*Reviews in Clinical Gerontology* 1997 **7**; 93–94

# Have geriatricians lost their way in rehabilitation and long-term care?

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## Editorial

Geriatric medicine started in long-term care, when the pioneers in the emerging specialty examined the inhabitants of the Victorian workhouses to discover elderly, largely ignored, yet eminently treatable patients. They focused attention on the then taboo subjects of incontinence, dementia and immobility. They developed a paradigm which entailed a proper assessment and, where appropriate, rehabilitation. This empirical process was central to their evident success, and achieved a reduction in unnecessary institutionalization by restricting long-stay care to those who could not, after full assessment and treatment, be discharged. The concept of progressive patient care developed, to make best use of somewhat meagre facilities. Day hospitals spread nationally, and outreach teams developed. Respite care schemes provided support to the huge numbers of informal carers, by sharing the load with the hospital service.

From this inauspicious start in workhouse accommodation, recognition of the importance of early intervention led to much discussion, and some heated disputes during the Seventies and Eighties over models of acute take and access to District General Hospital (DGH) facilities. These have now largely settled, and although we cannot yet write an obituary for agism, most departments not only have DGH access but also participate to some degree in an acute intake, increasingly in an integrated fashion with general medicine. This has, however, brought increasing pressures on the modern geriatrician and the eldercare team who, in addition to managing the acute take (with or without general medicine), are also likely to have a specialization that they wish to maintain and to combine in varying degrees with academic, teaching, research, audit and management activities.

Is it any surprise that exhaustion, burnout, or abandonment of the holy grail of rehabilitation occurs, since little or no time is left in a hectic schedule for rehabilitation, long-term care, day hospital, and community outreach and liaison. Indeed, our managers (be they of purchasing or of providing clans) now question whether they are still relevant, affordable, and important?

Rehabilitation may occur in a range of settings – acute, specialist stroke, orthogeriatric units or mixed wards, community hospitals, day hospitals, and outreach services in the community. However, just because these facilities may be less obvious, and often are provided outside the core of the DGH, the question arises whether they are any less relevant now than they were 50 years ago. As the printers of Fleet Street discovered, if they are now outmoded, unnecessary, or superseded by technological change, there is no justification in continuing with 'old Spanish customs'. What positive or negative evidence can be assembled of efficacy or benefit of these central tenets of geriatric medicine?

First, what is the evidence of efficacy? Here the last decade has shown the evidence-base growing rapidly, not only for comprehensive geriatric assessment[1,2] but also particularly for specific disease areas such as stroke,[3,4] or postfracture[5,6] rehabilitation. The evidence is more difficult to gather in the more diffuse, heterogeneous, generic fields and the concerns raised by Grimley-Evans in his *Age and Ageing* editorial about the validity of the available evidence are wise reminders to be cautious.[6] In the absence of well designed trials in appropriate patients, with good controls and valid instruments, informed common sense may be preferable to inappropriately applied and over-prescriptive guidelines. In terms of outcomes, in addition to effects on mortality, we have evidence accumulating of misplacement from reported audits,[8,9] and implied misuse of resources.[10]

The contrast between a trade such as printing and the profession of medicine is particularly apparent in geriatric medicine. It is a holistic discipline, and flourishes right at the uncomfortable interfaces between acute and chronic care, hospital and community, and health and social services.

In a time of change it is no surprise that it is an uncomfortable position to hold. The lack of an august evidence-base alone is insufficient reason to abandon common sense practice, born out of five decades of progress, revered and replicated internationally. If workload is the root cause of the change in priority and practice, then expansion of the specialty is the answer. The workload can be distributed between colleagues, each taking a defined responsibility by specialty, or geographically, and ratified in a modular job plan. As the farce of basing contracts on crude measures such as the *Efficiency index* becomes apparent, quality issues can be reaffirmed, and used as a lingua franca by purchasers, providers, and clinicians in their contract negotiations. The fine words of HSG(95) 8[11] re-emphasized the medical responsibilities in these areas, and the recent 'Community Care Challenge fund' invites new bids against these objectives.

Geriatric medicine in the UK is not so much at a crossroads, with a simple choice of direction, as at a roundabout, with multiple exits. Only some of the travellers appear to know from which direction they have come, and many seem not to know where they are heading. If nothing else, the erection of some clear road signs is required. The message of the past is that ignoring rehabilitation will produce unnecessary institutionalization, reduce independence, and add to the sum total of human misery. A virtuous cycle arises from rehabilitation, in that all parties benefit: the patient by dint of reduction in dependency and greater independence, heightened morale, and improved quality of life; the social care agencies with lessened institutionalization and reduced cost; altruistic carers can rejoice in relearnt skills; and ultimately society itself is enriched. If we do not involve ourselves, the quality of care will decline, hospital and nursing-home beds will be blocked, and social service budgets will become exhausted.

Geriatricians should not abandon their heritage, but should be actively seeking ways to demonstrate the benefits of their unique position and the legacy left by the pioneers. We must ensure that all trainees have exposure to these areas, and encourage research into them. We cannot expect generalists, be they hospital physicians, general managers, or general practitioners, to understand its importance unless we give them the evidence.[12] We must acquire the somewhat alien skills of marketing, and use the evidence-base of our specialty to sell it. Our failure to do so will hasten the demise of the health and social security system, and it will be our patients of the future who will ultimately pay the price.

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