

## Geriatric medicine: the Wirral experience

Gavin J Francis and James Barrett

### Gavin J Francis

MB MRCP,  
Consultant  
Physician in Acute  
and Geriatric  
Medicine

### James Barrett

MD FRCP, Professor  
of Healthcare of  
the Elderly and  
Consultant  
Geriatrician

Wirral University  
Teaching Hospital  
NHS Foundation  
Trust

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Since the birth of geriatric medicine in 1935 the role of the specialist physician in the healthcare of the older person has developed beyond recognition. The range of practice has always been wide; the last decade has, however, seen it reach its greatest diversity. There have also been many challenges within this diversification. Maintaining the historical role of the consultant geriatrician while adapting to the changing world of healthcare provision for the older person has perhaps been the primary challenge. Within the specialty debate has continued, even regarding the name we call ourselves, while the continuum from geriatric medicine through general medicine to acute medicine has become increasingly travelled.

### Demographic change and a changing role

Throughout the developed world the population is ageing, the proportion of the very elderly is growing, and the application of health technology to an increasingly aged population has become a norm. The social, societal, and healthcare demands of dependent, institutionalised individuals are now at their greatest. Today the UK population aged over 65 is approximately 17%, of which those over 80 account for 4% of the total population.<sup>1</sup> In the Wirral Hospital's acute medicine unit (AMU), patients over 73 years of age account for 44% of the total.<sup>2</sup> It is therefore hardly surprising that the care of the older person is becoming the core role of the NHS and this is reflected in geriatricians forming the largest specialty group within the Royal College of Physicians (RCP).

Models of geriatric medicine provision vary immensely dependent on geography and resource. Independent of this, over the past six decades there has been a nationwide shift in the role, manner, and even place of practice of the specialty. In the early decades most geriatricians practised outside the acute hospital setting. From the original workhouses, geriatricians then managed long-term care and rehabilitation facilities, as well as admitting patients for onward care in subacute settings often geographically separate from acute hospitals. During the 1980s as the generalist skills of the geriatrician became increasingly recognised, and with government policy closing many NHS long-term care facilities, geriatricians 'came in from the cold', increasingly establishing units

in acute hospitals and significantly contributing to the acute unselected emergency take.

This period also saw the development of subspecialty interest and service, latterly target driven by the National Service Framework for Older People.<sup>3</sup> Stroke medicine, movement disorders, falls, continence, and orthogeriatric medicine are today well-established core geriatric roles.

### The future challenge

In this new millennium geriatric medicine again meets further challenges to the historical role of assessing and treating the medical and rehabilitative needs of older people, by multidisciplinary comprehensive geriatric assessment of the health and social needs of patients. Three main themes highlight the current challenges to the specialty:

- the significant expansion of community-based care, out-of-hospital rehabilitation, and intermediate care
- the maintenance and development of high quality subspecialty service provision in a resource hit NHS
- the exponential year-on-year rise of unplanned emergency work involving elderly, often frail, patients with complex comorbidity, and social and rehabilitative needs – acute geriatric medicine.

### The shift to the community

The past decade has seen a phenomenal increase in the availability of community-based rehabilitation and intermediate care units, plus a growth of early supported discharge schemes for stroke, chronic obstructive pulmonary disease (COPD), and deep vein thrombosis (DVT) to name a few. These may or may not have consultant geriatrician input and the need or not for this input is widely debated among enthusiasts and critics. A Federation of Medical Royal Colleges report published in 2002 identified a lack of specialised medical input as being one of the reasons why intermediate care has not developed in the way originally envisaged.<sup>4</sup>

A net result of this expansion has been a decrease in hospital-based geriatrician-led rehabilitation, a

reduced bed base, and resultant increased geriatrician time free for other service. The subspecialty of community geriatric medicine has not expanded in pace with the shift of care to the community. Whether this is due to lack of resource or professional enthusiasm can be debated. Only 12% of current consultant time is devoted to community-based work and, worryingly for the future, only 14% of current consultants wished to do more. Six out of 10 current specialist registrars reported community-based work holding the least interest for them.<sup>5</sup>

Of course the divide between community and hospital-based care is an arbitrary one, and certainly one frequently traversed by patients, often on several occasions during the one illness episode. Managing this interface is a key skill of the geriatrician, but it is not the only way they have positioned themselves at the sharp end.

### Acute general medicine

Geriatric medicine as a specialty contributes more to acute/general (internal) medicine than any other specialty within the RCP.<sup>6</sup> The year-on-year increase in unplanned medical attendances has previously been mentioned. The ageing population with multiple comorbidities contributes a significant number of these and this, along with increased community resource, perhaps makes this aspect of acute healthcare delivery the greatest current challenge for the geriatrician. The increasing volume of acute medicine has been embraced by geriatric medicine with 53% of consultant respondents and 73% of specialist registrar respondents to a British Geriatrics Society survey wanting to maintain or increase geriatric medicine input to the acute take.<sup>5</sup>

Within the AMU at the Wirral Hospital, two consultants out of a total staffing of three consultants and one associate specialist are geriatricians. In addition to this the Department of Medicine for the Elderly also provides six additional consultant programmed activities based on our clinical decision unit (CDU)/medical admission unit (MAU). Out of 25 clinical acute medicine programmed activities 16 are thus delivered by geriatricians.

Anecdotally increasing numbers of new certificate of completion of training holders in geriatric medicine are opting to take posts with a high weighting towards, or almost completely within, acute medicine. This trend is likely to be reinforced as the number of available consultant posts in geriatric medicine falls as a result of a reduced bed base and ever tightening financial restraints facing NHS trusts.

Future developments in the geriatric medicine higher training curriculum are expected to reflect this. In a new modular curriculum acute medicine as a subspecialty interest may rank alongside our more traditional interests of, for example, movement disorders or falls. Future specialty training (ST) year 3 to year 7 trainees in geriatric medicine will thus be allowed to reach level 3 competence in acute medicine and state this as their subspecialty interest or assume consultant posts in acute medicine. This is rightly so, because not only is the number of emergency attendances of patients over 65 rising annually, but many even outside this age present with age-related needs or areas traditionally seen as the domain of the geriatrician.<sup>6</sup> Often inter-

twined with this is a loss of independence or functioning set in the context of complex social support systems.

Timely assessment of such patients by a specialist in elderly medicine proves invaluable in delineating a management strategy which may involve emergency admission, transfer to hospital-based rehabilitation, redirection to community rehabilitation, early supported discharge or social services transitional care, all with or without prompt specialist review in an outpatient setting.

Greater emphasis on this approach has occurred not only because it is good practice, but also because of increasing pressure on the number of beds, better availability of community support schemes, the 98% four-hour accident and emergency department access targets, and also Payment by Results (PbR) meaning that hospital time and resource must be efficiently used. One could argue that it will be the geriatricians and the acute medicine physicians, who will make or break trusts financially under PbR. This requires skilled emergency assessment, avoiding inappropriate admission, with clear further management, redirection to the community service and, importantly, timely discharge.

### Acute stroke care and the Wirral model

Geriatricians are not only providing greater input to acute work – 30% of geriatricians did unselected acute medicine in 1995 rising to 88.6% in 2000<sup>6</sup> – but the way by which this is provided has also altered in many ways. An obvious example is acute stroke care which within the UK is geriatrician led.

Thrombolysis for acute ischaemic stroke within three hours of onset is a recognised therapy. Geriatricians are leading in the implementation of stroke thrombolysis. Sadly in the UK even the most proactive units only thrombolysed under 2% of ischaemic strokes which is significantly lower than a similar group in Australia. The Wirral unit currently offers this treatment only during working hours, but within the next 12 months envisages round-the-clock consultant geriatrician-led routine thrombolysis, placing the specialty at the sharp end of delivery of this new treatment modality.

The need for the expertise of geriatricians at the sharp end is beyond argument, but how does this translate to what is happening on the ground. The unit in Wirral is a good example of how we have responded to this shifting need. Wirral Hospital is one of the largest district general hospitals in the UK and has recently received teaching hospital status from the University of Liverpool. It serves a population of approximately 375,000 with a particular skew to the elderly. The hospital has a comprehensive range of acute services. The Department of Medicine for the Elderly is a large unit consisting of 10 consultants with a full compliment of trainees at all levels. Each consultant has a general practice plus subspecialty interest including stroke, movement disorders, cardiovascular disease, orthogeriatric medicine and community care. Academic lead is directed by the Chair of Healthcare of the Elderly at Liverpool John Moore's University.

There is an acute stroke unit among 160 acute beds and 80 rehabilitation beds. The AMU consists of three consultant

physicians plus an associate specialist and a further whole time equivalent (WTE) specialist supplied from the Department of Medicine for the Elderly. Junior staffing includes support from trainees at foundation level and ST1 to ST7, including a trainee from the Mersey acute medicine training scheme. Medical attendances number 55 to 80 per day. This is divided into two – ‘unders’, including patients aged 73 and under, and ‘overs’ consisting of patients 74 and over. The unders take is led by a consultant physician from one of the specialties while the overs take is led by a consultant geriatrician.

Each team consists of one ST3 to ST7, two foundation year (F)2 or core medical training doctors and one F1 doctor. Ward cover is provided by two further F1 doctors with support as above. Doctors below ST3 rotate through an ‘acute medicine block’ constituting a five- to eight-week period in every six months and working shifts in acute medicine during that time. Trainees alternate between unders and overs providing exposure through the complete age range. Outside of the acute medicine block, trainees work on specialty wards.

All medical admissions are assessed on the 27-bed CDU apart from the critically ill who are assessed and stabilised in the emergency department before being directed to a critical care area. Patients who are low risk requiring cardiac assessment are admitted to the heart assessment unit (HAC) with twice daily cardiology review.

Every admission is seen by a foundation programme doctor or core medical trainee on CDU before being reviewed by a consultant or ST3 to ST7 trainee. The rota is such that staffing reflects demand – the evening peak on CDU has 10 doctors of which two are ST3 or above, and two consultants. On senior review patients are triaged to a specialty ward or are admitted to the 41-bed MAU particularly geared to those with potential for a brief admission, those requiring rapid assessment, or patients requiring stabilisation of acute physiological disturbance but who do not require critical care, for example diabetic ketoacidosis, sepsis or hypovolaemia. The CDU/MAU has consultant cover 9 am to 8 pm Monday to Friday with sessional weekend cover imminent. Of the sessions, 60% have consultant geriatrician cover.

Wirral Hospital has preserved and emphasised the need for a full post-take ward round where every admission receives consultant review within 24 hours. This is divided into four consultant lead rounds: two on MAU led by the consultants in acute medicine and two on the wards led by the unders and overs consultant physician/geriatrician. Doctors in training rotate between these. Such a comprehensive post-take ward round guarantees that the training needs of the juniors are enhanced while ensuring timely high quality consultant delivered care.

The geriatricians providing acute physician sessions undertake a key role in prompt assessment of the older person. Wirral Hospital has developed an extensive network of alternatives to admission. In providing rapid senior assessment by a specialist in acute medicine or elderly care a significant proportion of attendances to the CDU can be dispatched to areas other than hospital admission. Some of these alternatives are geriatrician led such as our rapid access transient ischaemic attack service with daily consultant-led cerebrovascular clinics provided by

three stroke physicians plus two vascular surgeons with one-stop carotid doppler ultrasound. Other services have geriatrician input such as intermediate care where two of our geriatricians have an interest.

Other valuable admission alternatives include the domiciliary intravenous antibiotic service and early supported discharge for COPD plus the community-based DVT service with daily doppler ultrasound in the cardiovascular department.

The geriatrician’s role on the Wirral CDU/MAU is further enhanced by a WTE occupational therapist and physiotherapist. Initial admission to MAU overnight for their input in those presenting with functioning or mobility issues is thus possible combined with a comprehensive one-hit senior medical assessment. Patients are then directed to acute admission for the ill, redirected to intermediate care, or discharged home with equipment or support forming the ‘acute single assessment process’. The process of discharge is further enhanced by three emergency medicine clinics per week with rapid access plus timely specialist review in a variety of clinics arranged through our local Choose and Book facility. These links are closely developed.

## Our ethos

Geriatricians often regard themselves as among the last true generalists, maintaining a high level experience, training and practice in a broad range of singular or coexisting pathologies. Additionally they have significant experience in community medicine and a key understanding of institutional care, community support services, and rehabilitation. Geriatricians are well practised in multidisciplinary working without which acute medicine fails. This includes liaison between physicians of different medical specialties but also with therapists, residential care staff, social workers, general practitioners and community pharmacists to name a few. These skills among others have seen the Wirral MAU discharge rates average over 35%.<sup>2</sup>

Future roles of the acute geriatrician will further emphasise our traditional comprehensive holistic assessment, management of the seriously ill, greater involvement in deflection to more appropriate settings plus providing subspecialty input. Other potential roles might include enhancing the community matron role as this is rolled out across England. Education will also predominate as the foundation programme places greater emphasis on core competencies and managing the critically ill. Where better is this served than within acute medicine led by a generalist? We must also lead in the training of tomorrow’s acute physicians emphasising the core values of geriatric medicine and our holistic assessment.

Geriatric medicine has always been a specialty to embrace change and develop to meet the ever evolving medical world. We now grasp the challenge of acute medicine with vigour and look forward to our next direction of practice.

## References

- 1 Grimley Evans J, Franklin Williams T, Lynn Beattie B, Michel JP, Wilcock GK. *Oxford textbook of geriatric medicine*. Oxford: Oxford University Press, 2003.

- 2 Admissions data from the acute medicine unit. Wirral Hospital, 2005.
- 3 Department of Health. *National Service Framework for Older People*. London: DH, 2001.
- 4 Federation of Medical Royal Colleges. *Medical aspects of intermediate care*. Report of a working party. London: Royal College of Physicians, 2002.
- 5 British Geriatrics Society. Consultant and specialist registrar survey. January 2004.
- 6 England Council of British Geriatrics Society. *The challenge of consultant geriatric medicine in England*. London: England Council of British Geriatrics Society, 2005. [www.bgs-england.org.uk/CurrentIssues/ConsultantChallenge.htm](http://www.bgs-england.org.uk/CurrentIssues/ConsultantChallenge.htm)