To the Editor:

The provision of care for nonsurgical patients in the hospital has been largely debated in recent years. We would want to contribute to the discussion concerning the future of hospital medical wards in the context of the demographic challenge to health care systems due to the progressive aging of the population and of the changes induced by technology (both diagnostic and surgical).

In this context, an important debate is ongoing regarding the number and organization of beds for patients affected by nonsurgical problems. The focus should be placed on the needs of different categories of patients, i.e., on one end of the spectrum, young patients with acute medical problems, and, on the other, old patients who are chronically and/or critically ill.

In Table 1 we report mean age, length of hospital stay, Diagnoses Related Group (DRG) weight, and Charlson Index of patients consecutively admitted between January 1, 2004 and June 30, 2004 to a geriatric ward (24 beds) with a four-bed Sub Intensive Care Unit (SICU) (in which severely ill elderly patients requiring frequent, but usually not invasive, monitoring of vital signs and/or intensive interventions, are admitted) and to a general internal medical ward (38 beds). The patients were classified according to age (>65 years old or ≤65 years old) in our 350-bed hospital (Poliambulanza Hospital, Brescia, Italy). Most patients (82%) are admitted through the Emergency department.

Data reported in the table warrant comment:

1. In a general internal medical ward, 64% of the patients are very old, with a mean age comparable to that of those patients in the geriatric ward. Thus, two different populations of inpatients (one of elderly patients and the other of adults in various clinical conditions) are identifiable, and both populations are appropriate for admission to the hospital.

2. In general, 78% of the medical population needing hospitalization are homogeneous for old age. As a consequence, this should be considered if the practice of geriatrics (i.e., integrated comprehensive patient evaluation) must be the rule in medical areas of the hospital. Is the general internal medical staff ready to acquire a special expertise in geriatrics culture? In fact, a structural change in the general internal medical wards toward geriatrics is unrealistic, but we may expect the large and progressive adoption of specific skill sets used in treating old patients.

3. The length of stay is the same in geriatric and in general internal medical wards. This finding confirms the importance of setting clinical procedures for elderly patients inside the mainstream of the clinical mission of a hospital.

4. Admission to the SICU is appropriate when advanced technical treatment must be given with a higher level of care than ordinary wards can provide, although a full intensive care setting is often not necessary. On the basis of our data, SICU could be seen as a new model of care available for the entire hospital, not only for the geriatric ward (5).

In conclusion, as modern hospitals need a reduced number of medical beds, mostly with a geriatric competence, we should discuss their internal organization (distribution) and consider the different levels of intensity of care, from both the technological (Intensive Care Unit, Sub Intensive Care Unit, etc.) and “cultural” points of view (geriatric versus nongeriatric approach).

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REFERENCES


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