



B G S

n e w s l e t t e r

A career change



In July 1998 I took up a new consultant post with Lifespan Healthcare NHS Trust, the community trust in Cambridge, after leaving The Queen Elizabeth Hospital, King's Lynn where I had worked since 1977.

Consultants do sometimes change posts but this is still fairly unusual. It seems my own story was sufficiently remarkable to prompt two respected colleagues to ask me to describe it in the BGS Newsletter. Clive Bowman first suggested the idea in late 1998 and I tentatively agreed but did not act, feeling that I needed more time in the

post before I could write anything useful. I was, however, galvanised into action by Richard Lynham at the BGS December meeting, who indicated that an account of my career change and view of community geriatrics would be a suitable contribution, so I agreed.

I feel that an account of this nature should, in addition to the service aspects, include the personal perspective. This may interest colleagues of a certain age as they reflect on their own careers and possibly sense the need for a change.



Dr Tony Luxton

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Increasing workloads

During my first 15 years as a consultant I had seen the workload grow from an initial 30-60 admissions per month per consultant to over 100. Local changes included a new district general hospital and an expansion of staff. I would perform some 10-20 domiciliary consultations per month which gave me a valuable opportunity to assess home conditions and the perspective of carers. The department would usually have empty beds. Generous local provision of care homes meant that those who needed them could usually gain a place quickly so blocked beds

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specialist medical society for health in old age

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were few. The result was that I had a fair degree of freedom to admit patients as necessary.

Over subsequent years bed numbers were reduced and workload still rose. Empty beds became a thing of the past and, increasingly, patients were accommodated as outliers on various surgical wards. Length of stay fell and ward life became ever busier and less satisfying. There was no time or opportunity to provide much follow-up care or to see patients at home. The overall impression was of providing a very acute service to make patients dischargeable as quickly as possible. I was aware that more care for older people was being provided outside hospital and that I was unable to participate in this aspect of the service.

On the positive side I had gained additional experience through secondments with the Health Advisory Service, liaison work with social services, being clinical director and BGS Service Advisor for East Anglia. These roles help one to network and I became involved with Lifespan Healthcare NHS Trust in planning a community geriatrician post to complement existing service developments. As discussions matured it became clear that a candidate for such a post would need wide experience: a few years as a consultant preferably with management experience possibly as a clinical director, familiarity with NHS organisation including primary and secondary care, knowledge of social services, and an awareness of the user and carer viewpoint. To put it another way, the role would not easily be filled by a newly accredited specialist registrar.

Learning new tricks

The inevitable question therefore gradually emerged and although I accepted that candidates for the post might well have experience similar to my own, I initially felt that 52 might be a little late to learn new tricks. As time went on I became more excited about the prospect of applying and after much thought decided to do so. I was glad to be invited for interview and quite delighted to accept the offer. The three month period of notice began; the feeling was distinctly odd, a mixture of regret at leaving and a wish to start the new post, all the time being

especially assiduous so as not to leave any problems or complaints behind! I was sorry to leave colleagues with whom I had worked for many years; they all showed great kindness that was matched by the warm welcome from my new Cambridge colleagues. I have a strong sense of gratitude to all who helped me make the change.

A mix of duties

The post itself is based in Lifespan Healthcare NHS Trust (seven sessions), with some duties at Addenbrooke's Hospital (four sessions) that include on call with post take ward rounds, out-patient clinics and acute ward rounds. The clinical duties with Lifespan include a continuing care ward, a rehabilitation ward and visits to patients in the community as requested by general practitioners. The mix of duties satisfies the statement set out in the BGS Compendium section relating to community geriatrics.

Development of community services

My post is new and part of the development of community services (called the Enhanced Community Health Service - ECHS), which includes specialist nurses, occupational therapists, physiotherapists, speech and language therapists, dieticians and podiatrists. Health Authority (HA) policy had resulted in the closure of over 100 beds and relocation of patients to the independent sector. Some of the released funds were used to develop ECHS. The intention was to provide specialist services to older people in care homes and other locations, thus maintaining HA responsibility for the provision of specialist care to this group. My appointment meant that general practitioners would have more access to a consultant geriatrician.

The ECHS has become very well organised; each care home has a named member of the ECHS staff who acts as a contact person and who can mobilise appropriate members to deal with specific problems. The health authority expected nursing home residents to receive general care from nursing home staff, supplemented by the usual access to general practitioners. People in residential homes, sheltered housing or in their own homes would of course continue to have the normal access to community nurses. Furthermore it was envisaged that ECHS staff would be able to

train the general nursing staff in nursing homes so that they could provide some elements of specialist care. The HA assumed that nursing home staff would possess general basic knowledge to allow them to benefit from training. Other assumptions were that staff would be able to attend training sessions and would stay in post long enough to pass on the benefit to the residents through improved standards of care.

Training care home staff

ECHS staff have developed systematic programmes of training for nursing home staff usually with sessions within the care home, but they have encountered problems. Staffing levels are sometimes such that staff cannot be released to attend training sessions; staff do not always possess the expected level of basic knowledge and staff frequently leave their posts to work elsewhere. Nevertheless, nursing home managers value the service and the programme of training continues.

Apart from the provision of clinical services my own role includes education and service development activities. My membership of the BGS Special Interest Group in Care Home Medicine is particularly relevant here for I was able to host a symposium in Cambridge on *'Models of Care'*, at which local staff were able to describe their role in the provision of specialist services in the community and to care homes.

Awareness of available services

Another aspect of community geriatrics is the encouragement of a 'whole systems approach'. Frail older people often need services from several providers. The user may therefore perceive many separate services each with its own referral and assessment system, eligibility criteria and hours of operation. If the providers were more aware of each others' services, were willing to share and trust assessments, co-operated to develop and share a single point of access and planned changes to their service paying regard to the effect on other providers, then the user might experience more of a single service with fewer gaps in provision, less duplication and easier referral and access.

I have made two contributions linked to this theme. The first was to organise a meeting on

the subject of falls with presentations covering the alarms, mobile wardens, assessment of the individual and their environment and evidence for interventions. The ensuing report covered these topics, serves as a source of information for all concerned with people who fall and provides a directory of services. The second concerned EPICS - elderly persons integrated care system - for which I hosted the second national meeting in Cambridge (the first was hosted by Chris Foote).

My other educational activities covering community geriatrics include lectures to various professional groups including general practitioners, the NHS Confederation, Regional BGS and BASE.

The future for community geriatrics

The future direction of community services for older people depends on Government policy, the response to the Royal Commission Report on Long Term Care, and the National Service Framework. A favourable change in policy would encourage the development of systematic provision of community services to frail people in a range of settings including care homes. Services could become more pro-active to offer assessment and treatment to individuals in the early stages of a change in health or competence, rather than waiting for a crisis to develop necessitating an abrupt hospital admission. To fulfil this vision services could be modelled on the ECHS in Cambridge, augmented by gerontological nurse specialists as envisaged by the Royal College of Nursing, and include the provision of teaching nursing homes which could disseminate good practice and perform research.

I believe that community services for older people need the involvement of geriatricians who regard these duties as a special interest in its own right. This may be difficult to achieve because of the competing demands of acute hospital work, especially for geriatricians with duties in general medicine. However, the introduction of consultant posts based in community trusts, with post-holders having limited acute hospital responsibilities, may be a way forward.

Tony Luxton

Consultant Geriatrician
Lifespan Healthcare, Cambridge

Editorial

page



The Newsletter has changed beyond all recognition in the 16 years I've been receiving it, due to the efforts of my predecessors and the office staff, in particular Rawia Habiby and her successor, the current sub-editor, Caroline Houston.

I see the Newsletter as the main means of communication to all members about the Society and what's going on in the world that's relevant to geriatric medicine, but am I right? Is it providing what the membership wants? What do members think of it? In order to find out I devised a short questionnaire for discussion at Regional meetings. It was distributed at the Council meeting in February and subsequently sent to all Regional Chairmen and Secretaries. I want to know what you think about its content and presentation and what could be done to improve it. Feedback to me by the end of June please. Eventually the Newsletter could well be replaced by electronic communications, but until then it should be as good as we are able to make it.

Go south young (wo)man!

The SAC newsletter in the February edition encouraged trainees to consider spending time abroad. In this edition Professor Adrian Wilson describes the challenges and rewards of practising in sub-Saharan Africa, and invites SpRs to do part of their training in South Africa (page 19). Would anybody who takes up his offer please write and tell us about their experiences.

BGS meetings should be interdisciplinary

Partnership is the name of the game and the BGS is not being left out. The President and I have met with officers of AGILE, the organisation of physiotherapists who work with

the elderly, and of OCTEP, the equivalent body for occupational therapists. We hope that these links will grow and would encourage members to invite their therapy and nursing colleagues to attend and contribute to Regional meetings.

NICE and the BGS

The National Institute for Clinical Excellence seeks the views of the BGS in its appraisals. The Executive agreed that for each topic one of the Society's Special Interest Groups or members with a particular interest in the subject would be asked to provide expert opinion on behalf of the Society. For example earlier this year Dr Colin Currie reviewed and responded to the appraisal of Hip Prostheses.

Intermediate care must not become another example of ageism

Intermediate care is a term that has crept into health service jargon and, whatever it actually means, seems to be here to stay. Many older people would benefit from rehabilitation as a step down from acute care, but would suffer if intermediate care were substituted for acute hospital care. The Secretary of State for Health, Alan Milburn, in his speech to the King's Fund promoting intermediate care, implied that acute hospital care was for clear cut entities such as coronaries and fractures and not the non-specific presentations of illness so common in older people. Significantly he referred to intermediate care as a bridge between home and hospital not the other way round. Intermediate care could become another means of depriving older people of the health care they need, unless there are service developments such as those described by Dr Tony Luxton (front page). There must be specialist medical input to old people when they need it, wherever they are. The consultation period on the findings of The National Beds Inquiry ends on 15 May. Dr Finbarr Martin, Chairman of the Policy Committee, has led the Society's response.

Rebecca Dunn

President's column



The Oxford English Dictionary describes euthanasia as a gentle and easy death or a means of bringing about such a death.

The Government apparently defines euthanasia as a deliberate intervention with the express aim of ending life and this act is illegal in the United Kingdom. Currently however it may be lawful, in certain cases, to withhold or withdraw life-prolonging treatment from patients with the result that their death is hastened.

All party Pro-Life Group

The House of Commons Library has provided us with helpful background information on the proposed Bill. Ann Winterton MP came first in the ballot for Private Members' Bills. She is chair of the all party Pro-life Group and in essence her proposed bill would lead to the prosecution of doctors who aid death by withdrawing or withholding treatment or nutrition. The Bill would apply to England, Wales and Northern Ireland. When she announced her intended Bill she said that this move came against a background of media reports that elderly and disabled patients were dying in NHS hospitals as a result of inadequate provision of nursing and medical care. She also specifically criticized recent BMA guidelines by stating that many people were increasingly fearful of entering hospital because the BMA, without legal authority, had issued guidelines to doctors allowing the withdrawal of medical treatment and of tubal feeding from patients who are not dying.

Landmark ruling

In 1993 the landmark case of Tony Bland resulted in a House of Lords ruling that, in his case, withdrawal of artificial nutrition and hydration would be lawful on the basis that it was not in Bland's interests for treatment to be

continued. The Bland case was distinguished by the Law Lords from cases of euthanasia on the grounds that withdrawing or withholding life-prolonging treatment was an omission not an act. Ann Winterton has described this distinction between an act leading to death and an omission, also leading to death, as a loop-hole which her Bill aims to close. She also states that she does not aim to force doctors to continue life-prolonging treatment where patients are dying or in cases where treatment would have no effect or would be burdensome to the patient. However, it would seek to prevent doctors or others from taking quality of life issues into account when deciding whether further treatment should be withheld.

Reactions to the Bill

There have been powerful reactions for and against the Bill. The Catholic Bishop's Conference of England and Wales, the Office of the Chief Rabbi and the Down's Syndrome Association are supportive and the BMA, Age Concern and the Alzheimer's Society oppose the Bill.

The Executive of the BGS discussed this issue at its meeting on 16 March. The consensus view was that the Bill would not clarify the complex issues surrounding patient care and artificial nutrition. Perhaps after due thought you might as individuals raise the matter with your local MP.

Progress through the Commons

The Bill is unlikely to become law under the Private Members System. It has passed its first and second readings and the Committee Stage. However it has been pushed down the timetable for debate in the Commons, leaving very little time before the summer recess for a third reading and passage through the House of Lords. If it is not agreed by the House of Lords by the end of July it will probably fail to become law.

Brian Williams

MEDICAL TREATMENT (PREVENTION OF EUTHANASIA) BILL

A Bill to

Prohibit the withdrawal or withholding of medical treatment, or the withdrawal or withholding of sustenance, with the intention of causing the death of a patient; and for connected purposes.

Be it enacted by the Queen's most Excellent Majesty, by and with the advice and consent of the Lords Spiritual and Temporal, and Commons, in this present Parliament assembled, and by the authority of the same, as follows:

1 Withdrawal or withholding of medical treatment

It shall be unlawful for any person responsible for the care of a patient to withdraw or withhold from the patient medical treatment or sustenance if his purpose or one of his purposes in doing so is to hasten or otherwise cause the death of the patient.

2 Interpretation

In this Act 'medical treatment' means any medical or surgical treatment, including the administration of drugs or the use of any mechanical or other apparatus for the provision or support of ventilation or of any other bodily function; 'patient' means a person suffering from mental or physical illness or debility; 'sustenance' means the provision of nutrition or hydration, howsoever delivered.

3 Short title, commencement and extent

- i) this Act may be cited as the Medical Treatment (Prevention of Euthanasia) Act 2000
- ii) this Act shall come into force at the end of one month beginning with the day on which this Act is passed.
- iii) this Act extends to England, Wales and Northern Ireland only.

**Standards of Care
in Nursing and Residential Homes**



The BGS has joined many other professional, provider and patient organisations in the Coalition for Quality in Care.

This has been put together by the Centre for Policy on Ageing (CPA) to promote the document *Fit for the Future*. This document is the product of many months of collaborative work by these organisations which was led by the CPA at the invitation of the Department of Health.

The BGS was successful in giving greater priority to the clinical aspects of the proposed standards. The purpose of the coalition is to urge the Government to implement the key

standards which are shown overleaf.

The BGS has also joined the Royal College of Physicians London and Royal College of Nursing in the production of the document *Standards of Medical Care in Nursing Homes*. Many members of the Society were involved within the RCP in the production of this document, with Bim Bhowmick and Clive Bowman being particularly prominent.

These two documents together should prompt the Government to give a firmer lead to health authorities and social services on the local measures necessary to improve the quality of clinical care to residents in homes.

Finbarr Martin
Chairman, BGS Policy Committee

COALITION FOR QUALITY IN CARE IN SUPPORT OF NATIONAL REQUIRED STANDARDS FOR RESIDENTIAL AND NURSING HOMES FOR OLDER PEOPLE

Key standards for implementation

- ◆ to ensure quality of clinical (medical, nursing and therapeutic), personal and social care in residential and nursing homes (care homes);
- ◆ to enhance the quality of life of all residents by meeting their cultural, physical and social needs whatever their race, gender,

disability or sexual orientation;

- ◆ to guarantee that all residents in care homes for older people have the right to a single room;
- ◆ to require that the accommodation provided for individual residents meets spatial standards which enable residents to lead fulfilled lives and be cared for effectively and appropriately with due regard for their privacy and dignity;

- ◆ to introduce effective complaints procedures backed up by means of redress applicable to all care homes;
- ◆ to encourage the growth of a trained and skilled caring work force dedicated to improving the quality of life for all residents by setting targets which will be required to be met over the next five years.

BGS SURVEY INTO LONG TERM CARE

Introduction

Many of you responded to the questionnaire that arrived with the Newsletter late in 1999. This was designed by Martin Severs and myself with the purpose of establishing, in a rough and ready way, whether the North and East Devon case of Pamela Coughlan was typical throughout the UK. You may recall that she won her appeal against her local health authority, and the judgement made in Court threw considerable doubt on the legality and equity of the criteria being used there to determine eligibility for NHS funded nursing home care. The Court described the Government guidelines to health authorities [HSG(95)8] as confusing and misleading in law, although not technically unlawful.

We were interested to establish:

- ◆ whether a similar patient would be eligible for NHS funded nursing home care elsewhere in the UK.
- ◆ whether geriatricians are involved in local decisions about eligibility for NHS funded nursing home care.
- ◆ whether this eligibility is related to the type of local provision, specifically if eligibility in different areas

is related to the continued existence of NHS run long term care (as opposed to NHS funded care in the private and voluntary sector).

These questions were intended to explore whether one of the aims of the NHS and Community Care Act (1990), equity of access to NHS funded care, had been achieved yet, six years after the provisions of the Act came into force.

The questionnaire

The theoretical patient described had sustained an intracranial event which has left her quadriplegic; she can speak but is dysarthric and mildly dysphagic but can cope with an adjusted soft diet. She has some upper limb function but is dependant on others for all activities of daily living. She is doubly incontinent and has no pressure sores. She suffers with regular headaches and gets chest infections more than once a year. She has no behavioural disturbance and after a prolonged period of rehabilitation, she has been stable for four months.

Responses

A total of 236 responses was received of which 157 were fully completed, 65 partially completed but fully interpretable for all questions, and 14 incomplete and at least one question was not interpretable.

England produced 184 responses, Wales 17, Scotland 28, Northern Ireland 7.



Finbarr Martin

This is a good response compared to previous attempts to collect information in this way from all members of the BGS. It is not a truly representative picture of the situation generally in departments of the UK and there were also multiple responses from some areas.

Question 1 - would such a person get NHS continuing care in your district?

Table 1

	Yes	Probably	Sometimes	No	No answer	TOTAL
England	35	5	4	139	1	184
Wales	7	1	1	8	0	17
Scotland	15	0	1	12	0	28
N. Ireland	2	0	0	5	0	7
TOTAL	59	6	6	164	1	236

Table 2

Distribution: yes + probably + sometimes versus no between England and Wales versus Scotland

	Yes/probably/sometimes	No	TOTAL
England & Wales	53	147	200
Scotland	16	12	28
TOTAL	68	151	228

Chi - Square Test, $p < 0.01$ (Scotland more likely to say YES)

Question 2 - does your health authority require approval (i.e. opinion of, assessment by, agreement at panel or signature of a local geriatrician) for a patient to get into the local NHS funded 'frail elderly' long-stay provision?

Table 3

	Yes	No	Don't know or no answer
England	128	53	3
Wales	12	5	0
Scotland	26	2	0
N. Ireland	3	4	0
TOTAL	169	64	3

Question 3 - is this local provision (indicate one or more of the below or specify if none apply)

- a) run by the NHS trust care?
- b) a block contract between the NHS and local P/V sector care homes?
- c) spot purchased by the NHS in P/V sector home/homes?

Table 4

	Number	3a			3b			3c		
		Yes	No	DK/NA	Yes	No	DK/NA	Yes	No	DK/NA
England	184	79	99	6	41	132	11	66	105	13
Wales	17	11	5	1	1	14	2	5	9	3
Scotland	28	24	4	0	5	23	0	1	27	0
N. Ireland	7	3	4	0	3	4	0	2	4	1
TOTAL	236	117	112	7	50	173	13	74	145	17

DK/NA = Don't know or No answer

Relationship between question 1 and question 3 - is an answer YES to question 1 (patient would receive NHS funded care) associated with the existence of locally managed NHS continuing care provision? (as opposed to the NHS funded provision being provided in the P/V sector)

Table 5

Question 1	Question 3a		subtotal
	Yes	No	
Yes	25	48	73
No	16	82	98
subtotal	41	130	171=TOTAL

Chi Square Test, p=0.05

i.e. a significant association between availability of local NHS managed provision (in separate designated continuing care wards or acute/rehabilitation wards) being associated with likelihood of patient deemed to meet criteria for NHS funded care.

Conclusions

Although the methodology is inadequate for definitive conclusions to be drawn, the impression is that:

- ◆ widespread variation exists in the application of eligibility criteria so that there is inequity of access for free nursing home care.
- ◆ in the majority of areas of the UK, free NHS care would not be provided for this case, although the Court of Appeal upheld that it

should be in the similar case of Pamela Coughlan.

- ◆ In most areas but not all, geriatricians are involved in these judgements, as recommended by DoH guidance.
- ◆ Where NHS provision still exists, the free NHS care is more likely to be considered appropriate, i.e. the historic patterns of provision still strongly influence access, in contrast to the objectives of the Community Care Act.

These conclusions are important. The BGS will continue to urge Government to act on the major recommendations of the Royal Commission on Long Term Care, in order that fair and equitable access to free nursing care be available for disabled older adults.

Finbarr Martin
Chairman, BGS Policy Committee

FUNDING OF LONG TERM CARE NEEDS TO BE PUBLICLY DEBATED

To mark the anniversary of the publication of the Report of the Royal Commission on Long Term Care, the BGS President along with the Presidents of the three Royal Colleges of Physicians, sent a letter outlining their concerns to the BMJ. The letter was published on April 1 as reproduced below.

Last March the Royal Commission on Long Term Care recommended a clear, consistent national policy to guide the partnership between public and private provision of long term care of older people.

Two important recommendations were:

- ◆ Personal care should be funded by taxation and board and lodging by individuals, with state help for the poorest.
- ◆ The government should

establish a national care commission to set criteria and monitor standards.

Legislation is before parliament to establish a national care standards commission that partially meets the second recommendation, but funding will be considered as part of the current comprehensive spending review. Funding, however, causes the most hardship and anxiety to older people and is the main source of inequity in the current system. Until the issue is resolved, the

distortions caused through friction between different authorities and budget holders will impede the introduction of a fair and satisfactory system of long term care.

When free (NHS funded) nursing care should be provided was the subject of Pamela Coughlan's court case with North and East Devon Health Authority last July. The Court of Appeal found that the NHS was responsible for providing free nursing care when health was the predom-

inant need, although nursing care could form part of a social services means tested package. The judgement concluded that the eligibility criteria used by North and East Devon Health Authority had been unlawful. Worryingly, these criteria had been faithfully taken from official health service guidance and were considered by the court to be confusing though technically not unlawful. If this was only an isolated case it would be important, but it is typical of the

situation nationally.

A recent survey by the British Geriatrics Society of its members found that most would not be able to offer or even recommend NHS funded nursing care for a person who was partially paralysed in all four limbs with double incontinence and great difficulties in speaking and eating. The wide variations across the United Kingdom depended mainly on the available resources.

This lack of equity is a national disgrace, disenfranchising the most needy people from the care they have every right to expect through the NHS. We appeal for the long term care of older people to be included in the ongoing public debate on the funding of health care. We also strongly urge the government to fund long term care properly and respond positively to the recommendations of the commission.

LONG TERM CARE CONFERENCE

The Laing & Buisson Long Term Care Conference was held in London on 14 March.

The annual L&B Long-Term Care conference is one of those affairs that seems to cast the physician as a voyeur of a parallel universe. An exceedingly small proportion of the over 300 delegates emanated from the world of Geriatric Medicine - even fewer if the excellent chairmanship of Beverly Castleton and your viraemic reporter are disregarded.

Trends and future prospects

William Laing gave an authoritative overview of market trends and future prospects, illustrating how there has been a degree of contraction through closure with a trend to increasing occupancy. The last decade has featured a trend to corporatisation of care, though over the last year this has perhaps stalled. Hamilton Anstead, chief executive of Four Seasons Healthcare, provided a critical review of the financing machinations of long-term care that were entirely understandable even to me. Much of the business that was on the Stock Exchange had been taken into private ownership, gone into receivership or was struggling. The demerits of financing through Sale-Leaseback schemes were aired; there has been some critical publicity in the

financial press recently regarding the business of one of the major players. Jim Flaherty, chief executive of Omega (UK) Ltd, subsequently challenged this portrayal. Mr Flaherty eloquently discussed the drivers of profitability for homes, namely the minimum wage and European working directive (increased costs), callous government (evidenced through an unwillingness to allow fees to rise reasonably), poor management and over-rented properties (whereby the sale to lease back had generated much capital that couldn't be serviced by the income stream).

Whatever your conceptions of the independent sector, the clarity of thinking and analysis that these speakers provided contrasted with much of the passionate rhetoric that so often characterises debate about long-term care.

Bed numbers

The National Bed Survey cropped up throughout the day and in my presentation I championed (ugh) the clinical characteristics and medical needs, and then speculated how health services may be configured in the future. In essence I suggested that the trend of falling numbers of acute beds would continue, similarly that the provision of long-term care beds would contract. Concurrently there

would be a rapid growth in intermediate care and the re-establishment of rehabilitation for older people. For aficionados of medi-management speak I suggested that whilst guidelines and protocols would guide acute care, integrated pathways could facilitate partnership action in intermediate care and that long-term care should be managed cohesively by a consortium approach. Smart or what!

Unresolved business

The general atmosphere of the conference was that the sector was approaching a point where innovatory funding was just about spent and that current fee levels simply were inadequate. The stock market enthusiasm for lastminute.com, launched the same day, gave the care home industry's difficulties a stark perspective. The Government needs to move swiftly for care as well as the NHS for the future of frail older people to be assured. Clients, residents, bed-blockers or patients, it matters not; there continues to be unresolved business.

Clive Bowman
Physician & Geratologist
International Institute on
Health & Ageing
University of Bristol

Council study day



Stimulating, educational and uncontroversial - that was the remit. Stimulating it was, educational most certainly, but uncontroversial? - I am not so sure! Nevertheless Prof Alan Sinclair certainly delivered.

Held amongst the glass and greenery of the Birmingham Botanical Gardens on a warm and sunny Winter's day (10 February), the Spring Council Study Day turned out to be a great success. The theme of the day, exploring those difficult and complex issues of rationing and its ethical implications, effectiveness and deployment of limited resources was both challenging and thought provoking, pragmatic and philosophical. The speakers, distinguished in their own fields, unique in their ideological approach to dealing with these difficult issues, and sharing a common regard and empathy with older people, were guided through the afternoon under Alan's capable chairmanship.

Rehabilitation intervention

Prof Graham Mulley, whose research and lecturing credentials are well known to Society members, reflected on the effectiveness of rehabilitation interventions in older people. Brick by brick he tore down the traditionally held view of rehabilitation being a soft science of doubtful benefit, its saving grace being that those who undertake it derive some satisfaction. Emphatically he claimed that rehabilitation is effective, some of the evidence being compelling; some supportive but not conclusive; some uncertain - a stimulus for further research; some not effective, so to be abandoned. Posing the questions '*What is evidence, what's its meaning and how do we interpret it?*' he proceeded to outline the problems with study of rehabilitation - the diversity of the conditions, the difficult goals and the moving baseline. Stroke rehabilitation epitomised the compelling evidence group, as did work in falls prevention, respiratory rehabilitation in COPD and the role of exercise in arthritis. Of uncertain effectiveness were the role of pre-discharge home

assessment visits and critical care pathways in stroke. More research and systematic review is required. Ineffective approaches include the use of intermittent compression for oedema in the hemiplegic hand. Prof Mulley drew attention to the fact that many outcome measures in rehabilitation are poorly validated and hard endpoints do not necessarily reflect the aims of rehabilitation - a view many clinicians on the shop floor would no doubt share.

Healthcare rationing

Lady Sally Greengross, Director General of Age Concern England, a doyen of our times and distinguished for her deep and wide ranging campaigning on behalf of older people, took us through the complex and vexed issues surrounding rationing of healthcare of older people. That it exists is uncontroversial, older people themselves feel so. The Gallup survey commissioned by Age Concern and the subsequent Age Concern Report '*Turning your Back on Us*', published last November, highlighted explicit and implicit age discrimination in the NHS. Lady Greengross made the point eloquently that only 30% of older people are vaccinated against flu - does this need an advertising campaign? What about breast cancer screening or drugs treatment for Alzheimer's Disease? - older people may be dissuaded from accessing services and treatments. And the long waiting times. Older people have less time to wait.

Ethics and ageism

From passion to more passion, Prof Grimley Evans guided us through the ethical implications of age-based rationing. He argued that the total expenditure on healthcare per person was around 25-30% below what was needed. The middle class wants emergency services, not to pay for long-term care. He believes there are four imperatives - decide on what we are trying to do, maximise efficiency not just effectiveness of services, reduce the need for services and plan for funding. He argued that the fundamentals of ethics are not universal. Thus there is a dichotomy between collectivism (the individual is there to serve the State) and individualism (the State is

there to serve the individual). Grimley ably guided us through the complex concept of equity, need and benefit, and the multifarious causes of ageism - food for thought indeed. Thus how should we adjudicate rival claims on limited resources?

The economic perspective

Alan Williams, Professor of Economics at York University and a specialist on the economics of health and healthcare, prolific writer and arguably an older person himself, enlightened us with his at times philosophical discourse. The core problem, he argues, is that there are far more potentially beneficial healthcare activities than any country can afford. Logic dictates therefore that some potentially beneficial healthcare activities will have to be withheld. He states that the two main objectives of healthcare in the NHS are to improve population health and to reduce inequity. Rationing cannot be avoided. He believes rationing should be judged by the capacity to improve health and reduce inequity. He argues that if a country equates the value of

health benefits in the old, to that of the young, then maximising the population's health as a whole will lead to discrimination against the old. Equally eloquently he argues that to reduce inequity in people's lifetime experience of health, it will be necessary to discriminate against the old. Thus the pursuit of each of the two objectives of healthcare necessitates discrimination against the old when prioritising healthcare.

The at times controversial, most definitely stimulating and thought provoking discourses brought together evidence, advocacy, ethics and economics and ended in a lively panel discussion.

And the take home message for me after a great Council Study Day - there is no clear answer!

Chandi Vellodi

Honorary Deputy Secretary

Study Day CME accreditation: 2.5 hours



COUNCIL MEETING, 10 FEBRUARY 2000 - SUMMARY OF PROCEEDINGS

European Association

Dr Williams reported on the plans for a European association of clinical geriatric medicine to promote continuing medical education in geriatrics, interact with UEMS and represent the interests of the specialty to European authorities. The association was expected to be launched officially in September 2001.

Clinical governance

The meeting reviewed the latest draft document on the implementation of clinical governance (CG), prepared by the BGS working group. It was stressed that this offered a practical working procedure, identifying resources needed to support implementation of CG. Although RCP London had pushed for the introduction of 2-3 performance indicators,

the BGS felt these indicators were spurious and could provide an undesirable alternative to a proper CG process. Prof Swift agreed to consult the RCP on a number of matters raised.

Treasurer's report

Dr Shepherd reported on the plans to buy premises and formal approval was given on the following matters:

- ◆ to proceed with plans to acquire premises as soon as possible; and
- ◆ that the officers be allowed to negotiate a purchase without recourse to Council, although a borrowing limit of £700,000 was set.

It was agreed that proposed arrangements for a revised subscription structure for PAMs should be studied by the Executive before being brought

back to the next Council meeting.

It was reported that the BGS were to buy the minority interest of the BSRA in *Age & Ageing*.

Policy committee

Dr Martin summarised the Committee's recent discussions including the results of the BGS long term care survey (see p8); BGS support for the CPA Nursing Home guidelines (see p7); the formation of a working group to discuss BGS engagement in PR activities; the Government's proposals to place more emphasis on intermediate care.

Honorary Secretary's report

Dr Dunn invited feedback on the Newsletter and the change in date of the Spring Council meeting.

Making decisions



Dr Adrian Hopper summarises the Government's proposals for making decisions on behalf of mentally incapacitated adults (October 1999).

'Making Decisions' is the Government's policy statement for reform of the law to improve and clarify the decision making process for those who are unable to make decisions for themselves. This policy statement follows from the consultation paper *'Who Decides? Making decisions on behalf of Mentally Incapacitated Adults'* (1997) and the Law Commission report *'Mental Incapacity'* (1995). The initiatives set out in this policy statement only apply to England and Wales. Similar approaches are being proposed for Northern Ireland and Scotland, although in Scotland, because of differences in the framework of the law, the detailed proposals are somewhat different (*'Making the Right Moves'* August 1999). The proposals are an intent to legislate, but at present there is no indication when that might be.

Important changes proposed

1. Capacity

- ◆ There will be a new statutory definition of incapacity which will focus on whether an individual is able to understand the nature and effect of the decision at the time a decision has to be made.
- ◆ There will be a presumption against lack of capacity. This is an important point for clinicians and emphasises the need for a demonstration of lack of capacity.
- ◆ The proposal defines a person as without capacity if **they are unable because of mental disability to make a decision, or unable to communicate a decision, e.g. if unconscious.**
- ◆ **Mental disability** is defined as any disorder of mind or brain, temporary or permanent, which results in impairment of mental functioning

- ◆ A person is unable to make a decision if the mental disability is such that the person is 'unable to understand or retain the information relevant to the decision or unable to make a decision based on that information'.

- ◆ Included in this proposal is that 'all practical steps' have to be taken to enable a person without capacity to communicate their decisions, and a reiteration of the current position that an individual has the right (if with capacity) to make unwise or irrational decisions.

2. Best Interests

Currently, in situations where the patient does not have capacity, clinical decision making is made in the 'best interests' of the patient. For medical decision making, 'best interests' is defined as what a 'reasonable body of doctors would do in that situation'. In this paper it is proposed that there should be statutory guidance on how the best interests of persons without capacity should be determined.

Included in these proposals are:

- a) A requirement to encourage a person to participate as fully as possible in any decision affecting them.
- b) Other people, who it is 'appropriate and practical to consult', should be asked about the person's likely or known wishes and feeling as to what would be in their best interests.

3. Continuing Power of Attorney

At present Enduring Power of Attorney is confined to financial affairs. A system of Continuing Power of Attorney (CPA) is proposed, which would allow a person to delegate decision-making powers on finance, healthcare and personal welfare to one or more persons (attorneys). A CPA must be made in a particular form which will need to be registered with a new registering authority, accompanied by evidence that the person was mentally capable at the time that it was created. The healthcare component of CPAs will allow a third party to consent or to refuse consent to treatment for a person when, and only when, they are without

capacity, although unless this has been specified in advance, a general CPA will not allow a proxy to make decisions about withdrawing of artificial nutrition and hydration.

4. Decision making by court

A single court jurisdiction is proposed to deal with all areas of decision making for adults without capacity. The court will be able to make decisions for a patient without capacity (including healthcare decisions), make declarations about capacity and appoint a manager to make decisions. The court’s powers in this area would include giving or withholding consent to particular forms of healthcare and appointing a manager to make similar healthcare decisions, which may require that the manager can access the healthcare records. Managers will not be delegated powers which are currently delegated to a court, such as withdrawal of artificial nutrition and hydration from someone in a persistent vegetative state, or the interpretation of an advance statement.

There is concern expressed in the paper that court appointed managers could refuse consent to healthcare. The government’s view is that most decisions like this are one-off and therefore could be made by a court rather than via an appointed manager.

No action is proposed at present for changes in the legal position regarding:

- ◆ Advance Statements about Healthcare.

The BMA’s Code of Practice ‘*Advance Statements about Medical Treatment*’ together with the current position, which includes the guidance of case law in which an advance refusal of treatment,

which is ‘clearly established’ and ‘applicable in all the circumstances’, is as effective as a decision by a capable adult, both provide sufficient ‘clarity and flexibility to enable the validity and applicability of advance statements to be decided on a case by case basis’.

- ◆ Independent supervision of Medical and Research Procedures.

- ◆ Public Law Protection for people at risk.

Under this heading the Law Commission recommended the repeal of Section 47 of the National Assistance Act 1948 which provides powers for compulsory removal of those in need of care and attention, even though they are not suffering from mental illness. This is a very controversial statute and the implication of this part of the report is that, at present at least, there is no intention of withdrawing this power.

Conclusion

These changes are mostly to be welcomed but will take medical decision making into new territory. In addition there are resource indications which will require funding, such as the expanded role of the Court of Protection. Statutory definition of capacity and best interests may require more detailed assessment and documentation of process than may be the case at the moment. Explicit powers of proxy decision making may produce differences of opinion between proxy decision makers and doctors. In turn, this may increase the need for review of decisions by court.

Adrian Hopper

Consultant in Elderly Care
Guy’s and St Thomas’ Trust

ERRATUM

In the February 2000 Newsletter we published an obituary on Dr Joseph Mellor Greenwood. It has been brought to our attention that the piece contained a number of inaccuracies, which we would like to correct.

- ◆ Dr Greenwood became medical

officer firstly at Crumpsall then at Monsall Hospital. After a move to Withington Hospital in 1934, he became medical superintendent in 1939, a post he held through the war.

- ◆ Dr Greenwood was joined at Withington Hospital by Dr James T

Leeming in 1967.

- ◆ all mention in the piece of the ‘Ministry’ refers to the Ministry of Health.

Our apologies for any confusion or offence these mistakes may have caused.

'United They Stand'

2000 Update



In 1995, the Audit Commission published the initial report 'United They Stand'¹ on the hospital management of hip fracture patients.

This highlighted major variations between hospital units in practice and outcome. The basis for many of the audit standards was the RCP report of 1989². Activity Variables included length of total wait in A&E (less than 1 hour), length of time to operation (less than 24 hours), percentage of operations cancelled for unacceptable reasons (i.e. other than for medical optimisation), evidence of early mobilisation (i.e. sat out within 48 hours of surgery), seniority and supervision of surgical and anaesthetic team members, operation on planned daytime trauma list (wherever possible), length of hospital stay and discharge destination. Qualitative variables included the presence of joint medical/orthopaedic liaison rounds, documentation of function, social history and focussed discharge planning, nursing documentation of pressure area risk, pain and continence. Widespread differences were seen between the trusts examined; those with co-ordinated orthogeriatric liaison tending to have better outcomes.

Improvements

The 2000 update³ examines a higher number of trusts than the original report (140 with 25 patients in each). There have been a number of improvements. 75% of A&E Departments now have special 'fast-track' procedures for hip fracture patients and 83% of trusts operate daytime trauma lists. There has been a small reduction (22% to 18%) in patients waiting more than 48 hours for surgery. Only 1% of operations and 11% of anaesthetics are now carried out by unsupervised SHOs (vs 9% and 30% respectively in 1995). However, there has been little improvement in other areas studied.

Only 7% of patients spend less than 1 hour in A&E (median 2.8 hours, with half the trusts performing worse than in 1995). Half of patients wait more than 24 hours for surgery. 43% of trusts cancel operations for 'potentially avoidable reasons'. Only 23% of trusts carry out joint medical/orthopaedic ward rounds and 29% of patients are not mobilised within 48 hours of surgery.

Interpretation of data

There are a number of problems in the interpretation of these data. Firstly, the standards for waiting time in A&E and for surgery within 24 hours are based on Category C evidence only (expert recommendation), and not on the results of clinical trials. There is evidence that mortality is higher in patients waiting longer than 48 hours for surgery⁴, but it is not adjusted for co-morbidity, and the 1 hour standard for A&E is arbitrary. So far it has proved unrealistic and unachievable in most trusts even with fast tracking procedures and there is some doubt as to whether data are recorded in the same way in all departments. Moreover, there is some incompatibility between the twin aims of performing supervised operations on daytime trauma lists and operating within 24 hours. There is also no measure in the report of valid medical reasons for failure to mobilise within 48 hours and definition of 'potentially avoidable reasons' for cancelling surgery was left to individual trusts. Nor is there an acknowledgement that there are other valid models of orthogeriatric liaison apart from joint ward rounds operational in many trusts. The summary does not mention length of stay, discharge destination, readmission rate, mortality or functional status. Whilst concentrating almost exclusively on simple activity data, there is little mention of quality indicators.

As is made explicit in the SIGN⁵ guidelines, there is grade A and B evidence from clinical trials on the value of pressure area assessment,

prophylaxis vs thromboembolic disease, treatment for underlying osteoporosis, investigation of index fall, nutritional supplementation and adequate analgesia, multidisciplinary assessment and focussed discharge planning, and the use of early supported discharge. Yet none of these issues is addressed in the executive summary nor in the external 'Value for Money' reports carried out at most trusts. Nor is there a retrospective analysis of the practices common to trusts where outcome indicators are good.

The way forward

I believe that the way forward is to dwell less on arbitrary though easily measurable time standards, and to focus more on the quality of medical and nursing care, multidisciplinary assessment, rehabilitation, discharge planning and outcomes. A trust with an effective fast-tracking system and available slots on trauma lists might please the external auditors without really delivering the goods.

David Oliver
 Consultant Physician
 Queen Mary's Hospital, Sidcup

P.S. I will be performing a postal survey of current arrangements for orthogeriatric liaison in departments of Geriatric Medicine and would be grateful for your co-operation in completing the forms.

References

- 1 Audit Commission. *'United they stand: co-ordinating care for elderly patients with hip fracture'*. London: HMSO; 1995.
- 2 *'Fractured neck of femur: prevention and management. Summary and recommendations of a report of the Royal College of Physicians'*. J R Coll Physicians London 1989; 23(1): 8-12
- 3 Audit Commission Update. *'United they stand: co-ordinating care for elderly patients with hip fracture'*. London: HMSO; 2000.
- 4 Todd CJ. *'Differences in mortality after fracture of hip: The East Anglian audit'*. BMJ 1995; 310.
- 5 Scottish Intercollegiate Guidelines Network. *'Management of elderly people with fractured hip'*. Edinburgh; 1997.

SPONSORSHIP OF THE BGS - A WORD OF THANKS

The Society is indebted to a number of pharmaceutical companies without whose generous financial support we could not hold such a range of meetings both at national BGS level and through our various Special Interest Groups, nor produce publications such as this Newsletter and the BGS Handbook. We would like to thank the companies which have sponsored us in the last year for the following purposes.

General sponsorship of BGS	Novartis; Roche
Newsletter	Pfizer; Bayer
1999 Handbook	Allen & Hanburys
Diabetes SIG	Servier Laboratories
Drugs & Prescribing Section	Boehringer Ingelheim
Care Home SIG	Pharmacia & Upjohn Ltd;
	Swiss Re Life & Health Ltd
Council Study Day, July 1999	Boehringer Ingelheim
Parkinson's Disease SIG	Medtronic
Cardiology SIG	Napp Laboratories

We are aware that some BGS Regional Groups will have obtained sponsorship for their meetings and would like to encourage meetings organisers to let us have details so that we can acknowledge them in the Newsletter.

BGS prizes

awarded at the 1999 Autumn Meeting



The Medal for the Relief of Suffering amongst the aged was presented to Lady Sally Greengross OBE of Age Concern.



Professor Sir John Grimley Evans receiving the Founder's Medal for distinguished service.



Jane Mickleborough receiving the Ferguson-Anderson prize for the best poster presented at the 1999 Spring Meeting in Cork, the first year the Society's prizes were awarded to members of disciplines other than medicine.



Dr Jacqui Close being congratulated by the President following the award of the Research into Ageing Palamountain Prize.



Dr David Lubel receives the certificate commemorating his six year service as Meetings Secretary, Honorary Deputy Secretary and Honorary Secretary. He is the last member to hold the six year linked offices of Meetings Secretary and Secretary.



Michael Lake CBE of Help the Aged receiving the Medal for the Relief of Suffering amongst the aged.

The challenges for medicine in sub-Saharan Africa

Adrian Wilson, the William Slater Professor of Geriatric Medicine at the University of Cape Town, gives his view of the challenges faced at the start of the new millennium.

It is sometimes difficult to conceive the challenges facing our discipline in sub-Saharan Africa (SSA) as we enter the new millennium. This is an era which will, over the next generation, see the number of over 60s increase by 148.8% (the fastest of any global region), and this is despite AIDS-related plummeting life expectancy. Yet exacerbated by the impact of HIV/AIDS, the aged of SSA, and in particular older women, are left to shoulder the burden of care for their ailing or dying grand-children, with only the benefit of erratic inter-generational support and little or no formal support mechanisms. Two countries alone in SSA deliver state pensions to the aged. Where pensioned employment exists (around 4% of available work) it is directed almost exclusively to men. Health services throughout SSA are crumbling under the combined impact of epidemic infectious disease (particularly HIV/AIDS), the failure to sustain, replace or renew dated and collapsing equipment, and the

enticement out of the system of key medical and nursing expertise. Wealthy 'first world' countries like Britain, having mismanaged their own nursing establishment and staffing projections in the 80s and 90s, now trawl the world and SSA for potentially registerable trained nurses. These nurses are lured away with the incentive of higher, hard currency salaries. Consequently the medical and nursing skills base in Africa is in drastic decline: yet another nail in the coffin of this very important cohort of older Africans. Add to this a near total absence of data; policies which are obsessively maternal and child-health oriented; the absence of structured and in-context training; erratic,

unfocused research; and an overall political ignorance and lack of will to face up to these critical issues. The scenario is grim.

The African Foundation for Research and Interdisciplinary Training in Ageing (AFRITA)

AFRITA is a non-profit making trust based in Harare, Zimbabwe, whose purpose is to promote, maintain and link training and research in ageing to policy development within Africa, for the benefit of all its older persons and elder communities.

Specific objectives:

- ◆ to promote training in all age-related disciplines
- ◆ to promote appropriate research related to regional priorities and facilitate linkages between competent institutions for the translation of research results into training and policy
- ◆ to influence policy development within and between African countries, in liaison with other prominent organisations (e.g. WHO)
- ◆ to promote the health of older Africans through information strengthening, stronger inter-professional linkages, and training and policy networks.

For information contact:
Mrs R Immerman, AFRITA,
PO Box 19, Harare, Zimbabwe
Tel: +263 477 6296. Email:
oak@oakzim.icon.co.zw

How do we develop our specialty to respond to this, and provide an optimum working and training environment?

Much hope has to be pinned on an informal network of effective and independent agencies who, each from its own perspective, seeks to address these challenges, and are staffed by committed and experienced professionals. These agencies include:

- ◆ HelpAge International which champions ageing as a priority development issue.
- ◆ The United Nations Institute of Ageing

(UN-INIA, based in Malta) which, in partnership with AFRITA (see inset), are actively engaged in programmes of 'in context' and interdisciplinary training and research in ageing.

◆ The World Health Organisation (WHO) which, in partnership with the above in January 2000, facilitated Africa's first workshop to define a Minimum Data Set for SSA.

Teaching in its infancy

As this is written, the teaching of Geriatric Medicine in SSA is in its infancy. The only functioning and longstanding academic Department of Geriatric Medicine is in Cape Town. Here we recognise that, in the face of the challenges outlined above, traditional (western) models of service development, delivery and training, cease to be applicable or indeed an option. The thrust of the Cape Town Department is towards innovative development of locally appropriate, resource independent, problem focused and responsive services, paralleled with a clinical training which emphasises interdisciplinary collaboration, teamwork, community and outreach

experience, and bi-directional care. Of necessity this invokes the evolution of new, Africa-specific, approaches to elderly care, but using where appropriate the template of experience and principles of many years of geriatric medicine in the developed world.

Interdependency of ageing disciplines

In SSA one has to recognise the interdependency of ageing disciplines; they cannot survive in isolation as they do, for example, in the UK. In Cape Town geriatric medicine is now coalesced with the related disciplines of gerontology and psycho-geriatrics. This has combined the strengths of each discipline and eliminated an unsustainable reduplication of skills and resources, to form an interdisciplinary partnership which will serve as a model for future geriatric service development in SSA, and respond to and meet all these challenges of Africa in the new millennium.

Adrian Wilson

Professor of Geriatric Medicine
University of Cape Town

GO SOUTH YOUNG (WO)MAN! OPPORTUNITIES FOR SPR TRAINING EXCHANGES IN SOUTH AFRICA

Cape Town hosts the only functioning academic unit of Geriatric Medicine in sub-Saharan Africa. This is set in the context of scenic diversity adjacent to the Atlantic and Indian Oceans, diverse cultures and traditions, and a world class university seated against a backdrop of Table Mountain, where there is a vibrant Medical school with a robust academic programme. Geriatric Medicine has coalesced with Psycho-geriatrics and Social Gerontology into a single integrated entity where the combined strengths of each discipline will be used to promote appropriate service provision and in-context training. Conventional training opportunities from Cape Town Geriatric Medicine include:

- ◆ problem-focused outpatient

clinics: a Memory Service (this is inter-disciplinary), Falls and Syncope Clinic, and TIA/Neurovascular Clinic.

- ◆ satellite, community based, rehabilitation units amounting to some 80 beds.
- ◆ two community based multidimensional assessment units (equivalent to UK Day Hospitals).
- ◆ specialist hospital services e.g. stroke unit, syncope assessment, psycho-geriatrics.
- ◆ acute inpatient assessment beds.
- ◆ outreach clinical assessment.

But the difference is that these services take place in the context of an urban poly-culture reflecting especially African, but also Asian and Western lifestyle and morbidity. Whilst the

problem focused specialty clinics are held in the teaching hospital (Groote Schuur), outreach and multidimensional assessment services are locality based in the most deprived areas, which reflect the unique and specific needs and patterns of African ageing. In addition service links are developing up the east coast at the town of George, in order to stimulate training exchange and provide and disseminate services.

Our main focus of research is in rural and urban Xhosa communities: including the patterns and extent of dementia, stroke and its risk factors, and evaluation of the influence of nutrition, culture and epidemiologic transition in these contexts. There thus exists the opportunity to visit and work in

remote rural areas in the Eastern Cape, and in the urban high density townships of the Cape Flats such as Khayalitsha, Langa, and Hanover Park. This diverse setting will obviously provide unique experience and an additional dimension to any SpR taking up the opportunity of a training exchange.

The unit is staffed by a department head (Professor of Geriatric Medicine), a senior lecturer (Consultant), and a full-time Career Registrar (equivalent to old-style British Senior Registrar) and in addition a rotating Registrar (SpR equivalent) trainee who comes through the unit every four months.

The experience and training opportunities described above match British Geriatrics, yet offer additional specific experience of ageing in the African

context and cultures. All overseas training has first to be assessed on merit from the UK standpoint, and in this regard Cape Town is no exception. It would be up to any potential exchanger to satisfy his or her local training supervisor, Post-graduate Dean and ultimately



Prof Wilson and his multidisciplinary rehabilitation team

the relevant Royal College that experience in Cape Town is accreditable. In practice this should not pose problems: it is in principle a straightforward process, and can be concluded with a minimum of bother.

In conclusion this is an invitation to adventurous SpRs to consider taking up the option of anything between a three and six month exchange, with the Career Registrar at the University of Cape Town in order to obtain complimentary, mutually beneficial, and mutually accreditable experience. Or indeed for any SpR to negotiate with your training supervisor and PG Dean to take accreditable 'time out' within your UK geriatrics training, and enhance your experience, by joining us here for a while.

More information about the University of Cape Town can be obtained

from the UCT website: www.uct.ac.za

And for further information please feel free to contact me at awilson@uctgsh1.uct.ac.za
Tel: +27 21 406 6211
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Getting an abstract accepted by the BGS

Age & Ageing Abstracts Editor, John Gladman, gives his overview of the BGS abstract adjudication process.

Between 150 and 200 abstracts are submitted to the BGS for each meeting. A peer review process is used to assess them. Some members of the BGS Scientific Committee independently score all abstracts. Then the Committee meets and accepts those of the highest scientific standard, rejects those of the lowest standard and discusses the merits of the intermediate group. The

approach taken is to give the benefit of the doubt, especially where there is disagreement between Committee members. This leaves a little over 100 abstracts. Platform presentations are offered to the highest scoring abstracts, provided that the author has not asked to present a poster. In the future, BGS meetings will have some themed sessions and relevant poster presenters may be asked, in advance, to prepare a brief platform presentation for them.

To publish or not to publish?

Publication of the abstract in *Age and Ageing* requires that the abstract is satisfactorily presented either on the platform or as a poster.

Chairmen of platform sessions are asked to confirm that the presentation accords with the abstract. To ensure that the posters are also scrutinised, poster assessors who are experts in their fields are appointed to review the posters at the meeting. If the presentation or poster is significantly different from the abstract then it is not published. If the presentation or poster proves to be of an inadequate scientific standard, it will also not be published. Some abstracts that were 'given the benefit of the doubt' by the earlier triage by the Scientific Committee may be deemed not suitable for publication on these grounds. Minor modification of the abstract is possible for resolution of ambiguities, genuine errors or typographic mistakes. However new data cannot be added and conclusions cannot be altered. Amendments need to be made on the day of the meeting. About 20 abstracts may be deemed not suitable for publication at the meeting, either because they were not presented, were withdrawn by the authors, or deemed unacceptable by the assessors. A similar number are accepted subject to minor amendment.

Reasons for non-acceptance

The Society does not do this to be unpleasant. There is a widespread desire that the BGS should promote high quality scientific research in our speciality. It follows that our published abstracts should be of high standard too. Two steps



John Gladman

forward in this direction have been the use of the structured abstract and electronic submission. Gone are the wordy, unfocussed, crammed offerings of the past. The BGS abstract guidelines encourage good practice and should be followed. However many abstracts that follow the rules for submission are still not accepted; there are many reasons for this.

◆ Presentation of local service data

A number of abstracts are presented by clinicians who have looked at their practice and described what they did or the outcomes of the patients. Typically this involves a retrospective review of some medical records. This sort of activity takes place up and down the country, and is presented at local 'audit' meetings. In those settings it is a worthy activity. It shows that the clinicians are

interested in and thinking about their professional practice, and it may lead on to useful personal or local changes in practice. But such work is not necessarily research, nor does it necessarily warrant publication in *Age and Ageing*. It is important that our trainees do not mistake such activity for research. Research involves testing a hypothesis in a way that allows the findings to be generalisable. There is on-going debate about the place of true, closed loop audit in the BGS Scientific meetings, but there is agreement that the conclusions must be generalisable.

◆ Conclusions that are unsubstantiated by the data presented

This is worrying from a scientific perspective, because it questions the impartiality of the researcher. To avoid this trap, it is helpful to present the findings of studies locally before submitting to the BGS, to help clarify the logic of an argument.

◆ Unintelligibility

This may be for several reasons. Sometimes the attempt to fit the abstract into the word count borrows from the art of telegrapher, with excessively shortened sentences or absurd abbreviations. Sometimes pompous medical jargon is used. Sometimes the grammar and structure of the writing makes it difficult to interpret the work. Authors should work to a deadline that is several days before the deadline for submission, and they should show their abstract to someone who is literate in English. This allows time for corrections. Newcomers to research should not assume that this advice is patronising or unimportant. Proof reading is essential.

◆ 'Salami' abstracts

There may be very good reasons why a single project yields more than one abstract. But in some cases, authors find it difficult to keep to the word limit so they cut their work in two or more thinly pared slices. This results in a number of weak and wordy abstracts, none of which stand alone. A related fault is to submit more than one abstract that refer to each other. If one is rejected, the other then becomes impossible to interpret.

The Scientific Committee sends out a letter giving reasons for rejection to every author

whose abstract is not accepted. These are intended to be educational. Sometimes re-submission is actively encouraged. This 'formative' approach is also taken at the poster sessions at the Scientific meetings.

Rough justice

This process is not infallible. Each abstract can only be considered briefly. Scientific Committee members are not experts in every field embraced by the Society. The abstracts are blindly marked at the Committee stage but it is sometimes possible to identify the authors. Poster assessors cannot be blinded. Members of the Scientific

Committee have had abstracts from their own teams rejected during this process and the poster assessors have not shied away from rejecting submissions from the great and the good. The Committee and assessors are keenly aware of their responsibilities. In the end this peer review process is 'rough justice' – it is rough, but it is broadly just.

John Gladman

Age & Ageing Abstracts Editor
Senior Lecturer in Geriatric Medicine
Nottingham University

ABSTRACT DEADLINE FOR BGS AUTUMN MEETING: 1 JUNE 2000

THANK YOU!

Poster assessors

The smooth running of the BGS Spring and Autumn Meetings relies in part on the willingness and hard work of members who give of their own free time to act as assessors of abstracts, posters and oral

presentations. Thank you to all our volunteers - your help is much appreciated!

BGS grants & prizes

We would also like to thank all the BGS members who have helped us to

adjudicate the various grants and prizes the Society awards. These include the Dhole Bursary, Specialist Registrar Start-Up Grant, Amulree Essay Prize, Medical Students' Elective and Vacation Project Award and Eli Lilly Travel Award.

DHOLE BURSARY - INCREASE IN AWARD

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

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

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

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

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

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

Deadline for applications: 14 December 2000

BUSSE RESEARCH AWARDS

Promoting the international research in gerontology, two Busse Research Awards will be given at the XVIIth World Congress of the International Association of Gerontology in Vancouver in July 2001. Two gerontologists (junior or mid-career) will be selected. One award will recognize

a scientist from the social/behavioural sciences; the other from the biomedical sciences. Awards are \$5000 each, with up to \$3000 travel/living expenses. Awardees must present a lecture based on their research at the conference. Deadline for receipt of applications: 15 October 2000.

Contact: Harvey Jay Cohen, Busse Research Awards, Center for Aging, Box 3003, Duke University Medical Center, Durham, NC 27710, USA. Tel: +1 919 660 7502. Fax: +1 919 684 8569. Email: betty.ray@duke.edu. Website: www.geri.duke.edu/busse/busse.html

STROKE ASSOCIATION RESEARCH PROJECT AWARDS

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

Prof S Ebrahim, University of Bristol. '*Does stress cause stroke? An examination of psycho-social factors in the Caerphilly and Speedwell cohorts*'. £44,880 for one and a half years.

Dr P Langhorne, University of Nottingham. '*An individual patient*

data-meta analysis of community occupational therapy trials for stroke patients'. £12,081 for one and a half years.

Dr A Lehman, University of East London. '*Exploration of the use of leisure centres to provide a community based physical exercise programme after stroke*'. £48,437 for one year.

Prof J Young, St Luke's Hospital, Bradford. '*Development of a primary care based service for stroke aftercare*'. £174,512 for three years.

Apology

In the February Newsletter we erroneously omitted the name of Dr G Ford of Newcastle University from the credits for the project '*The role of cervical auscultation in the prediction of aspiration*'. In addition, we wrongly inferred that Prof D Barer had a clinical attachment at the Freeman Hospital in Newcastle; he is in fact based at Queen Elizabeth Hospital in Gateshead. Our apologies to both Dr Ford and Prof Barer for our mistake.

TEACHING GERIATRICS STUDY

The Teaching Geriatrics in Medical Education study (TeGeME) is a collaboration between the WHO Ageing and Health Programme and the International Federation of Medical Students' Associations. The main aim of the study is to gain insight of how/if ageing issues, old

age care and geriatric medicine are incorporated into the medical curriculum world-wide. Therefore, a questionnaire is distributed to a collaborating medical student at all medical schools in around 40 countries. WHO will use the information to raise awareness about

the importance of developing appropriate teaching modules in geriatrics and pointing out the deficiencies identified.

For more information contact Ingrid Keller at WHO/HPS: kelleri@who.ch Tel: +41 22 791 3448.

SENIOR LECTURER, UNIVERSITY OF WESTERN AUSTRALIA

A 5 year post from July 2000, at Royal Perth Hospital. Applicants must have a primary medical qualification registrable in Western Australia, Fellowship of the Royal Australasian College of Physicians or equivalent. The position involves clinical service, research, undergraduate and postgraduate teaching. Considerable experience in geriatric medicine, research and commitment to teaching are essential.

Research interests within the department include cognition in older people, osteoporosis, health services for older people and the effects of ageing generally.

Contact: Prof Leon Flicker on tel: + 61 8 9224 2750, fax + 61 8 9224 2063, email: leon.flicker@rph.health.wa.gov.au or Prof Lawrie Beilin on tel: + 61 8

9224 0258, fax: + 61 8 9224 0246, email lbeilin@cyllene.uwa.edu.au Website: <http://jobs.uwa.edu.au/>

Applications including teaching portfolio if applicable and quoting reference number A10/20, with the details of three referees should reach the Director, Human Resources, University of Western Australia, Nedlands WA 6907, by 26 May 2000.

GENETIC RESEARCH ON AGEING

The Harvard Medical School, Children's Hospital and the Beth Israel Deaconess Medical Center, all of Boston, MA, are conducting genetic research studies on ageing. We are looking for genes that enable some people to delay or escape diseases in old age.

We are recruiting the following:
 1) Individual centenarians who do not have living brothers or sisters aged 90 or older.
 2) Individuals aged 98 and older and their living brothers or sisters who are at least 90 years old.

We collect health and family history information, and a small blood specimen. People from anywhere in the world can participate and travel is not necessary. Participation is free of charge.

If you feel you may be able to help in the recruitment of volunteers please contact Louis Kunkel, or Stephanie Brewster, tel: + 1 617 355 5312 or email: sbrewster@rascal.med.harvard.edu

OSTEOPOROSIS RESEARCH

'Osteoporosis and Nutrition in Elderly Women'

The Department of Chemical Pathology at St Thomas' Hospital is working on this study investigating whether protein/calorie supplements may be a feasible and cost effective way of preventing bone loss and disabling fractures in frail, undernourished women over 70 living in the community. They are hoping to recruit another 100 ladies for this study.

If you feel you may be able to help in the recruitment of volunteers or would like more information, please contact: Bonnie Peterson, Clinical Research Nurse, 5th Floor, North Wing, St Thomas' Hospital, London, SE1 7EH.
 Tel: 020 7928 9292 ext 6903.

MSc IN REHABILITATION

Certificate, Postgraduate Diploma and MSc in Rehabilitation

University of Nottingham, Rehabilitation Sciences Network

Multi-disciplinary courses teaching research skills relevant to rehabilitation.

Core modules: scientific foundations of rehabilitation, clinical reasoning and research design and analysis.

Optional modules: the evidence base for such topics as manual therapy, rehabilitation medicine, stroke, learning disability, cognitive assessment and cognitive rehabilitation.

Contact:
 Janet O'Flynn, Ageing and Disability Research Unit, Queen's Medical Centre, Nottingham, NG7 2UH. Tel: 0115 970 9408.
 Email: janet.o'flynn@nottingham.ac.uk
 Website: www.nottingham.ac.uk/rehab/msc/htm

STROKE GUIDELINES

National Clinical Guidelines for Stroke

The Royal College of Physicians recently published national guidelines prepared by the Intercollegiate Working Party for Stroke.

As a service to medicine Boehringer Ingelheim has offered to supply complimentary copies of the concise guide to any interested parties.

Contact: Dorothy Tuffley, Boehringer Ingelheim Ltd, Ellesfield Avenue, Bracknell, Berks, RG12 8YS.
 Email: tuffleyd@bra.boehringer-ingelheim.com

PURCHASE OF PREMISES - OUR NEW HOME

As members will already know, we have been planning for some time to purchase premises for the BGS administrative office and as a base for committee meetings.

We have now found a suitable property, situated in the Clerkenwell area of London, within easy reach of several mainline railway stations.

An extraordinary meeting of Council was held on 14 April, at which the purchase was formally

approved and we have now exchanged contracts with the vendor.

There are still some contractual issues to be finalised and building work to be carried out, but we are hoping to be able to move in the early summer.

A full report on the premises and the financial implications will be included in the next Newsletter.

GERONTOLOGICAL SOCIETY OF AMERICA

53rd GSA Annual Meeting

Washington DC, USA

17-21 November 2000

A multi-disciplinary meeting on ageing research with 350 scientific sessions, 32 interest groups and pre- & post-conference workshops.

Topics include: Alzheimers' Disease, caregiving, death & dying, dementia research, depression, ethical dilemmas, gender issues, productive ageing, improving patient-provider interaction.

Call for papers: on GSA website.

Contact: The Gerontological Society of America, 1030 15th Street, NW, Suite 250, Washington, DC 20005-1503, USA.
Tel: +1 202 842 1275.
Email: geron@geron.org
Website: www.geron.org

INTERNAL MEDICINE

European Federation of Internal Medicine - 3rd Congress

Edinburgh

9-12 May 2001

Abstract deadline: 30 November

Contact: EFIM 2001, c/o AKM Congress Service, PO Box, 4005 Basel, Switzerland. Tel: +41 61 686 7711. Email: info@akm.ch
Website: www.akm.ch/efim

INFLUENZA

Options for the Control of Influenza IV

Hersonissos, Crete

23-28 September 2000

Topics include: vaccines, public health and economic impact, epidemiology and surveillance, animal influenza.

Grants for young scientists: residual funds from a previous conference will be used to support a number of young scientists to present papers.

Contact: BIOMEDIA, 101 rue Mademoiselle, 75015 Paris, France.
Tel: +33 1 4219 0024. Email: options4@wanadoo.fr

PARKINSON'S DISEASE CONFERENCE

Parkinson's Disease - from science to practice

Royal College of Physicians, London

20 July 2000

A one day multi-disciplinary conference aimed at geriatricians, neurologists, therapists and nurses.

Topics include: falls & postural instability and the management of nocturnal problems.

Abstract deadline: 31 May 2000

Contact: Medical Education Partnership, PO Box 22096, London SW2 1GD. Tel: 020 7349 5072. Fax: 020 7351 4053.
Email: info@mepuk.com

STROKE CONFERENCE

Consensus Conference on Stroke Treatment & Service Delivery

Royal College of Physicians Edinburgh

7-8 November 2000

An update meeting to look at any new evidence since the 1998 Consensus Conference on Medical Management of Stroke and also to address key issues regarding the treatment and delivery of stroke services throughout the UK.

Key questions: What is new in medical treatment? Who to admit and when? How should hospital care be organised? Where should rehabilitation take place - hospital or home? Can we reduce the emotional impact of stroke?

Fee: doctors £200; PAMs, nurses and others: £125

Abstracts are invited for poster presentation.

Contact: Margaret Farquhar, Royal College of Physicians of Edinburgh, 9 Queen Street, Edinburgh EH2 1JQ. Tel: 0131 225 7324. Fax: 0131 220 4393.
Email: m.farquhar@rcpe.ac.uk

HEALTH CARE MODELLING

St George's Hospital & Medical School

Healthcare Modelling Website

The website has been updated.

Modelling website: www.sghms.ac.uk/depts/gm/index.htm

Modelling base: p.millard@sghms.ac.uk

CONTINENCE COURSE

The Leicester Continence Training Course for Specialist Registrars

Leicester General Hospital

6-8 November 2000

This non-resident course will provide an overview of what is new and relevant to continence issues, with an emphasis on clinical and practical management. Course director: Prof Mark Castleden. Course coordinator: Dr Nelson Lo.

Topics include: setting up and running a continence clinic; community continence service; urodynamic equipment, investigation and interpretation; management of incontinence - physiotherapy, surgical and medical approach.

Numbers: limited to 30 places

Fee: £350

Contact: Dr Nelson Lo, Department of Medicine for the Elderly, Leicester General Hospital, Gwendolen Road, Leicester LE5 4PW. Tel: 0116 258 4048. Fax: 0116 258 8169.

MEDICAL ETHICS SIG

Medical Ethics SIG meeting

Northern General Hospital, Sheffield

8 June 2000

Topics to include: advance directives, end of life decisions, ethical issues in gerontological research and publishing.

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

'HEALTH OF THE OLDER PERSON'

Health of the Older Person

William Harvey Hospital, Ashford

26 September 2000

Topics include: Parkinson's Disease, nutrition, terminal care.

Speakers include: Prof A Sinclair, Dr B Beates, Dr A Heller, Dr M Ring, Dr A Ferguson, Dr D Seamark, Dr A Smith.

Contact: Dr David Smithard, tel: 01233 616214 or email: david.smithard@msmai.skhr.stham.es.nhs.uk

PGEA applied for. CME: 5.5 hours

PARKINSON'S DISEASE SIG

The Parkinson's Disease SIG is currently updating its database of members. Many people have changed addresses, phone numbers or aquired email addresses. If you are/were a member or wish to become a member, please contact Dr Hindle so that the SIG can update you on its activities and send you the newsletter.

Contact: Dr J V Hindle, Llandudno General Hospital, Llandudno, Conwy, LL30 1LB. Tel: 01492 862366. Fax: 01492 876973. Email: jvhindle@globalnet.co.uk

MERSEY/NORTHWEST REGIONS

Millennium Meeting - the Giants of Geriatrics revisited

Haydock, Merseyside

21 June 2000

Contact: Dr T Smith, St Helens & Knowsley Hospitals, Prescot, Merseyside, L35 5DR. Tel: 0151 430 1245. Email: daintysmith@hotmail.com

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