The Future of Geriatric Medicine

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Geriatrics was born out of expediency nearly 35 years ago, when the elderly were virtually excluded from the teaching hospital and non-teaching hospital beds were threatened by stagnation from an inexorable increase in the proportion of apparently irremediably incapacitated patients of advanced age[1,2]. Nurtured by a handful of dedicated pioneers, who showed that positive re-enablement programmes after the acute phase of illness had abated could help many old people to live out their lives in the community[3-6], it was brought to fruition in the late 1950s and early 1960s by the influx of a number of doctors highly trained in general medicine. It is now suffering from serious arrested development.

A recent survey has shown 25 unfilled consultant posts and eight unfilled senior registrar posts in geriatric medicine in England and Wales[7]. Those of us involved in making such appointments are well aware of the poor quality of many of the candidates. Outside the major centres, overseas graduates form the bulk of the junior medical establishment of departments, and the shortage of nursing and remedial staff is critical. The desperate need in some Health Districts has been met by appointing individuals who would certainly not have satisfied the standards required for a post in general medicine. This fact is reflected in the hesitation of the Royal College of Physicians to give *carte blanche* to the acceptance of all geriatricians as general physicians with a special interest in the elderly, and its insistence on the inclusion of a substantial content of general medical experience at registrar and/or senior house officer level in training programmes for the specialty[8].

It is asserted frequently that the reason 'geriatrics' fails to recruit staff adequate in quality as well as number is the overall paucity of facilities in terms of buildings, equipment, location and research. This is partly true and understandable, if not excusable, as nearly all geriatric units originated in the chronic wards of the non-teaching hospitals. Nevertheless, the extent to which each one evolved depended as much on the initiative of the consultant in charge as upon the financial resources and particular needs of the district it served. However, the greatest bar to progress towards integration with general medicine is the persistence of reactionary attitudes that continue to regard ageing as an inevitable process of slow dissolution accompanied by a variety of troublesome syndromes with sociological and psychological overtones which do not warrant the high technology of contemporary medicine[9-11]. This has led to the acceptance of a system geared to a service in which the emphasis has been on custodial care rather than therapeutic dynamism, in-patient management rather than out-patient investigation and treatment, long-term institutional care rather than community support. Appointing authorities and District Management Teams must accept a large share of the blame by equating 'geriatrics' with the management of chronic illness.

Because the geriatrician is more often than not geographically and intellectually isolated from his colleagues in the District General Hospital, and frequently working in poorly equipped obsolete wards with no immediate access to the support services of the modern general hospital, the specialty is not seen to offer a career structure comparable to that in other branches of medicine and the major specialties[12-14]. A self-perpetuating vicious circle is set up in which this unrewarding image of 'geriatrics' leads to an ever-diminishing resource in competition with the 'acute services' in spite of an ever-increasing need. The single fact that there are at present more than $6\frac{1}{2}$ million people in this country aged 65 years or over, representing an increase of 25 per cent during the past 15 years, as compared with 7 per cent for the total population, indicates the importance of ensuring optimum use of in-patient facilities and of promoting research in all aspects of ageing and preventive medicine. Though ageing is a normal and unavoidable biological event and not a disease *per se*, it embraces a period of increasing physical, sociological and psychological risk; hence disablement in the general population increases in proportion to chronological age, and the greatest users of the Health Service are those aged 75 years onwards[15]. When hospital admission is indicated, the majority in this age group is directed to geriatric departments. The image is further tarnished by illogical planning without agreed aims and objectives defining the role of the geriatric department *vis-à-vis* the general medical departments of the District General Hospital. The credibility of the specialty is then inevitably damaged by what is seen to be its failure to meet its dual commitment, first direct to the community for acute emergencies and planned admissions, and secondly to the elderly slow-stream patient in other departments[16,17]. The mistake we have made is not in creating a specialty for the medical care of the elderly, as some would hold, but in the assumption that it would be possible to provide within every Health District properly designed and equipped departments and sufficient medical, nursing and para-

medical personnel to staff them. It is becoming abundantly clear that efforts to do so have resulted in the reappearance of two standards of medical practice against which Professor Thomson warned in the Lumleian Lectures of 1946[2] when he made a vehement plea for the establishment of the care of the elderly within the main streams of clinical medicine.

Several options have been suggested as possible solutions to the dilemma:—

1. An age-defined specialty akin to paediatrics, giving the geriatrician total responsibility for all patients above a certain age, and requiring the general physician to reciprocate below that age.
2. Replacement of retirements of general physicians by geriatricians.
3. Integration of geriatrics with general medicine by appointing physicians with an expressed interest, as occurs with other specialties.
4. Establishment of comprehensive geriatric units in selected centres only.

To abandon the specialty altogether would be as shortsighted and misplaced as continuing the present policy. What is needed is a change of direction, not of objectives. Any form of coercion, such as that implicit in the replacement of retirement vacancies in general medicine by geriatricians (whole-time), would be difficult to administer equitably even if it were acceptable to the profession; in any event this and compromise schemes whereby an age-defined specialty is adopted from 75 years onwards, as in Hull[18] and Hastings, would be dependent for success on major changes in medical education to meet the manpower requirements. Likewise, it is unrealistic to suppose that the problems of poor recruitment would be solved solely by offering a certain proportion of general medicine in the younger age groups as an enticement to the physician to enter the field of geriatrics.

It is contended that a combination of options 3 and 4 is the logical development of Professor Thomson's thesis. There will continue to be a pressing need for departments of clinical gerontology in centres of excellence to ensure that the health care of the elderly in the future—preventive, curative and palliative—attracts as much attention and expertise as that of the younger age groups, but, as long as there are restrictions on financial and manpower resources, attempting to establish such units in each Health District can only result in a progressive lowering of standards. The time is ripe for this policy to be modified by integration at the periphery with general medicine, involving combined appointments at consultant and registrar level, as visualised in the Royal College of Physicians' report[8].

In order to produce the physician with an interest in this aspect of medicine we must first offer appropriate teaching programmes at undergraduate and postgraduate level. To do so, it is essential to provide the right *milieu* in which to demonstrate the interplay of the physical, psychological and sociological factors which contribute to morbidity and the management of the whole patient, as well as the nature of biological ageing and its effect upon the pattern and therapeutics of disease, the complexities of multiple pathology and the specific syndromes and hazards of senescence[19-21]. Such a department, wholly committed to the post-retirement age groups, envisages a continuum of care through the acute, recovery and disablement phases of disease, which extends the interface between hospital medicine and general practice into the community, with collaboration at planning and field levels between health and social services.

The model (Fig. 1) is expensive to build and to man, but the importance of its contribution to general medical

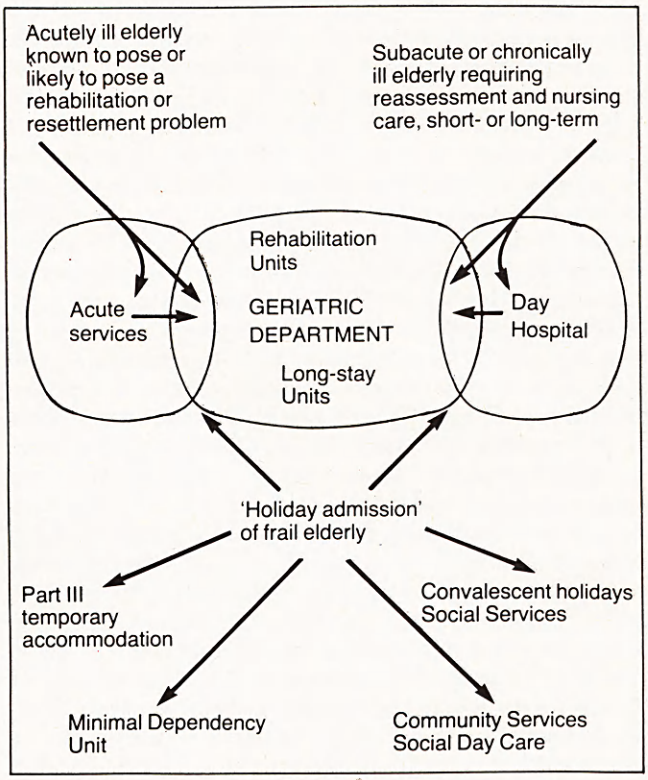

Fig. 1. *Model department of clinical gerontology (Williams: Pitman Medical).*

education should not be diminished by the misconception, often expressed in debate by the physician involved with all age groups, that high technology geriatrics is exclusive to him. It provides fast-stream admission units comparable in every respect to the acute medical wards, medium-stay rehabilitation wards and long-stay wards designed specifically for the requirements of the elderly patient in each of the three phases of illness. In addition, it provides a day hospital and its own autonomous physiotherapy and occupational therapy departments, a minimal care unit for phased return to independence in selected cases, and, ideally, nursing home/residential care facilities where possible within existing Part III accommodation. All but the long-stay annexes should be in the District General Hospital with immediate access to high technology investigation and treatment. Rotation of

junior doctors between the departments of clinical gerontology and other medical departments would form an essential part of vocational training for internal medicine as well as specialist training for those aspiring to be physicians with an interest in the elderly. The mixture of health and social service staff in the nursing home would facilitate in-service training for local authority personnel and go a long way towards achieving uniformity of attitudes to confusional states, incontinence and other aspects of abnormal ageing which alienate the uninformed[22].

In the final analysis it is a combination of an inherent aversion to the Shakespearean image of ageing, embarrassment and helplessness in trying to cope with slow-stream problems for which they have not been adequately trained, and fear of that chimera of the acute services, the elderly 'bed-blocker', that prejudices so many doctors against geriatric medicine. Once it is established that the general medical unit and the department of clinical gerontology provide comparable acute diagnostic/therapeutic services and that the fundamental difference between the two is that only the latter has additional facilities for rehabilitation of function and resettlement in the community, recruitment to the specialty should improve.

A policy for the future, therefore, accepting a complete reversal of the present trend by concentrating the limited resources in teaching centres wholly committed to the care of the elderly, coupled with a reappraisal of the long-term hospital provision and Part III accommodation, would eventually produce an adequate supply of properly trained and motivated doctors to cope with the problems at the periphery, be they general physicians or physicians with an expressed interest in the elderly. The consequent dilution of the burden of longer term care, which would be spread among all physicians instead of one or two geriatricians in each Health District, and the creation of nursing home facilities in a residential home setting under the auspices of the hospital service, would not only halt the regrettable decline in the standard of care of the elderly, but enhance our understanding of ageing and stimulate interest in the whole spectrum of disease from fast-stream to slow-stream illness.

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