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CORRESPONDENCE

Correspondents are urged to write briefly so that readers may be offered as wide a selection of letters as possible. So many are being received that the omission of some is inevitable. Letters should be signed personally by all their authors.

Geriatric patients in acute medical wards

SIR,—It is obvious in considering the problems of bed-blocking in the general wards (Miss Christine McArdle and others, 6 December, p 568) that provision of alternative accommodation is necessary and I agree with the conclusion that funds should be diverted as a matter of urgent priority into these areas in order that the patient may have the appropriate treatment at the appropriate place.

In practical terms at the moment, however, this can be only a pious hope. We should therefore consider whether there are any alternatives which at little expense could provide some of this appropriate care. The actual cost of the care of these patients is surely the same whether they are occupying a bed in a general ward or a department of geriatric medicine, since they are low users of resources and the cost per patient per week is dependent on how all the resources of a district general hospital are used. As the cost of one-third of the patients in the ward studied was presumably £49·01 per week or less it follows that two-thirds of the patients cost £243·40 per week and this would be the cost per patient per week had there been no bed-blocking problem. The presence of the bed-blockers can therefore be argued to have saved £10 368 in that ward during the period studied, as without them the costs per patient week would have risen to around £243·40.

We are not told how many of the patients transferred were able to be returned to the community, but it is reasonable to suppose that some were, this being the experience of all geriatricians. It is also our experience that the sooner we can start treating these patients, the shorter their stay in hospital. I would therefore suggest that in order to relieve the situation, pending the provision of sufficient suitable units, one of the following actions could be taken where bed-blocking problems exist.

(1) Allow the appropriate consultant colleague in geriatrics or psychogeriatrics to take on the total care of the patients concerned in the general medical ward. This must include offering him the full supporting services of all departments and junior medical staff as necessary.

(2) Assess the total number of bed-blockers in the district general hospital over a period and arrange for a suitable number of properly staffed wards in that hospital to be made available to the consultant geriatrician or psychogeriatrician specifically to manage this group of patients. Presumably this would mean an overall reduction in the number of beds available to consultants working in the acute specialties, but this reduction need not be as great as the total number of bed-blockers and would thus lead to an increase in throughput in the acute wards.

(3) Increase the staffing in the geriatric and psychogeriatric departments by transfer of nurses from the general wards and closing beds in the acute wards. This would have the effect of improving the throughput in the acute wards because of the disproportionate reduction in work load which these patients represent.

I believe that any or all of these suggestions could lead only to better treatment of all patients concerned with a corresponding shortening of average length of stay.

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SIR,—Miss Christine McArdle and her colleagues (6 December, p 568) certainly put up a good case for not admitting sick elderly patients to an acute medical unit. It would have been more helpful if there had been more information on the condition of these patients on their admission to the unit. It is my experience that cases of the type described are usually patients over the age of 75 and their method of admission to the medical unit in most cases is as sociomedical emergencies via the 999 call system.

We have been informed at different times in the past that our neighbouring acute medical unit at Broadgreen Hospital had similar problems to those recorded in the above paper. About two years ago we started operating a system in our admission unit whereby patients aged 75 or over admitted as 999 calls to the acute medical unit were transferred within the first 24 hours to the geriatric unit at this hospital, provided they were fit to travel by ambulance. At a recent meeting of the British Geriatric Society I reported the first 10 months' experience of this scheme, during which 70 patients were transferred. I noted that 37 of these were later returned to the community and only two remained in long-stay wards. There was, of course, a high death rate in this group of patients and a full analysis will be published in due course. This particular piece of research at least indicated that sociomedical emergencies over the age of 75 who were previously an insoluble problem for an acute medical unit were dealt with quickly and effectively by a geriatric service.

The aims of the geriatric service, if it is to be effective, include therefore the immediate admission from the community of sociomedical emergencies in old age. Any policy whereby such patients are primarily admitted to the acute medical wards is liable to fail. The failure will occur owing to the fact that by the time the physicians consider that the problem has become a geriatric one the patient may have reached an irreversible state of chronicity.

No geriatric unit, however efficient, can deploy its rehabilitation service and social workers effectively in the service of elderly patients who have become confused, chronically helpless, and without motivation, as a result of spending long periods of time in a medical ward.

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