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Editorial

The older patient; the need for Geriatric Units

The age revolution altered the entire health care scene.

By the 1950s the average age of the patients who sought health care services and occupied beds at hospitals ranged from 45 to 50 years old. In the first years of this century the average age of the patients hospitalised in health services went up to nearly 80 years old [1].

The physiological alterations in ageing have deeply affected how diseases' symptoms appear and have led to added difficulties in diagnosis and therapeutic options. Comorbidities and chronic conditions have transformed health care practice and long-standing concepts, like the single disease. Consequently, physicians realised they should brace themselves for this evident reality.

Geriatrics, which is a specialty with more than a century, started being structured 70 years ago in Britain by Marjory Warren who developed the norms of a holistic approach to these patients and organised the first long-term care unit for patients over 65 [2]. In those days, patients in this age group were in small number since the average life expectancy rate in Great Britain was around 65 [3,4].

Without great difficulty Marjory Warren found acceptance with her then colleagues to develop geriatrics. Paediatrics, which is a specialty organised and recognised since the second half of the 19th century (the first children's hospital in England, the Hospital for Sick Children, was founded in 1852) [5] with an age-range up to 10 years old, was in one of the extremes of the age curve. Geriatrics then appeared as the medicine at the other extreme end, taking care of patients over 65 who were regarded as the elderly, i.e. people who ended their professional activity and were in the last stage of life.

However, during the 20th century the number of older patients grew immeasurably and average life expectancy at birth in Europe is now around 80 years old or more. Therefore, as a result of the population ageing, hospital services and medical appointments grew full of much older patients [6].

At the beginning of the specialty's development, geriatrics were based on an arbitrary age definition, which was grounded on the age of retirement in developed countries and seemed to allow the conclusion that all older patients over 65 were geriatric patients. Following this reasoning, those who did not understand or who did not want to accept the need for geriatric units claimed that since most of the patients treated by health care departments were, according to the age criteria, geriatric patients, these departments were already in fact geriatric departments and, thus, there was no need for geriatric units.

This misunderstanding is still present today, especially in countries where geriatrics were difficult to implement and explain to health professionals.

The rise of the average life expectancy allowed for the development of distinctive stages in the care for older adults, meaning their response to diseases and how these appear is different when they suffer from an acute disease or from complications due to chronic diseases. In fact, it is no longer accurate to identify a patient as geriatric or as an older geriatric patient all those who are 65 years old or more.

All older patients have particularities that lead to a medical practice that is different from the one provided to non-older patients, to the training in geriatric medicine and to the development of a new kind of hospital physician [7]. However, not all patients over 65 are geriatric patients or required hospitalisation in geriatric units. Today, 70 years after Marjory Warren, there are three types of older patients:

- type I (the fit older patient): healthy older patient without known illnesses, but who suffers from an acute disease. This patient does not have to be treated by a geriatrician and, therefore, can be seen by any physician with up-to-date knowledge of geriatrics and hospitalised, if needed be, in a conventional health care department;
- Type II (the stable older patient): older patient living independently mobile in a suitable family and social environment with under control chronic disease(s) who suffers from an acute disease. Like Type I patients these individuals might be treated by physicians, who are not specialised in geriatrics but have training in the area, and be hospitalised, if necessary, in conventional health care departments;
- type III (the complex older patient): older patients with multiple chronic diseases, organs and/or systems with function loss, cognitive impairment, frail, and from a socially disintegrated background. This patient is a geriatric patient who should be hospitalised in a geriatric unit.

The differences concerning types I and II might be slim. Therefore, in which unit to hospitalise a patient always depends on the discussion of each case between the specialist in internal medicine and the geriatrician as well as common sense and mutual understanding.

The purpose of Geriatric Units is to assist this still restrict type of older patients. They should be set in a separate ward, autonomous from other services, but in close connection to all other hospital departments, especially physical medicine and rehabilitation.

Medicine today not only demands for a growing number of geriatricians, but also requires all physicians who take care of older

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patients to be prepared to offer them the best service possible, which should be grounded on knowledge of how ageing alters diseases' symptoms and how to treat them [8,9]. In addition, it demands a paradigm shift in physicians working at hospitals and the development of a ward in all great hospitals where more complex and difficult older patients (type III) can be assisted, the Geriatric Units [10].

These units will be used to: train all physicians in geriatric medicine; divulge intervention norms that will make pharmacological therapy more proficient; prevent geriatric syndromes that appear as a result of inappropriate intervention during hospitalisation; minimise expenses; shorten the patients time of stay in hospital; prevent cognition and motor impairment; allow a patient to be discharged home; reduce inhospital mortality; and support all hospital departments that need the medical opinion of the geriatrics unit's team [11–13].

Disclosure of interest

The author has not supplied his declaration of conflict of interest.

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