The general practitioner and the geriatrician

A joint study day was held at the Royal College of General Practitioners on 22 January 1975, which was organised by the Royal College of General Practitioners and the King Edward's Hospital Fund for London King's Fund Centre.

Dr N. C. Mond welcomed the 75 participants, saying it had seemed logical to widen the discussion to include 40 general practitioners, 14 geriatric physicians, and a variety of interested people and voluntary organisations, with the purpose of examining the problems experienced in the care of the aged sick.

The Chairman was Dr Harry Levitt, *O.B.E.*, who introduced the four speakers for the morning session.

Mr D. Hobman, Age Concern, spoke on ' Who Cares? '

Sheltered housing had been hailed as the panacea, but schemes today compared badly with the almshouses of old. The nature of deprivation changes: a sound middle-class economy presupposes that the aged can 'phone the doctor before 0900 for an appointment, and can tell their doctor their multiple problems and fears in a five-minute appointment. Research should be carried out into the causes of deprivation today, studying the life-style and the factors it is based on.

In relation to the health services the relationship to the doctor is fundamental, but doctors are hospital orientated. Will a community orientated system be able to do more? Personal contact, without intrusion, should be the aim. The doctor may be the best person to organise investigations and provide reassurance, but is he or she adequately equipped to deal with all the at least 20 options? The patient is likely to say she didn't want to trouble the doctor, as was shown in one of the studies carried out by Age Concern. Doctors ought to play their part in helping to involve our society in efforts to improve the life-style of the elderly, and could contribute to the health councils, providing information, and keeping in touch with the whole range of social benefits becoming available. Age Concern is preparing a manifesto on the rights of the elderly and seeks the doctors as allies, in advancing changes in attitudes, and encouraging self-help within the community. Over-protectiveness was also a danger.

Professor M. Hall, University of Southampton, spoke on ' Caring in the Community '

The doctor has more roles than just that of interaction between patient and doctor. Many admissions of the elderly are categorised as ' social admissions ' or the social breakdown syndrome. This may be due to physical, mental, or social disability, and it is difficult to break the cycle leading to adoption of the ' sick role '.

Community care means supplying the basic needs of health, emotional security, social involvement, and a purpose in life. The key to good community care lies in providing services to enable people to help themselves and each other. This can be achieved by educating first undergraduates in the process of ageing, and so changing attitudes to old age.

The geriatric problem would be considerably reduced if male mortality could be reduced. Industry and the unions should study this question urgently. The formation of self-help groups could help many of those with chronic brain failure to be maintained in the community. Finally, there is the need for health, not only through health education, but also the use of all geriatric services should be known to the health team. In Southampton geriatric physicians have been holding outpatient clinics in health centres and group practices, and these experiments have proved their value.

Dr T. Arie, Goodmayes Hospital, spoke on ' The Psychogeriatric crisis '

It was important to consider not only the population dimension, but to relate it to the individual clinical crisis that occurred at 0200 hours. He held it to be the greatest challenge to medicine for the last quarter of a century. There are more than 6½ million aged, who are the biggest consumers of the health and social services, occupying nearly half the health service beds, and

the biggest users of the general practitioners' services. Brain failure, or dementia, occurred in about a fifth of those over 80. Yet, a survey carried out in Edinburgh showed the confusional state was the least likely to be known to the general practitioner. Dementia was the commonest condition leading to institutional care, often following distressing night calls.

In psychogeriatric work, every decision was permeated with the population dimension. The frequent clinical crisis arose with emotive words to emphasise urgency, but was used to enforce action, especially when the family had guilt feelings or felt unable to cope any longer. Preventing such crises depended on maintenance, planned in advance, for those in the vulnerable group, and was needed round the clock such as could be given by a teenager, or neighbour. On either side were the alternatives of community care through the statutory or voluntary services. The hospital, to which the patient may have to be admitted because of the crisis, may have inadequate resources of beds and staff, and be isolated from the mainstream of medicine. Such shortcomings could lead to adverse criticism, with failure of recruitment setting up a vicious circle. The psychogeriatric problem is a community problem and community physicians can share in its preventive aspects.

Dr K. Thompson, Croydon, gave ' A View from General Practice '

The general practitioner was well aware of the factors that transmuted the elderly person into the geriatric patient, but the geriatrician often remained encapsulated, spending half his time on administrative duties, and visiting the elderly patient at home alone. We should see what could be done about changing the patient rather than the environment. An old lady might benefit more from having a thyroid scan than a home help. The team approach certainly provides opportunities for programmes of preventive care, but education in the clinical aspects of ageing is lacking in the pre-clinical and clinical stages of medical training, and postgraduate courses seem to be attended by the converted. He described his own at-risk register of some 140 patients given an annual health check, and claimed as a result a reduction in the number of geriatric tragedies, so that acute retention, decompensated mental failure, drug intoxication and fractured femur had become rare occurrences. Thus general practice could emerge from the slavery of symptom-orientated demand. It would be justifiable for doctors to earn the right to a special fee for this type of examination.

But there was more to helping the aged patient than the traditional diagnosis and treatment of his illness. Before a primary care team could be functional much indoctrination was often needed, while it was unpredictably fragile when disrupted by marriage, pregnancy, and retraining programmes among its female members. Early diagnostic certainty can allow for future planning and management, but complete restoration of health and strength is unusual in this age group in which a therapeutic triumph may precipitate a domestic upheaval. Health education for old people and their principal helpers was important and much appreciated, but self-help groups must develop beyond the ventilation of grievance and progress to formal training in practical techniques of nursing care. The present financial crisis should make us look more carefully towards the idea of the ' hospital at home ', so successful in Paris, but which also represents a great annual economy.

The afternoon session was devoted to group discussion of the questions:

(a) Should geriatrics be included in the medical curriculum and if so, at what stage, where, and by whom should it be taught?

(b) What steps should be taken by the district health care planning teams to improve the identification and assessment of old people at risk through disease or disability?

(c) What is normal for old age? Could co-ordination and co-operation of general practitioners with particular interest in the subject produce valuable information for the planners?

(d) Is the problem of dealing with mental disorder among the aged becoming unmanageable and causing serious disorganisation in the health and welfare services?