The process of disciplined identification of common geriatric syndromes and risks in targeted individuals with careful prescription of preventive and treatments would seem, at face value, a logical response to a growing population of frail older patients in acute care hospitals. Yet, the evidence that such an approach produces measurable improvements in patient outcomes remains extremely limited, other than in the context of designated geriatric units.

Hospital geriatric consultation services are now commonplace in most developed nations. Their role and function varies considerably, ranging from ‘triage’ services manned by individual geriatricians designed to identify patients suitable for transfer to post-acute services, through to well-resourced teams comprising geriatricians, specialist nurses and therapists who actively contribute to care provision in mixed ward settings. It is this latter, more intensive style of service that has been subject to the most intense evaluation. Although early studies showed promise in terms of improved patient outcomes [1], the majority found no differences when assessed against a range of clinical and administrative outcomes [2–6]. A meta-analysis of comprehensive geriatric assessment services identified no effects of this form of service [7].

The majority of studies have been conducted in North America. Arguably, in other jurisdictions where the background standard of geriatric assessment and the clinical and financial incentives for care might differ considerably, there may be different outcomes. The study of Kircher et al. [8], published in the current issue of this journal, presents the findings of a study conducted in Germany, where the authors report that geriatric consultation services have been established in the setting of a ‘social welfare healthcare system’. There might be sufficient contextual differences that geriatric consultation services could be more effective. The authors report that commencing in 1994, geriatric consultation services consisting typically of a geriatrician, nurse and social worker were established in a number of hospitals in Germany. The trial was conducted several years later, such that the five participating hospitals had already been exposed to the service for at least 3 years.

This study, once again, failed to demonstrate any positive outcomes for patients allocated to the intervention group. A strength of the study was the inclusion of four ‘control’ hospitals, which apparently had no exposure to formal geriatric consultation. Patient outcomes in this group were similar to both the intervention and control groups in the intervention hospitals. This finding reduces the likelihood that contamination effects account for the lack of apparent impact of the intervention, which has been offered as a possible explanation for lack of impact in other similar studies [2, 3, 9].

It should be noted that the study outcome measures were recorded from 3 to 12 months after discharge from hospital. They included mortality, functional status and hospital and long-term institution utilisation rates. Short-term outcomes such as acute care length of stay, functional status and patient satisfaction at discharge, discharge to institutions and short-term re-admission rates were not reported. Some studies, albeit involving more intensive inpatient interventions, have demonstrated short-term benefits that were not sustained into the medium term. For example, a large multi-centre study of veterans in the USA demonstrated improvements in functional status and patient well-being at hospital discharge that were not sustained into the medium term [10].

The reasons why these apparently appropriate service interventions have no measurable effect have been delineated by several earlier researchers: existing services are already at or near optimal performance; compliance with interventions is sub-optimal—particularly those that require the most intensive staffing resources; there is a type II trial design error—the study was inadequately powered; there are contamination effects; patient selection is incorrectly targeted; the study intervention is new and immature at the time of the trial; or that the intervention simply has no impact [2, 3, 9]. The German study has design attributes—it appeared adequately powered, the service was mature and a device for assessing contamination effects was included—that discount several of these explanations. However, this service was provided in the context of a previous history of availability of the service and thus the possibility of an existing high standard of care cannot be excluded. The failure to measure short-term outcomes raises the possibility that some real benefits were not identified.

Before concluding that geriatric consultation services lack efficacy, we must ensure that there are no worthwhile benefits that have yet to be identified. Winograd suggested that there is a need for further research that targets specific recommendations with more intense clinical responses [5]. This is based on the idea that the interventions most likely to influence outcomes are the most resource intensive and were least likely to be implemented in previous trials because of staffing limitations. An excellent example is the very specific strategy devised by Inouye to reduce the risk of developing delirium [11]. More research is needed to explore this concept.

How then, are we to advise health administrators on the provision of acute hospital geriatric services? First, in the face of good evidence of efficacy of designated geriatric units,
it is reasonable to recommend that such units should be established in any hospital with sufficient geriatric caseload. Geriatric consultation services would then serve the role of identifying patients suitable for transfer.

Some hospitals have responded by replacing all general medical services by geriatrician-led services. Alternatively, geriatricians are offered clinical appointments on general medical teams. These approaches may secure the desired clinical benefits, but have the disadvantage that valuable geriatrician time is deployed in providing care to patients without ‘geriatric’ problems. This is undesirable in jurisdictions where geriatricians are in short supply.

Regardless, there are many hospitals that cannot or will not establish such units—in some cases for internal political reasons including resistance by other medical craft groups, and in others because of insufficient clinical demand. This is often the case in rural settings. In addition, because of concomitant treatment requirements, some patients cannot be admitted to a geriatric unit.

In these circumstances, some mechanism to bring geriatric expertise to the clinical setting is required. This might take the form of strategies aimed at improvements in process, without necessarily changing clinical outcomes. The strategy might also have an educational role [12]. A systematic approach to geriatric assessment, targeted appropriately, might improve the efficiency of assessment, the selection of patients for post-acute care in geriatric units and assist in the organisation of nurse care planning and discharge planning. To achieve such outcomes, the entire process of screening, assessment and care planning may require reconsideration. The notion of external geriatric consultation service ‘visiting’ wards might be replaced by an integrated approach, in which geriatricians and other aged care specialists are more closely involved in the day-to-day activities of the ward. This involvement could be in relation to supervision of processes, not necessarily a direct clinical role. The emphasis of the approach would be on improving efficiency, with any improvements in clinical outcomes representing a bonus.

There are some notable attempts to achieve at least some of the ingredients of this type of approach. The Hospital Elder Life Program is one such example [13]. Many orthopaedic geriatric units incorporate some of these approaches. Standardised assessment protocols, such as the inter RAI Acute Care instrument, provide one element of a framework that would improve documentation and reinforce care planning where it is often erratic [14, 15].

Frail older patients will represent an increasing proportion of hospital caseloads in future. Hospitals inevitably will respond to this phenomenon. There is a continuing need to explore practice models which will deliver geriatric specialist expertise to general ward settings. The lessons learnt from the extensive study of geriatric consultation services suggest the need to consider a wider array of potential strategies.

References