

GUEST EDITORIAL

The specialty of geriatric medicine in Malta - at a crossroads

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Is geriatric medicine a specialty? If yes, what does its specialisation consist of? And what actually is a geriatrician's expertise? These three questions are still commonly asked, despite the fact that geriatric medicine has been recognised as a specialty in the United Kingdom since 1948¹. Different opinions still abound on what the specialty should consist of. Some answers to these questions can be found in several publications, documents and papers produced by learned societies, colleges and experts in the United Kingdom.

The British Geriatrics Society² defines geriatric medicine as "that branch of general medicine concerned with the clinical, preventive, remedial and social aspects of illness of older people. Their high morbidity rates, different patterns of disease presentation, slower response to treatment and requirements for social support, call for special medical skills. The purpose is to restore an ill and disabled person to a level of maximum ability and whenever possible return the person to an independent life at home". The Royal College of Physicians of London³ described a typical geriatrician practising in the United Kingdom as follows: "The consultant physician in geriatric medicine in the 1990s, occupies a respected post in the general acute work of the district general hospital and has recognised specialist expertise within the field of general medicine, rehabilitation medicine, continuing care and the community aspects of geriatric medicine".

Basically, from its roots in long-stay institutions, the specialty has evolved into providing input for elderly patients at the acute phase of their illness. It has been stated that "Geriatricians knew that the best hope of preventing the need for long-term care lay in the early assessment and rehabilitation of typical geriatric patients and so the direct admission of such patients from their homes to geriatric units"¹.

Various models of hospital based units providing a geriatric service have been described. However, they all aim to be needs-related i.e. cater for those ill elderly who would benefit from the expertise provided, and age-related i.e. cater for elderly patients from specified age groups⁴. Also they all aim to have beds based on the main district hospital site. Some have separate acute and rehabilitation wards, others do not make this distinction. Some have responsibilities for long-stay wards, others do not⁵. Although there are a variety of models, whose set up in a particular region depends on local circumstances, resources and personalities, the basic principles that guide the profession are the same. These include: the accurate assessment and management by a multidisciplinary team; prompt intervention at the acute phase; emphasis on a return home; with long-stay care

only as a last option. "That older people should have access without delay and at the point of need to the highest standards of medical diagnosis and treatment and, concurrently, to skilled interdisciplinary assessment and management tailored to their needs is axiomatic to those working within this specialty"⁶.

The range of services and components of a specialised department for the care of the elderly should include: inpatient, outpatient and day hospital facilities; interdisciplinary team practice with manpower policies that reflect the required staffing ratios and skill mix; operational policies that ensure prompt and appropriate admissions; liaison with general practitioners and other community services; liaison with other hospital departments in particular general medicine, orthopaedics, psychiatry; well planned discharge procedures; continuity of care; respite care; quality in long-stay wards; facilities for education and research; involvement of senior staff in management and planning².

What about the situation in Malta? Till 1991, the practice of geriatric medicine as a specialty in Malta was associated solely with long-stay care at St. Vincent de Paule Hospital (SVPR). Then Zammit Clapp Hospital (ZCH) started providing "a specialised geriatric service"⁷. Its role was described in a Department of Health circular to all medical practitioners which stated that "The hospital will cater for elderly people with acute medical problems requiring urgent care and rehabilitation which normally would be referred to St. Luke's Hospital"⁷.

In keeping with geriatric units in the United Kingdom, ZCH's task was to develop a range of services that complemented treatment received by older people in hospital². ZCH's main objective was always to provide a specialised service by a multidisciplinary team for those frail and ill elderly whose medical problems were complicated by functional and social factors and who wanted to continue living at home, as geriatric medicine is defined. ZCH's admission policies were always oriented to patients' needs and patients were admitted only after detailed discussions with general practitioners or after assessments at the day hospital or after assessments at other hospitals. Only patients whose medical problems could be managed properly with the resources available were ever admitted and certainly the hospital was accessible to all referred elderly patients who would benefit from the expertise provided.

ZCH revolutionised the approach and care given to the elderly in Malta and introduced a number of innovative services and practices such as medical rehabilitation; interprofessional team approaches; a day hospital; input from community liaison nurses; family training sessions

and home assessment visits carried out by several team members; personalised client care programmes in a quality environment; respite services. There was good liaison with referring general practitioners, continuation of care and an ability to respond to a crisis in the community. There was also a good working relationship with most consultants in other hospital departments. The hospital became a teaching centre for undergraduate and postgraduate students from all professional disciplines, including foreign visitors.

Although it is a small hospital with a maximum of 60 beds, there has always been a high turnover of patients. For example in 1996 the number of admissions for that year peaked at 1072, of whom 53% were transfers from SLH, whilst in 1997 a record number of 713 new referrals were assessed at the Day Hospital. Over the years 1994 to 1997, a range of 74% to 83% of yearly admissions were discharged back into the community whilst the yearly percentage of admissions transferred to SVPR was always under 2%.

Even at SVPR, the quality of care improved with less congested wards and better resident-oriented practices, the multidisciplinary assessment and management of all admissions, a move to prioritising applicants for admission according to needs and the introduction of respite services.

The specialty of geriatric medicine in Malta was growing and developing. For example, plans were submitted to expand the type of services provided by ZCH. The importance for the specialty to have a base in the main acute hospital was mentioned but still needed to be fully addressed. Advice was given that long-stay facilities at SVPR should continue to concentrate on improving the quality of the environment and to cater for those applicants most in need.

However, recent policy changes have stunted the specialty's growth. For example the change in admission criteria into ZCH by stopping direct admissions from the community has inactivated the unit's previous ability to respond promptly to a genuine need and crisis. Continuity of care has been interrupted. Restricting ZCH to being solely a "rehabilitation hospital" does not make sense within the specialty as rehabilitation cannot be separated from the medical issues that go hand in hand, which can, and should be tackled by the geriatricians. An inability to admit patients assessed at the day hospital who would obviously benefit from inpatient treatment at ZCH is a very frustrating and demotivating experience for the interdisciplinary team members. Patients accepted for admission can only be referred by

consultants in other specialties. At SVPR there is no longer any input from the geriatrician on who should be admitted.

As a result, all elderly patients are being first directed to SLH. If admitted, their placement might be inappropriate, in already inundated wards with the danger that "their presence is resented and their needs are inadequately met"³.

Such restrictions also interfere with the rights of patients. "In the event of a need for specialist guidance, treatment and advice, old people can expect to be referred to a hospital department best able to meet their needs"⁸. The rights and duties of general practitioners are also curtailed. "GPs should refer patients to the most appropriate department for their particular problems"⁸; "The GP is best placed to decide whether the patient should be referred for acute care or less acute assessment and rehabilitation which may be on another site"².

The specialty of geriatric medicine in Malta is at present at a crossroads. It is imperative it is allowed to follow the correct path and practise as it should, in its own right and as recommended by international bodies and experts in the field. Otherwise, doctors and other health professionals would, not surprisingly, be reluctant to enter or remain in a field that is reverting to becoming a second class specialty.

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