

EUROPEAN UNION GERIATRIC MEDICINE SOCIETY

POSITION STATEMENT ON GERIATRIC MEDICINE AND THE PROVISION OF HEALTH CARE SERVICES TO OLDER PEOPLE

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EUGMS POSITION STATEMENT

The European Union Geriatric Medicine Society, EUGMS, is the collaborating and co-ordinating organisation of the national geriatric medical societies of the European Union member states, but also includes Switzerland. The EUGMS' mission is to develop geriatric medicine in all member states as a recognised independent medical specialty, contributing to the care of all older people with age-related diseases.

The EUGMS is the geriatric medical organisation in the European Union

The ageing process manifests itself differently in individuals. Some remain in good physical and mental health even in very old age. Others suffer from chronic diseases and functional limitations, which make them dependent on the support of relatives, friends, volunteers or professional carers.

Their growing number demands investment in the education and training of doctors, nurses and allied professions, as well as in hospitals and community services.

The number of people >60 years will increase by up to 10% over the next 20 years in some countries of the European Union.

Demography and normal ageing in the European Union

The percentage of people in Europe over 60 is estimated to rise significantly during the next two decades. This projected increase is not uniform over the countries in Europe, varying from 3.9 to 9.4% between 1993 and 2020 (table 1).

Table 1

The increase in people >60 years in the 15 European Union member countries from 1993 to 2020, represented as percentages of the total population for each country.

Country	Percentage increase
Austria	6.7 %
Belgium	7.7 %
Denmark	4.2 %
Finland	9.4 %
France	8.0 %
Germany	7.3 %
Greece	6.5 %
Ireland	6.5 %
Italy	8.6 %
Luxembourg	7.1 %
the Netherlands	7.2 %
Portugal	6.0 %
Spain	7.6 %
Sweden	3.9 %
United Kingdom	4.7 %

Calculated from data of Walker et al 1997

Needs and assessment in older people

Needs, demands and supply are aspects of health and social care. The 'needs' are the individual's problems that will benefit from health care measures, like prevention, diagnostic procedures, treatment regimes and terminal care. The 'demands' are what older people request, and the 'supply' is the services offered to these older people.

For many older people, preventive strategies can be applied, for example, for obesity, cardiovascular diseases, diabetes mellitus, stroke and osteoporosis. Other special medical conditions in older patients are: hypertension, falls syndrome, pulmonary embolism and hyperlipidaemia. Many older people benefit from surgery e.g. joint surgery/replacement, cataracts, vascular, etc. The benefits of an active life, exercise, good nutrition and vaccinations are emphasised. Programmes for case finding and screening have a place.

Physical frailty is often combined with mental problems, such as depression and dementia. These patients either live at home, or with family, or in a residential or a nursing home. They are not beyond responding to acute medical care, rehabilitation and good medical treatment with expertise in geriatric medicine. Older people need an integrated network of health care and social services to provide the continuity of care, which does not exist in most European Union member states.

Expertise in geriatric medicine, including good

comprehensive assessment, evaluation and management of frail, older patients, is effective in improving health, activity and function. It reduces morbidity and mortality, prevents hospital admission, and delays or postpones institutionalisation.

A special group are patients who need terminal care. Cancer still contributes to the end of life in many older people. Other morbidities such as congestive heart failure, dementia, stroke, and chronic pulmonary disease may have a terminal care element and support and special facilities must also be created for these patients.

The EUGMS accepts the challenge of supporting the development of new clinical services, and being instrumental in devising educational and training programmes for health and social care personnel. The EUGMS also wishes to stimulate research to investigate the health-related problems of the older people in the European Union. We are aware of the current limitations of knowledge and facilities, and realise how large is the level of personal and financial investment and commitment needed to meet the older patient's health related problems. Only with close co-operation between governmental organisations and professionals will older patients receive the services they need.

The EUGMS has accepted the challenge of developing new services, education, and training in geriatric medicine.

What is geriatric medicine?

Geriatric medicine originated in the late 1940s in the United Kingdom, specialising particularly on rehabilitation and social reintegration into the community. During the last few decades it has developed in two directions, but often combining both. Some countries have focused on the management of older patients in the community, either at home or in residential and nursing homes. Others have developed the discipline as a distinct hospital specialty, frequently in close relationship with general medicine. Despite this spectrum of services, the original goals of maintaining independence or re-establishing it after a health-threatening event, prevail in all.

Geriatric medicine can be described as 'the specialty for health related problems in older people, including acute, chronic and rehabilitation problems, in the community, long-stay and hospital settings'. The term 'health related problems' emphasises the interaction between physical, mental, emotional, social and environmental aspects. The specialty also recognises the unique features of disease presentation in older people, the management of multisystem and multiorgan diseases, the need for comprehensive geriatric assessment, and the need for tailored and safe drug prescribing, a contribution to discharge planning and the handling of ethical issues and terminal care.

Geriatric medicine is the specialty concerned with health related problems in older people, including acute, chronic and rehabilitation problems, in the community, long-stay and hospital settings.

Geriatric medicine has only been recognised as an independent specialty in Denmark, Finland, Ireland, Italy, the Netherlands, Spain, Sweden, Switzerland and the United Kingdom. The EUGMS recognises the autonomy of the member states for the organisation of their health care systems, education and training facilities. Nevertheless the EUGMS strives, together with other organisations, like the European Union of Medical Specialists, to harmonise the specialty over the European Union.

The EUGMS strives to harmonise geriatric medicine across the European Union.

Geriatrician's skills

As with patients of any age, acquiring a sound medical history is paramount and this must be combined with the ability to communicate, make considered judgements and manage older people in language they use and understand. A geriatrician should be able to discuss alternatives, provide privacy and time for patients and carers, and relieve anxiety and distress induced by the interview and examination.

Specific skills of geriatricians include comprehensive geriatric assessment and management of older people, including experience in non-specific, atypical clinical presentations and multiple co-morbidities. The geriatrician has special skills in the assessment and management of older patients with psychological and social problems, as well as those with the principle geriatric syndromes, such as mobility disorders, falls, incontinence, pressure ulcers, dementia and delirium.

The geriatrician opposes age discrimination, discusses decisions regarding discharge arrangements with the patient and their carers, directs and advises a multidisciplinary team in a patient's treatment, rehabilitation and long-term care plan where necessary, respecting at all times the expertise and skills of other professionals. The geriatrician has knowledge of palliative care, of health promotion and preventative health care and of the local social support system.

The geriatrician is skilled in the management of complex problems and has an in-depth understanding of ageing, and how this affects the pharmacodynamics and pharmacokinetics of commonly prescribed drugs in older patients.

It is the opinion of the EUGMS that the skills, which the geriatrician requires, are fundamental to achieve a high professional standard in the acute and chronic medical care and rehabilitation for older people. These include the promotion of good health in later life, the prevention of illness, the reduction

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of disability, supporting older people in their own homes, maximising independence, preserving dignity and respect, and the involvement of older people in the management of their illnesses and discussion of their future care.

A geriatrician combines obtaining a sound medical and social history with the ability to comprehensively assess and examine older patients, paying particular attention to atypical presentation, co-morbidity, functional assessment and polypharmacy.

Undergraduate and graduate training in geriatric medicine

Changes in demography bring ageing, medical gerontology, and geriatric medicine into the centre of medicine and make them key elements in undergraduate and postgraduate teaching.

During undergraduate training students need to be aware of aspects of normal and successful ageing: the older patient's history, interdisciplinarity, ethical and end of life issues and the assessment of older patients. Problem-based questions related to geriatric medicine should be included in the final examinations.

Postgraduate training should include old age psychiatry, palliative medicine, long-term care, acute and primary care, and rehabilitation medicine. Departments of internal medicine need experience in geriatric medicine, which should be included in the board examination.

The EUGMS is aware of the importance of education for all medical students and will strive for geriatric medicine to be included in all undergraduate curricula within the European Union. Enhancement and harmonisation of education is supported by programmes which train the teachers, such as the European Academy for Medicine of Ageing.

Medical gerontology and geriatric medicine are key elements in the training of medical students and specialists' alike. There is a need for well trained qualified teachers.

Postgraduate training and assessment in geriatric medicine

Geriatric medicine faces a rising demand for acute hospital admissions, long term care, care in the community, and for clinical and health services research involving older people. A geriatrician must be trained in disease prevention and health promotion in order to reduce disability and morbidity.

Educational principles should ideally be a patient-centred learning process, reinforced by reflective critical appraisal by the trainee. The purpose of the training is to promote the development of a physician, who has the appropriate level of knowledge, skills, attitudes and competence, to work as an independent and effective specialist in geriatric medicine. The typical multidisciplinary nature places a marked importance on aspects of team working with other disciplines.

The specialist training contains core abilities and an objective-based curriculum to ensure the geriatrician has the

skills outlined above.

Clinical performance assessment requires multiple instruments in day-to-day practice, and qualified enthusiastic supervisors and mentors. Assessment methods may include: CD-linked or website-based knowledge tests; confidential self-evaluation; observation of clinical performance with feedback by patients and members of the medical team; mini-clinical evaluation of multiple-clinical encounters by different assessors, and assessment of practical procedures. This type of methodology requires extensive evaluation before being recommended as a standard.

The development of these programmes needs strong support from the professional discipline, specialist's societies and national governments.

The EUGMS will work with the Geriatric Medicine Section of European Union of Medical Specialists to define a minimum standard to be achieved and an acceptable length for clinical training. At least two years full exposure to the discipline as a trainee will be asked for, and co-training in internal medicine is advised to ensure provision of acute medical services for older people. Guidelines for specialist training and clinical attachments to academic and clinical institutes by trainees will be developed.

The EUGMS co-operates with the Geriatric Medicine Section of the European Union of Medical Specialists to define core abilities, an objective-base curriculum and quality control of the geriatric medicine specialist training.

Interactions with, nurses, paramedics and other specialties

Geriatric medicine demands multidisciplinary teams of specially trained geriatricians, nurses, physiotherapists, occupational therapists, speech therapists, social workers, psychologists and dieticians in both the community and hospital settings. These skills will only be passed to others by geriatricians participating in the programmes for specialist training and continuing medical education, and interacting with other specialties managing older patients.

The EUGMS recognises the importance of developing nursing and professions allied to medicine. The Society will support the initiatives of nurses and will stimulate other disciplines to develop international interactions in the European Union.

The EUGMS is well aware of the need for co-operation with other hospital and community specialties, both for training and the implementation of new technology and ideas, in order to guarantee the availability of modern medicine for all older people.

Postgraduate training and CPD (continuing professional development) programmes for other medical specialists, psychiatrists and family medicine doctors should include geriatric medicine.

The EUGMS encourages the interaction and co-operation between geriatricians, general practitioners, medical specialists, nurses and paramedical disciplines, to meet older patients' health related problems.

Research in geriatric medicine

Geriatric medicine is a 'young' speciality, without a strong research tradition. Furthermore clinical research in geriatric medicine is associated with particular difficulties (e.g. consent issues, life expectancy issues for long prospective trials, need for carer involvement, etc), which are reasons why older and geriatric patients are frequently excluded from clinical studies. In the past the potential gain for improvement from particular interventions was underappreciated, and few cost-benefit analyses were available. Where appropriate, it is necessary to change inclusion criteria, so that older complex patients are enrolled in clinical trials. One advantage of a European society for geriatric medicine is that it can facilitate multicentre co-operation and clinical trials by virtue of its network and potentially large patient sample available for recruitment. Basic medical research is needed into the diseases, problems and functional limitations affecting older people.

To combat the lack of too few young scientists with the required clinical and research training, courses are necessary to train those interested in the methodology, practicalities and presentation of research. Established and experienced academics should be asked to provide advice for young researchers. Several European centres are involved successfully in research, but could profit from an exchange of ideas, technology and co-operation.

There is always the question of funding, and how to obtain it. The EUGMS and its related expert-groups will actively try to influence the official research organisations of the European Union towards its areas for research and on their funding strategies. Such a combined approach would certainly have more impact than requests for support by separate groups.

Co-operation with the International Association of Gerontology is self-evident, and the network of the European Academy for Medicine of Ageing and other European academic centres can be used for multicentre initiatives. Special attention will be given to the recruitment and training of young promising researchers. To create facilities to train them and to prepare them for future academic positions might offer a solution for the existing and expected shortage for researchers and professors in geriatric medicine.

Medical gerontology and geriatric medicine attract too few young scientists for research; a combined programme of research training is recommended by the EUGMS and the International Association for Gerontology.

Ethical issues in geriatric medicine

Ethical dimensions in geriatric medicine include respect of a patient's decisions, abuse, research and confidentiality.

Respect for patient's decisions is related to the patient's understanding of treatment procedures and the alternatives if nothing is done. A patient must be provided with sufficient information to provide an informed decision.

A decision regarding resuscitation should be made for every individual. Do not attempt resuscitation (DNR) decisions can be based on the patient's request, perceived poor quality of life or futility. Any DNR decision based on futility must take into account the burden of pathologies. Outside a specialist unit the success rate is small. Decisions on resuscitation have to be discussed with the nurses. There is no ethical or legal obligation to provide futile, or non-beneficial treatment. It should always be made clear that not to resuscitate on medical grounds does not mean the same as withholding treatments that are beneficial to patient's outcome and comfort.

Abuse of an older person can be physical, psychological, verbal, neglect, financial or sexual. Anger may be an expression of distress and doctors need to be able to manage stress, in those they treat and within themselves.

Living wills, expressed before mental incapacity takes place, does not mean that the patient has to receive treatment, although refusal of treatment should be acknowledged and followed. There is a common law duty to give appropriate treatment to incapacitated patients, when the treatment is clearly in their best interests. Withdrawing treatment is emotionally difficult but ethically not different from withholding treatment. Withdrawal of treatment should not imply withholding of palliative care.

Issues relating to ethical principles for research are included in the Convention on Human Rights and Biomedicine (1997) as well as the Declaration of Helsinki. A patient can freely consent to research. If a patient is incompetent to make decisions, it has to be done by those authorised to make the decisions. All research must have local Ethical Committee permission and none must involve placebo if a safe effective standard therapy is available.

Confidentiality must be respected at all times although in some cases information may be transmitted to another health professional if it is in the best interests of the patient. Certain problems \conditions must be reported to other parties, such as elder abuse, and particular infections.

The EUGMS is aware of the ethical issues related to older patients and the differences existing between countries, but will attempt to establish a guidelines framework for clinicians and researchers.

Ethical issues in geriatric medicine need special attention and training; the EUGMS encourages discussion on ethical issues and will attempt to establish international guidelines.

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Health promotion for older people

The high prevalence of chronic diseases and disability in older people demands a health promotional approach, to improve health and to prevent the health care systems from collapsing under an excessive demand for services.

The World Health Organisation, WHO, defined health promotion as 'the process of enabling people to increase control over and to improve their own health'. The WHO has launched a campaign for 'active ageing' to enhance quality of life. The word 'active' refers to continuing participation in social, economic, cultural and spiritual affairs.

Health is a state of complete physical, mental and social well-being and is more than the absence of disease. Health promotion includes physical environment, education, occupation, income, social status, social support, gender, culture and health care. It is a life time necessity, with good health in youth propagating better health in older age.

Primary prevention is preventing a disease before it has occurred. Lifestyle has an important role and this is known for smoking, regular physical activity, vaccination and healthy nutrition. For ethical reasons not all of these could have been proven by randomised controlled trials in older people.

Secondary prevention is the early detection of a sub-clinical disease, by screening or case finding. Examples are screening for breast and cervical cancer and falls prevention. Early treatment reduces morbidity and mortality. Preventive home visits may reduce functional decline, nursing home admissions and mortality. These programmes are effective when based on multidimensional geriatric assessment and follow-up home visits.

Tertiary prevention is to minimise disability and handicap from an existent disease. It relies on the skills of a team, especially those of the medical, nursing and rehabilitation staff.

The EUGMS will contribute to the further development of clinical guidelines for health promotion and preventive strategies.

The high prevalence of chronic diseases and disability in older people demands health promotion and prevention strategies; the EUGMS will develop guidelines for these measures.

Co-operation with other societies

Bridges are needed to societies representing other physicians and health care professionals, including sociologists, epidemiologists, lawyers and architects. The aim is to foster understanding and research in areas where multidisciplinary approaches could prove most successful, as well as writing joint guidelines and consensus documents, providing educational and training programmes and attempting to influence European health care policy.

Two levels of priority can be set in the co-operation with medical and surgical specialties.

The first involves old age psychiatry and family medicine. In some European countries, old age psychiatry has been developed as a branch of geriatric medicine. In most countries, primary health care for older people at home and in nursing homes is provided by general practitioners, with or without a special interest in geriatric medicine.

The second priority should be the collaboration with other medical specialist societies, which deal with diseases or syndromes of older patients.

The EUGMS recognises the importance of interaction and will establish links with other disciplines together with the International Association of Gerontology.

Collaboration with societies for old age psychiatry and family medicine has a high priority for the EUGMS; non-medical disciplines will meet with the International Association of Gerontology.

Collaboration with other organizations in geriatric medicine and gerontology

The EUGMS is not the only organization dealing with health care in older people in Europe. Others are the European Region of the International Association of Gerontology, ER-IAG, the Geriatric Medicine Section of the European Union of Medical Specialists, GMS-EUMS, and the European Academy for Medicine of Ageing, EAMA. All try to improve the services for health-related problems in older people. Overlap and competition between the organizations are unproductive and wasteful of scarce resources. By a process of close collaboration and joint working in specific areas, a greater and more effective EU-wide force could be fashioned. The EUGMS, as the principal focus of national geriatric societies, may function as an umbrella, respecting the already existing organizations. The ER-IAG, the GMS-EUMS and the EAMA have accepted a position on the EUGMS' board to participate together in their activities.

The research proposals of the IAG give a high priority to social, economical, behavioural and biological aspects of older people and give special attention to health promotion and preventive measures. The EAMA trains teachers to a high standard. The tasks for the GMS-EUMS are quality control and the development of guidelines for education and training in geriatric medicine. By working together these guidelines will be acceptable to both societies.

The EUGMS, the ER-IAG and the GMS-EUMS wish to influence the political climate and the national governments regarding the development of health services for older people. Through the EUGMS and GMS-EUMS a link can be made to the European Commission and the ministers of health care.

Geriatric medicine is a growing specialty in the European

Union. To meet society's needs, to guarantee the quality of services and to allow the free movement of specialists between the member states, is a process that takes time and energy, but is worth doing. The ingredients for a successful future are available now.

The EUGMS co-operates with the International Association of Gerontology, and the Geriatric Medicine Section of the European Union of Medical Specialists for promoting well-being of older people and highlighting health related problems in older people.

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