Psychiatry in the Geriatric Hospital: Its Goals and Limitations

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It is widely accepted that pathology in the aged nearly always comprises a considerable psychiatric component. It is paradoxical that despite an acknowledged interdependence of the physical and psychiatric aspects of care most geriatric facilities separate the two disciplines. At the Geriatric Hospital in Geneva, Switzerland, to reach the major goal of offering comprehensive medical service to the aged, the medical staff consists of internists and psychiatrists sharing equal responsibility and enjoying equal status. This principle is personified in the medical director of the hospital who has training in both internal medicine and psychiatry. In the Hospital opened 3 years ago only 200 of the 320 beds are occupied due to the difficulty of recruiting nursing personnel. We admit all aged patients with both physical and psychiatric disorders placed on mixed floors. The average age of the patient is 79. The patients are admitted for diagnosis, treatment and rehabilitation – with the exception of those needing surgery or the agitated, ambulatory patient in need of protection (i.e. closed facilities) 20–25 patients are admitted weekly while the average length of stay is 46 days. 2 years ago we opened a Day Hospital which offers ongoing treatment for over 80 patients. Recently the Day Hospital is also being used as a rapid diagnostic centre.

Closely connected with the Hospital is the Geriatric Centre assuring the coordination of all geriatric services in the Canton of Geneva as well as providing direct extramural psychogeriatric care. This Centre refers patients to the Hospital, but the majority, 60%, of the hospital patients come from

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Feder

59

referrals by private physicians. For 3 years, internists and psychiatrists have worked closely together sharing in decision-making and aiming at total care. We think that the patients benefit from the fact that the psychiatrist is fully integrated in the therapeutic team and does not function only as a consultant in psychiatry. His intervention is more natural and he is accepted easily by the patients. We hardly ever encounter the well-known misgivings of the aged toward psychiatry. The psychiatrist has an important preventive role in the early discovery of psychiatric illness. All too often the patient, his family and even the treating physician have a tendency to focus on the physical symptoms. The patient does not merely need a diagnosis, but above all, an emphatic attitude on the part of all toward his psychosocial or psychiatric problems, the latter frequently underrated in favour of the somatic manifestations, a priority considered more important.

Another aspect of the full-time psychiatrist in a geriatric hospital is the full-time battle against regression – mainly through the sensitizing of the staff of the meaning of patient behaviour. Frequently the aged patient must be motivated to want to get well, which may include, besides the direct treatment, a manipulation of the patient's environment. The psychiatrist uses traditional psychiatric tools such as psychopharmacology, individual psychotherapy and increasingly group therapy. All must be adapted to meet the special needs of the aged. In addition the psychiatrist plays a key role in substantiating the value of those programs that the patients and staff tend to consider as 'non-medical' and therefore secondary, such as occupational, recreational therapy, group gymnastics, etc. Management of patient's families is often difficult and serious problems are apt to manifest themselves in the course of hospitalisation. Group sessions with family members organised by the psychiatrist are very helpful.

The integration of psychiatry and internal medicine is of special significance in the training of interns. It is important to evaluate psychiatric problems in the context of somatic and social realities and vice versa. This model of medical practice is often time-consuming and is sometimes accepted with great difficulty by the very busy interns, however, many of our interns are the general practitioners of tomorrow, and we feel that preparing them for this type of comprehensive medicine is of great importance. The psychiatrist, by working along with the interns at the same time that he supervises them, should make psychiatry not more admirable, but more understandable and more useful.

Another important function of the psychiatrist in our setting is the supportive role with the nursing staff. Facing human deterioration and fre-

60

Feder

quent deaths, the staff has often great difficulty in accepting the active therapeutic measures we propose – and even greater difficulty in accepting the decision to do nothing. It is important to search tenaciously, based on day-to-day shared experiences, for new attitudes in working with the infirm aged as well as ongoing team evaluation of the effectiveness of our therapeutic programs.

Training for doctors, nurses, aides and the growing number of volunteers consists of more or less formal practical and theoretical courses, regular case presentations with emphasis on either somatic or psychiatric problems, or both. Discussion groups are used to work out anxiety, management of the difficult, unpopular patient as well as attitudes towards one's own aging and death.

For the psychiatrists the 3 years in the Geriatric Hospital provided great satisfaction and a fair share of frustration. Everyone seemed to be enthusiastic about the philosophical aspect of the hospital, but difficulties arose in the course of the day-to-day activities. Even in the terminology describing our work the phrase coexistence is often used, rather than integration – which shows clearly the underlying role strain existing. The different style of work of the psychiatrist made it necessary to work out such problems as how to keep files, how to make the rounds, taking temperatures, or rather not taking, etc. The psychiatrist in the geriatric hospital has to understand that he is sometimes considered as representing a less important and in any case less urgent aspect of medical intervention. Acute medical problems take priority and only after they are more or less resolved is psychiatric treatment requested. Conversely, sometimes the psychiatrist is viewed as a magician called on to solve the insoluble. It was expected that the psychiatrist should know how to give his time without taking the time of others. The dynamics are made

even more complex by certain resistance both manifest and latent to psychiatry on the part of the medical staff. This may be viewed partially as a result of inadequate training in psychiatry in medical school and consequently, insecurity in handling psychiatric problems. The resistance is partially due to fear of exposing one's own anxieties and unresolved emotional problems. For this psychiatrist the 3 years in the Geriatric Hospital was a most challenging experience. Despite difficulties the endeavour must continue to reach the ultimate goal: truly comprehensive geriatric care.