

PDF hosted at the Radboud Repository of the Radboud University Nijmegen

The following full text is a publisher's version.

For additional information about this publication click this link.

<http://hdl.handle.net/2066/25870>

Please be advised that this information was generated on 2019-06-16 and may be subject to change.

A travel account of an 11-city tour of British geriatric units

MARCEL G. M. OLDE RIKKERT

Department of Geriatric Medicine, University of Nijmegen, PO Box 9101, 6500 HB Nijmegen, The Netherlands. Fax: (+31) 24 3617408. e-mail: M.Olde-Rikkert@czzoger.AZN.NL

A country in which greetings cards that congratulate people on their 70th, 80th, 90th and 100th birthdays are available in nearly every kiosk must be an interesting country for a geriatrician to visit, and the United Kingdom has been visited many times by foreign geriatricians since Marjorie Warren started her pioneering geriatric wards in the West Middlesex Hospital.

In the Netherlands, this gero-tourism to the UK started more than 40 years ago. To be precise, it was 1955 when the first Dutch geriatrician, Dr Schreuder—who later became the first professor of medical gerontology in the Netherlands—and the first Dutch researcher in geriatrics, Dr Van Zonneveld, came to London to meet Dr Warren. She was pictured as a heroine in the short article they wrote about their journey for a Dutch journal [1]. Following Schreuder and Van Zonneveld's trip, many Dutch geriatricians have crossed the North Sea to learn from the UK experience. Following this tradition, I was very happy to be given the opportunity to visit my own heroes of British geriatrics by the Netherlands programme for Research on Ageing (NESTOR).

In this short communication I will not try to describe all the interesting things I saw, but I would like to mention the most unexpected contrasts and similarities that I found between British and Dutch geriatric practices. I have learned a lot about peculiar Dutch customs from the humorous observations of two British expatriates [2]; I hope that British geriatricians will be equally interested in my impressions of British geriatrics.

To get an impression of the variety of British geriatrics, I visited 11 of the largest geriatric centres in Yorkshire, the West Midlands, Staffordshire and Durham. Having prepared by reading the *Guidelines of the British Geriatrics Society* and articles from Dutch colleagues who visited some geriatric departments recently [3-5], I expected to find four types of geriatric services: age-based, needs-based and two types of

integrated services. However, I was surprised to encounter a different type of geriatric service in each of the departments I visited. The 11 departments differed not only in their strategy of admitting patients, but also in their levels of subspecialization, integration with community services and general medicine, and the degrees of rehabilitation and respite care on offer. In each department I found a strong belief in the way in which geriatrics was organized at that particular place. In fact, I was congratulated having visited "the best geriatric department in the UK" at least half a dozen times.

In essence, all the departments I visited were operating a needs-based model—only the 'needs' were not only those of the geriatric patients, but also the geriatricians' needs, the trust's needs, the general practitioners' needs and the hospital's needs. This may explain why departments based in abstract terms on the same model can differ so widely in daily practice. Apart from the great differences between the different geriatric services, I was also impressed by some features they had in common: very large wards, a high percentage of acute admissions, short length of stay and excellent levels of geriatric care. Coming from a country in which it is hard to find a hospital that was built before the Second World War, it was an eye-opener to see that this quality of care can be achieved with old-fashioned hospital furniture and in buildings old enough to be well-known by all but those suffering from very severe long-term memory deficits.

During the visits, which varied in length from one afternoon to 2 weeks, I joined several ward rounds. A large part of geriatric practice was similar to the geriatric care offered in the Netherlands and seems to be universally accepted. However, as Lynn Payer reported with regard to other medical disciplines [6], I did observe some cultural differences in the way geriatrics is practised. In the Netherlands only a few geriatric patients would recognize their consultant geriatrician if he or she were to wear a blue suit instead

of a white coat. In contrast, in the UK, the opposite is true. I was also surprised that British geriatricians mostly talk with the patients' family themselves. In the Netherlands this work is delegated generally to trainees. On second thoughts, it seems logical that family members get the best information there is and that trainees get strict supervision before they can take over this task. Thus, in Holland a law was recently introduced which aims to achieve, among other things, a higher professional standard of patient-doctor communication.

Another striking contrast concerns the number of beds in one hospital room. In our country many geriatric patients and their caregivers would not accept placement in rooms which they have to share with six to 20 other patients; such sharing is common practice in the UK. A British colleague assured me that he had been surprised that during a recent illness he himself had accepted placement in a similarly large ward without difficulty. Similarly, a geriatric patient in the Netherlands would not be pleased if his or her surname were to be written in large letters on a bed-side identification card, which seems to be common practice in the UK. Finally, it would be unacceptable in the Netherlands to admit patients suffering from a stroke or a myocardial infarction to a geriatric ward, although I saw this happening in the UK. At present, even if Dutch geriatricians could offer the same quality of care as offered by cardiologists or stroke physicians, such placement would be regarded as inappropriate by the general public.

In a discussion on law and ethics with a British geriatrician, I was informed about the lack of legislation on such topics as authorization of mentally incompetent patients in non-financial affairs, performing research with subjects incapable of giving consent, patients' rights and care agreements between patients and doctors. Despite the differences in legislation between the two countries, it was less clear whether there are real differences in everyday, 'bedside', ethics. Perhaps it is typically Dutch to try to solve important problems in medical ethics by making new laws. Interestingly, I saw some examples of the British way of coping with similar problems. Audit appeared to be a widely used tool of trouble-shooting, quality control and quality improvement. Setting professional standards in this way may be even more valuable than having legislation because, according to our experience, laws rarely solve the clinicians' problems. However, while we are perhaps overfed by jurisdiction, the UK may be overfed by audit. (This was illustrated by the fact that, during one of the audit meetings I visited, it was remarked that the only thing which still had to be audited was 'hospital time'—and indeed, when I started watching the hospital clocks systematically, I noticed that there seemed to be many different time zones in British hospitals.)

Although British geriatrics has a long tradition, the

way in which geriatric services should be organized seems to be even more disputed in the UK currently than in the Netherlands. Following the early arguments for an age-based system [7] and Grimley Evans' plea for integrated services [8, 9], the geriatricians I met firmly disagreed on how geriatrics should be provided for the people of Britain. During a meeting of senior registrars many possible ways of managing a service were discussed, and the trainees told me of their fear that geriatrics would lose its genuine devotion to frail elderly patients by emphasizing acute care and integration with general medicine too much. However, on the other side there are those who feel that British geriatricians still lack sufficient knowledge and skills of emergency medicine [10]. For Dutch geriatricians this discussion is very interesting because we deal with similar problems. Our admission strategy is mostly needs-based, but in practice it is frequently hard to select the right patients in this way. In both countries there is an urgent need for studies on admission strategies, as performed by Kafetz *et al.* [11], and on how to organize geriatric services most efficiently and effectively.

Apart from learning about the position of geriatric medicine in the British National Health Service, it was interesting to learn about how elderly people are treated in British society. I sensed social forces operating in opposite directions: on the one hand, there clearly is ageism in British society; on the other hand, there is a lot of sympathy towards older people. For example, ageism manifested itself in the refusal of a general hospital in London to admit coronary care patients aged 75 and over, which was a hot topic during my stay. I also traced ageism in the traffic signs depicting old, osteoporotic pedestrians, which do not seem to help create an optimistic image of ageing. Conversely, there are a lot of organisations, such as Help the Aged, that try to help troubled elderly people and are largely run by volunteers. The fact that a beautiful, optimistic poem on ageing, written by Jenny Joseph, was chosen as the best post-war poem by the readers of *The Guardian*, points to a strong anti-ageist view in British society [12].

Although generally geriatricians only get interested when the 50th birthday has long passed—and the British Geriatrics Society has only just reached 50—visiting British geriatric departments continues to be a fascinating experience for Dutch geriatricians. I would like to congratulate and thank the members of the BGS for remaining an excellent tourist attraction for such a long time, and wish the society a long and happy future. I look forward to sending her one of those lovely centennial cards.

Acknowledgements

I would like to express my gratitude to Dr M. Connolly, Dr O. Corrado, Professor P. Crome, Dr D. Heseltine, Professor M. Horan, Professor R. Kenny, Dr J. Knox,

Professor M. Lye, Professor G. P. Mulley, Professor I. Philp and Dr J. Young for the very friendly welcome and the inspiring and informative talks and site-visits I was offered.

This journey and travel report was supported by The Netherlands Programme for Research on Aging (NESTOR), funded by the Ministry of Education, Culture and Sciences, and the Ministry of Health, Welfare and Sports.

References

1. Schreuder JTR, Zonneveld van RJ. Geriatric hospitals in England. [In Dutch]. *Ned Tijdschr Geneesk* 1955; 99(II): 1676-8.
2. White C, Boucke L. *The UnDutchables*. Lafayette: White Boucke, 1995.
3. British Geriatric Society. *Guidelines, Policy Statements and Statements of Good Practice*. London: BGS, 1994.
4. Lagaay AM, Verhaar HJJ. British geriatrics—Experiences of two Dutch physicians. [In Dutch]. *Medisch Contact* 1996; 51: 967-9.
5. Oolbekkink M. Different country, different history, different organization. [In Dutch]. *Vox Hospitii* 1996; 20: 12-5.
6. Payer L. *Medicine and Culture*. London: Victor Gollancz, 1990.
7. Bagnall WE, Datta SR, Knox J, Horrocks P. Geriatric medicine in Hull: a comprehensive service. *Br Med J* 1977; 289: 102-4.
8. Evans JG. Ageing and reasoning. *Br Med J* 1991; 303: 869-70.
9. Evans JG. Hospital services for elderly people. The United Kingdom experience. In: Evans JG, Williams TF, eds. *Oxford Textbook of Geriatric Medicine*. Oxford: Oxford University Press, 1992.
10. Coni N. The unlikely geriatricians. *J R Soc Med* 1996; 89: 587-9.
11. Kafetz K, O'Farell J, Parry A *et al*. Age-related geriatric medicine: relevance of special skills of geriatric medicine to elderly people admitted to hospital as medical emergencies. *J R Soc Med* 1995; 88: 629-33.
12. Ezard J. Evergreen status for a poem about growing old. *The Guardian*, 12 October 1996.

Received 29 January 1997