



'Acopia' and 'social admission' are not diagnoses: why older people deserve better

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Introduction to the problem

In any NHS general hospital, a quick trawl through the clinical notes of older patients would identify several with labels, such as 'acopia', 'social admission', 'bed-blocker' or 'atypical presentation'. None of these are recognized diagnoses and their presence on discharge summaries would cause consternation to clinical coders. Moving from what staff write to what they sometimes casually say – sometimes even within earshot of a geriatrician or (worse) patients or visitors – we hear more value-laden terms (e.g. 'crumble', 'bed-blocker' or 'GOMER').¹ One consultant colleague from another hospital recently opined to me that even internal – rather than geriatric – medicine house jobs had 'far too much social work medicine to be of any use in training'. In another instance, a physician clinical director stated at a directorate meeting, without self-consciousness, that he was spending too much time 'market gardening' (i.e. caring for old patients who were 'cabbages'). In a third, a surgeon arrived on my ward with his usual entourage, and laughingly announced (in front of our own ward team) that he 'didn't understand how anyone could stand to work in a ward looking after all these "crumblyies"'. In my experience and that of fellow geriatricians, such incidents are depressingly commonplace. If even senior practitioners seem to have so little interest in performing what is actually much of the job of acute medicine in the 21st century, what price adequate mentorship for their juniors?

My contention is that the use of such terminology is inappropriate, unprofessional and singularly unhelpful to patient care. It would certainly not be used if the patients were children or younger adults. Similarly prejudicial remarks have long been recognized as inappropriate when applied to, for example, gender or ethnicity. Are older people the last frontier?

It isn't just about politically correct language, however. These attitudes affect diagnosis and

treatment. The customary diagnostic rigour, which we have been trained to apply as standard, can be mysteriously replaced in older patients by ageist therapeutic nihilism. Education, training and received values in medicine need to change to reflect the reality of modern medical practice. The core business of hospitals in the NHS and throughout the developed world is in patients with illnesses which are long-term and common and in treatments which are low-tech and palliative or disease-modifying. Yet professional values and training still overly prioritize the acute, the rare, the high-tech and the curative. If we are providing a public service based on need, we must give adequate assessments to the patients who actually turn up in the system, rather than those whom we would find more personally engaging, or those 'consumers' who shout loudest.

Why better medical care for frail older people matters

Patients over 65, mostly with multiple long-term conditions and many with frailty and functional or cognitive impairment, account for around 60% of admissions and 70% of bed days in NHS hospitals. Those with two or more long-term conditions account for the majority of adult bed days in the NHS, and presentations related to frailty are a major part of acute medicine and a major co-morbidity in acute and elective surgery.^{2,3} What do we mean by 'frailty'? It may be usefully conceived of as 'poor functional reserve', or 'a failure to integrate responses in the face of stress,' such that such patients are much more vulnerable to de-compensation in the face of challenges such as illness, drug side-effects or metabolic disturbance.⁴ They then present to health and social care with 'geriatric syndromes' such as falls, immobility or confusion. In reality, these presentations are not in fact atypical, but *typical for older people who are ill*. Older people are, in turn, the most frequent users

Box 1

Extract from 'The Way we Age Now'⁷

'Mainstream doctors are turned off by geriatrics, and that's because they do not have the faculties to cope with the Old Crock. . . The Old Crock is deaf. The Old Crock has poor vision. The Old Crock's memory might be somewhat impaired. With the Old Crock, you have to slow down, because he asks you to repeat what you are saying or asking. And the Old Crock doesn't just have a chief complaint – the Old Crock has fifteen chief complaints. How in the world are you going to cope with all of them? You're overwhelmed. Besides, he's had a number of these things for fifty years or so. You're not going to cure something he's had for fifty years. He has high blood pressure. He has diabetes. He has arthritis. There's nothing glamorous about taking care of any of those things.'

'There is a skill to geriatric medicine. . . a developed body of medical expertise. And it was not until I visited my own hospital's department of geriatrics for the first time that I began to appreciate it. The job of any doctor should be to support quality of life, by which we mean two things; freedom where possible from the ravages of disease and enough function for active engagement. . . most doctors treat disease and figure that the rest will take care of itself. . . if the patient is becoming infirm then that isn't really a medical problem is it. . . but it is a medical problem. . . people can't stop the ageing of their bodies and minds, but there are ways to make it more manageable and avert some of the worst effects.'

of both secondary and primary care and will increasingly be so in developed nations, as survival rates improve for conditions previously fatal in mid-life. This will impact on the day-to-day work of doctors who are currently in training. Conservative projections suggest that by 2025, the number of people over 80 years old and those dependent for two or more activities of daily living will increase by around 50%. As Rockwood has stated, 'if we design a system for patients with one thing wrong, but patients with several things turn up, the problem lies not with the users but with the system, yet these patients are often deemed "inappropriate admissions".'⁴

As clinicians, we must bear some responsibility for this. In surveys, the majority of students and recent graduates in medicine and allied professions state openly that they do not wish to pursue a career working with older people.⁵ The reality is that the most of them will be working principally with older people, whether they like it or not. This is well-illustrated by analyzes of hospital activity and case-mix,^{2,3,6} which is not reflected in the balance or emphasis of current medical education. Even in emerging curricula for higher specialist training in the UK from the Royal Colleges, there is little content on the complex specialist needs of older people. If this is the message even from the

top, old attitudes are inevitably re-enforced. As the quote in Box 1 illustrates, such problems are not limited to the UK.⁷

In England and Wales, the 2001 National Service Framework (NSF) for older people laid down clear aspirations for improving general hospital care of older people, 'rooting out age discrimination', and stating that 'all staff working with older people require appropriate skills and training'.⁸ Yet its 2006 iteration, 'A New Ambition for Old Age', clearly stated that things hadn't improved that much, concluding that 'we need to make hospitals age proof and fit for purpose'.⁹ There has been much attention in these documents and in both professional and the lay press on 'dignity in care' for older people. As doctors, however, we need to recognize that unenthusiastic and poorly informed medical care is equally undignified. High quality care requires a structured medical assessment, accurate diagnosis and a robust treatment plan as rigorous as that which we would automatically expect for a younger patient.

Why are labels like 'acopia' still used?

I will speculate on a few reasons why terms such as 'acopia' are still used, and why the underlying attitudes they exemplify persist. Many are amply supported by empirical evidence, although this article does not purport to be a systematic review. My comments on the influence of health policy and health service reform here are UK-specific but will have resonance for those in other health systems where, generally, specialist services for older people with complex needs are, if anything, far less developed than in the UK.

Medical education

Geriatric medicine does not feature prominently in the curricula of many medical schools, nor sufficiently highly in the core curricula for post-graduate medical training.^{9,10} Thus some attitudes might be rooted in ignorance rather than malice or indifference. Conventional medical education emphasizes 'textbook' presentations of single conditions from lucid patients, which are amenable to curative treatment. Clinicians need to think differently about frailer, older patients. Effective geriatric medicine requires practitioners to address problems such as functional decline, confusion or carer stress by identifying underlying reversible diagnoses, accepting that in many cases we can only hope at best to modify the course of

illness, and to commit to a shared responsibility with other professionals. This doesn't fit the heroic model of personal responsibility more traditionally associated with hospital medicine.¹¹⁻¹³

Perceptions of prestige

Despite a growing emphasis on holistic care, communication and team-working, there is still a bias in the values of medical training towards the high-tech, the novel and the rare – and of course, the well-remunerated.^{13,14} In a recently reported survey of Norwegian medical students, junior and senior doctors asked to rank 33 diagnoses in order of their 'prestige'. Conditions such as acute coronary syndrome and leukaemia were at the top, with typically geriatric and mental health problems at the bottom. Results were consistent across all three groups. The authors concluded that:

'... the existence of a barely concealed, tacit, prestige rank order of medical specialities has been known for some time and influences priorities and decisions within the medical community – possibly without the awareness of decision makers.'

The care of older people is therefore seen as unattractive and low status by many, compounded by the lack of potential for private practice income. In particular, with the exception of general practice in primary care, there is a growing move away from generalists towards organ specialists – and even sub-specialists within those disciplines. And whilst there are those who might doubt the rationale for a speciality seemingly based on age-related rather organ-specific illness, the worrying implication is that patients in hospital with multiple problems might increasingly be passed around between several 'hyper-specialists' with no individual taking an overview and ensuring continuity.

Cultural and political values

As part of wider society, doctors are not immune to prevalent ageism in cultural, news and political values which favour the concerns or the votes of younger people, focusing on consumerism rather than unmet need. At best, the media coverage of older peoples' care is reduced either to good news stories of successful ageing or to a series of 'scandals' around feeding, hospital hygiene or cleanliness,¹⁵ such as those reported in the *Daily Mail's* ongoing 'Dignity for the Elderly Campaign'.¹⁶ These tend to ignore equally pressing but less dramatic or eye-catching deficiencies

in the care of older people around poor recognition, diagnosis and treatment for common conditions such as osteoporosis, incontinence or dementia. Meyrowitz, in his work on the media characterization of older people,¹⁷ concluded that:

'Old people today are generally not appreciated as experienced elders or possessors of special wisdom but to the extent that they can behave like young people... that is the extent that they remain capable of behaving like young people... i.e. working, enjoying sex, exercising and taking care of themselves.'

The surgeon and medical writer Atul Gawande, in his recent piece on attitudes to geriatric medicine in the USA (Box 1), pointed out that such attitudes do infect medical professionals.⁷ Anthropological and observational studies on the socialization of doctors into received values tend to confirm this view.¹²⁻¹⁴

Government policy

UK Government policy has prioritized vote-winning targets such as waiting times, elective surgery, outpatients, 'choose and book' and extended surgery hours for GPs, over the needs of the principal (and often less vocal) service-users.¹⁷⁻²⁰ In a recent major national survey of 1600 health service managers from a variety of trusts and clinical areas, they consistently rated older people and those with mental health needs as the most neglected groups in the service and those which had benefitted least from NHS reforms.²¹ We also know that, historically, there has been relative under-investment in services likely to make a difference to older people – reflecting a covert ageism in priority setting. Examples include services for dementia²² (when compared to psychiatry for younger adults), incontinence²³ and – until the recent expansion – in palliative care for older people with non-cancer diagnoses.²⁴ Stroke services provide a topical example, with many patients still not receiving evidence-based stroke unit care and with outcomes worse than in most European countries. Until recently, specialist neurologists have had inconsistent involvement with stroke patients. It is perhaps no coincidence that the advent of a hyper-acute, high-tech and potentially curative treatment in thrombolysis and the shift of stroke from the elderly care into the cardiovascular NSF has provoked a recent flurry of activity and interest.²⁵

Contracting

Contracting systems further distort priorities,²⁶ so that acute unselected emergency admissions and subsequent rehabilitation of these patients are loss-leaders for hospitals, with profit to be found in elective surgery and outpatient activity.

Performance targets

The Quality and Outcomes Framework for the GP contract has few performance targets to incentivize more joined-up and proactive care for frail older people,²⁷ and the 2005 Primary Care White Paper 'Our Health, Our Care, Our Say'²⁸ – which has at its heart a desire to devolve more care to the community – was uncoded,¹⁹ as indeed was the original NSF for older people.²⁹

Language and rhetoric

The language used – for instance 'bed-blocker'³⁰ and 'inappropriate admission'^{3,4} – and contractual mechanisms designed to incentivize admission avoidance or earlier discharge of older patients from hospital, all reinforce the premise that older people are somehow a 'problem', impairing the functioning of the system by their very presence.³¹ Of course, patients of any age should not be in hospital beds unnecessarily. However, when ill, they deserve appropriate and timely assessment and intervention irrespective of age.³² This was clearly spelt out in the NSF for older people,⁸ yet other more pressing government policies, most notably the increasing push to devolve assessment and care of older people to 'the community', risk making this no more than rhetoric.^{19,29,33}

Research funding

Funding and assessment frameworks for research in a competitive environment, where grant income and publication in 'high impact' (often basic science) journals have significantly weakened the presence of specialties such as geriatrics within medical schools.³⁴ The first wave of academic departments and chairs in geriatric medicine was established in the UK in the 1960s and 70s. However, the emphasis on major biomedical research centres, basic science, translational research and the effects of the Research Assessment exercise have meant that specialties such as geriatric medicine, which often focus on less lucrative clinical and health services research, put the speciality under threat in many medical schools.

Though there are nearly 1000 consultant geriatricians in the UK, there are now many vacant chairs and defunct academic departments within medical schools, or staff in senior academic posts with no clinical background or certified training in the speciality. This weakens the potential to influence curriculum content, or provide academic role models within medical schools and further skews research priorities away from clinical service delivery to the largest user groups. The advent of the National Institute for Health Research³⁴ may help redress the imbalance with basic science and translational research, but this remains to be seen.

What should we write instead?

For every older patient presenting to hospital with so called 'non-specific' or 'atypical' presentations; with falls, immobility, confusion or incontinence; with functional impairment; with multiple problems; complex needs; concerned professionals or carers in the community insisting that 'something must be done'; or who cannot give a good history themselves due to cognitive impairment or communication problems, we as clinicians should be considering the wider psychosocial context of the patient's illness and disability. However, even if we assume that all that is 'someone else's job' and focus more narrowly on the 'medical model' and specific medical skills, we should be asking, at a minimum, the following questions:

- Why is she here and who recognized the problem?
- What can she do now?
- What could she do before, and can we corroborate this story?
- Is there a medically reversible reason for her loss of function?
- If we cannot reverse all her medical pathology, what *can* we modify?
- Which of her problems should we prioritize for intervention and what is the risk-benefit balance involved in acting on each?
- If not, can each be reversed by rehabilitation?
- If not, can the disability be overcome with equipment or services?
- If we cannot reverse all her medical pathology, what can we modify?
- If the illness trajectory is irreversible, what can we do to optimize her comfort, dignity and quality of life?

These issues are key components of Comprehensive Geriatric Assessment (CGA) – a technology which, whilst it might be perceived as a soft or low-tech skill, has a range of benefits especially

Table 1
Elements of comprehensive geriatric assessment (CGA)^{32,35}

Components	Elements
Medical assessment	Problem list Co-morbid conditions and disease severity Medication review Nutritional status
Assessment of functioning	Basic activities of daily living Instrumental activities of daily living Activity / exercise status Gait and balance
Psychological assessment	Mental status (cognitive) testing Mood / depression testing
Social assessment	Informal support needs and assets
Environmental assessment	Care resource eligibility / financial assessment Home safety Transportation and telehealth

CGA may be defined as 'a multidimensional, interdisciplinary diagnostic process focused on determining a frail older person's medical, psychological and functional capability, in order to develop a co-ordinated and integrated plan for treatment and long-term follow-up'¹⁹

in patients assessed with the full facilities of the hospital (Table 1).^{32,35} These benefits include lower mortality, increased physical function and ability to remain at home, reduced readmission to hospital, care home placement and improved quality of life.³⁵ CGA may be defined as:

*'a multidimensional, interdisciplinary diagnostic process focused on determining a frail older person's medical, psychological and functional capability, in order to develop a co-ordinated and integrated plan for treatment and long-term follow-up.'*³²

As Gawande has emphasized (Box 1), we as doctors should not assume – having first conveniently labelled many of these questions as somehow 'social' – that they then become the sole responsibility of other professional groups. But in order to do this, we have to embrace our role in caring for older patients, rather than avoiding it.

Beyond CGA, individual syndromes such as falls, delirium or incontinence are also very common in general hospitals and there is a considerable empirical evidence base for effective treatment, with effect sizes comparable to many high-tech treatments for conditions affecting younger individuals. At the moment these

tend to be under-recognized or inadequately treated.^{22,23,25,36,37} This makes a nonsense of labels such as 'too much social service medicine' or 'market gardening'. The interventions are out there, but so are ignorance, indifference and ageist attitudes.

The way forward

Of course, there is little use in pinpointing the problem without suggesting at least some solutions. Were we to engage in blue-sky thinking, we would certainly not design from scratch systems of service delivery, training and performance management which mitigate against high quality care for the largest group of service users. Most staff will deal with older people and most staff currently lack the right skills. Many clinical management decisions or policies include elements of arbitrary ageism which fly in the face of research evidence. Ideally, we need to:

- Re-balance medical education and training to give staff the right skills to care for the patients they will actually see.
- Expose medical and allied staff to high quality mentors and role models who can inculcate better attitudes to older patients.
- Shift the emphasis in research funding and governance a little more towards clinical and health services research on frail older people.
- Where there are evidence based treatments for common conditions of ageing such as osteoporosis, falls, incontinence or delirium we need to actually deliver them (we currently fall woefully short).
- Produce performance and inspection targets and frameworks which place high quality assessment and care for older people at the centre of service delivery rather than its periphery (or even worse as a 'problem' for the system) – which in turn means targets which make a meaningful difference to older people rather than superficial 'box ticking'.
- Ensure that there are high-quality alternatives to hospitals in primary and community care, to ensure that admission avoidance or earlier discharge for older people doesn't result in their receiving third rate or non-existent alternatives.
- Within hospitals, there should be adequate access for older people with functional impairment to the full range of skills in multidisciplinary teams.
- Finally, we need to encourage open debate about prioritization and rationing in healthcare. If there is a societal view that older peoples'

needs are less important, then so be it – but this should be overt and not covert.

If we were to survey one hundred case-notes for older patients containing the labels 'acopia' or 'social admission', I would estimate that the amount of genuine, often-reversible and frequently-undiagnosed pathology would be substantial. There remains a major role for the medical/diagnostic model as part of effective, holistic care for such patients. The use of this kind of terminology and the sloppy thinking it exemplifies would be considered professionally unacceptable in younger, fitter patients, and it should be equally unacceptable for the old and the frail. As doctors, we need to start seeing the care of older people as the complex, intellectually stimulating and central business that it is. We should not be afraid to challenge colleagues whenever they use such terms and to ensure they know better next time.

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