Geriatric wards in acute hospitals

SIR—Rozzini and Trabucchi [1] raise concerns that appear to arise from a service and a specialty under pressure from political and managerial forces. Similarly, Rockwood [2] cites examples of medical and scientific cultures that mitigate against the rational development of care and services for the older patient.

The rising pressure from increasing acute hospital admissions in the older patient and political imperatives to reduce costs are creating a crisis that may produce expedient solutions that compromise the most vulnerable of patient groups. We believe that geriatricians must reassert the evidence base for their practice. If we are not seen to lead the development of services for older adults, then we cannot claim to have their interests at heart.

Rozzini et al. raise questions regarding the most effective model of care for the older adult admitted to hospital. They argue that debate remains on the effectiveness of geriatric ward versus medical ward care, and which components are effective. We recently conducted a systematic review of the evidence for acute geriatric assessment—either in care provided by mobile teams or of care based on specialist geriatric wards [3]. We identified 20 randomised controlled trials (10,427 participants, 10 ward trials and 10 team trials). Geriatric assessment wards were associated with significantly more patients surviving and returning to live in their own homes (four extra for every 100 patients treated; 95% CI 1–6) when compared with conventional care in general medical wards. There was no evidence of benefit from geriatric assessment teams (no patients per 100; 95% CI 1–4 to 5).

Careful descriptions of the acute geriatric assessment interventions provide many explanations for these differences. Firstly, the delivery of daily nursing care differs between wards with nurses trained and experienced in dealing with frailer older adults and roving teams in general medical wards with non-specialist nursing staff. Secondly, the co-ordination and, more importantly, delivery of recommendations made during the comprehensive assessment process [3]. For example, only 62% of prescribing recommendations were implemented in one study and less than 33% of recommendations for specialist referral [4]. This evidence for ward-based geriatric assessment, however, is not strictly new [5] and we are without excuse if we have not made it widely known.

Some will say that financial and cultural or medico-political pressures are increasingly driving the reduction in geriatric ward numbers [1]. It must be clear in the debate that the steps taken for short-term reductions in acute hospital beds will result in a greater cost burden to society, including...
the long-term care of an increasingly and unnecessarily dependent population. Ultimately, in an era of patient choice, we should be widening this debate to the public. As geriatricians we must not agree to provide ineffective or harmful services simply because of current political expediencies—if we do we will leave our children to re-invent what we already know.

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