AN INTRODUCTION TO GERIATRICS

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BAILLIÈRE, TINDALL & CASSELL
London

BAILLIÈRE, TINDALL & CASSELL, LTD
7 & 8 Henrietta Street, London W.C.2

First published 1965

Printed in Great Britain by
Morrison and Gibb Ltd., London and Edinburgh

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PREFACE

Conversation, wrote Oliver Wendell Holmes, depends on how much can be taken for granted. The author of a book on geriatrics is particularly concerned about how much prior knowledge of the subject he can expect in his readers. No matter how geriatrics is defined—and this subject is debated early in the book—much of its day-to-day content is general medicine. In addressing this book to senior medical students, junior hospital doctors and general practitioners working in hospital geriatric units, I have assumed that my readers know their general medicine, and are not looking to this book for descriptions of conditions with which they are familiar from ordinary medical practice, and which they can read about in medical textbooks.

Although such conditions may be encountered daily in the geriatric ward, I have concentrated instead on subjects which are a distinctive part of the work of a geriatric unit but which are less often met with or discussed in general medical wards, and about which most medical textbooks are silent. Much of the subject-matter is clinical, but I have included an account of those aspects of the social medicine and psychology of old age which are essential to the hospital doctor. The specialist will wish to know a great deal more than is to be found here, but there is a rich literature on these subjects available to him.

The principle I have followed is to deal at greatest length with those subjects which most bewildered me when I made the transition from general medicine to geriatrics. In such a large field a small book must be selective, and I can only apologize for the inevitable omissions.

Geriatrics is too young a subject to have developed its own orthodoxy, and I am acutely conscious that my ideas about what

is important and what is correct are not necessarily shared by others.

This book developed out of lectures delivered annually since 1961 at the introductory postgraduate courses in geriatric medicine which have been held at Foresthall Hospital, Glasgow, under the auspices of Glasgow Postgraduate Medical Board. These courses were directed by Dr W. Ferguson Anderson, Adviser in Diseases of Old Age and Chronic Sickness to the Western Regional Hospital Board, Scotland. To Dr Anderson I owe my training in geriatrics and the opportunity of working in the admirable geriatric service which he has created. I deeply appreciate all I have learned from him of the technical and organizational aspects of geriatric medicine and, more important, of the fostering of a spirit of co-operation and loyalty among people from different disciplines who come together with the common purpose of improving the lot of the elderly. Geriatrics in general, and this book in particular, owe an immense debt to Dr W. Ferguson Anderson.

Since this book was written two changes have taken place which require notice. One is the appointment of Dr Anderson to the David Cargill Chair of Geriatric Medicine in the University of Glasgow—an honour which gives great pleasure to all his friends and colleagues. The other is the decision of the Institute of Hospital Almoners to change the title of their members to Medical Social Workers.

I wish also to pay tribute to the many colleagues with whom I have been privileged to work and from whom, through discussion and exchange of ideas, I have formulated many of the concepts elaborated in these pages. These include my medical associates, Drs F. A. Walkey, J. Pritchard and A. M. P. Thomson of Foresthall, and Dr R. Davidson, Psychiatrist, of Woodilee Hospital, Glasgow. No less valuable has been the help obtained from my non-medical colleagues, particularly Miss M. Mackenzie, Almoner, Mr A. Farquharson, Superintendent Physiotherapist, and Mrs M. Bincer, Occupational Therapist, all of Foresthall Hospital, Glasgow, and the innumerable resourceful and kindly members of the nursing staff of the various hospitals with whom

I have been privileged to work. Many other medical friends from Glasgow and elsewhere have contributed to the development of my ideas by their published and unpublished observations. In the interests of easy reading I have included no references in the text, but those familiar with the geriatric literature will have no difficulty in detecting the sources of many ideas expounded here.

My special thanks are due to the following who so kindly read and criticized the manuscript: Miss C. Henderson, Mr Andrew Atkinson, and Drs John Brocklehurst, Robert Davidson, Alastair Marshall, Ian Melville and Thomas J. Thomson. I also wish to pay tribute to my wife for typing the manuscript and for helping me in so many other ways.

I am indebted to Mr Walter Atkinson for the illustrations which he prepared specially for this book; several of his drawings were taken from material kindly supplied by the following: Dr John Thompson (Figs. 11, 12 and 13); Zimmer Orthopaedic Ltd. (Figs. 8*a* and *b*, and 9); Stanley Cox Ltd. (Fig. 4); and New Equipment Ltd. (Fig. 6).

Lastly, I should like to thank Baillière, Tindall & Cassell, Ltd., for the help and encouragement given to me during the preparation of this book for publication.

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Glasgow 1965

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WHAT IS GERIATRICS ?

What is geriatrics ? Is it a branch of general medicine or a specialty in its own right ? Who is a geriatric patient ? Does this mean any ill person over the age of 65 or are some of these ' medical ' rather than ' geriatric ' cases ? Is there in fact any definite age boundary between geriatric and medical patients ? What is meant by ' acute ' and ' chronic ' cases, and is geriatrics concerned solely with the chronic sick ? What is a geriatrician ? Can any doctor take up geriatrics, or are special training and experience required ?

These and similar questions are debated whenever geriatricians forgather, and whenever they confront their colleagues in general medicine. Not surprisingly individual physicians hold divergent views, so that the following opinions, which derive from my own experience, are not necessarily shared by others.

However, I believe that geriatrics must be understood historically as having evolved from general medicine in order to meet the special needs of one section of the patient-population—the elderly and the infirm. Many elderly patients enter hospital not only because they are physically ill, but because bodily disturbance and mental distress have unfitted them for survival in an under-protected or over-strained environment. A young person who becomes physically ill can usually cope with his personal and environmental problems until his health is restored. But an older person who falls from the ship of health finds himself struggling in the dark waters of psychological and social turmoil. The geriatric unit is his life-boat. Geriatric units arose because elderly patients so often need specialized services—comprehensive physical and psychological diagnosis and assessment, a full medical-social evaluation, an intensive programme of physical

and psychological rehabilitation, and a planned restoration to a suitable environment in the community. General physicians charged with the care of ill younger people cannot be expected to devote the necessary attention to the specialized needs of elderly persons.

HISTORY OF GERIATRICS

Two factors are responsible for the growth of geriatrics in the United Kingdom. One is the increase in the proportion of old people in the population and in their demand for medical attention; the other is the existence of a National Health Service aiming to cater equally for the entire population. Before the introduction of the National Health Service in 1948 two distinct types of hospital existed in this country: the voluntary hospitals which catered primarily for the acutely ill, and the local authority infirmaries which looked after mainly the aged, the infirm, and the chronic sick. The former were usually well staffed and equipped, as indeed were some of the latter, but all too many elderly sick were denied admission to the voluntary hospitals and were cared for in ancient unsuitable buildings of low amenity with inadequate medical and nursing staffs and with virtually no diagnostic or therapeutic facilities.

In the 1930's one or two pioneers, such as the late Dr Marjory Warren at the West Middlesex Hospital, laboured to improve the lot of patients in institutions of this type, and in so doing they founded geriatrics. But it was not really until after 1948 that large-scale action led to the appointment of physicians to take charge of these institutions and to reform the old methods of caring for the elderly and the chronic sick. Gradually special intensive units were set up for the admission and treatment of elderly patients, and some of these were situated in general hospitals. Interest in the methods developed in these units is now widespread and geriatric specialists, equipped with new knowledge of the medical problems of the aged, are taking their places again beside their medical colleagues, in general and teaching hospitals.

THE GERIATRIC PATIENT

Geriatric patients are sometimes described as 'old chronics'. This is a lamentable approach to a definition of the geriatric patient. It is quite true that most geriatric patients are elderly and that many of them have a protracted stay in hospital; but need, rather than age or chronicity, is the defining factor of the geriatric patient. It is the patient's need of the services of a geriatric unit that turns him into a geriatric patient, and he acquires the title in the act of crossing the threshold. As every general physician knows, there are more people over the age of 65 in general medical wards than there are in geriatric units, because not all ill old people need the services of a geriatric unit. On the other hand more than 10% of patients admitted to geriatric units are under the age of 65.

The reason for the difficulty in defining a geriatric patient is that each doctor really means by this term a patient who will be better cared for in his geriatric unit than anywhere else. If a geriatric unit has developed a first-class rehabilitation service, then you may find within its walls women of 50 with mitral stenosis who have suffered cerebral embolism and hemiplegia and who cannot receive the necessary rehabilitation anywhere else. If a unit has some trained mental nurses, a good occupational therapy department, and spacious grounds you will find in it depressed and demented patients. If the unit is in the general hospital, and can draw on the facilities of that hospital, you will find patients with medical emergencies in the geriatric wards. The argument about who is or who is not a geriatric patient is essentially a boundary dispute. No two units have quite the same boundaries, but the territory inside the border is much the same. There one finds the great majority of geriatric patients. These are old people, most of them over the age of 75, who are physically disabled and often mentally incapacitated as a result of one or many disease processes, and who require to be investigated with a view to diagnosis, treatment, rehabilitation and, where possible, discharge to the community.

'Acute' and 'Chronic'

A distinction sometimes made between 'medical' and 'geriatric' cases is that the former are 'acute' and the latter are 'chronic'. There is some measure of truth in this distinction, but the terms are often misused, with the creation of much misunderstanding and ill-feeling. Elderly patients who suffer from medical emergencies such as haematemesis are 'acutely ill' and are probably better treated in a medical than in a geriatric ward, no matter what age they may be. But many people who quite correctly enter geriatric units are 'acutely ill', if by that term we mean patients who have recently developed a severe illness from which they are in danger of dying and for which they urgently require skilled medical attention. These include cases of strokes, collapses and falls, and the sudden onset of confusional states. Such acute illnesses may prove on investigation to have been caused by cerebral, myocardial or pulmonary infarction, by subarachnoid or gastro-intestinal haemorrhage, by pulmonary or urinary infection or by one of many other acute processes.

The majority of geriatric patients have been ill for a long time when they enter hospital. In that sense they may be called 'chronic' cases. This does not mean that they are irremediable, or that they do not require investigation and treatment along orthodox medical lines. In fact, one of the perennial lessons of geriatrics is that the illness of the so-called 'chronic' patient may be due to the fact that he has never received proper investigation and treatment.

The true chronic sick patients are those who, after undergoing full investigation and treatment in hospital, remain unfit to return to the community. Many of these patients are elderly, but in many the disability is mental rather than physical, and a considerable number of them are comparatively young, such as those who suffer from chronic respiratory insufficiency, rheumatoid arthritis, multiple sclerosis and the like. Such patients are often to be found in geriatric units because there is nowhere else for them to go, and not necessarily because this affords the most suitable environment for them. Certainly geriatrics means very much more than the care of the chronic sick, and some

believe that responsibility for the latter should revert to general physicians.

'Social' and 'Medical'

Another regrettable image of the geriatric patient is that he presents a 'social' rather than a 'medical' problem. This too is merely a half truth. It is certainly correct that many patients come into geriatric units because they live alone and have no one to care for them, or because their relatives have become exhausted by looking after them. These patients constitute a social problem only because they have an unsolved medical problem. If they had no medical problem they would have no social problem, or at least their social problem could be dealt with by non-medical agencies. The geriatric physician's first duty is to deal with the medical problem by the conventional techniques of diagnosis and treatment. If he succeeds in doing this he very often automatically solves the social problem. In other cases the patient cannot be restored to his environment unless he first receives a full course of rehabilitation. Rehabilitation, that is improvement in the patient's physical, psychological and social functioning, is a major activity of the geriatric unit, because successful rehabilitation can make it possible for the patient to be discharged to the community. An understanding of the patient's home, his family and his attitude towards them is also required for the successful discharge of the geriatric patient. The interest of the geriatrician in rehabilitation and social medicine has given rise to the unfair image of the geriatric physician as being a 'glorified physiotherapist' or a 'glorified almoner'. The truth is that the geriatrician, like every other good doctor, concerns himself not only with health and disease, but also with ability and disability, and with adjustment and maladjustment. The patient's buttons become as important to the doctor as his blood-sugar—they are usually after all more important to the patient. This is not to say that geriatrics is about buttons, but it at least recognizes that such things exist. Geriatrics is about patients, and nothing which concerns patients is alien from it.

Geriatric patients are of many types. Old age, physical

infirmity, mental incapacity and social disability are common but not invariable features. The one thing that they have in common is need. They are ill people who need the special facilities for diagnosis, management, and physical, mental and social rehabilitation that have been developed in units devoted to the purpose.

ACTIVITIES OF A GERIATRIC UNIT

In younger people it can be assumed that the sole cause of admission to hospital is the illness of the patient, and that after the illness has been cured he can be left to resume his work and his home life at the point where they were interrupted. These assumptions cannot be made in the geriatric patient. He may have been ill for some time at home, but his admission to hospital may have been precipitated by the illness or exhaustion of his spouse, the marriage of a daughter, the unsuitability of his house, or even a family quarrel. Again his discharge depends not just on his illness being cured, but on his attaining a functional status appropriate to his home environment. For example, a patient who lives alone in an upstairs tenement building with an outside lavatory cannot be discharged home unless he is sensible, continent, ambulant, and able to dress and feed himself and climb stairs safely; although a lower standard of functional independence might be acceptable in more favourable social circumstances, such as the presence of a devoted daughter with no young children on her hands who did not go out to work. The geriatrician's activities must include diagnosing and treating the patient's illness, promoting the maximum degree of functional independence, improving the social milieu, and informing himself as completely as possible of the patient's social condition. To acquire this knowledge he must visit the patient's home before admission, discuss family circumstances frankly with the relatives, and study the patient's performance of daily tasks during formal physiotherapy sessions and in the course of his ordinary activities in the ward. Thus the geriatrician's day must be organized to include ward rounds, domiciliary visits, interviews with relatives,

supervision of physiotherapy and occupational therapy, and discussion with the almoner.

PSYCHOLOGY OF THE GERIATRIC PATIENT

General physicians are becoming increasingly aware of the importance of the psychological aspects of physical illness, although it can still be assumed that most ordinary medical patients will react normally to their illness. However, the geriatric patient's ability to comprehend the nature and significance of his illness is often at fault, and his will to recover may be weakened by the effects of bereavement, retirement, or solitude, or by feelings of uselessness or of being unwanted. The old person who is 'normal' and anxious to return to outside life as soon as possible is something of an exception in the geriatric unit. The geriatrician cannot afford to ignore the psychological aspects of his patients' illness or to refer his responsibilities to a psychiatrist, although he will certainly look to the latter for guidance. But to a large extent the geriatrician is his own psychiatrist. Study and correction of his patients' mental attitudes forms a large and vital part of his work.

THE GERIATRIC TEAM

Geriatrics is team-work. Team-work means that everyone knows and respects everyone else's part in the team, and everyone works to the same end. For example the physiotherapist who is training the patient to walk independently explains to the nurses how far he should be allowed to go on his own and how much or how little help he should be given. Or the nurses may be able to tell the physiotherapist that the patient can walk perfectly well when he wants to, but only when he thinks he is not being observed. The occupational therapist who is training the patient to dress must ensure that the nurses do not do for him what he is capable of doing himself. But the nurses may be able to point out to the occupational therapist the patient's difficulties with his sleeves or his buttons, and ask for something to be done

about these. The nurses may be able to report to the doctor vagaries of the patient's behaviour which he does not observe during his relatively short visit to the ward, but which may offer a key to the understanding of his illness; or the doctor or almoner may communicate to the nurses or to the physiotherapist details of the patient's private life which they require to know if they are to treat the patient in a sufficiently understanding and sympathetic way. These are but a few of the ways in which interchange of information leads to fuller understanding and better care of the patient by all. In a good geriatric unit the staff —ward sister, physiotherapist, occupational therapist, almoner, and doctor—all have their morning coffee together, or interchange information and opinions at a more formal weekly case conference.

LONG-STAY PATIENTS

Not every geriatric patient can return home after initial treatment. Some require more or less permanent hospital care, usually because they are too disabled to live independently in the community and have no relatives able to care for them at home. Such patients survive for an average of two years in hospital, some for ten years or longer. Although less than one-third of patients admitted to a geriatric unit become long-stay patients, these occupy two-thirds of the beds in the geriatric service.

The care of the elderly long-stay patient is an important part of geriatrics. Medical supervision of the patients must be vigilant in order that the doctor may detect improvement or deterioration, or the development of complications or of new illnesses. The doctor must also interest himself in the organization of nursing activities in the long-stay ward, and in the prevention of the physical and psychological hazards of prolonged hospitalization. The imaginative use of group exercises, of productive occupational therapy and of self-help activities not only brighten the patient's day, but reduce the incidence of such complications as pressure sores, incontinence, and pneumonia.

WHAT IS GERIATRICS ?

We can now return to our original question and define geriatrics as a way of practising medicine amongst elderly patients suffering from physical, mental and social disability, which aims to restore them to independent or partially independent living, with the co-operation of their relatives and of the social agencies of the community. Geriatrics is thus to be thought of as a method rather than a specialty. It is a method which is applicable to all patients, but which is particularly suited to those elderly and disabled persons who are looked upon as ' geriatric patients '.