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Origins and development of geriatric medicine in Australia

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Abstract

After a tentative beginning 50 years ago, geriatric medicine has become an accepted part of medical practice in Australia. It includes the rehabilitation of elderly people, general aspects of aged care in the community, undergraduate and postgraduate education and research. (Intern Med J 2001; 31: 422–425)

Key words: geriatrics, home care service, medical education, medical specialties.

AN ADDITION TO AGED CARE

Apart from care by the family, aged care, which is now a complex organization in which statutory and voluntary bodies are responsible for domiciliary, residential and hospital components, was originally in the form of custodial care in large institutions before geriatric medicine began. This addition has been defined as 'the branch of general medicine concerned with the clinical, preventive, remedial and social aspects of illness in the elderly'.[1] The demographic imperative has often been cited as the principal reason for its origin; but the medical imperative, the need for attention to physical and mental disabilities, underscored the involvement of the medical profession. Unlike other specialties, it did not spring from the need for an in-depth method confined to a narrow section of medical practice, such as haematology or nephrology. In contrast, the width rather than the depth of involvement embraces both mental and social aspects of health, including a major component of community practice. A number of events during the last half-century have been responsible for this development in Australia.

THE FIRST HOSPITAL-BASED SERVICE

In 1950, the Hospital Commission of New South Wales (NSW) requested the Royal Newcastle Hospital to survey the known people with multiple sclerosis in the Hunter Valley, with a view to setting up a special hospital clinic for that purpose. Dr Chris McCaffrey, the medical superintendent, appointed Dr Richard Gibson and Miss Grace Parbery, social worker, to conduct the survey.[2] In their report to the Commission, they pointed out that 'the answer to this problem lay in the provision of medical, nursing and domestic care at home …for this group *and for the chronic sick in general*…such institutions that do exist do not cater for the infirm as a general rule and are usually overcrowded' (my italics).[3]

If hospitals had acted on this recommendation, geriatric medicine would have become established at that time. However, it was almost 5 years before the Hospital Commission granted permission to the Royal Newcastle Hospital to institute an extramural service for patients in that district. Even when the 'Newcastle Experience', as it became known, had clearly demonstrated a successful and cost-effective method of hospital-based domestic care and rehabilitation (the Willam Lyne hospital was opened for this purpose in 1957), there was no universal acceptance.

REVOLUTION IN THE UNITED KINGDOM

The name 'geriatrics' appeared in New York at the beginning of the last century.[4] Dr I. L. Nascher provided cogent argument as to why special attention was necessary. However, practical application of these ideas only became a reality after Dr Marjory Warren had made her demonstration at the West Middlesex hospital in London in the 1940s.[5] At that time, the

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medical profession in Australia was more concerned with avoiding a National Health Service than following the British example of introducing geriatric practice into general hospitals. Nevertheless, Dr Warren's diligent application of basic medical principles in situations that had long been neglected impressed individual visitors and became a positive influence in subsequent development in this and other countries.

INITIATIVE FROM LEADERS IN PUBLIC HEALTH

Following on from Newcastle and from the influence in the United Kingdom, the third initiative for medical intervention for disabled elderly people in Australia came from leaders in public health. The Aged Persons Homes Act had been promulgated in 1954. Sir Abraham Fryberg, Director General of Health and Medical Services in Queensland, was critical of the concept that special housing would satisfy elderly people's needs. After visiting Dr Warren in London, Sir Abraham invited her to Queensland. These events culminated in Dr Peter Livingstone's return to Brisbane as Australia's first trained geriatric physician after becoming a Member of the Royal College of Physicians of Edinburgh in the new specialty of geriatric medicine. He became Director of Geriatrics in Queensland's Department of Health and Home Affairs in 1961, beginning clinical work at the Princess Alexandria Hospital. (P. G. Livingstone, pers. comm., 1987).

The impetus from leaders in public health for the establishment of geriatric services was also initiated in other States. Mount Royal Hospital, originally founded in Melbourne by the Immigrants Aid Society in 1853, had become a custodial institution for elderly people. A century later, following the visit in 1951 of the Secretary-Superintendent Col. R. L. Elliot to Britain and Scandinavia and the efforts of Dr John Lindell, chairman of Victoria's Hospital and Charities Commission, the Herbert Olney Geriatric Centre was founded at the Hospital.[6] Rehabilitation began about the same time as in Newcastle with Dr Graeme Larkins as director.[7] He elected to remain part-time in private practice, a trend now being followed by many geriatric physicians. Following his death only 2 years later, he was succeeded by Dr R. Butterworth. Community involvement became an added feature under Dr Boyne Russell (B. Russell and R. Dargaville, unpubl. obs, 1976). In 1975, Mount Royal became the centre for the National Australian Research Institute.[8]

Lidcombe State Hospital in NSW was another centre outside the mainstream of medical practice that contributed to the early development of geriatric medicine.[9] Having evolved from the Rookwood asylum, Lidcombe had been principally committed to custodial care until shortly after the middle of the 20th century. Two transitions then took shape; in addition to several medical and surgical specialties within the hospital, a geriatric service, including the surrounding community, was initiated. This latter activity was largely the response of a group of young doctors whose interest in the medicine of late life had been stimulated by their experience at Lidcombe. Some had come to Lidcombe as NSW Public Service Board cadets, with the idea of a career in psychiatry. Two of them, G. R. Andrews and A. G. Broe, were later to be appointed to university chairs in geriatric medicine; both subsequently added research to their clinical activities. Dr Sidney Sax's distinguished career in aged care administration began at Lidcombe. Dr Ted Cullen, another member of the group at that time, became prominent in Community Aged Care and Disability Services in NSW.

Initiative from leaders in public health, together with the example from the United Kingdom, had a similar result in Western Australia. Dr W. S. Davidson, Deputy Commissioner of Public Health, returned from an overseas visit convinced that 'salaried medical practitioners with suitable qualifications should be in charge of geriatric departments in general hospitals'.[10] But the existing medical climate in 1963 was such that the service had to begin, not in a hospital, but in one of the State Government benevolent homes. There was no intention of converting this to a geriatric centre. However, responsibility for the care of residents in this establishment provided a valuable (if somewhat unintentional) acquaintance with many of the medical and social problems of residential care. It was almost 10 years before the opportunity occurred of becoming a department in a hospital; this was a serendipitous event aided by the discovery of streptomycin, thereby allowing a redundant chest hospital to be transformed into a general hospital, including a geriatric unit. A further lapse in time occurred before all Perth metropolitan hospitals accepted this addition. Country centres are yet to follow.

REHABILITATION

Following the end of the war, this practice, initially for the comparatively young, became prominent. In time, war veterans acquired disabilities associated with ageing and Departments of Veterans' Affairs became

areas for the growth of geriatric medicine. Physicians at Daw Park Rehabilitation Hospital in Adelaide had been appointed as 'Specialists (Rehabilitation)'. In effect they became physicians in geriatric medicine within the hospital. Assessment units were set up at Daw Park and became closely affiliated with domiciliary units already in existence. Similar services became based in Royal Adelaide Hospital and other main hospitals in that State. In Sydney, NSW, an academic department of geriatric medicine was established at Concord Veterans Hospital.

ALTERNATIVE PROPOSALS TO GERIATRIC MEDICINE

In 1969, Dr Rollo Greenlees was appointed geriatrician to South Australia's Public Health Department. However, without access to a hospital base, except for a long-stay ward associated with the Royal Adelaide Hospital, such an arrangement proved to be far from adequate for geriatric medicine to become a viable form of practice.

The Australian Association of Gerontology, formed in the early 1960s, consisted of members from a variety of disciplines concerned with the problems of late life. Because of particular aspects of medicine, the doctors in this group decided to form the Australian Geriatrics Society (AGS), later to become the Australian Society for Geriatric Medicine. They were concerned with the direction in which the new specialty was heading; alternatives to a hospital-based system, considered to be essential for the successful conduct of geriatric practice, were being proposed.

The Hospitals and Health Commission expressed the view that geriatrics is basically the provision of community health services for the elderly. The AGS argued that this would separate domiciliary services from the other phases of geriatric medicine. The Society was also concerned about proposals that the formation of a few centres of excellence would be sufficient for the education of medical undergraduates. University chairs in geriatric medicine were deemed to be undesirable by the Commission, who considered that it would be sufficient to appoint lecturers in this subject to departments of community practice.[11] Even when university chairs were subsequently established, one or more of their legs generally belonged to another discipline, such as the chair in Community Medicine and Geriatrics in the University of Sydney at Westmead in 1978. In the following year, the Professor of Geriatrics occupied a chair in the School of Community Medicine in the University of New South Wales. In subsequent developments, academic departments of geriatric medicine have generally become affiliated with university departments of medicine. Undergraduate teaching gradually became accepted as part of the curriculum in these departments; by 1999 there were 12 such operations in progress.[12]

The education and qualifications of geriatric physicians became a further issue of concern. When the subject of specialist training was raised with the Royal Australasian College of Physicians, members of the AGS were initially informed that this would be included in the existing training for the general physician. It was, however, eventually conceded that specialist training in geriatric medicine was necessary and would in future be undertaken as part of the training for Fellowship of the College.[13]

Ever since the pioneer work of Marjory Warren, rehabilitation had been a fundamental part of geriatric medicine. The two practices evolved in parallel so that they were often regarded as synonymous. The National Committee of Enquiry into Compensation Rehabilitation regarded care of disabled elderly people as part of its brief; they considered that rehabilitation and geriatric medicine should be combined. The Universities Commission considered that geriatrics should be encouraged as part of the broader framework of rehabilitation medicine.[14] The AGS agreed that the two disciplines had much in common, but could not support an arrangement by which they were to be united. The two streams were destined to develop separately.

AGED CARE REFORM

The Commonwealth Government's Aged Care Reform movement followed the McLeay Report in 1982.[15] This was primarily a reaction to the unsatisfactory state of residential care. In the absence of assessment, there had been many inappropriate admissions to nursing homes. Standards of care had become scandalous and cost had grown to unacceptable proportions, particularly when compared to the relatively small amount devoted to assisting elderly people in the community. The formation of Geriatric Assessment Teams, later renamed Aged Care Assessment Teams, was followed by the initiation of the Home and Community Care program. With this addition of resources, the Commonwealth Government played a positive role in aged care. This aspect of reform led, however, to a departure from the comprehensive geriatric service, originally devised by Gibson[2,3] and subsequently developed elsewhere, for

example in Adelaide, in which provision of both hospital and home care was a carefully monitored joint exercise. With the gain of available resources for aged care came loss of coordination and continuity of care.

THE STATUS QUO

'Geriatrics was born of sin and should work towards its own extinction' (a statement attributed to Lord Sholto Amulree, the first president of the British Geriatrics Society). Extinction has been achieved in the sense that geriatric medicine is no longer relegated to the back wards of chronic hospitals, but is part of the established profession. Its original focus over the wide spectrum of aged care has been somewhat narrowed by the evolution of other specialties. Although geriatric physicians still have a major involvement with dementia, psychogeriatrics has developed. Palliative care, the numerous forms of assistance provided by government and the activity of organizations such as the Alzheimer's Association now complement geriatric services to an important degree. Opportunities for successful attention to elderly people's disabilities and handicaps have increased; but a multiplicity of agencies and the appearance of new specialties, with different means of assessment and delivery, have the potential for diminishing continuity of care. Private practice has become the choice of an increasing number of geriatric physicians: might this jeopardize the close association necessary with other members of the team? Geriatric medicine needs to maintain a wide spectrum, embracing the community as well as the hospital, giving further attention to the difficult problems of residential care and expanding its role in education and research.

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