

# The Physician and the Confused Elderly Patient

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Most doctors are vividly aware of the increase in the proportion of their case load made up of the elderly, and particularly the very old, in whom the highest prevalence of physical and mental morbidity is found. With the resources of the family diminishing and those of the Health and Social Services diversely stretched and poorly co-ordinated, it is not surprising that this increasing demand is inadequately met. As a result, many old people are living in precarious settings and are unable to cope with added stresses, such as episodes of illness, leading to hospital admission in which the need for supervision and nursing often outweighs the need for specialised medical care. As confusion is a factor frequently predisposing to such admission, it is not surprising that the 'confused elderly patient', often perceived more simply as the 'demented old woman', is an increasing source of concern to the acute specialties. Indeed, Bergmann and Eastham (1974), in a study of people over 65 admitted to an acute medical unit, demonstrated that over 40 per cent of patients showed some psychiatric morbidity, more than half of whom were demented or suffering from acute confusional states.

As this represents a significant proportion of the physician's total case load, especially in terms of bed occupancy, the appraisal of such disorders clearly becomes a crucial part of everyday hospital medical practice. The psychogeriatrician is accustomed to being consulted when disposal is proving a problem, and the main emphasis of this article is on those aspects of appraisal and management of confused elderly patients that relate to their prospects and preparation for discharge. The aim is to provide the physician with some rules of thumb and hints from personal experience that may help him to start such planning as soon as possible after admission. This is followed by a discussion of one way in which a change in the organisation of acute hospital care might find these and other vulnerable old people a more suitable niche than is usually the case at present.

## ASSESSMENT OF THE CONFUSED PATIENT

### *Background Information*

The term 'confused' is often used far too loosely of the elderly, and its extrapolation to 'demented' is even more dangerous because of the implication of irreversibility and further deterioration. The 'demented old woman' anchored to

her bed by her catheter and cot sides may have been a 'fine old lady' a couple of days previously, and may be so again in a couple of weeks' time. She may not know what is going on around her by virtue of blindness, deafness, sheer anxiety, or of being unconscious at the time she came in; she may simply be dysphasic or she may be so suspicious that she believes the whole set-up is a façade. On the other hand, she may really be confused, though one would have to question her relatives to know whether this was a product of her illness or whether she had been demented for years. Clearly, the mental state must be examined, using definite but simple criteria for confusion but it is also necessary to know how this state relates to previous function. Because this latter aspect is more easily neglected and because of its implications for planning the patient's care, it will be dealt with first.

Certain questions need to be asked. Was the patient running a household before this illness, or at least playing a responsible part in it? If so, was she coping adequately, or were things going from crisis to crisis? If dependent on others, was she becoming a problem or a heavy burden to them? If there had been chronic mental deterioration, how far along the usually fairly regular path of dementia had it gone (forgetfulness; inability to shop or cook for herself; getting lost or wandering out of home; unable to dress or maintain personal hygiene; incontinent of urine; getting lost even in the home; failing to recognise relatives and friends; incontinent of faeces; unable to feed)? On the whole, few people who have got down to the last couple of rungs of that ladder get into acute medical wards, and it is worth emphasising that a recent or intermittent history of faecal soiling or incontinence in the absence of urinary incontinence is likely to indicate severe constipation and faecal impaction rather than severe dementia. Attention should also be paid to the time scale; has deterioration been over days, weeks, months or years, and how much fluctuation has there been? Dementia should not be diagnosed in the absence of a history of several months' continuous impairment, and the significance of recent confusion is easier to ascertain if its time relationship with the physical illness precipitating the admission can be identified.

It is a fair rule of thumb that, whatever the patient's mental state on admission or at the height of a confusional episode, it will generally return to a level near to that prior to the episode. The time scale of such recovery depends on the nature of the acute illness and on the extent of mental deterioration, if any, already present. Thus, the confusion due to an acute infection usually settles within days, that of a myocardial infarction or cardiac failure within a week or two, while that of a cerebrovascular lesion may take a couple of months to clear. If there was pre-existing dementia, in which case the triggering illness may have been more trivial, recovery may be slower. It should be reiterated that confusional states may arise in the elderly as a result of myocardial infarction, respiratory or urinary infection, or a cerebrovascular accident without any of the classical symptoms and signs of such lesions being apparent.

The information gained about previous functioning will therefore permit

**Table 1.** Performance levels and needs for support in dementia.

Severity of dementia	Performance prior to presenting illness	Support likely to be needed after discharge
Mild	Forgetful; problems with cooking, money and shopping; neglecting housework; self care good	Can live alone if supported by relatives, neighbours, warden (sheltered housing) or home help; may need Meals on Wheels
Mild/moderate	Getting lost outside home; accidents with fires, cooker, TV, etc; able to dress; still predominantly continent	Very precarious if living alone previously (especially if recovery incomplete, new physical handicap or need for regular medication). Might be worth a trial at home. Better in residential care (Part III or Rest Home) or with relatives
Moderate	Very poor memory for events of recent years; gets lost even in the home; needs help with dressing; incontinent of urine	Not a good candidate for residential care (unless returning to a Home where she had been for some time). If living with relatives may need to return to them. (Notify psychogeriatrician early on in case he can offer advice, support or even transfer to one of his beds.) Such transfer probably necessary if no caring relatives. Could cope in nursing home
Severe	Memory and conversation very limited. Incontinent of urine and faeces. Unable to wash or dress. Difficulty with feeding and walking	Long stay bed unless exceptionally devoted relatives wish to have patient home. Notify psychogeriatrician early on

provisional predictions about the likely extent of, and delay in, mental recovery, which might be incorporated into plans for the patient's discharge (*see* Table 1). With this in mind it is therefore initially useful to find out how well the patient has been coping at home prior to the illness, how much support was needed, and how much actually provided. Was the patient already lurching from crisis to crisis, or heavily burdening her spouse or family, and, if so, were plans afoot to move her to a different setting (for example, to live with relatives, or into residential care), or was everything adequately compensated until the crisis of the acute illness? Was the admission really precipitated by an acute medical need, or was it just the last straw in a deteriorating chronic situation? With this knowledge it will be possible to predict the likelihood of a viable return to the previous setting and to ensure that the family and others involved appreciate this from the very start. If things

were already borderline or worse it enables the doctor to initiate moves towards an alternative placement without delay.

The confused patient will obviously not furnish this information herself, but all too often further search is neglected. One potential informant is the general practitioner, though communication is often attenuated by passage through a Bed Bureau, or distorted by the traditional onus on the G.P. to present his patient in terms of clinical signs and interest rather than to emphasise the social and nursing needs that may really underlie the request for admission to hospital; unhappily, too, the referring doctor often knows little about the patient. Relatives or friends accompanying the patient to hospital can usually answer most of the questions outlined above, and the short time needed to ask them is worth while even on a busy 'take' day. If the opportunity is missed, there are few patients whose Kardex entries do not include a telephone number through which a relative or neighbour can be contacted. Use of the telephone in this way may not seem quite part of medicine but it may save days or weeks in hospital for the patient. Nursing staff often pick up a good deal of useful information that never gets to the doctor, and they should be instructed to ask the questions outlined above at the time of admission, or of visitors, and should get the answers into the notes, or at least to the doctor. Failing this, or in addition, contact with the G.P. can be made subsequently at his surgery. Health visitors, home nurses, social workers and home help supervisors may throw up abundant information as well. This should not be disdained as social work, and should start as early as possible after admission. If there is a social worker who knows the sort of questions the doctor needs answered, she may be better placed to make these enquiries.

This is a two-way process in that, as the doctor's picture of the patient's previous function materialises into a plan for the future, he may guide the expectations of the relatives and community workers accordingly; it must be remembered that it is during the first few days that the mistaken assumption tends to develop in the community (and particularly in the family) that the patient will never leave hospital again, or at least that she will never return home. In psychogeriatrics the discharge is usually planned before admission; in medicine planning must at least start soon after. These sorts of enquiry often do not come naturally to doctors, especially if they have only worked in hospitals, but if they are more inclined to make them as a result of this article it will have been worth writing.

### *The Mental State*

Assuming that care is taken to detect disorders such as deafness, blindness and isolated dysphasia, the majority of patients whose mental state suggests confusion will be suffering from an organic brain syndrome. The main features of this syndrome in the acute medical setting are listed in Table 2 where they are contrasted with those of functional disorders. Although the mental state of the acute organic brain syndrome (syn. acute confusional state, delirium) is difficult

Table 2. Mental state – diagnostic features.

Organic brain syndrome	Functional psychiatric illness	
Impaired memory for recent events; poor grasp of events in the ward; disorientation in time and/or place; poor concentration; muddled thoughts and talk; difficulty with practical tasks; incontinence (if severely confused)	Memory for recent events and orientation reasonable (allowing for any impairment in interest, concentration or co-operation). Onset of symptoms dating from well before admission or from convalescent phase	
<i>Other more florid features, suggestive                      of an acute component to the syndrome</i>	<i>Depression</i>	<i>Paranoid State</i>
Restlessness; irritability; aggression; labile mood; paranoid thinking; illusions or hallucinations (mainly visual); marked fluctuation in arousal, concentration, orientation or other symptoms; worsening of symptoms at night; frank clouding of consciousness; patchy performance on memory testing.	Mood consistently low; pessimistic; apathetic; agitated; preoccupied with physical symptoms especially pain; lack of spontaneous talk; unexplained anorexia	Stable persecutory delusions; auditory hallucinations; suspicious or hostile manner

to differentiate from that of the chronic (dementia) in the elderly, a point emphasised by both Bergmann and Eastham (1974) and Hodkinson (1973), the more florid symptoms listed in Table 2 tend to point to the acute syndrome (though this may be in the form of an acute confusional exacerbation of a pre-existing dementia). This again underlines the importance of obtaining a proper history.

The physician may himself be confused by the variety of tests used to substantiate the diagnosis of organic brain syndrome. The most valid are those that test new-learning ability, and reduce to a minimum the influence of variables such as concentration, original intellectual level and educational background. The more sophisticated tests used by psychologists are aimed at mild levels of impairment in younger people, and are seldom of much use with the confused elderly. The battery that forms the basis of Bergmann and Eastham's (1974) and Hodkinson's (1973) studies is a useful one, but the learning component is diluted by other variables; it is not very sensitive to near misses and is a little long. It is probably just as useful for the clinician to have a short list of questions such as the day of the week, the date, the place, the patient's age, address, and date of birth, and the name of the Prime Minister. By applying these to all elderly patients passing through his hands he will soon work out his norms. Generally speaking, one or two units of error in the date in people over 75 years of age are permissible, though errors in age, date of birth, and address are more sinister. If in doubt, other questions can be asked about the events of the last few days or hours in the patient's life. When poor performance could be due to dysphasia it is

necessary to present the questions in a simple multiple choice manner, and this may also be helpful if it is suspected that lack of interest or concentration is distorting the picture. The patient may be prepared to recognise the correct answer even if he will not try and think of it. The answers to these questions should be recorded in the notes as a basis for comparison on later testing.

These questions are aimed chiefly at identifying the patient who is not confused. Disorders of communication and severe anxiety may have mimicked the organic disorder, but so also may functional illnesses. The most easily mistaken is the paranoid state (schizophrenia-like illness) in which patients become suspicious of those around them, developing persecutory delusions and usually auditory hallucinations. The lack of true confusion and the auditory, as opposed to visual, hallucinations are the key features. Depression may also mimic confusional states, and the clinician should be alerted by consistent depression of mood, pessimism, self-reproach, apathy, retardation or an unhappy agitated manner. It is the agitated depressive who can most easily mimic confusion. Both paranoid and depressive illnesses are usually less closely related in their time course to the physical illness than is the organic brain syndrome, occurring either in the convalescent phase or having a history going back weeks, months or years before admission.

The objectives of the mental state examination will therefore be to ascertain whether disturbed behaviour is due to an organic brain syndrome or not, and, if so, whether it is mild or gross. It would tell very little about the patient's previous, and thus the likely future, level of mental functioning but, by repeating a simple schedule of questions, progress can be charted. Lack of objective evidence of confusion should alert the clinician to look for other and usually remediable causes of abnormal behaviour, and, if necessary, to call in the psychiatrist

## MANAGEMENT OF THE CONFUSED ELDERLY PATIENT

### *Treatment of Symptoms*

The greatest impact on the patient's confusion will usually come from the investigation and treatment of the underlying physical illness, though it may be stressed that in the elderly this may turn out to be some very minor or mundane condition. It is, however, appropriate to draw attention to those aspects of caring for the elderly that tend to be neglected in acute medical (not to mention surgical) wards. If the patient is anxious and confused her condition can be helped only if things are explained to her and she is treated with dignity; too often we hurry past, are discouraged from explanation by difficulties of communication, or show frank irritation with the patient's demands or obtuseness. As well as accepting a slower tempo of recovery in the elderly we must recognise the speed with which they lose skills if rehabilitation is not a fundamental aspect of treatment from the beginning. Prolonged use of catheters, failure to regenerate toilet rhythms and habits, immobilisation in bed or chair, lack of social contact,

and staff condescension may all sustain regressive behaviour, greatly delay full recovery, and thus postpone discharge. It usually falls to doctors to take the initiative in these matters, though if we encourage multi-disciplinary team work, remedial therapists will often watch these aspects better than doctors.

Table 3 contains some suggestions on drug therapy in the disturbed elderly patient; they simply represent personal preferences. The drugs mentioned may control disruptive behaviour, though confusion as such would not be affected, except when overdosage would exacerbate it. The use of injected neuroleptics should be avoided where possible, as a see-sawing effect tends to occur. It should always be remembered that pain may be a factor in restlessness and noisiness, especially at night, and should be treated in its own right. If these remedies are ineffective the advice of a psychiatrist should be sought, and such help is desirable in the case of a depressive or paranoid illness. If the patient is moderately severely demented, and especially if she constitutes a heavy burden on relatives, the whole approach to therapy may need to be slanted towards 'care and comfort' as opposed to 'cure'.

Table 3. Medication for elderly confused patients — some suggestions.

Situation	First line of treatment	Second line of treatment
Night sedation	Chlormethiazole (Heminevrin) 0.5-1 g nocte (more potent, if less palatable, in syrup form). <i>Or</i> Dichloralphenazone (Welldorm) 0.65-1.3 g nocte	Promazine (Sparine) 75-100 mg at 7 p.m. with Chlormethiazole or Dichloralphenazone 2 hours later. <i>Or</i> Promazine 100-150 mg I.M nocte
Daytime restlessness or irritability	Thioridazine (Melleril) 25-50 mg t.d.s. (also useful for mild paranoid symptoms)	Haloperidol (Serenace) drops; start at 3 drops (0.3 mg) t.d.s.; increase by 1 to 2 drops per dose each day until behaviour controlled. Give Procyclidine (Kemadrin) 5 mg t.d.s. as well
Severe restlessness or aggression (acute)	Haloperidol 3-5 mg I.M Procyclidine 5 mg I.M	Repeat Haloperidol 5-10 mg and Procyclidine 10 mg I.M after 30 minutes if no response. <i>Or</i> Chlorpromazine 75-100 mg I.M after 30 minutes if no response
Paranoid state (or severe paranoid symptoms in acute organic brain syndrome)	Trifluoperazine (Stelazine) 1-3 mg t.d.s. with anti-parkinsonian drug	Increase dosage slowly to dosage of 5 mg t.d.s.
Depressive illness	Tricyclic antidepressant increasing to dosage of 75-125 mg/24 hours	ECT

### *Longer Term Management*

The importance of early enquiry into the patient's previous level of functioning and home circumstances in guiding prognosis, planning for discharge, and shaping the attitudes of the patient (and more particularly of his relatives and friends) cannot be over-emphasised (*see* Table 1). The expectation should be one of recovery to somewhere near the level prior to the acute episode, or to a better level in some cases (treated paranoid or depressive illness, remedied deficiency disorders), allowing, of course, for the prognostic implications of the physical illness itself. Provisional plans can then be adjusted in the light of progress in hospital. The problem cases are obviously those in which the situation was already precarious, especially if the patient was living alone and without supervision.

In instances where the patient had been coping badly alone at home for some time, with reports of accidents with fires, cookers, kettles, etc., inadequate diet, and wandering away from home, the writing is usually on the wall for residential care or a move to live with a relative. If such problems were isolated or had really only arisen just before admission, a trial return home with extra domiciliary support (home help, meals on wheels, home nursing, relatives, etc.) might be justified, though a social worker should be consulted early on so that the home services will be organised for the time of discharge and contingency plans made in event of things breaking down. If there is to be heavy dependence on social services it is as well to arrange for the discharge to take place just after rather than just before a weekend. In some cases the patient will have to wait in hospital for a residential placement, but the frustration of waiting will be reduced if the necessity is realised soon after admission, and an immediate application for a place is made.

Residential homes can usually be regarded as able to cope with people who can dress, are continent and mobile, and are not too disruptive by virtue of wandering or aggression. Again, the criterion should be performance before admission rather than in the ward itself and the application should be made right away rather than delayed until recovery has reached the residential care level.

When patients are living with relatives the limits are much less clearly defined, as in most areas the statutory resources are under such pressure that relatives may have to carry quite heavy burdens. It will usually be apparent early on if the relatives were already bearing an excessive load and it will often become apparent that they were anticipating that hospital admission would end their responsibility for the patient. In such cases guidance will need to be sought from the geriatrician or psychogeriatrician. If their criteria for long-term care are such that the patient would not muster sufficient priority, family misapprehensions will need to be cleared up at an early stage if discharge is to go ahead. The same will usually apply in that other difficult situation when relatives try to use an acute medical admission to put on pressure for a Part III placement by renouncing any further responsibility for the patient, the implication being that he or she will have to spend the prolonged waiting period in the acute medical ward. This sort of



confrontation is much less likely to arise if planning has started soon after admission; it can be made clear to the relatives at that time that the patient will in fact be returning to them. In this type of instance the relatives should be given every possible assistance in the period following discharge, arrangements being made for surveillance and support by the community nursing or social services.

At this point it is worth mentioning the part the psychogeriatrician may play in the management of the elderly confused patient in the medical ward. In some areas, of course, there will not actually be a psychiatrist specialising in the elderly, though the general psychiatrist will be able to advise on management and will have access to long-stay psychogeriatric beds; often the geriatric service will carry a greater psychogeriatric load in such cases and may be the appropriate one to contact. As a psychogeriatrician I would see my role in the acute medical ward falling into three main parts: first, to help with diagnosis and management of behavioural problems in the elderly patient in the ward; secondly, to advise on the prognosis and management of cases that might be regarded as borderline or too precarious on the criteria outlined above; thirdly, to provide continuing support in cases in which mental problems are likely to continue after discharge, with a view to rescuing the situation if necessary. In some cases it would be necessary to transfer the patient to the psychogeriatric unit for further rehabilitation or treatment; in others, transfer to a long-stay bed might be necessary. Of course, the psychogeriatrician would hope that, by running an effective service himself, he would reduce the frequency with which 'purely social' admissions of demented patients occurred in the medical wards; i.e. they would go into his own acute beds. If one managed to fulfil all these functions, one would, like the geriatrician, pray one's physician colleagues to heed the advice proffered so far, and particularly to avoid assuring relatives that patients are in need of long-term hospital care until the inevitability of such a course of action has been agreed.

The foregoing comments amply illustrate the inadequacy of our resources for helping old people who impinge on the hospital services. In some areas these resources are more plentiful and such a combative attitude is not necessary. My main theme, however, is that observation of the principles outlined above should permit an early provisional plan for the patient's discharge. If this is compatible with a return to the setting whence he was admitted it is important to abort conflicting attitudes on the part of relatives, etc., that may otherwise unnecessarily prolong stay in the hospital. If further care in a residential home or a psychogeriatric short or long-stay unit seems indicated on grounds of mental impairment, the sooner the psychogeriatrician is consulted, the better.

#### WHO SHOULD LOOK AFTER THE CONFUSED ELDERLY PATIENT?

The sort of patient with whom this article has been largely concerned epitomises a large group of very old people whose chronic physical, mental or social

vulnerability often leads to urgent need of residential or hospital care at times of illness or other crisis. By virtue of their availability, acute specialist medical beds are frequently the haven in such instances, despite the fact that they may not be appropriate to the patient's needs, and that such a placement may, in economic terms, be grossly wasteful of expensive and specialised resources. Perhaps more worrying than this is the extent to which an acute hospital service for the elderly, based on specialist medical beds, may fail to meet the needs of this age group as assessed by the G.P. Thus, there may be many patients whom he feels it is pointless to refer, either for lack of strictly medical criteria, or possibly because the real need is for the patient to be nursed in comfort and dignity in what seems likely and appropriately to be a terminal illness, for which it might be difficult to discourage resuscitation in the hospital setting.

For these reasons it seems desirable to centralise the responsibility for the acute services for the elderly in departments of geriatrics. Such departments would then be responsible for using their resources in a way that would offer optimal support to those in primary health care. Liaising with and educating these and other agencies involved with the elderly should encourage a more appropriate use of facilities, especially those of sheltered housing and residential care. By improving the overall levels of care in this way the geriatric department would be in a good position to take a lead in the more preventive aspects of geriatrics that provide the real incentive in this specialty.

Many geriatric departments have already moved well along this path, using differing criteria for patient allocation between themselves and the physicians, but usually with the onus properly on the geriatrician to take the cases in which the problems are least amenable to specialised medical skills. When such a step is to be considered it is obviously necessary for the increased undertaking to be matched by re-allocation of beds, on the basis of levels of occupancy by elderly people in the existing medical wards, and of manpower. It is not crucial for such departments to be manned entirely by full-time geriatricians, though it is desirable that each team should contain at least one who will be responsible for maintaining the service, reviewing policy and liaising with other services. Apart from the training value of such departments to would-be physicians or G.Ps, there is a further aspect of staffing that is affected by a geriatric or psychogeriatric service 'going acute'. Generally speaking, the high priority that has to be placed on acute turnover will lead to redeployment of chronic beds for short-stay functions; this should be accompanied by increases in both nursing and remedial staff.

This development, however, still leaves many confused patients straddling the boundary with psychogeriatrics which, if the two services are run differently, can become a very troublesome gap as far as the G.P. is concerned. There has been a rapid increase in specialisation in the psychiatry of old age in the last few years, which has led to the development of thriving comprehensive services for people over the age of 65 such as that described by Arie (1972). The similarity in the principles of running the two types of service and the extensive overlap of

clientele make it seem a logical step for the two specialties to merge to create departments of geriatric medicine and psychiatry. Such departments would then provide a joint front to the G.P. whose referral could be dealt with by whichever specialist seemed most appropriate, admission, if necessary, taking place to the type of bed indicated by his assessment (i.e. acute areas could provide a spectrum from a medical geriatric ward, through a ward catering for the physically ill but disturbed patient, to the psychiatric ward that would cater for a mixed bag of organic and functional illness). This would be a more closely integrated version of the acute service described by Arie and Dunn (1973), and one would envisage the 'joint unit' having a more expanded role than in their service. The confused patients, about whom this article has been written, would probably be spread mainly between this 'mixed' ward and the main medical geriatric one. This functional division could also be maintained in the chronic areas, with wards for mentally intact geriatric patients at one extreme, those for ambulant demented at the other, and the mixed disabilities in the middle.

This plan for bed usage obviously works best when the acute beds of both specialties are situated in the District General Hospital. The bare minimum would be to have enough beds in the D.G.H. to cater for the acute 'medical geriatric' and acute 'mixed' case load, though the sooner the 'psychiatric' ward moved to the same site the better. It has been indicated that this joint service would need to increase its short-stay facility at the expense of its long-stay beds, over and above any beds 'donated' by the specialist physicians. Some of this short-stay function would clearly be carried out by Community Hospitals, though it is to be hoped that this would tie in with the overall 'geriatric' admission policy (i.e. to accommodate those patients not requiring D.G.H. facilities) rather than developing as a freelance effort by G.Ps. The better the 'geriatric' service and the closer its liaison with, and attention to the needs of, the G.Ps, the more chance there will be of the Community Hospitals remaining integrated with the district service as a whole.

The potential strength of such a joint department is that by giving both specialists joint admission rights to any area of care (be it day hospital, acute admission ward or long stay area) demarcation problems would be eradicated. There would be more scope for adjusting a large reservoir of beds to meet prevailing needs, and cross-consultation would be encouraged. The two specialists would be able to educate each other, not to mention the trainees working in the department. A joint department could also be much more influential over policies in residential care and housing in the Local Authority by virtue of its greater monopoly over hospital admission and its ability to guarantee support to back up desired changes. These other services might thus be encouraged to use their resources more carefully, thereby increasing the extent to which chronically incapacitated old people found themselves in settings in which they were receiving adequate support, and consequently reducing the frequency of unnecessary or prolonged admissions to hospital.

## CONCLUSION

This article has set out primarily to help the physician to assess the causes and significance of confusion in his elderly patients, with a view to facilitating their successful return to the community. Emphasis is laid on the patient's level of performance prior to the presenting illness as the best guide to the mental function to be expected after discharge. A few general principles of assessment and short-term management of confusion are outlined but the main concern is with the early planning of longer term care. The extent to which, in an era of inadequate resources, the latter reflects expediency, rather than ideals, for the long-term support of old people is regrettable, but we must be concerned with realities.

Having played down the role of the psychogeriatrician in relieving physicians of unwanted patients, I have, in the final discussion, focused on ways in which the problems of hospital care for the elderly might be improved by enabling geriatricians and psychogeriatricians to play a greater part in acute hospital provision for this clientele. It is proposed that while the physicians and general psychiatrists would continue to take those patients best suited to their particular skills and resources, joint departments of geriatric medicine and psychiatry should carry the overall responsibility for each district for the provision of basic hospital care for elderly patients, the cut-off points depending upon the generosity of the re-allocation of resources. This merging into one department would permit more flexible use of beds to meet prevailing needs, would greatly facilitate liaison with other services dealing with the elderly, and would provide a firmer base from which to influence the development of policy in these other services, and for proceeding with preventive programmes. Unless the hospital services for the elderly (acute as well as longer stay) are centralised in this way, so that resources can be allocated and rationed as fairly as possible, there is a real danger that fears of the silting up of medical units will make it very difficult for old people to gain acute admission to District General Hospitals.

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