High hopes . . . for geriatrics

A view from the top—

As a schoolboy I assumed that everybody really wanted to be a doctor and was only messing about with mathematics or mouldy old classics to put a brave face on some personal inadequacy that prevented their pursuing a medical career.

For some of us the one serious problem in medicine as a career is that it is *all* so interesting; we find it hard to dedicate our lives to the study of one organ when so many fascinating things happen elsewhere in the body. One solution to this problem lies in geriatrics. No other specialty combines to the same degree the intellectual satisfaction of having to know some things in depth with so invigorating a breadth of relevant knowledge—medicine, of course, but also psychology, sociology, biology, social policy, a shade of anthropology and a deal of ethics. There is a splendid unpredictability in clinical practice in the search for the causes and solutions for non-specific presentations such as 'falling about', 'off legs', 'wobblies' and 'round the twist', but most of all there is the joy of craftsmanship in weaving a person back into the tapestry of life, individual lineaments intact. Of course there is the daily reminder of the inescapable and universal tragedy of human transience, but there is also daily satisfaction in that, however awful a patient's situation, there is always something that can be done to help or comfort.

Geriatrics is a specialty characterised not so much by its techniques as by an attitude of mind, a philosophy and above all else a sense of responsibility in its practitioners. In that lies its future. 'The elderly' are not a separate species; older people have problems that afflict the frail and erring human race at all ages, but for them nemesis is closer, they have poorer reserves, and their physiological and mental tolerance for approximate medicine is low. To knowledge and good sense the resourceful geriatrician must add scrupulous attention to detail. The things about geriatric medicine that make it necessary for older people also make it good for the younger and vulnerable. Why then has it come to stand so aloof from the mainstreet bustle of modern medicine?

As recently outlined in a College report [1], the history of geriatric medicine as a specialty has not always been a cheerful tale.

We are still working to a tradition of two sorts of generalist physician, both defined less by what they do than by what they will not or cannot do, and both of whom may prove soon to have had their day. It may be that the training patterns we have inherited equip neither 'general physicians' nor 'geriatricians' with the combination of attributes needed for future hospital care.

The 'general physician with an interest' is seen as an endangered species but is not in such mortal danger as future patients who find themselves in the hands of the wrong organ specialist, or the patient with multiple diseases being batted to and fro between doctors knowledgeable only in parts of him. Most people arriving at hospital in a hurry are ill in poorly defined and complex ways. Whatever their ages, such patients are not a loose congeries of organs each of which can be dealt with separately by independent specialists.

We are envisaging a new type of hospital physician which for lack of a better name we must call the Secondary Care Physician of the Future (SCPF). The SCPF will inherit the philosophy and responsibilities of the geriatrician with the skills and resources of the general physician. SCPFs will be in the front-line of the hospital of the future, resuscitating, assessing, passing on to the organ specialists those patients with single-organ disease, retaining responsibility for the diagnosis, assessment and management of those with ill-defined or multi-organ illness. Like today's geriatricians their responsibilities should not end until the patient is safely back in the community in the hands of a primary care team.

Strategy calls for more than a front line. Patients will still need the other components of a modern geriatric service, the rehabilitation unit, outpatients, the day hospital, the home visiting programme, the community liaison [2]. These deserve not less but more concentrated attention than they now receive. We geriatricians deceive ourselves if we think we are equally good at all the things most of us have to do. We will need doctors with particular expertise in rehabilitation, or in day care or community liaison working as consultant team-members with the SCPFs. Proper recognition and development of expertise in these areas will open up the range and flexibility of careers; not everyone interested in hospital-based medicine wants to do the on-call stints. Given the likely workloads of the future, not every doctor who starts off as an SCPF will want to spend all of his or her working life in the front-line of a hospital acute medical unit. Already there is talk of paediatric neonatologists moving on to care for larger children when bifocals and tremor render the veins of rabbit-sized neonates almost invisible and largely impenetrable. Why should not continuing medical education equip us all to change as well as to update our work?

A line of SCPFs deployed in front of single-organ specialists and departments sounds all very cosy for large teaching centres, but what about the smaller medical communities of the district general hospitals

(DGHs)? Here indeed the future is more misty. Given market pressures and an increasingly knowledgeable and litigious public, it may be that the range of organ specialist services provided at DGHs will shrink as larger centres win contracts with their prestige and economies of scale. If this proves so, the DGH consultant will need to be primarily an SCPF with some ancillary skills such as endoscopy shared out with his or her colleagues but referring on to the larger centres a sizeable portion of what might now be retained for local specialist treatment. With more work falling to senior rather than junior staff, it would seem equitable as well as prudent for DGH consultants and their patients not to be segregated into potential A and B streams of medicine and geriatrics; it is unlikely that purchasers will fund the two equally and we do not want departments of second-rate medicine for the elderly.

I am confident that the ideas and ideals which geriatrics has developed over its 50 years will live on like genes but I am less sure that they will or should always manifest the same phenotypes as today. My high hopes for geriatric medicine are that whether or not it persists in name it will none the less gild the whole future of European medicine.

References

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—*Looking to the top*

Many acute illnesses of elderly people are remediable and need to be managed as in any other adult irrespective of age. But age can and does modify patterns of morbidity often because of multiple pathology, and its slows recovery. In addition, functional, social, financial and psychological factors may also affect the pattern of disease in the elderly and require the expertise of other professionals working as part of a multidisciplinary team. The geriatrician is but one member of the team working together to enable the elderly patient to reach his or her maximal potential with the ultimate aim of returning to the community.

The practice of geriatric medicine varies from region to region and even from hospital to hospital. At least 20% of departments in England and Wales have parallel commitments to general medicine. The rest serve solely the elderly on a 'needs related' or 'age related' basis in liaison with other specialties, especially orthopaedics, psychiatry and urology. The reorganisation of the NHS will make it necessary to arrange contracts in these 'geriatric' subspecialties with the purchasers of health care. The NHS reforms and the introduction last year of the community care act will result in more community based work for the geriatrician and in even closer liaison with general practitioners and local authorities to form resettlement programmes. Maintaining more of the elderly in their own homes is to be welcomed but it must not be done at the cost of failing to diagnose and treat disease. The process by which the elderly are supported in the community is therefore all important and must be adequately funded.

Demographic projections for England and Wales for the next decade indicate a need for 36 new consultant posts per year but if, in addition, the Calman report is fully implemented to produce the high quality consultant-delivered service in which I hope to practise then these figures are an underestimate. Because the elderly are now also becoming better informed and less likely to ascribe illness to the ageing process, consultation rates will go up even more. Nowhere is there a better argument for a larger slice of the cake.

Training to be a geriatrician will not only provide experience in basic medical science but also in aspects of law, epidemiology, other specialties (orthogeriatrics and psychogeriatrics) and rehabilitation. It should also result in the organisational and managerial skills necessary to bring about successful outcomes for the older patient. Research opportunities are vast due to the relative lack of clinical trials of treatment in old age. The gains to be achieved in treatment do not diminish with the increasing age of the patient; in fact the opposite may apply. Geriatric medicine is fertile ground for teaching undergraduates not only clinical symptoms and physical signs but also about atypical presentation, multiple pathology, polypharmacy, the multidisciplinary team approach, discharge planning and healthcare provision. The principles of bedside teaching founded by Sylvius in 1664 are easily met: 'My method . . . is to lead my students by the hand to the practice of medicine, taking them every day to see patients . . . that they may hear the patients' symptoms and see their physical findings'.

The needed expansion in geriatric medicine in the next few years will initially demand better resources which will soon provide high quality medical care and enable more of the elderly to remain in their own homes, ultimately bringing cost savings for the Department of Health.

When I began training in this specialty six years ago, a consultant likened the practice of geriatric medicine to pushing a very big rock up a steep hill. My hope is that this rock, with the help of better funding for healthcare and research, will get smaller and the road ahead will level off.

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