) posts across the country recently. The knowledge based assessment pilot for geriatrics was also a success. The BGS welcomes a fresh outlook from younger geriatricians in shaping the future of the society. I urge you all to get involved and contribute.

Phyo Myint
Chair, Trainees' Committee

Joint Committee on Human Rights hears from RCN, British Geriatrics Society, NHS Confederation and Association of Directors of Adult Social Services on older people in healthcare

On 14 May 2007, Prof Peter Crome, Pauline Ford (RCN), Jenny Owen and Swayne Johnson (ADASS) and Dr Gill Morgan (NHS Confederation) gave evidence to the Joint Committee on Human Rights as part of the latter's inquiry into the human rights of older people in health care. Prof Crome outlined the main human rights issues for the Committee, highlighting areas such as privacy, dignity and confidentiality. He said that there was a general lack of encouragement for people to make themselves heard and he emphasised that there was too much pressure to discharge people from hospital, perhaps prematurely.

Ms Ford agreed in principle with Conservative peer, Lord Onslow's suggestion that a lack of understanding of concepts of the Act lay behind instances of poor behaviour by care staff. She said that abuses by staff were not widespread but that human rights could be used as a lever to ensure that older people received the treatment and attention they needed. Ms Ford agreed that there was a need for all nurses to be educated in human rights and said that there had been decades of challenges within the UK to try to get society to view ageing in a more positive light. Failure to do this was part of a cultural problem.

Full report available from the BGS website (current issues)

Tom Wilson 1918 - 2007

in memoriam

I speak as a friend and former colleague of this humble Giant, Thomas Scott Wilson, known to us all as TOM, who recently died, aged 89 years.

He started life just south of the border in County Monaghan, but crossed the border to be raised and educated in Belfast.

He was the youngest of five sons - his father was a headmaster, and mother a schoolteacher. Each of his brothers achieved excellence in their respective fields as did Tom, as I shall illuminate.

He qualified from Queen's University, Belfast in 1940. He was not just a keen tennis player, but distinguished himself to become Captain of Tennis at Queen's.

Beth and Tom married in 1941 and remained happily married until she sadly predeceased him a short while ago.

He leaves and was extremely proud of the achievements of his 4 children, Paul, the eldest, now retired from Telecommunications; Graham, a Chemical Engineer currently working in Beijing; Jackie, trained as a Teacher, ran her own nursery school until recently and now enjoys life playing golf – a subject also close to Tom's heart having been captain of Truro Golf Club. And last but not least Liz, who works locally as a Manager of a Large General Practice in Truro, and to whom I owe the honour of asking me to eulogise on my old friend and colleague.

He was on active service during the war in the Royal Air Force as a Squadron Leader and Medical Officer as far afield as Burma and Singapore

After demobilisation, he returned initially to Belfast, but found the atmosphere stifling and moved to London. By happy chance he became Medical Officer at St John's Hospital, Battersea 1946-48 - it was at this time he met up with Trevor Howell who had been awarded a grant to establish a geriatric research unit. They became friends, and much influenced by another

founder member of the specialty - Marjory Warren who encouraged his interest in rehabilitation. Tom became increasingly interested in aspects of what is now known as 'Geriatric Medicine', particularly incontinence in the elderly – an unpopular, embarrassing condition, but he was able to stimulate interest and help alleviate a common, distressing problem, and most importantly, prove that it could be reversible.

His ground-breaking research – in which he had to develop and even create his own apparatus – led to him publishing in the Lancet and being awarded an MD from Belfast University.

He was approached by Dr Charles Andrews, a visionary physician at the City Infirmary, Truro in the year of the inception of the NHS in 1948 – and became – after a delay occasioned by the British Medical Journal being unable to know what category the advertisement for a Consultant in 'Geriatric Medicine' should be placed - the first Geriatrician to be appointed in the NHS in the country, here in Cornwall. He held this post from 1948 until June 1981 when he retired.

I was appointed a short while before – much attracted by the department that Tom had created, and the colleagues with whom he worked – Eric Morton, Jimmie Donovan, Mabel Andrews, Margaret Balsillie, Inge Williams, Roger Indge, Charles Moon, Denise Russell, to name but a few. He had worked hard to establish a unit at Treリスケ, that opened a year or so later.

In addition to being so innovative in geriatric rehabilitation and incontinence, he also virtually invented the specialty of psychogeriatrics – mental health problems being so important in old age - and did, in 1968 with the aid of a certain Minister for Health, rather better known for some of his other achievements, Enoch Powell - open the first psychogeriatric unit in the country which he generously named after one of his mentors – the same Dr Charles Andrews.

He had a reputation well outside of Cornwall, serving on various National and Regional Committees including being Chairman of the very influential Regional Medical Committee

He was a founder member of the Medical Society for the Care of the Elderly, which became the British Geriatrics Society, for which he was the Treasurer. He was the youngest of the 8 doctors who founded this specialist society that now has nearly 2,500 members.

For his enormous achievements he was awarded the prestigious BGS President's medal in 1995 at a meeting here in Cornwall

Tom was not just a far sighted doctor, he enjoyed many his leisure pursuits. He was a member of Falmouth Tennis Club, playing at club level for many years. He was Captain of Truro Golf Club, a game he enjoyed in this country and on numerous holidays in the Algarve. He shared a love of sailing with his two sons, competing in the Flying 15 Classes regularly at Restronguet Sailing Club and in his later years made very fine models of sailing vessels.

He was an inspirational man, whose reputation was widely known, and who received frequent visitors from far and wide to see his achievements. These were balanced by a very human, humane, witty, and

humorous character. I will never forget our Friday lunchtime X-ray meetings which were lubricated by at least one tumbler full of sherry, after which he would drive off into the wilderness to perform another domiciliary visit. He never wrote letters, but had a very able memory, despite the ravages of sherry and cigarettes, to which he was clearly immune. I will recall his manner of holding a partly consumed ciggie in the palm of his hand as he escorted yet another dignitary down the corridor of the hospital.

I can bring breaking news. The hospital in which he worked (formerly Barncoose – now Camborne Redruth) has agreed to name a unit in which people prepare for their homegoing as **The Wilson Suite**, a fitting tribute to this great man – and, it should be noted that this is, appropriately, the best room in the hospital!

He will be missed, but fondly remembered.

Doug MacMahon

EUGMS

- report on geriatrics in Europe

reported on the fourth European Union Geriatric Medicine Society (EUGMS) conference in Geneva in 2006 in the President's column last year.

While I have moved on from being President of the BGS, it has been a great pleasure that I still remain a full Board Member of the EUGMS, representing the British Geriatrics Society.

Firstly, the good news, you are all members of the EUGMS by affiliation from the BGS. There has been a strong British tradition of participation in the Society with Brian Williams being one of the founding members and a former President of the Society. The scientific meetings and congresses that have been run

so far have been excellent and have contained a strong British presence thanks to the tireless work of Alan Sinclair in his period of office as Academic Director of EUGMS. Any members who have attended the meetings will realise that they have been first class and very clinically based. The two secretaries of the Society, Karen Anderson Ranberg, Des O'Neill (very familiar to all of us in the BGS), are actively pursuing promoting geriatrics opinion into European policy.

Karen has started an initiative to facilitate geriatricians visiting units in other countries. They are, at the moment, trying to recruit three centres from the UK, but members should be aware that if they would like to explore what is going on in a different culture and country in Europe, there is a developing network whereby one can spend a sabbatical time in another unit in Europe.

The next conference is the third symposium of the European Union Geriatric Medical Society and takes

place on the 28th - 29th September 2007 in Frankfurt. It has been organised by Professors Hahn and Hans Werner (Hans is the Treasurer of the EUGMS). The society alternates symposia on specific topics with congresses in which are major meetings covering all of geriatrics. The symposium this time covers Infection in the Elderly and has an impressive line up of speakers. The meeting is recognised for CME and should prove a really valuable and interesting symposium. I would strongly encourage members of the BGS to attend and help develop a spirit of European geriatric medicine.

A date to fix in your diary for 2008 is the 3rd - 6th September, when the fifth congress of the EUGMS will take place in Copenhagen. Danish geriatrics is very strong and is similar to geriatrics in Great Britain. The Health Service in Denmark is funded out of taxation

similar to the British system and there is a strong tradition of first class research and clinical services in geriatric medicine there. The congress is to be supported by Queen Margrethe and there will be privileged access to the famous Tivoli Gardens. I have the honour of chairing a session Movement Disorders in Elderly at this meeting and there will be involvement of many other UK and Irish geriatricians.

Details of all EUGMS activities can be found on their website www.eugms.org. Details of the Frankfurt meeting can be found on eugms@gmx.de and details of the Danish meeting can be found on www.woco.dk.

J R Playfer

Britain's forgotten isle

Elderly care on the island of St Helena

I am not sure why I wanted to go to the island of St Helena but I do remember that back in 1992, I had a map of the world on the wall and I had drawn a circle around St Helena. I just knew that one day I would go there.

Some 15 years later I find myself living on St Helena with my wife Belinda who is Saint Helenian and my two year old son Tobias. I am working as the manager for a new nursing home that is under construction. The people that will move into the home are currently living in three separate antiquated facilities called Sundale, The Haven and the Elderly Care Unit which is a ward in the general hospital.

Saint Helena is a very remote island in the South Atlantic Ocean, 2000 kilometres west of Africa, measuring 122 square kilometers. It was famously the prison island of Napoleon after his final defeat and subsequent second exile. Less famously, it was home to a large prisoner of war camp for the Dutch/Afrikaans boers during the Anglo Boer war in South Africa. There is no airport and only the one

ship, the Royal Mail Ship *St Helena* that calls regularly, bringing people and supplies. If she sails to Ascension Island, where there is an airport, she takes four days to get there and back, Cape Town takes nearly three weeks and twice a year she goes to England and is away for five weeks.

The island is a British Dependent Territory with no industry and only limited tourism. We are very dependent on aid from the UK. Some 4,000 people live here so it is a very close knit community. Approximately 25% of the population is over the age of 60, the mandatory retirement age for government workers, and in recent years more and more people of working age have left the island to find employment on Ascension Island, the Falklands and increasingly

Ian Runnery has recently joined the BGS Nurse Consultants Special Interest Group.

the UK. The principle reason for leaving is the low wages paid on island. Even a qualified nurse can earn more on the Falklands as a cleaner.

The migration of people off island is having serious consequences for the care service of older people. It is becoming increasingly difficult to find staff to work in the care facilities or as home helps. All three care facilities are short staffed

and the average age of a home help is 55. As elsewhere, people are living longer, and with more chronic disease the needs of our older people are becoming more complex.

There are usually four doctors working on the island, one of whom is always a surgeon. There is no requirement for any of the doctors to have specific geriatric experience but it clearly would be advantageous if one had. We were fortunate in 2005 to have a visit by a member of the BGS, Dr Paul Goldstraw who was contracted to review and make recommendations for a geriatric medical service. We have not been able to implement a number of his recommendations because of staff shortages and financial restrictions but his report is one that I frequently refer to. It is my hope that we will be able to develop a specific elderly care service for the island



Staff and Residents of Sundale on St Helena

through tele-medicine backed up by a visit every couple of years.

In the meantime, we have to prepare for the new nursing home, the Community Care Complex (CCC). There are real problems with the CCC. It is not big enough as it will only accommodate 42 people and we have 55 people in care. Originally a 60 bedded facility was asked for but funding was only granted for a smaller home. Now of course additional funding has to be sought to build a 20 bed wing. In the meantime part of The Haven will remain open. There are also problems with the design of the CCC as it does not make the most efficient use of staff and additional staff will be required. Finding those additional staff is going to be difficult.

Those are some of the challenges, but the rewards, in terms of caring people and knowing that one can make a difference, are great. In the UK, I was often told that I was getting too involved, as if this was somehow a bad thing, but out here one cannot help but get involved. In my job I can start the day helping someone in the bath, meet with a doctor to investigate why someone is ill and plan treatment, then visit someone at home to provide advice on how to make the home more accessible and end the day in a meeting discussing strategic objectives for public health. I say "end the day" but you are always on call and often family members will ring in the evening to discuss concerns about elderly relatives. We may be a small and isolated community but there is an intensity to this job that I have not experienced elsewhere.

There are times when I do get worried that we are going to be overwhelmed by the numbers of older people that we care for. This is why we must strive to provide the best medical and social care service that we can in order that people can have a healthy old age. We really struggle with our limited resources but I would not want to work anywhere else.

Ian Rummery
Mgr.sundale@helanta.sh



A boer cemetery in the spectacular landscape of St Helena

which brings together health and social care and which has access to a geriatrician on a regular basis. The geriatrician could provide a range of services from staff training and supervision, right through to direct consultations with patients. All of this could be done



BGS Spring Meeting report

Brighton - 2007

Leading geriatrician, philosopher and poet, Ray Tallis is fond of telling his medical students: "All old people are different, which is why they're interesting. All young people are the same, which is why they're boring."

The saying invariably leads to laughter as it did when he repeated it during a symposium on epilepsy at the BGS' Spring Meeting last month but it nonetheless sums up the enduring appeal of our speciality: its sheer complexity and variety.

Those qualities were certainly in evidence during the three day event where topics ranged from major ethical issues to how to improve the length of someone's gait

Our hosts (from upper left, clockwise):
Prof Rajkumar, Drs Nicola Gainsborough, Michael Vassallo and Mark Bayliss



by sticking a piece of plastic tape on the floor.

The latter, in fact, came during the first session of the programme on movement disorders when **Ann Ashburn**, professor of rehabilitation at Southampton General Hospital, was speaking about the effectiveness of physiotherapy, particularly the use of visual and auditory clues, for people with Parkinson's Disease. The session had opened with **Romi Saha**, consultant neurologist at Royal Sussex County Hospital, Brighton, on what to do "when the drugs don't work". Remedies ranged from the mega – £25,000 worth of deep brain surgery – to the micro: PD medication needs to reach the duodenum to be effective so might be better taken on an empty stomach or with small meals.



The relationship between low weight and a propensity towards dyskinesia was discussed by consultant physician **Jagdish Sharma** of Kings Mill Hospital, Mansfield, who stressed the need to aim for the lowest effective dose of levodopa per kg of body weight. Dr Sharma illustrated his talk with videos of thin patients suffering extreme dyskinesia as well as a slide of Laurel and Hardy to illustrate body types.

More interesting visuals came from **Catriona Good**, consultant neurologist at Brighton and Sussex University Hospitals, who used outlines of humming birds, morning glory flowers and even a hot cross bun to aid the recognition of various pathologies in brain scans and from **Khaled Amar** with his films of sleeping patients with restless legs syndrome. "Some can have a hundred movements an hour with micro awakenings which lead to reduced sleep and efficiency".

The Parkinson's theme continued into the sponsored evening symposium where members heard of a new treatment whereby a gel form of levodopa carbidopa can be delivered directly into the intestine by a small pump worn by the patient.

Opening our doors

Brighton saw one of the first steps along the path to giving our meetings a regular multi-disciplinary input with a session devoted to nurse consultants specialising in care of the elderly. There are around 65 such senior nurses in the UK now, who have been meeting for six years. In late 2005, the BGS opened its doors to the group, as a first serious step towards making the Society truly multi-disciplinary. The group held its first AGM last year.



Their aim, as their chair **Clare Abley** from Newcastle explained, is to raise the profile of the nurse's role in delivering expert care, to be a forum for sharing innovation and developments, to identify priorities for short and long-term research and to foster whole-person centred care.

It was a lively and informative session which included details of specific projects such as the nurse-led intermediate care services in Derbyshire as well as ongoing concerns over dignity and privacy for elderly people. During her talk on the need for 'zero tolerance of lack of respect' Sally Mansfield, nurse consultant at Leeds Teaching Hospitals Trust, asked members to spend a minute thinking about what would be their greatest worry in this area if they themselves were elderly residents in care homes and then another minute working out possible solutions.

Two female members who said they had recently given birth revealed their fears about not being given enough time or a secure enough environment in which to bathe or shower. Prof Graham Mulley said that he feared being "horribly constipated and nobody noticing. I want someone to ask me about it out of earshot of everyone else, to give me access to lots of fruit and vegetables and the chance to go for a walk if I'm physically able to do so."

The session also highlighted a troubling attitude among nurses towards care of the elderly. A Dutch survey of 113 student nurses and 90 nurses in their mid-30s found limited, even poor, knowledge and attitudes that were at best neutral and at times negative. Only 1.3 per cent said they actually preferred working with older patients. "Care is seen as too basic, the complexity of the job is not recognised," said

Marieke Schuurmans, associate professor of care of older persons at Hogeschool Utrecht. "Changing these attitudes is a great challenge but it has to be done." Demographic changes would mean that even if they had not chosen the speciality, most nurses were sooner or later going to find themselves nursing the elderly.

Fighting sepsis

The conference's reputation for attracting experts who can make their field both accessible and fascinating was further reinforced by its two guest lecturers. **Jon Cohen**, professor of infectious diseases and dean of Brighton and Sussex Medical School, painted a dramatic picture of the fight against sepsis.



"Severe sepsis and mortality increase with age: at 50 to 60 the graph really takes off," he said. Switzerland has the lowest death rate in Europe, Portugal the highest – "probably related to the availability of intensive care units" – with the UK and Ireland towards the top of the middle cluster. "Overall mortality is around 30 per cent, despite ICU care and antibiotics. This is a bad disease."

The favourite target for sepsis, a systemic inflammatory response to infection by a microorganism, is the lung (47 per cent of cases) followed by the abdomen (15 per cent) and the urine (ten per cent). What makes tackling it particularly difficult is that in acute cases there is no time to wait for laboratory tests to identify the pathogen responsible.

"You have to make an empiric judgement about treatment. If you guess right the patient is much more likely to survive but if you get it wrong you can get it very wrong."

We are also, he added, not very good at recognising the condition in the first place. "It's easy in advanced cases when the blood pressure is in the boots but we're very bad at picking it up in the early stages."

Understanding of sepsis has changed over recent years. It used to be thought that the storm of over-reaction by the body to the pathogen was essentially an uncontrolled immune response until it was established that its incidence also occurred in patients who were immuno suppressed by old age or chronic illness. The good news, however, is that increased understanding is leading to new developments in treatment. These include activated protein C, low dose steroids,

intensive insulin therapy, statins, Eritovan and immuno nutrition.

“Though we need to retain sepsis as a clinical term we should try to abandon the idea of finding a single drug and focus instead on specific infectious diseases. As with cancer there is not going to be one answer. We should go for an incremental approach rather than the big bang.”

Stroke management - what's new?

The other guest lecturer was **Hugh Markus**, professor of neurology at St. George's University of London who spoke on new ideas for stroke management. Strokes cost the UK £7bn a year in mortality and morbidity. But although patients take up a lot of nurses' and therapists' time they take up much less of doctors', particularly compared to some other countries which deal with the problem more proactively. Many European countries, for instance, admit all transient ischaemic attack patients because the risk of TIAs being followed by a stroke is much greater than was previously thought. The key to the efficacy of treatments such as carotid endarterectomy is speed: benefits tail off if they are done after a few weeks.



Similarly, thrombolysis for acute ischaemic strokes tends to be more effective the sooner it is given. Prompt treatment also lessens the risk of transforming infarcts into haemorrhages. New developments currently being trialled include fast tool screening by paramedics, augmenting thrombolysis with ultra sound and alternative mechanical procedures for dealing with a clot. Advances in brain imaging are increasingly able to identify salvageable tissue.

“Improving acute care would mean a better outcome, long term cost savings and a reduced risk of recurrence. We also need to educate people to realise when they're having a stroke so they can phone an ambulance. Getting patients to present earlier is a major challenge but the cardiologists have done it.”

Blacks, whites and greys in between

It was not just physical conditions that the meeting covered of course. In the capacity and consent session, for example, **Premila Fade**, consultant in medicine for the elderly at Poole Hospital, gave an elegant account of the history of the philosophical and legal concepts

of autonomy and the radical rethinks of recent years.

“In the past the legal system was very deferential to doctors: if you could find a body of medical opinion to support you, you were OK. So in 1974 it was not negligent not to tell a patient about the risk of spinal surgery because other doctors routinely did not.”

That has now changed following a case in which it was ruled that a eye surgeon was negligent in not telling a woman he was about to operate on that there was a minute risk of 1 in 14,000 attached to the procedure. Information must now be given according to what a 'reasonable' patient would want to know. It must be “significant, specific and include details of alternative treatments.”

In terms of someone's capacity, an unwise or seemingly irrational decision is not evidence of incapacity. “A key part of autonomy is the right to make our own mistakes. This is not a black and white area but very grey and case specific. There was a patient in Broadmoor who developed gangrene but refused amputation. He said he would rather die with two legs than live with one.

Although he had had schizophrenic and delusional episodes in the past, the court ruled that he had the capacity to make this decision which was logical to him.”

Mind and body

Similarly, in the last session of the meeting, a symposium on rehabilitation Raymond Tallis, emeritus professor of geriatric medicine at Manchester University (and recent Desert Island Discos guest), outlined our notions of mind and body from the Cartesian concept of dualism – the 'ghost in the machine' – to our current understanding of the endless interplay between the physiological and the psychological. Today we appreciate that psychiatric illnesses such a schizophrenia and depression have biological and neurochemical components and that physical conditions can be affected by emotional components such as stress.

Mental states can therefore affect physical recovery as the following speaker **Marie Johnston**, professor of health psychology at Aberdeen University explained. Motivation, for example, is greater when patients have a sense of self efficacy, the confidence that they can perform a behaviour and and achieve an outcome.

Rehab experts are now fine tuning techniques to boost confidence and maintain a positive, persevering mood.

In the previous session **Andreas Hiersche**, Macmillan consultant in palliative care for the South Downs Health NHS Trust, had tackled one of the most difficult areas in geriatrics – end of life issues. Talking about the question of food and water in the terminal stages of an illness he outlined some of the big questions. Not eating and drinking could be part of the natural process of dying – and even a conscious choice for some patients - but how uncomfortable is it to die without nutrition and hydration? Are lethargy and blurred consciousness part of that same natural progression or are they a result of dehydration? Is a dry mouth the same as thirst? How do you balance the risks and burdens of artificial feeding against the need for symptom relief?

“Malnutrition is always a risk for the elderly and we have an obligation to ensure that those who can eat have something to eat but where death is imminent the position changes. It can though, be extremely difficult to estimate how long a patient will live: different diseases have different time scales.”

The problems were compounded by the public reluctance to get involved in any discussion of dying. His conclusion was that there could be no blanket policy but a symptom focussed approach would offer the best source of comfort and good care.



Dr Hiersche was followed by Douglas Chamberlain, visiting professor of cardiology at Brighton University, who spoke on cardiac resuscitation in the elderly.

Although such factors as comorbidity and inflexible chest walls made skeletal and other trauma more likely – “cautious compressions save bones but not lives” – there was no evidence of an increase in cerebral impairment in patients who survived. “If the heart recovers so might the brain at all ages. Resuscitation is not futile especially if there is a shockable rhythm.”

0 = dead; 100 = great

At the same time people needed to be aware that the rate of success was not the same as that portrayed optimistically in television dramas. Patients also ought to be encouraged to discuss the concept of ‘do not attempt resuscitation’ directives. “Their views ought to be properly recorded and reviewed regularly.” To warm applause he added: “Us elderly have the right to die with dignity but also the right to the best medical care and it’s hard to get the balance right.”

A speaker from the floor who had trained under the eminent cardiologist provoked laughter when she recalled his ONF ‘diagnosis’ or Overall Nick Factor – “where nought is dead and 100 is great.”

Changing misconceptions

Correcting misconceptions or shedding new light on seemingly familiar conditions can be one of the most valuable aspects of the meetings. Presenting a paper on the consequences of an increasingly overweight elderly population, **Dr Iain Lang** from the Peninsula Medical School in Exeter, pointed out that although we are constantly reading about fat children the greatest weight increases are among 55 to 74 year-olds. Obesity at the age of 50 doubles or triples the risk of mortality. In the older age group, 65 – 70 year-old, however, the risk of mortality is not increased though the risk of disability is. “So they don’t die but they need extra health care with all the associated costs. This could be a double whammy.”

Though obesity brings problems it may also have some benefits as was mentioned during the Friday breakfast symposium on osteoporosis (well attended despite the revelry of the previous evening). Along with postural instability, frailty, slow responses and environmental factors, ‘lack of padding’ was a factor in fall related fractures. The session also heard from Steven Boonen, professor and consultant in geriatric medicine at

Luminaries of the BGS Brighton Meeting - 2007

Winner of the **Fergus Anderson Prize** for best scientific poster: **C P Wilkinson** (co-authors: R Fuller, N Dudley and J Blacktop) for their poster entitled: “What characteristics would patients favour in switching from warfarin to an anticoagulant alternative for stroke prevention in atrial fibrillation?”

Winner of the **John Brocklehurst Prize** for best clinical effectiveness and audit poster: **E Wood** (co-authors: J Walker and J Beynon) for their poster entitled: “Prescribed and non prescribed over the counter (OTC) medicines; the potential for drug interactions/adverse events”.

Winner of the **Eva Huggins Prize** for the best poster in the Nurse Consultants category: **G Grout** for her poster entitled: “Now you see them now you don’t: mental health problems in old age in the general hospital setting”.

Leuven University, Belgium, on the effective role played by strontium ranelate in women over 80.

Another frequent misconception is that a first epileptic fit is uncommon in the elderly. On the contrary, Raymond Tallis pointed out in a well-attended breakfast symposium on the subject, the biggest group of first timers - up to 50 per cent of epilepsy sufferers - are the over 60s.

“A seizure is an unpleasant experience which can have physical consequences like a fracture and can also have psycho-social consequences. Like a fall, a seizure can be a watershed in someone’s life, making them lose confidence and become afraid to go out.”

Diagnosis was not always easy but the key issue was to distinguish genuine epileptic seizures from syncope caused by underlying heart problems. “This must be pursued vigorously. Very few people die of fits but people do die of undiagnosed cardiac arrhythmias.”

His talk was followed by a discussion on how to set up an epilepsy in the elderly clinic and the role of the specialist nurse, led by Jan Bagshaw who has that position at Hope Hospital in Manchester.

Advances in technology and refinements of procedures mean that conditions that were untreatable a few years ago can today have very good outcomes. That was the message from Michael Eckstein, consultant ophthalmologist at the Sussex Eye Hospital. Remarkable results could now be achieved, for example, in the ‘wet’ or vascular type of macular degeneration; cataracts were done as day care surgery under local anaesthetic and diabetic retinopathy was usually caught early by digital photoscreening.

White noise and ambience

This was the Society’s first visit to Brighton, a place first made fashionable by the Prince Regent in the 1700s and then popular by the Victorians with their new railway, extravagant piers and fondness for seabathing. Since then the city has combined a rather racy reputation – it was classically the destination for a naughty weekend – with the artistic, creative and sybaritic. Its 400,000 inhabitants for instance have more bars and restaurants per capita than anywhere else in Britain – attractions probably sampled by many members after the intellectual rigours of the day. More than 600 attended the conference – the most since the move out of London three years ago – and feedback suggested that most did in fact like to be beside the seaside. Some felt the centre itself – home to many a party political conference and rock gig – was rather hard to find one’s way round initially and that perhaps the interior felt a little ‘tired’ (it is due for a major revamp). Set against that was the appeal of

the location itself and its convenience, good rail links and proximity to Gatwick making it easily accessible for visitors from Scotland and Ireland and particularly from overseas.

Other sessions included:

Dementia Update

Dennis Chan, consultant neurologist in Brighton gave a systematic analysis of the topic – “Neurodegeneration: Can we prevent it?”. He concluded that due to evolving knowledge and research probably we will be able to prevent it, at some point in the future.

Ken Miles, professor of imaging at the Brighton and Sussex Medical School, gave a detailed presentation which included a review of imaging techniques available and their roles. He referred to the NICE guidance on imaging and also discussed the potential cost/ benefit implications of making a correct diagnosis of the dementia subtype, versus the cost of treating a patient diagnosed using clinical assessment alone.

Diabetes and Endocrine Update

Dr John Quinn, consultant in diabetes and endocrinology in Brighton discussed the concept of insulin resistance, the clinical issues and broader social and public health implications. He explained how the reduced biological response to insulin results from a complex intracellular pathophysiological process and highlighted the implications of the metabolic syndrome with regards not only to insulin resistance but also including hypertension and changes in blood cholesterol. Measurement of waist circumference is key in the diagnosis of metabolic syndrome, and treatment options must be based primarily around life style advice as well as possible therapeutic options.

Dr Steve Holt, consultant nephrologist at the Royal Sussex County Hospital, explored why renal function worsens with age and whether this is a physiological or pathological process. He concluded that renal dysfunction is common however it remains unclear whether this is due to the kidney ageing or the result of co-morbidities. Key factors are undoubtedly hypertension, diabetes, vascular stiffness, angiotensin II and nitric oxide. It was postulated that salt intake may also be important due to data from Kuna Amerinds of Panama.

Dr Anna Crown, consultant endocrinologist at the Royal Sussex County Hospital in Brighton, discussed the factors involved in the awareness of hormone therapy amongst our ageing population. Dr Crown explained that hormone treatment is a balance of risk and benefit which has been highlighted by the HRT

evidence which evolved over time. Studies of hormonal therapy are variable in the elderly with inconsistent results and a lack of important outcomes. The take home message from this presentation was that this is a complex subject in which applying therapies indicated for patients with pituitary dysfunction to an elderly population with a view to “maintaining youth” is probably not recommended.

Hospital acquired infections

Alison Holmes, director of infection prevention and control at the Hammersmith Hospital, London, described the tremendous importance of optimising preventive and management strategies for hospital acquired infections, particularly referring to clostridia difficile associated diarrhoea (CDAD). She highlighted some potential improvement strategies and was optimistic that clinicians could use the current media attention and political agenda as a leverage tool to drive change.

Dr Martin Llewelyn, senior lecturer and consultant in infectious diseases at the Brighton and Sussex Medical School, spoke about necrotising soft-tissue infection (NSTI), urging clinicians to be aware of the infection when formulating a differential diagnosis on a patient with an area of presumed uncomplicated skin infection or deep vein thrombosis. He stressed that particular attention must be paid to symptoms (severe pain and risk factors including diabetes and alcoholism), signs (bullae, bruising, hypotension and pyrexia) and investigations (such as white cell count, C - reactive protein, serum creatinine) to aid early recognition during the lag phase, and stimulate urgent surgical and intensive care consultant review.

Acute coronary syndrome in the elderly and cardiac interventions

Stephen Holmberg focused on the use of drug eluting stents, which has shown promising results in the management of coronary heart disease. He presented research data comparing this with other forms of treatment. It seems a very good option for symptomatic angina with fewer complications when compared to coronary artery by pass surgery.

David Hildick-Smith gave an excellent presentation on the different cardiac interventions in the elderly. The three main areas covered in his talk were management of valve disease, structural heart disease and the use of pacemakers internal defibrillators.

Valve problems are common in the elderly but treatment options are limited because risks often outweigh the benefits, however newer treatment like percutaneous valvuloplasty will prove to be more useful with fewer chances of complications. There is however, less evidence for interventions in structural

disease like patent foramen ovale and further trials are required.

There is no upper limit to the use of pacemakers in the treatment of bradycardias, its use for resynchronisation therapy in heart failure is still rarely used in over eighties.

The use of internal defibrillators has improved survival but their use in the elderly is still restricted due to various factors and the appropriateness of the procedure in this age group is debatable.

Heart failure and the Palliative Care Team

Jan McFadyen, nurse consultant in palliative care described the approach, which improves the quality of life of patients and families facing problems with life threatening illnesses like heart failure. Early identification and assessment of physical, psychological and spiritual problems is vital. She talked about the main role of palliative care team including the support of relatives, end of life initiative and advanced care planning. She concluded by outlining future challenges such as payment by results and PCT commissioning strategies.

Clinical update - Arthritides

Ken Davies, professor of rheumatology in Brighton Medical School spoke eloquently about the diagnosis and management of the different types of arthritis in the elderly. He described the different presentations of arthritis in the elderly and how to distinguish between them with the use of different laboratory tests and imaging. He emphasised that a methodical history taking is important in order to come to a diagnosis. He discussed the pharmacological treatments including the use of immunosuppression.

Falls and Bones

Dr A Johansen showed that there is considerable evidence to suggest that delay in hip surgery is detrimental. In this audit done in University Hospital of Wales, Dr Johansen and his colleagues found that a significant number of delays were caused for anaesthetic reasons. He looked at the different groups of patients identifying the high-risk groups and the implications of delayed surgery in these. He suggested that the problem could be minimised by changing our practice.

Diabetes

Dr Simon Croxson, who has a special interest in diabetes in later life, talked about the management of late onset diabetes, focusing mainly on insulin therapy. He discussed some useful points for general physicians such as, when to start insulin in the elderly; the

positive and negative points of insulin therapy; which insulin to use and what to do when switching from oral therapy to insulin.

He described the various types of insulin available, highlighting the pros and cons of novo mix insulin, glargine insulin and the newer levemir insulin. He also talked about the various devices used to inject insulin and the practicality of using them. He concluded his talk by enlightening us about the exciting new therapies such as glucagons like peptides, exenatide and inhaled insulin.

Vascular Surgery Update

Aortic aneurysm rupture is associated with high mortality in the elderly. In his talk **Mr Waquar Yusuf** discussed how we could potentially reduce the risks of this happening. He described it as a common condition, which could be easily picked up by the use of ultrasound scanning and the cost implications were half that of screening for breast cancer. He spoke about the current guidelines, which is to screen men from

their 65th birthday and discussed the treatment options and when and whom to treat.

Open surgery is associated with high mortality and morbidity is being replaced by endovascular surgery, which seems a much better option. He presented the evidence from two important trials EVAR 1 and EVAR 2, which has had a major impact on our practice. His conclusion was that in carefully selected patients the outcome of intervention was promising but more resources were required.

Liz Gill, Freelance Journalist
Nabarun Sengupta
Charlotte Willis

The DiaCarb Diabetes and Nutrition Study

In late summer 2007 the DiaCarb Diabetes and Nutrition Study is due to commence in the United Kingdom. This is an international multicentre study including the Netherlands, Spain, and Israel, looking at evaluating the benefits of giving a newly-developed diabetes-specific feed, DiaCarb, developed by Numico, a Dutch-based company to older patients with diabetes who because of dysphagia or other conditions causing poor nutritional status require nutritional support via a PEG or naso-gastric tube. The study is being coordinated by the Diabetes Research Centre for Older People in Luton where Professor Alan Sinclair is Centre Director and UK coordinator for the study.

Nutritional management of patients with diabetes during acute illness has been a relatively neglected area in the past but there is now greater recognition of the importance of glycaemic control, lipid management, and nutritional planning in improving both metabolic control and clinical outcomes. Several publications including a recent systematic review, Elia M, Ceriello A, Sinclair AJ et al, *Diabetes Care* 2005; 28: 2267-2279, report improved glycaemia and a reduction in postprandial glucose levels in patients with diabetes given diabetes-specific feeds containing higher concentrations of MUFA (monounsaturated fatty acids), fibre, and less carbohydrate.

The international nature of the DiaCarb study requires the recruitment of 20-25 patients in the UK and Prof Sinclair hopes to enlist the help of 10 centres each recruiting 1-2 patients only, making the study feasible and achievable within the timeframe of the study. Subjects will be randomised to receive either DiaCarb or a standard isocaloric enteral feed for 12 weeks, with relatively simple assessments required. The inclusion criteria include:

1. Hospitalised patients or those residing in a care home
2. Requiring at least 6 weeks tube-feeding via a PEG or naso-gastric tube
3. Able to give informed consent

Patients initially hospitalised will require community follow-up after discharge (whether to home or a care home) for the duration of the study. Each recruiting centre will receive over 2000 euros for each patient which can be used to fund future study leave, book purchases, conference travel, etc. Colleagues may wish to enlist the help of a specialist registrar, SpR, to gain some early clinical research experience and all contributions will be recognised through any future publication.

If any colleague is interested in talking or learning more about the study or would like to receive a copy of the feasibility questionnaire for the study, please contact Professor Alan Sinclair on 01582 743285 (office) or email him at Sinclair.5@btinternet.com or alan.sinclair@beds.ac.uk

**MASTERS/
POSTGRADUATE DIPLOMA IN
GERIATRIC MEDICINE**

Keele University
Two years part-time
2007 - 2008

Who is it for? Aimed at all those working within the field of Geriatric Medicine. It will appeal to those who wish to further their interest and develop expertise in the field of ageing.

What will it involve? The aim of the course is to enable participants to develop a critical awareness of the health needs of older people, the way services are developed and delivered, as well as the present state of knowledge about the management of disease in later life. Integral to this is to understand and develop core skills in research methods. The tutorial team is multidisciplinary and is drawn from a group of international scholars in the field of ageing.

How is it assessed? The course is spread over six modules and is assessed through a range of learner-centred methods including written assignments, a report on a service development issue, a case report, a clinical audit and a research dissertation.

Contact Rachel Parkin:
pma06@keele.ac.uk

CLINICAL EXCELLENCE AWARDS - 2008 ROUND

The British Geriatrics Society process for the 2008 round of the Clinical Excellence Awards is now open.

In order to comply with the requirements of ACCEA the Society must seek its candidates through self nomination.

All eligible Consultants are encouraged to apply for a BGS nomination and we will only consider applicants who send us completed Curriculum Vitae Questionnaires (Form A). This year, the deadline for the receipt of nominations is 30 August 2007.

All intended applicants should read the latest information on the ACCEA website www.advisorybodies.doh.gov.uk/accea. It is necessary for applicants to complete a new form each year. At the moment, the only form we have been given relates to LOCAL applications. The BGS only nominates for NATIONAL awards, but please do not let this discrepancy confuse or inhibit you from putting an application in. More detail may be found on www.bgs.org.uk (link to the Clinical Excellence Awards on the homepage).

In the autumn those who have been successfully chosen by the BGS for nomination will be invited to complete a 2008 form.

Applicants are asked to note that nomination by the BGS in one year does not automatically guarantee nomination in the next year.

Please use your Regional Clinical Excellence Award Advisor for advice.

Applications need to reach Sarah Allport at the BGS Office by **30 August**.

Sarah Allport
Committee Secretary

**MULTIDISCIPLINARY MASTERS
DEGREE / DIPLOMA**

**Cardiff University Department of Geriatric
Medicine**
**2007/2008 Multidisciplinary MSc/Postgraduate
Diploma**
Course in Ageing, Health and Disease
(Two years part-time)

The course will commence in October 2007 and will provide an advanced course of study suitable for graduates in medicine, nursing, professions allied to medicine, social care practitioners, other professionals and managers who work with older people. Applicants without a degree but with vocational qualifications and related work experience, may also be considered.

More detail can be found on the BGS website (Notices/ Courses) or email: swetmanc@cf.ac.uk



**Please diarise the
dates of the BGS
Autumn scientific
meeting. 21-23
November in
Harrogate (no
scientific meeting in
October this year)**

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

BGS/RIA CLINICAL FELLOWSHIP OPPORTUNITY

Research into Ageing
 The British Geriatrics Society and Research into Ageing are delighted to invite applications for a clinical research training fellowship, open to members of the BGS with an NTN in Geriatric Medicine, wishing to train in academic geriatric medicine.

This fellowship is jointly funded by the BGS and Research into Ageing. Outline applications are invited from the prospective applicants for a **project start after December 2007**. The funding is for a period of up to three years and should **not exceed £250,000**. A PhD training is encouraged.

How to apply
 Contact **Dr Lorna Layward** at Research into Ageing on **lorna.layward@ageing.org** or **telephone 0207 843 1571** for an application form.

The **deadline for submission** of completed applications is **5 p.m. on 13 July 2007**.

GERIATRIC MEDICINE SYMPOSIUM

21 June 2007

RCP, Edinburgh

Visit:
<http://www.rcpe.ac.uk/education/events/geriatric-med-jun-07.php>

MEDICAL ETHICS

A National Study Day organised by the BGS Special Interest Group in Medical Ethics

29 June 2007

PGEC, Nottingham University

Phone 0115 840 2608 or email:
sue.pinkett@nuh.nhs.uk or **jane.turner@nuh.nhs.uk** for more information

PARKINSON'S DISEASE

From Science to Practice - multidisciplinary care in Parkinson's Disease and Parkinsonism

4 July 2007

RCP, London

Visit the BGS website for more details (Notices/ Regional and SIG meetings)

BGS REGIONS

Trent Branch - 19 June 07 - Dakota Hotel and Conference Centre off Jn 27 of M1

North East/North West Thames Joint Regional Summer Meeting
 11 July from 1.30 p.m. - South Mimms Premier Travel Inn (ex-Holiday Inn)

Trent Branch - 18 Oct 07 - Dakota Hotel and Conference Centre off Jn 27 of M1

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

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

NUTRITION / SARCOPENIA

IANA Symposium Nutrition & Long Term Care / Sarcopenia

25-26 June 2007

in association with King's College London and Bedfordshire & Hertfordshire Postgraduate Medical School

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

INTERNATIONAL VACANCIES

Australia and New Zealand

If you have Specialist qualifications in Geriatric Medicine and want to work with a dynamic team that will stimulate you clinically and academically then this role will appeal to you.

The Canberra Aged Care & Rehabilitation Service is hospital and community focused providing continuity of care across the ACT and is affiliated with the Australian National University Medical School and RESCENA research unit. A conjoint appointment with the ANU is available.

We also have great opportunities throughout New Zealand.

Please contact us on (+1) 917 577 48 77 for information or an informal discussion on these unique opportunities.
darryl@nyheadhunter.com
www.nyheadhunter.com

ELDERLY MEDICINE

Thirteenth Leicester Medical Conference National Conference in Medicine for the Elderly

27 June 2007

Leicester

includes kidney disease, depression, heart failure, osteoporosis and diabetes

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

DUAL SENSORY LOSS

28 June 2007

Birmingham

A round table discussion of interested professionals in the field of dual sensory impairment (hearing and sight) in older people

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

FALLS**Prevention of falls and injuries
in hospitals and care homes****2 July 2007****London**

Speakers include Dr Finbarr Martin, Dr David Oliver, Prof Val Pomeroy, Dr Frank Miskelly, Deborah Sturdy

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

BONE HEALTH**Bone Research Society Annual Meeting (Formerly Bone & Tooth Society)****3-5 July 2007****Aberdeen, Scotland**

Topics – bone, osteoporosis, orthopaedics, genetics, calcified tissues, mineralised tissues, surgery, bioengineering, matrix proteins, skeletal development, metabolic bone disease.

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

STROKE**The Sixth Biennial Sunderland Stroke Meeting - 2007
Sunderland University****4 July 2007**

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

For further information, contact:
Mrs Debbi Wallace,
Tel: 0191 565 6256 x 42109
Email:
Debbie.Wallace@chs.northy.nhs.uk

**TEACH THE TEACHERS
ANNUAL OPEN MEETING 2007****Health Care of the Elderly
Annual Open Meeting 2007****5 July 2007****QMC, Nottingham**

The meeting will begin with a business meeting of the CPII Course Management Committee, in which there will be a brief resume of the HCE undergraduate teaching in 2006/7 and information about changes to the course for 2007/8. This will provide a necessary briefing to all HCE clinical teachers and SpRs.

The larger, educational part of the meeting will aim to “teach the teachers”, with an emphasis on core Health Care of the Elderly topics that are both important for teaching and everyday practice. It aims to make clinical tutors better teachers and specialist clinicians. The special value of this event is that it brings old age psychiatrists and geriatricians together for educational purposes.

To reserve a place email joanna.zuranska@nottingham.ac.uk or phone 0115 823 0230

BONE DISEASE**National Association for the Relief of Paget's Disease
University of Oxford Workshop****10-11 July 2007****Oxford**

Topics – bone, osteoporosis, genetics, calcified tissues, mineralised tissues, metabolic bone disease, drug discovery, molecular pharmacology.

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

DEMENTIA**Improving services and support
for people with dementia
A national audit office
conference****12 July 2007****London**

includes the NICE-SCIE guideline:
Dementia: supporting people with dementia and their carers

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

Applications are invited from all junior doctors including FP1/SHO/FP2/SPR /Staff Grade doctors in Geriatric Medicine in Wales for a **new yearly RG Award 2007** to be awarded at the Annual Autumn BGS meeting for submission based on Best Research-project done/ presented/ published during the last year

The award will be adjudicated by a scientific panel from Welsh BGS

Send your application by 30 June, with a summary of your research project on one A4 page along with any evidence of presentation/publication/poster to -

Eirlys Harries, Secretary to Dr Abhaya Gupta, West Wales Hospital, Carmarthen SA31 2AF eirlys.harries@carmarthen.wales.nhs.uk

Letters



to the Editor

Dear Editor

I was very disturbed by the article on NICE and the management of Alzheimer's disease in the November issue of the BGS Newsletter (<http://tinyurl.com/29anwx>). I found it a weird and alarmingly unbalanced riposte to the careful appraisal by NICE. To cite just one example, invoking GMC guidance with the implicit threat that failure to prescribe cholinesterase inhibitors might contribute to possible loss of registration is preposterous. Even if it is felt that a reminder is needed that the care of our patients should be our paramount concern, the statement should be balanced by noting the need to weigh the prescribing of a drug with marginal clinical benefit against, for instance, the possibility of side effects and contributions to polypharmacy.

The whole article might well have come directly from the pharmaceutical industry. To find it bearing the imprimatur of the BGS is of great concern. Given the extreme pressures the drug industry is known to be exerting both directly and through interested organisations we should at the very least have been given a comprehensive statement of interests from all those concerned in drawing up this statement. Hopefully you will be correcting this major omission. I can confirm that I have no conflict of interest.

Yours sincerely

David Griffith
Consultant Physician
Care of
Older People

Dear Editor

I support the idea of a CME journal (March editorial refers) provided by the Society. I have little personal experience of Rila publications generally, or this one in particular as I have never organised a subscription to it, but the concept of a journal whose quality is backed and approved by the BGS is sound.

I hope your trial period is successful, and that the approach can be continued.

I would be happy with £15 per year on the subscription, taking the quality as guaranteed.

Kind regards and thanks for your work on behalf of the Society.

Peter Gorman

*Reply from the Editor of
CME Geriatric Medicine:*

"No pressure then" - DF

Dear Editor

I am an advanced trainee (fellow) in geriatric medicine in Melbourne, Australia.

Currently I am involved with a project looking at the merits of cognitive screening tests and their settings.

This is further influenced by the recent copyright of the MMSE.

A few in Australia are still enthusiastic about the AMT, and a recent literature search provides articles (from Europe) that can support this proposition. Your obituary to the AMT (BGS March 2005) by John Starr and Alasdair MacLulich gave a good account of what most Geriatricians say, however without any references. Would it be possible for you to either put me in contact with these authors or have you any references to these assertions? I would also be interested to know if there are any position statements or guidelines by your Society regarding choice of cognitive screening tests.

With thanks

(Shame about the cricket)

Michael Rose

Jed Rowe

a tribute to my friend



First impressions are important. As I drove nervously from Glasgow, on a grey Tuesday morning in September 1982, to my interview for the West Midlands Geriatrics Training Scheme, I still remember my sight of the large gasometers by Junction 9 on the M6.

I almost did a U-turn back to Glasgow. Still I got the job and on New Year's day 1984, arrived in my VW Golf to a new town (Walsall), a hospital flat, a new specialty and with a newish (and heavily pregnant) wife. At that time, as now, there was a regular meeting of registrars (or rather senior registrars) and at one of those early meetings I first met Jed and first impressions stuck: large, loud, enthusiastic, opinionated, untidy; and if till then I

had doubts about switching specialties (from Guts to Geriatrics) they were quickly



Is it a tie? Is it a bow tie?

dispelled. A few conversations with Jed (and one or two of his instant lectures) were all that it took to become infected with his enthusiasm. It wasn't until I joined the University Department as Professor Bernard Isaacs' Senior Lecturer (a rather obscenely short 16 months later), that I discovered why Jed was the way he was.



Hmm, not sure if this goes with my Gucci shirt.



You know how much I like a co-ordinated wardrobe.

At that time he was Bernard's clinical lecturer, and what I observed was a willing slave to the charisma, inspiration (and frequent absence) of his boss – always available when Bernard failed to turn up for a ward round and he was always (often at half an hour's notice) required to be a master of the instant lecture. That skill stuck.

Technology has changed and Jed has graduated from dog-eared OHP acetates through floppy disks to the pendant memory stick. As the ever popular centrepoint in our departmental meetings, he has always stood up when lesser mortals fail with an apparently fresh, well-informed and researched 'instant' talk, laced with humour and incisive wit. Rated at one time as one of the most popular lecturers in the Medical School, he has the trick (like his mentor, Bernard Isaacs) of turning the most unlikely topics (such as dementia or incontinence) into a fascinating exposition. Therein lies his skill in seducing young doctors into our specialty.

Another interesting role Jed had was that of substitute geriatrician to the Jewish Community in Birmingham. Only once did I find what that was like; after Jed left to go to Liverpool, I was expected to follow on as the Isaacs slave (though I resisted). However, on one occasion, at 48 hours' notice, I was asked to fill in to provide the keynote speech at the Triennial Conference of the then League of Jewish Women. I was so scared, I can't remember what I talked about but they were very kind to me! Again, through Bernard's influence, Jed was introduced

to the fascinating sub-specialty of Falls, slaving away for hours in the Hayward Building's Gait Laboratory,

whose watchword (inspired by Henry Ford) was: "You can do any research

Dear friends and colleagues,

Finishing your career naturally involves some reflection. I've come to realise I had a charmed life within medicine and I have been supported and encouraged by so many people since I qualified. Even my sartorial attempts, politics and overhasty tongue have never been held against me. I was fortunate enough to end up in a speciality for which I had a natural affinity and an ever developing passion. My colleagues, some of whom I've known for a quarter of a century have become as close as family. They have dried my tears, taken me birdwatching, repaired my Austin 10, looked after my children, as well as more thankless acts like dealing with complaints about my pigheaded clinical practice.

Since first joining I've always known the BGS as a friendly and helpful society and anyone going to headquarters can sense this the moment they cross the threshold. Involvement with the falls section enabled me to work with the most competent and energetic colleagues who also happened to be about the nicest. They are just a sample of all those talented souls sharing a devotion to the speciality who I have been running into at meetings for more than two decades.

I shouldn't have been surprised, but I have been moved to tears by all the messages of support, kind words, gifts, and offers of help from these wonderful people.

How can I thank you all?

Love Jed

project you like as long as it's about Falls". Jed's contribution to Falls research and clinical practice is the basis of his national reputation.

But what about Jed the friend; again, first impressions; shortly after our arrival in Birmingham, and knowing no-one, I remember well the invitation which cemented what has become over twenty years of close friendship with Jed and Teresa. At their terraced house in Hallam Street in West Bromwich, Jill and I first experienced Jed's considerable culinary skills, met Teresa, his larger than life wife (acquired as a doctor-nurse Mills and Boon thing at Sandwell Hospital) and enjoyed excellent and imaginative food washed down with vodka (which refused to freeze at minus 18 degrees). I also remember marvelling at how they had managed to get a huge cast iron bath up the narrow staircase of their house. After that, close friends, with family holidays and frequent exchanges of evening entertainment. Jed even lived with us for a few

months near the end of his strange safari to Liverpool for his first consultant job – never mind – we got him back to become the King of Moseley Hall – the only one of our group to make the community hospitals his HQ, with a busy in-patient service, charismatic team leadership and establishment of a Falls clinic which attracts visitors from all over.

Jed is still the large, loud, enthusiastic, opinionated man I first met 20 odd years ago and just as untidy: "Did you ever meet anyone in a suit who was any good?". His career may have been cut slightly short by motor-neurone disease, but he has contributed more than most do in three lifetimes. He inspired me as well as many others. It has been a privilege being a close colleague and it continues to be a joy to be one of his closest friends.

During early April this year, the



weather got better and better, culminating in a gloriously warm April 15th. From all round the country Jed's friends and colleagues gathered at my house near Bromsgrove. Teresa was dreading the occasion, while Jed and the rest of us were nervous. It took only 30 seconds after his arrival (me driving his beloved Austin 10), a few hugs and, yes, a few tears shed amongst friends, to dispel our anxieties. Somehow the weather

conspired to ensure the success of the occasion. As we gathered round the table on my back patio, glorious sunshine greeted the moving presentation by Peter Crome of the BGS President's Medal to Jed "for outstanding service to the Society". I can't remember exactly what Jed said in response, but there was hardly a dry eye as he eloquently reminded us of Jed the Wordsmith, of the inspirations in his life and the warmth of friends helping Teresa and him through difficult times. After the formal proceedings, all tension disappeared and we enjoyed a lovely party, excellent food from a local pub, table tennis on the lawn and tractor rides for the kids (and David

Barer). We need not have been concerned about Jed's stamina. He outlasted most of the guests and it was such a pleasure to observe his greatest skill, the enthusiastic use of the spoken word as he moved easily amongst his friends and colleagues. In any conversation, Jed always gets the last word, so too in this message – Jed's response after the party (printed opposite):

Alistair Main

The National Council for Palliative Care launches two year dementia project

January 2007 saw the start of the National Council for Palliative Care's new two year dementia project to promote increased and better quality palliative care for people living with dementia. NCPC's mission is to ensure that all those who need palliative care have access to appropriate services regardless of diagnosis or care setting. NCPC has been looking extensively at the specific needs of people with dementia as a particularly disadvantaged group for access to palliative care.

Lloyds TSB Foundations are funding the dementia project which will be managed by Alison Blight. The funding recognises the need to extend NCPC's emerging work on the palliative care needs of people with dementia. This includes the recent publication 'Exploring Palliative Care for People with Dementia', followed by two highly successful workshops in October 2006 and January 2007.

Working Arrangements

NCPC's Older People's Policy Group has overall responsibility for the dementia project and it has approved the formation of a Dementia Working Group (DWG) to steer direction of the work. A wider reference group will ensure access to specialised advice. The project will be highly collaborative; NCPC will work closely with other national bodies with expertise and knowledge in the area.

Project Objectives

The DWG had its first meeting on 23 February 2007 and terms of reference were agreed for the project. The objectives are to:

- map current provision of palliative care services for people with dementia
- highlight gaps in provision within different care settings
- understand user and carers' needs of palliative care services, including marginalised and diverse groups
- identify and share notable practice
- develop practical guidance to promote palliative care for people with dementia.

Innovative local practice

NCPC has developed a template to record examples of innovative practice in meeting the palliative care needs of people with dementia. We would like you to use the link to provide NCPC with information about good local practice in different care settings www.ncpc.org.uk/download/policy/dementia/lpt.doc

Briefing Bulletin

As the project gathers pace, the first briefing bulletin is due for publication this summer.

If you want to find out more about the project contact Alison Blight at a.blight@ncpc.org.uk or visit NCPC's web site at www.ncpc.org.uk/policy_unit/dementiawg.html

Taiwan, episode two

1000 year old eggs, pigs' ears and the queen's accent

Following in the pioneering footsteps of Duncan Forsyth, Finbarr Martin and David Oliver, John Gladman and Maeve Rea braved the intense hospitality of the Taiwanese Fellows in the second week long teaching programme.

Said John Gladman, "Whilst we were in Taiwan, we recognised that the Fellows needed higher level input than simple coverage of the basic elements of geriatric medicine. Accordingly, we provided some professional developmental teaching, choosing topics such as teaching, communication skills, clinical effectiveness, critical analysis and service structure. We were also able to comment on some of the Fellows' research work in progress.

An important theme that ran throughout the week was polypharmacy. During the week we came to

understand how the services in Taiwan predispose towards this problem, and we compared it with the UK. We reflected on exactly how much benefit frail old people get from drugs that are only proven to work in younger non-frail populations and how much more likely they are to get side effects leading to activity limitation.

During the case-based teaching, we exposed the difficulties that we all face in stopping drugs. Thus, the catchphrase, 'Be brave!' came up time and time again. It takes a certain confidence to stop drugs that other doctors, often senior ones, have been prescribing."

The dizziness of a patient just disappeared when I stopped a drug prescribed by another doctor. I had never experienced this before.

Where Duncan and David feasted on snake soup, John and Maeve were treated to some very mature (1000 year old!) eggs and pigs' ears. Both dishes were wasted on John. Clearly his taste in food is a little more conventional than his taste in waistcoats.

Queen's accent

Dr Julie Lai, one of the Fellows, said: "UK geriatricians are more focused on comprehensive care of elderly patients. Last July, Dr Khanna Pradeep had asked me, 'Why do you talk about money so frequently?' This question reminded me that I did put more emphasis on payment systems than on quality of care we provided. If only the healthcare delivery system in Taiwan just started to value comprehensive care for older people, we could focus on doing what *should* be done instead of what *can* be done.

I had lots of fun while talking to the British teachers. For example, I really enjoyed listening to the Queen's accent." [I bet it comes as a surprise to Maeve Rea to have the soft, lilt of the Emerald Isle described thus]. Dr Lai concludes: "I would like to thank

Teachers, fellows and dignitaries at the reception hosted by the Taiwanese embassy in London



all the British teachers who gave us a memorable and fruitful experience. I will be delighted to have every teacher come to my wedding...if someday I do marry.”

‘British gentleman’ and ‘elegant lady’

Dr Bill Lin, also a Fellow, said: “I did not realise the importance of the function reserve and the problem of polypharmacy in elderly people.

I was also highly impressed by the lectures on rehabilitation, international classification of function and health, clinical effectiveness of guidelines, and how to evaluate the evidence and geriatric service.

I will never forget Prof Gladman’s encouragement: ‘Be brave and stop inappropriate medications for the elderly’. The dizziness of a patient just disappeared when I stopped a drug prescribed by another doctor. I had never experienced this before. Dr Rea taught us about the urinary incontinence, drug use in elderly people, learning types, concepts of teaching, but her most unforgettable lecture was the role play. I had never stood in the patient’s shoes before, but after the role play, I learned to do so, in communicating with



A president, a teacher and two dignitaries

my patients.

At first glance, I felt that Prof Gladman is really British gentleman and Dr Rea is very much an elegant lady. During their brief stay, one achievement must be mentioned, which is their incredible chopsticks kung-fu. They can easily pick up peanuts by chopsticks, with grace, and this is difficult, even for the Chinese”.

A delegation of Taiwanese, including some of the Fellows visited England in April, and attended the Spring meeting conference. Apart from David Oliver’s valiant efforts to learn to speak fluent Mandarin in one month (presumably partially successful as there was not too much laughter while he acted as their guide), the BGS arranged for the Taiwanese embassy in London to host a reception for the delegation.

Prof Gladman concludes his report on his teaching week, saying: “‘Be brave’ was apt in another way. All the Fellows will soon be required to develop geriatric services across the country. That will mean developing collaborations and training teams. It will involve developing services for falls or incontinence, and all this will require new ways of working and overcoming administrative and other barriers.”.

The enormity of the task is not lost on Bill Lin who says: “A half of our training programme has passed. I think we must set up our own geriatric service when we go back to our working places, including case finding, MDT organisation, emphasis on functional status and cost reduction. Hopefully, our efforts will make our government aware of the importance of holistic care for older patients instead of subspecialty-orientated medical practice.”

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