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Prevalence And Range Of Geriatric Medicine Services Across Europe – A Survey Of 39 Countries

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Prevalence And Range Of Geriatric Medicine Services Across Europe – A Survey Of 39 Countries

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Key Summary Points:

Aim:

- Establish the prevalence of various geriatric services across Europe

Findings:

- Geriatric Services across Europe varied significantly.
- Nordic and Central-West countries had the most developed services, with a mixed picture in South Europe countries and limited services in East Europe countries.

Conclusions:

- This survey highlights areas for development in Geriatric Services across Europe.

Key Words: Geriatrics, Services, Europe, Survey

Abstract

Introduction/Purposes

The role of geriatricians has evolved across Europe in response to increasing ageing populations. However, there is much variation with some countries providing a range of Geriatric Medicine (GM) services whilst others have few or no services. This survey assessed the type and frequency of different GM services provided across Europe.

Methods

A cross-sectional survey of the board members of the European Union of Medical Specialists-Geriatric Medicine Section was performed, requesting information on the existence and frequency of 25 types of possible GM-related services (ranging from inpatient, rehabilitation, liaison, outpatient and community services). The questionnaire classified service availability from institutions into four levels: No-0(not available), Yes-1(Minority of institutions;<25%), Yes-2(Some;25%-75%) or Yes-3(Majority;>75%). A descriptive comparative analysis was performed.

Results

We got responses from 39 countries, divided into 4 geographical regions: Nordic (n=5), Central/West Europe (n=9), East Europe (n=17), South Europe (n=8). We found great variation in services between countries, with the Nordic (80%) and Central/West (86.2%) countries providing most of the surveyed Geriatric Medicine services, whilst East Europe lacked most Geriatric Medicine services (24.9% only) and South Europe having a mixed picture.

A notable 33% of the countries reported having no acute geriatric wards, 17.9% in a minority, 17.9% in some and 30.7% in most of the institutions in their countries.

Conclusion

This is the first large survey of provision of GM services across Europe and shows wide discrepancy across European countries. The data will be helpful for discussions with policy makers in developing GM services in their countries.

Introduction

The population aged 85 years and above in Europe is expected to double by 2050 **[1]**. In 2019, the Science Advice for Policy by European Academies (SAPEA) report *Transforming the Future of Ageing* stated: 'In Europe and around the world, people are living longer than ever before. It is one of the greatest achievements of the past century, but it also brings challenges for European countries' **[2].** Older people often present with complex clinical presentations and include geriatric syndromes such as frailty, mobility disorders, falls, incontinence, malnutrition, pressure ulcers, dementia, and delirium. Geriatricians' expertise is crucial for providing comprehensive and high-quality care to older individuals.

To meet this challenge, geriatric medicine has evolved across Europe in recent decades. In a survey carried out in 1994, only 8 out of 25 European countries recognised geriatric medicine **[3],** but by 2022, It was an accepted specialty in 23 European countries, although the length of training varied between 4 and 9 years **[4]**. In 2014, the European undergraduate curriculum in Geriatric Medicine was published to cover the minimum requirements that a medical student should achieve by the end of medical school **[5]**. In 2019, the European postgraduate curriculum in Geriatric Medicine outlined the minimum recommended training requirements to become a geriatrician at specialist level in the EU, and these European Training Requirements in Geriatric Medicine were updated in 2025 **[6]**.

The role of geriatricians is also evolving and expanding in response to the dynamic needs of the increasing ageing population. Geriatricians are increasingly practising comprehensive geriatric assessment in a variety of settings including in the community and in emergency departments, and are subspecialising in areas such as ortho-geriatrics, onco-geriatrics, falls and bone health clinics, movement disorder clinics and frailty units. However, it is unclear to what extent these developments have occurred across different countries. The aim of this survey was to assess the existence and prevalence of a wide range of geriatric medicine-related services in European countries.

Methods

We conducted a cross-sectional survey (August 2023) of the board members of the European Union of Medical Specialists (UEMS)-Geriatric Medicine Section, which has members from most European countries (with Israel additionally being an associate member). Where there was no representation or response from a particular European country, a respondent was sought from personal contacts from the European Geriatric Medicine Society (EuGMS) members. The survey focused on the existence and frequency of twenty-five types of services related to geriatric medicine (Table 1).

Respondents were asked to provide their insights into the availability of these services within their respective healthcare systems. Our questionnaire categorised service availability, based on the percentage of institutions offering the service in the country, into four levels: No (not available), Yes (Minority/ <25%), Yes (Some/ 25%-75%) or Yes (Majority/ >75%). A descriptive comparative analysis was performed to explore the landscape of such services in the continent.

Results

Overall Availability of The Services Across Four Regions

Responses were obtained from 39 countries, which were further categorised into four geographic groups: Nordic, Central/West Europe, East Europe and South Europe (Table 2). The results are presented according to the four pre-defined levels (tables 3 to 6). Our analysis reveals significant variation in the provision of different geriatric medicine services across the continent.

Nordic countries provided an average of 20 out of 25 (80%) services. Notably, Norway stood out by providing 24 out of the 25 services surveyed.

Similarly Central/West European countries offered on average 21.55 (86.2%) out of the 25 services. Only France and Ireland provided all of the services surveyed, closely followed by Switzerland and United Kingdom (UK) (providing 24 out of the 25 services).

East Europe countries demonstrated a substantially lower average service availability at an average of 6.2 out of the 25 services (24.94%), and two countries offered none of the 25 services (Albania and Kosovo.)

In South Europe, there was a more mixed picture. Spain, Italy, Turkey and Israel were similar to Central/Western Europe and Nordic countries providing 20-22 out of 25 (80-88%) services, whereas Greece and Portugal were more like the East countries providing only 7 (28%) and 1 (4%) of services respectively.

Specific Geriatric Medicine Services

Acute Geriatric specialist wards represented one of the most established yet unevenly distributed services. While all Nordic and Central/West European countries reported having such a service, 40% of the South Europe countries and half of the East Europe countries reported a lack of acute geriatric wards.

The findings revealed that 61.5% of countries (24 out of 39) reported no **geriatricians in their Emergency Departments**. Regionally, 16 out of 17 East Europe countries lacked geriatricians in their Emergency Departments, except for Slovenia, which had some presence.

A similar pattern was observed in acute frailty units and geriatric admission units. France, Germany, Ireland, Switzerland, UK, Iceland, Norway, Sweden, Spain and Turkey had **acute frailty units** in hospitals with varying degrees of existence. Other countries had not yet developed this geriatric service. **Geriatric admission units** were not part of geriatrics services in the majority European countries, being available in only 17 (43.6%) of countries.

We found that almost all Nordic and Central/Western countries had **geriatricians who work in Internal Medicine wards** (except for Luxembourg), and more than half of East and South Europe countries provided such a service by geriatricians.

Apart from Iceland and Cyprus, all Nordic, Central/Western and South Europe countries had a developed **ortho-geriatric** service, with >75% availability in Denmark, Finland, Sweden, Germany, Ireland, Netherlands, Switzerland, UK and Malta. On the other hand, this service did not exist in 65% of East Europe countries.

Surgical liaison services showed a similar distribution to orthogeriatric services. It was virtually absent in East Europe except for Latvia. It was also unavailable in most of the South Europe countries apart from Spain, Turkey and Israel where they offered a limited service (<25%).

Geriatricians were also present **in Prehabilitation clinics** in all Nordic countries, two-thirds of Central/Western European countries, 37% of South Europe Countries and in only 11% of East European countries. France was the only country with involvement of geriatricians in Prehabilitation services in a majority of institutions.

Geriatric rehabilitation wards or units were available in all Nordic, Central/West and South Europe countries, except Greece, Portugal and the Netherlands, while in East Europe, only 29.4% of countries had them.

Long term/continuing care wards or units or hospitals were available to some degree in most Nordic, Central/West and South Europe countries apart from Denmark, UK (where private care homes take care of such patients) and the Netherlands (where the separate distinct “Elderly Care Physicians” look after long term patients in care homes). Such services exist to some degree in almost half of the East Europe countries.

Falls clinics led by geriatricians demonstrated one of the greatest regional disparities, being available in all of Nordic and Centra/West Europe (except for Austria), less than half of South Europe, but completely absent in East Europe.

A similar pattern was observed in **osteoporosis services led or supported by geriatricians,** being available in all Nordic countries, 75% of Central/West Europe and 62% of South Europe, but only 23% in East Europe.

Geriatrician-led movement disorder clinics are available in all Central/West countries except Belgium and Luxembourg. However, the availability of such clinics dropped to 50% in South Europe, 40% in Nordic countries, and to just 11% in East Europe. Ireland, Malta and the UK had such clinics in a majority of institutions.

Geriatricians leading or contributing to continence care services remains underdeveloped across the continent. It was available in two-thirds of Central/West, 40% of Nordic, 35% of South, and 23% of East Europe. Malta was the only country with widespread availability (>75%).

Onco-geriatric services, led or contributed to by geriatricians, are widely available to some degree in Central/West Europe (excluding Austria, Iceland, Sweden), in 62% of countries of South Europe, 60% of Nordic countries, but in only four (23.5%) countries of East Europe. The Netherlands had high availability of onco-geriatric services with >75% coverage.

Community geriatrician services were widely developed in Finland, Ireland, the UK, Italy, Malta, and Israel (>75%). Such services are available to some degree in all Nordic countries, two-thirds of Central-West, 75% of South, and 23% of East Europe countries.

Geriatric Day Hospitals/units (with multidisciplinary team) services are established in all Nordic, South Europe and Central/West European countries except for the Netherlands, Iceland and Portugal. Only 29% of East Europe nations provide such services. Belgium, France, Ireland, Italy and Malta have widespread availability (>75%) of such services

Older people's syncope services (including Tilt testing) led or contributed to by geriatricians were present to some degree in two-thirds of Central/West countries (except Austria, Luxembourg, Switzerland) and were mostly unavailable in most Nordic, South and East Europe nations (except Denmark, Cyprus, Italy and Latvia).

Care home based geriatrician services were available in all Nordic, Central/West and South Europe countries with the exception of Belgium, Germany, Luxembourg, Greece and Portugal. Most countries in East Europe had no geriatricians involved in care homes (apart from some limited services available in Bosnia, Czech Republic, Hungary, Latvia, Poland and Serbia). The Netherlands has its own specialised field called 'Elderly Care Medicine' which is separate from postgraduate training in geriatric medicine and these Elderly Care physicians work in care homes **(4).**

Stroke services led by geriatricians were available in Nordic countries (except Iceland), most of Central/Western Europe (excluding Belgium and Luxembourg), and parts of South and East Europe. Ireland, UK, and Latvia offered higher availability (>75%).

All Nordic, Central/West and South European countries (excluding Spain and Portugal) have **memory clinics led or contributed to by geriatricians,** with wide availability (>75%) in Finland, Iceland, France, Ireland, Netherland, Switzerland, Italy and Malta. Such memory clinics are also available in about half of the countries in East Europe, namely Czech Republic, Estonia, Hungary, Latvia, Lithuania, Poland and Serbia.

Acute old age psychiatry services led or contributed to by geriatricians (including mental health/delirium/dementia wards) were available in all Central/West European countries, and in slightly more than half in Nordic and South European countries. In East Europe, geriatricians were not involved in old age psychiatry services with the exception of Hungary, Latvia, Lithuania, Slovakia and Slovenia (the latter with >75% availability).

All Nordic and Central-West Europe countries excluding Denmark and Luxembourg had **geriatricians involved in or leading palliative care services.** Finland and France stand out with wide availability (>75%). East and South Europe showed variable availability, ranging from limited services (<25%) in Czech Republic, Estonia, Lithuania, Slovakia, Malta, Spain, and Israel, to medium availability (25%-75%) in Hungary Latvia and Turkey.

General geriatric outpatient/ambulatory clinics are available in all Nordic, Central/West and South Europe countries apart from Denmark, Austria, Cyprus and Portugal. Half of the East Europe countries including Czech Republic, Hungary, Latvia, Lithuania, Poland, Romania, Serbia and Slovakia had limited to medium availability of this service.

Discussion

This survey shows considerable variation in the availability of geriatric medicine services across the continent. Geriatricians are usually board certified either in geriatric medicine (in countries where geriatric medicine is a recognised medical specialty) or in other medical specilaities, usually internal medicine, with subsequent advanced clinical training and certification in geriatric medicine. The training and certification processes differ depending on the country and could affect the scope of practice. In some countries without opportunities to train in geriatric medicine, physicians get trained in the specialty abroad. Geriatricians possess specialised skills to assess and manage older people with medical and psychological conditions, as well as understanding the related social circumstances. These conditions are characterised by complex clinical presentations and include geriatric syndromes such as frailty, mobility disorders, falls, incontinence, malnutrition, pressure ulcers, dementia, and delirium. A geriatrician's skills are fundamental to delivering comprehensive, high-quality care to older people during acute episodes, during the rehabilitation period and when managing long-term conditions **[7]**. They deliver care by leading or supporting a variety of healthcare services. Many geriatricians further specialise in specific areas by acquiring additional training and experience, leading to sub-specialisation.

Acute geriatric specialist Wards, acute frailty units and geriatric patient admission units

A third of countries in our survey reported no acute geriatric wards, particularly in South and East Europe, and acute frailty units were only available in a quarter of the countries surveyed, with none in East Europe. Geriatric patient

admission units were available in less than half of the countries surveyed. Acute geriatric care is a critical component of hospital healthcare for the older patients requiring hospital admission. Three key services—**acute frailty units, acute geriatric specialist wards, and geriatric patient admission units**—play complementary roles in ensuring timely, specialised, and holistic care for older patients. These units are designed to admit complex geriatric patients early during hospital admission. They are typically staffed with multidisciplinary healthcare professionals trained in dealing with older adults to provide comprehensive geriatric assessment (CGA), with the aim of improving the overall patient outcomes as well as potentially reducing length of stay **[8].**

Geriatricians working on internal medicine wards

Nearly all Nordic and Central/West countries and more than half of East and South Europe countries had geriatricians working in internal medicine wards. Geriatricians trained in both general and geriatric medicine can work on internal medicine wards. Geriatricians bring expertise skills in the ward by managing patients with multi-comorbidity, leading multidisciplinary teams, optimising medication and focusing on functional status and quality of life.

Geriatric rehabilitation wards and Long term / continuing care wards or units or hospitals

Geriatric Rehabilitation wards or units were available in Nordic and Central/West European countries with variable availability. Long term/continuing care units were present in almost half the East Europe countries and most of the other European countries. Geriatric Rehabilitation aims to optimise functional capacity, promote activity and preserve functional reserve and social participation in geriatric patients. It focuses on patient-centred goals which reflect individual preferences established through co-operation with the patient and his or her caregivers **[9]**. Similarly, Long-term or continuing care wards provide care for patients who have lost their independence and require extended hospital stays, typically over 90 days. These units offer continuity in medical, nursing, and rehabilitation care, including support from physiotherapists, occupational therapists, and psychosocial services, with the aim of preventing further loss of independence and providing maintenance care **[10]**.

Geriatrician presence in the emergency department

Less than half of the surveyed countries reported having some presence of geriatricians in their emergency departments (EDs). The presence of a geriatrician in the emergency department (ED) is increasingly being recognised as valuable for improving care for geriatric patients. Evidence has shown that conducting comprehensive geriatric assessments can help reduce the length of hospital stay **[11]**. Geriatricians bring specialised skills in assessment, medication management, discharge planning, and education for ED staff, which contribute to improved geriatric patient outcomes. There is much scope to further develop this type of service across the continent

Ortho-geriatric services

Orthogeriatric services are generally well developed across most of Europe apart from East Europe where more than half of the countries lacked this service. Ortho-geriatric services combine orthopedic and geriatric expertise to manage fractures in older patients, through multidisciplinary management, addressing pre- and post-operative optimization, rehabilitation, fall prevention and bone health management. It has been more than 50 years since the role of the geriatrician in the management of patients with a hip fracture was first described **[12].** This integrated approach showed better outcomes and improved cost-effectiveness **[13]**.

Onco-geriatric (cancer) services

The majority of countries have developed some degree of onco-geriatrics apart from East Europe where only four of the seventeen countries have this service. Even in countries where onco-geriatrics exist, only in the Netherlands was the service available in the majority (>75%) of institutions. Compared to other Geriatric services, onco-geriatrics is a relatively new concept that combines geriatric services with oncology to provide tailored care, taking into account both the complexity of cancer treatment and the needs of older patients, including comorbidities, functional status, and treatment tolerance. Applying CGA can improve management of older patients undergoing cancer treatment, including medication optimisation **[14]**.

Falls clinics led or contributed to by geriatricians and general geriatric outpatient/ambulatory clinics

Fall clinics led or contributed to by geriatricians are well developed in most Nordic and Central/West European countries whereas none of East and half of South European countries had this service. In contrast to specialized falls clinics, many South Europe and slightly more than half of East Europe countries offered general geriatric/ambulatory clinics. Falls clinics provide a comprehensive, multidisciplinary approach to assess fall risks, create personalised prevention plans, recommend home safety modifications, offer education, and provide ongoing support, all aimed at

reducing fall risk, improving mobility and confidence, and enhancing quality of life. Research evidence shows notable declines in fall rates, enhanced balance and mobility, and a decrease in fear of falling among those who attend a falls clinic **[15]**. In addition, having a geriatric outpatient assessment helps to reduce mortality and care home admission **[16].**

Osteoporosis services led or contributed to by geriatricians

The majority of Nordic, Central/West and South European countries had geriatricians involved or leading osteoporosis services, compared to only a few of the East European countries. Osteoporosis is common in geriatric patients and it is managed through prevention, lifestyle changes including exercise, and medications. Across Europe in 2019 (European Union, plus Switzerland and UK) 32 million individuals age 50+ are estimated to have osteoporosis, equivalent to 5.6% of the total European population age 50+ **[17]**. Management and investigations of osteoporosis can be different in frail patients due to their multi-morbidities and susceptibility to side effects of medication. **[18]**. Consequently, there is an increased demand for geriatricians to lead or contribute to osteoporosis services.

Movement disorders/Parkinson's disease (PD) services led or contributed by geriatricians

Movement disorder clinics/services led or contributed to by geriatricians were common in Central/West Europe, in approximately half of Nordic and South Europe countries, but in only a few East Europe countries. Traditionally, movement disorder and Parkinson's disease services have been led by neurologists. Recently, however, more geriatricians are leading or contributing to these services to address the need for a holistic management approach, especially in frail older patients. PD prevalence is increasing with age and it affects 1% of the population aged above 60 years **[19]**. Management of PD should be integrated, holistic and individualised to meticulously balance the risks of interventions considering the vulnerability of these frail individuals.

Continence services led or contributed to by geriatricians

Despite urinary incontinence (UI) being considered as one of the "Geriatric giants" due to its potential to cause disability and increase the use of medical and social care services **[20],** geriatrician-led UI services are limited generally across Europe. UI is a common condition that increases with age and significantly affects quality of life. It has an overall prevalence of 38% in women over 60, rising to 77% in older women living in nursing homes **[21]**. When managing incontinence in older adults, simple approaches adopting a medical model (e.g. based around anti-muscarinic drug treatment) are often unsuccessful and may lead to adverse effects. Effective management requires a holistic whole 'chain of continence 'strategy addressing mobility, cognition, and toileting routines **[22]**. We believe geriatricians need to "re-own" this sub-specialty and work with other specialties and healthcare professionals involved in care of older people with UI.

Surgical liaison

Our survey revealed that surgical liaison services exist to a varying extent in Nordic and Central/West European countries but are underdeveloped apart from a handful of countries in South and East Europe**.** It was estimated that by 2030, one fifth of populations aged over 75 years old will undergo surgery annually **[23]**. With an increasing aging population, both elective and emergency procedures are now faced with the challenges of managing patients with multiple comorbidities peri-operatively **[24].** Frailty can be present in up to 20% of emergency surgery, and it is the key factor that increases risk of complications, length of stay in intensive care unit and overall hospital stay **[25]**. Studies show that with geriatrician input through various stages of care, such as pre-surgical assessment, post-surgical ward round, discharge multidisciplinary team (MDT) meetings, or inpatient subacute care and rehabilitation, the length of stay in the hospital can be reduced **[24,26]**. In the UK, the National Emergency Laparotomy Audit (NELA) tracks process and outcome measures for patients undergoing emergency laparotomy, aiming to improve care quality. As part of this, review of all patients aged over 70 years by geriatricians has become a NELA standard **[27]**.

Involvement of geriatricians in prehabilitation services

Our survey found that geriatricians' involvement in prehabilitation was limited, with only 15 out of 39 countries offering such services and even in those most had less than 25% coverage, with France being the only country with large-scale geriatrician involvement in prehabilitation. This type of service, which is increasingly becoming popular, aims to improve a patient's fitness for surgery by assessing physical health, nutrition, and psychological well-being before an operation. Interventions including exercise, nutritional advice, lifestyle modification, psychological support, and medication optimization can be offered to reduce postoperative complications in older patients **[26]**. The inclusion of geriatricians in prehabilitation of older patients is important as they are at higher risk of adverse postoperative outcomes due to co-morbidities and frailty. For example, it might help in diagnosing and treating previously

unrecognised movement disorder, optimisation of chronic conditions, therapy-directed exercise and pre-emptive home adaptations **[26]**.

Community Geriatricians (Geriatricians seeing patients in their own homes)

The availability of community Geriatric services varies across Europe with a relative lack in East Europe countries compared to other regions. Community geriatricians manage subacute or chronic conditions in geriatric patients at home, helping to maintain quality of life for geriatric patients, reduce the risk of hospital admissions and enhance knowledge among MDT members **[28]**. The care models include home visits and virtual ward rounds with GPs (including for care home residents), supporting district nurses/rehab teams and home visits.

Geriatric day hospitals / units with multidisciplinary team

Geriatric day hospital (GDH) were once a successful multidisciplinary model in some countries that integrated geriatric, nursing and rehabilitation care into an outpatient setting**.** However, preference has shifted toward community-based services such as fall clinics and home visits **[29]**. Nevertheless, despite declining prevalence, GDHs have persisted in most Nordic, South, and Central-West nations, although only a minority of East Europe countries offered GDHs. Although GDHs have a preferred outcome compared to groups receiving no CGA, they showed no clear advantage over comprehensive inpatient, outpatient and home-based care **[30]**. This finding has raised questions about the effectiveness of GDHs.

Older People's syncope services (including tilt testing)

Syncope is common in the older population. The consequences can be severe, particularly in older population. Evidence supports geriatrician-led syncope services for older patients over single-specialty care (e.g., cardiology/neurology) **[31].** By applying CGA, geriatricians can help identify fall risk, cognitive/visual impairments, gait disorders, and cardiovascular/neurological issues—reducing unnecessary tests and costs **[31] [32]**. Yet, geriatrician-led syncope services remain limited in Europe, with some availability in Central/West Europe but very little in other regions.

Care Home based geriatricians

Some studies have demonstrated that integrating geriatricians into care homes reduced non-elective hospital admission, improved medicine optimisation, and increased advance care planning **[33]**. Current models include care home visits and virtual MDTs with GPs and sometimes pharmacists. The Netherlands uniquely recognises nursing home medicine as a distinct specialty with its distinct training curriculum **[34]**. Our survey showed that the availability of such services varies widely across the continent, with East Europe countries lagging behind.

Palliative care services led by or contributed by geriatricians

By 2030, cardiovascular disease, dementia and cancer are predicted to be the most common non-communicable-disease causes of death **[35]**. Geriatricians frequently encounter these conditions, making palliative skills essential for holistic patient and family care. Recognising this need, the EuGMS Palliative Care Special Interest Groups developed a palliative care curriculum for geriatric training **[36]**. Our survey showed that palliative care led or contributed to by geriatricians was common in Nordic and Central/West Europe, but less available in East and South Europe, with some services present in Latvia, Hungary, and Turkey.

Stroke services led or contributed to by geriatricians

Our survey showed consistent involvement of geriatricians in stroke services in most Nordic, Central/West Europe countries, but limited availability in East and South Europe. The UK's Sentinel Stroke National Audit Programme (SSNAP) Annual Report 2023 showed that over a third of stroke patients are over 80 years old. 7% of stroke patients have dementia. Older stroke patients are ten times more likely to experience limitations in ADL and nearly six times more mobility limitation than younger patients **[37]**. Geriatricians are uniquely trained to manage older stroke patients' complex needs—including delirium management and navigating ethical treatment dilemmas **[38].** In many countries management of stroke is under the remit of neurologists, and in some cases specialist stroke physicians. Further developments in care pathways whereby those older people with a stroke who would benefit with involvement by geriatricians are warranted.

Geriatricians present on trauma ward

Older adults represent a growing proportion of trauma patients, with UK data revealing that those aged over 75 years comprise almost one-third of cases, primary due to falls **[39]**. Integrating geriatricians into such "silver trauma" units

reduces length of stay, lessens the need for critical care and reduces cost **[40].** Some Nordic and Central/West European nations now routinely include geriatricians in trauma teams, whilst such integration remains limited in East Europe and uneven in South Europe.

Specialist acute old age psychiatry services led or contributed to by geriatricians (including medical mental health/delirium/dementia wards)

Older adults with mental health conditions often have complex physical comorbidities, requiring combined psychiatric and medical care **[41].** Some evidence shows that having geriatrician contribution in mental health facilities leads to reduced length of stay, referral to other specialties, and falls risks along with cost benefit. It also boosted confidence of psychiatrists in managing physical health problems **[42]**. This integration was observed in some Nordic, Central/West and South Europe countries although East Europe had limited such integration (with the exception of Slovenia).

Memory services led or contributed by geriatricians

Our survey showed variable availability of geriatrician involvement in memory services with higher access in Nordic and Central/West European countries, but more variable across South and East Europe. Some evidence, albeit inconsistent, demonstrates that multidisciplinary approaches involving geriatricians in dementia care and in memory clinics increased patients' quality of life **[43]**. However, a French randomised controlled trial found that integrated memory clinics did not significantly slow functional decline or hospital admissions in Alzheimer's patients compared to usual care **[44].**

Strength and Limitations

One of the strengths of this survey is the high number of countries (39) and Geriatric services (25) being surveyed, and to our knowledge it is the largest such survey. We also assessed the frequency of the services provided. This helps us to understand the current status of geriatric services across Europe together with regional differences, and facilitates identification of areas requiring further development of appropriate services in individual countries across the continent.

The paper has some limitations. The survey was conducted by asking key members of each countries according to their personal knowledge, which may have introduced a degree of subjectiveness and missing information, although at the outset we encouraged respondees to liaise with colleagues in their own countries to try and get an accurate picture, and we believe that was generally complied with.

Future Implications

Our survey's results should be taken in context with other important ongoing Geriatric Medicine initiatives in Europe, including the COST Action 21122 "PROmoting GeRiAtric Medicine in countries where it is still eMergING (PROGRAMMING)' [https://cost-programming.eu/], which has the aim of improving education and training in Geriatric Medicine for health care professionals in countries where the speciality, as well as geriatric services, are in the early stages of development **[45].** Our findings will also contribute to the knowledge already gained from other initiatives to ensure that future training for healthcare professionals is fit for purpose and includes education on the different types of geriatric services being developed **[46].** Spreading basic geriatric knowledge beyond geriatricians to the majority of doctors and allied healthcare professionals should also be an important goal for improving care for older people, particularly focusing upon the importance of multidisciplinary teamwork and highlighting the insufficient number of Geriatricians globally.

The difference in availability of geriatric medicine services highlighted in this paper will also offer an insight for policymakers, healthcare providers and leaders who may consider developing new Geriatric services lacking in their countries by facilitating knowledge exchange and dialogue among the countries.

Conclusion

This survey revealed the evolving role of geriatricians in the continent. Geriatric medicine has traditionally been related to Bernard Issacs's famous "geriatric giants'' or "four Is", namely immobility, instability, incontinence, and impaired intellect/memory. However, over time, geriatricians are now involved in newer services like onco-geriatric services, community geriatric services, movement disorder clinics, palliative care and acute geriatric services. Nevertheless, the involvement of geriatricians in these various services is not uniformly distributed in Europe. This survey revealed significant disparities in the availability of geriatric services in different regions and countries in Europe. Overall, Central/West and Nordic countries demonstrated a more comprehensive range of geriatric services and higher availability of each service compared to other regions. South Europe showed a more variable picture among countries

and East Europe countries generally lacked many of the geriatric services compared to other regions. We suggest a repeat survey after 5 to 10 years to assess the progress of each service across European nations.

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Declarations of Interest:
None

Research Ethics Approval:
As this was a quality improvement project survey of representatives of European countries on the board of the UEMS-Geriatric Medicine Section, who all agreed to respond to the survey from their knowledge of Geriatric services in their country, no formal research ethical committee approval was required.

Authors Contributions:
TM, MAV,MvL,JM concepted and contributed to the design via the UEMS Geriatric Medicine Section Board. TM, KET, ME analysed the data. KET and ME wrote the first draft. ZA and TM adjusted the manuscript and formatted to the needs of the journal. All authors KET,ME, ZA, JM, MAV, MK,MV, MvL, RRO, TM commented and contributed to the manuscript and approved the final draft.

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Table 1: Survey of types of Geriatric Medicine practiced in Europe

In your country do you have the following services/ sub-specialities related to Geriatric Medicine?		No	Yes (minority) [<25%]	Yes (some) [25-75%]	Yes (majority) [>75%]
1.	Acute Geriatric specialist wards				
2.	Geriatricians working on Internal Medicine wards				
3.	Geriatric Rehabilitation wards or units				
4.	Geriatric patient Admission Units				
5.	Geriatrician presence in the Emergency Department				
6.	Acute Frailty units				
7.	Ortho-geriatric services				
8.	Onco-geriatric (cancer) services				
9.	Falls clinics led or contributed to by geriatricians				
10.	Osteoporosis services led or contributed to by geriatricians				
11.	Movement disorder / Parkinson's disease services led or contributed to by geriatricians				
12.	Continence services led or contributed to by geriatricians				
13.	Surgical liaison in surgical wards by geriatricians				
14	Prehabilitation Clinic by geriatricians				
15.	Community Geriatrics (Geriatricians seeing patients in their own homes)				
16.	Geriatric Day Hospitals/units (with multidisciplinary team)				
17.	Older people's syncope services (including Tilt testing)				
18.	Care home based geriatricians				
19.	Memory services led or contributed to by geriatricians				
20.	Specialist acute old age psychiatry services led or contributed to by geriatricians (including medical mental health/delirium/dementia wards)				
21.	Geriatrician presence on trauma wards				
22.	Long term/continuing care wards or units or hospitals				
23.	Stroke services led or contributed to by geriatricians				
24.	Palliative care services led by or contributed to by geriatricians				
25.	General geriatric outpatient/ambulatory clinics				

Table 2: Responses from 39 countries by regions

Central-West Europe	East Europe	South Europe
• Austria • Belgium • France • Germany • Ireland • Luxembourg • Netherlands • Switzerland • United Kingdom	• Albania • Bosnia • Bulgaria • Croatia • Czech Republic • Estonia • Hungary • Kosovo • Latvia • Lithuania • Montenegro • North Macedonia • Poland • Romania • Serbia • Slovakia • Slovenia	• Cyprus • Greece • Italy • Malta • Portugal • Spain • Turkey • Israel
Nordic (North Europe) • Denmark • Finland • Iceland • Norway • Sweden		

Table 3: Availability of Geriatric Services in Nordic Countries

	Acute Geriatric Wards	Internal Medical Wards	Rehab Wards	Geriatric Admission Units	ED Geriatrics	Acute Frailty Units	Ortho-Geriatrics	Onco-Geriatrics	Falls Clinic	Osteoporosis	PD Services	Continence Services	Surgical Liaison	Prehab Clinic	Community Geriatrics	Day Hospital	Syncope Service	Care Homes	Memory Services	Old Age Psychiatry	Trauma Wards	Long Term Care	Stroke Services	Palliative Care Services	Outpatient Clinics
Denmark	2	2	2	1	3	0	3	1	3	2	0	0	2	1	2	2	3	2	2	0	1	0	2	0	3
Finland	3	1	3	2	2	0	3	2	2	1	0	0	1	1	3	1	0	2	3	2	2	2	1	3	1
Iceland	2	1	2	0	0	1	0	0	2	2	0	0	1	1	1	0	0	2	3	0	0	1	0	1	2
Norway	2	2	1	1	1	2	2	1	1	1	2	1	1	1	1	1	0	1	2	1	2	1	1	1	1
Sweden	2	1	3	3	0	1	3	0	1	1	1	1	1	1	1	1	0	1	2	1	2	1	1	1	1

Table 4: Availability of Geriatric Servives in Central/West Europe

	Acute Geriatric Wards	Internal Medical Wards	Rehab Wards	Geriatric Admission Units	ED Geriatrics	Acute Frailty Units	Ortho-Geriatrics	Onco-Geriatrics	Falls Clinic	Osteoporosis	PD Services	Continence Services	Surgical Liaison	Prehab Clinic	Community Geriatrics	Day Hospital	Syncope Service	Care Homes	Memory Services	Old Age Psychiatry	Trauma Wards	Long Term Care	Stroke Services	Palliative Care Services	Outpatient Clinics
Austria	3	2	3	0	0	0	1	0	0	0	1	2	0	0	1	2	0	1	1	2	1	1	1	2	0
Belgium	3	1	1	0	3	0	1	1	1	0	0	0	3	1	0	3	1	0	2	1	1	1	0	1	3
France	3	1	3	3	1	3	2	2	2	2	1	1	1	3	2	3	1	1	3	1	1	3	1	3	3
Germany	3	0	2	0	1	1	3	1	2	1	2	1	1	0	1	2	1	0	2	2	3	2	1	1	1
Ireland	3	2	3	3	2	2	3	2	3	3	3	2	3	2	3	3	2	2	3	3	2	2	3	2	3
Luxembourg	3	0	3	3	1	0	2	1	1	0	0	0	1	0	0	2	0	0	2	1	2	3	0	0	3
Netherlands	3	3	0	3	3	0	3	3	2	1	2	0	3	2	0	0	2	0**	3	3	3	0**	2	2	3
Switzerland	3	2	3	2	2	1	3	1	2	2	1	1	3	1	2	2	0	2	3	3	2	2	1	1	1
UK	3	2	3	2	2	2	3	1	3	2	3	1	2	1	3	2	1	1	1	1	1	0	3	1	3

** The Netherlands has its own specialized field called ‘Elderly Care Medicine’ in long term care/care homes

Table 5: Availability of Geriatric Services in East Europe

	Acute Geriatric Wards	Internal Medical Wards	Rehab Wards	Geriatric Admission Units	ED Geriatrics	Acute Frailty Units	Ortho-Geriatrics	Onco-Geriatrics	Falls Clinic	Osteoporosis	PD Services	Continence Services	Surgical Liaison	Prehab Clinic	Community Geriatrics	Day Hospital	Syncope Service	Care Homes	Memory Services	Old Age Psychiatry	Trauma Wards	Long Term Care	Stroke Services	Palliative Care Services	Outpatient Clinics
Albania	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Bosnia	0	0	1	0	0	0	1	0	0	0	0	0	0	0	0	0	0	1	0	0	1	0	0	0	0
Bulgaria	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Croatia	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0
Czech Republic	1	1	1	3	0	0	1	1	0	1	0	0	0	0	0	0	0	1	2	0	0	3	1	1	2
Estonia	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	1	0	1	2	0	1	0
Hungary	1	1	1	1	0	0	0	0	0	1	1	1	0	0	0	0	0	1	1	1	0	2	1	2	1
Kosovo	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Latvia	1	1	2	0	0	0	2	2	0	1	1	1	1	0	2	2	1	2	1	2	1	2	2	2	2
Lithuania	3	2	0	0	0	0	0	0	0	1	0	1	0	1	0	2	0	0	2	2	0	2	0	1	2
Montenegro	0	0	0	0	0	0	1	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
North Macadonia	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0
Poland	1	1	0	0	0	0	0	0	0	0	0	0	0	0	1	1	0	1	1	0	0	2	0	0	1
Romania	0	1	1	1	0	0	0	0	0	0	0	0	0	0	1	1	0	0	0	0	0	0	0	0	2
Serbia	1	1	0	0	0	0	0	1	0	0	0	0	0	0	1	1	0	1	0	0	0	0	0	0	1
Slovakia	1	1	0	0	1	0	0	0	0	0	0	2	0	1	0	0	0	0	1	1	0	2	0	1	2
Slovenia	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	3	0	0	0	0	0

Table 6: Availability of Geriatric Services in South Europe

	Acute Geriatric Wards	Internal Medical Wards	Rehab Wards	Geriatric Admission Units	ED Geriatrics	Acute Frailty Units	Ortho-Geriatrics	Onco-Geriatrics	Falls Clinic	Osteoporosis	PD Services	Continence Services	Surgical Liaison	Prehab Clinic	Community Geriatrics	Day Hospital	Syncope Service	Care Homes	Memory Services	Old Age Psychiatry	Trauma Wards	Long Term Care	Stroke Services	Palliative Care Services	Outpatient Clinics
Cyprus	0	0	1	0	0	0	0	0	0	1	0	0	0	0	1	1	2	1	1	0	0	2	0	0	0
Greece	0	1	0	0	0	0	1	1	0	0	0	0	0	0	0	1	0	0	1	0	0	0	1	0	1
Italy	3	3	2	1	0	0	1	1	1	2	1	1	0	0	3	3	1	3	3	2	0	3	1	1	3
Malta	0	0	3	0	0	0	3	0	3	0	3	3	0	0	3	3	0	3	3	1	3	3	0	0	3
Portugal	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Spain	2	1	2	1	1	1	2	1	1	1	0	1	1	1	1	1	0	1	0	1	2	2	1	1	2
Turkey	2	2	1	2	1	1	1	1	0	1	1	1	1	1	2	1	0	1	2	1	0	1	0	2	3
Israel	2	1	2	2	1	0	1	1	0	1	1	1	1	1	3	2	0	3	2	1	0	1	1	1	2