Do geriatricians need guidelines?

**PERSONAL VIEW Virginia Aylett**

What does a geriatrician do? It is easy for most specialists to define themselves: a cardiologist looks after the heart, a respiratory physician the chest. But for a geriatrician it can be surprisingly difficult. Are we simply general physicians for older people, or do we have a more specialist skill?

This has recently been a cause for (occasionally heated) debate in our department. We are in the process of making plans to merge two large departments of medicine for the elderly from opposite sides of our city. On one side there is a specific cut-off age for acute admissions, while the other has a “needs related” policy. At first glance the second would seem to be preferable: older patients with a “single organ” problem are sent to the relevant specialty, while patients with more complex needs are admitted under our care. But the problem with this is that it is open to abuse by our specialty colleagues, and referrals are all one way in our direction: a 92 year old marathon runner can still be turned down by a specialist on the grounds that “he’s old.” A letter in the BMJ once described general physicians as the “prostitutes” of the hospital, accepting any and every patient turned down by other specialties. By this token geriatricians are the one-legged crack whores (probably not a definition the British Geriatrics Society would endorse).

I think I may have discovered the answer, in a roundabout way, courtesy of the latest set of guidelines from the National Institute for Health and Clinical Excellence. In general, geriatricians hate (or, at best, have a healthy mistrust of) guidelines. Our patients are too complex, too heterogeneous, too awkward, to fit into nice neat guidelines and pathways. However, the subject of thromboprophylaxis has recently been taxing our department, and it was hoped that the recent NICE guideline on this would answer some of our questions.

The guidance, aimed at adult hospital inpatients, is hefty and considered, drawing its conclusions from numerous randomised controlled trials. Yet I struggled to find the answers I was looking for, and even a trawl through the 513 pages of the full guidance didn’t make things clearer. In retrospect I should have started with the panel of experts who looked at the evidence: general physicians, orthopaedic surgeons, even a palliative care physician—but not a single geriatrician. Patients over the age of 80 take up around 20% of hospital inpatient beds, so it would not be unreasonable to expect that an expert would have been consulted. Perhaps if there had been, caveats would have been included. For instance, what do we do with the patient who is at high risk of falling on the ward? What about the patient who is already on two antiplatelet agents? But these patients are not covered by randomised controlled trials, so they go unnoticed in guidelines.

So what does a geriatrician do? We care for the patient who would never be included in a randomised controlled trial: the cognitively impaired, the patient with multiple comorbidities, the patient with not long to live, the patient where the researcher stands at the end of the bed and says, “Perhaps not.”

Accepting this as a definition brings with it several advantages but also more challenges. For a start, we can ignore the vast majority of guidelines; they were not written with our patients in mind. The patients could also be exempted from the tyranny of the Quality and Outcomes Framework. Along with DNR (“Do not resuscitate”) perhaps we could develop a “DNRCT” (“Do not subject to randomised controlled trials”) notice. This would allow us to treat patients in a way we think appropriate (on the basis of experience, if not research), without fear of reproach. However, we are now in an evidence free zone, and there are problems with using experience as a guide, which sometimes gets it wrong. Extrapolating results from trials (or doing more trials) is not the answer: in older patients the benefits of any given treatment are uncertain and the risks almost certainly higher. In any case, large trials are usually about preventive medicine—is this appropriate in our patient group? We need to think about different ways of doing research on older people. Observational or qualitative studies are a possible solution; these are not perfect either but are perhaps more generalisable. More pertinently, we need to ask what older people cares about statins, or hypertension?

I am not hopeful that “DNRCT” would catch on in the emergency department, and so for acute admissions we may need to stick to an age cut-off. But once they are through the door, send us your confused, complicated, dying, and difficult patients, and we will care for them with the attention, respect, and dignity they deserve. Just don’t expect us to stick to your guidelines.

Virginia Aylett is consultant in medicine for the elderly, St James’s University Hospital, Leeds

[Virginia.aylett@leedsth.nhs.uk](mailto:Virginia.aylett@leedsth.nhs.uk)

Cite this as: BMJ 2010;341:c5340

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Cite this as: BMJ 2010;341:c5340

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**How do we heal the divide between GPs and Consultants? Des Spence, p 736**
Death by appointment

We normally associate Anthony Trollope (1815-82) with high class literary soap operas about English clerical and British political life rather than with science fiction. But in 1881 he wrote a short novel, *The Fixed Period*, that was set 100 years in the future and that described contrivances that allowed the instantaneous transmission of information across the world a little like the internet.

The purpose of his book, however, was satirical. It is set in a former British colony in the South Seas, now an independent republic, called Britannula, and is narrated by its first president, Mr Neverbend. *The Fixed Period* of the title is 67 years, at which age the citizens of the republic must, by law, enter a college, there to prepare for their own euthanasia by means of cut wrists in a warm bath.

Mr Neverbend, by the name of Gabriel Crasweller, a successful sheep farmer and businessman. Ten years older than Neverbend, Crasweller discovers when his time comes that he doesn’t want to die. His health has never been better, he still runs his businesses with great ability, and in general he enjoys life thoroughly. He appeals to President Neverbend to postpone his “deposition” in the college preparatory to death.

But Neverbend does not bend. He listens to the appeals neither of his wife nor of his son; nor to those of Crasweller’s beautiful daughter, with whom his son is in love. For him the principle is the principle and the law the law. That Crasweller is in the peak of health is less important or real to him than the suffering that would be saved if every 68 year old were put down as a matter of course.

In the end Crasweller is saved just in time by a British invasion, whose object is to suppress the fixed period. Neverbend to postpone his “deposition” in the college preparatory to death.

The law of fixed period was passed at a time when the colony’s entire population colony was still young, like the colony itself. The first person to be “deposited” in the college of preparation for euthanasia (where every comfort was provided) was an older friend and supporter of Mr Neverbend’s.

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**BETWEEN THE LINES**

Theodore Dalrymple

**The Fixed Period of the title is 67 years, at which age the citizens of the republic must, by law, enter a college, there to prepare for their own euthanasia by means of cut wrists in a warm bath**

**MEDICAL CLASSICS**

**4st 7lbs** By the Manic Street Preachers

Released 1994

This song from the Manic Street Preachers’ 1994 album *The Holy Bible* is an uncompromising account of life with anorexia nervosa, with lyrics written by the band’s guitarist, Richey Edwards.

Edwards remains one of rock music’s most enigmatic characters. He was beset by numerous mental health problems, including depression, anorexia nervosa, and self harming, but was gifted with a searing intelligence that allowed him to articulate his troubles with a heartfelt eloquence.

In “4st 7lbs” Edwards details his own experiences with anorexia. This is no cry for help. Uniquely, it is a window into the mind of a person with anorexia—her underlying contradictions, defiance, resilience, and desperation for personal control.

The song divides neatly into two. The opening guitar riff sets the scene for the first half: rebellious, obstinate, and proud. “So gorgeous sunk to six stone,” spits singer James Dean Bradfield, cast in the role of a teenage girl diarising her cascading weight loss. She is unfazed by documenting the erosion of her body in gory detail: “Cheeks sunken and despaired. Cling film on bone.” Most tellingly, what she sees in the mirror is a twisted beauty to her own eyes. “I’m getting better.” There’s a desperate clutching on to adolescence—“May I bud and never flower”—which shuts out the real, adult world from her personal prison.

I’ve looked after patients with anorexia on general medical wards. It’s a flawed environment in which to manage such a fragile condition, and it can be easy to focus on the physical concerns, forgetting that patients’ tendency to body dysmophoria can often wildly skew their view of themselves. Svelte supermodels Kate Moss, Emma Balfour, and Kristin McMenamy get admiring name checks here, as another day brings “naked and lovely at 5st 2.” The numbers are closing in, as the girl reaches desperately for her ideal body shape: “I want to walk in the snow and not leave a footprint.”

In the second half of the song Edwards’s lyrics point us towards the patient’s reasoning, which can lead to such defiant battling over weight control. This is her choice and her control statement. The music now is slower, calmer, and more accepting. “I choose my choice, I starve to frenzy. This discipline’s so rare so please applaud.” But tellingly, there is also self awareness that this is a path to destruction, “Such beautiful dignity in self abuse,” with a devastating final sign-off that “I’ve finally come to understand life. Through staring blankly at my navel.”

Empathy for such a self destructive process can be hard to muster, but Edwards’s words stir a deeper understanding of this complex condition. Less than a year after “4st 7lbs” was released, Richey Edwards vanished and has never been found. He was declared presumed dead in 2008.

Stuart Flanagan specialty doctor in genitourinary medicine, NHS Camden, London, and resident doctor, BBC Radio 1’s Surgery programme stuartfl1@yahoo.com

Cite this as: *BMJ* 2010;341:c5363

Cite this as: *BMJ* 2010;341:c5365
The great divide

Recently I apologised for some poorly made and insensitive comments about hospital consultants. This made me reflect on an old open wound, the relationship between consultants and general practitioners. When I was a student, medical education was the preserve of hospitals. The prevailing notion was that general practitioners were on the nice but dim side and were largely just failed hospital doctors. Anybody could be a GP, went the story. Nurses and physiotherapists joined the culture of GP bashing. But hospitals were not for me, and I travelled to “GP land,” leaving behind me many doctors that I deeply respected and some I did not.

After an excellent training year I was cast out into partnership. I found that, just as in the hospitals, there were some poorly performing doctors, many doctors that I deeply respected, and some I did not. But I was unprepared for the reality in general practice, for in the mid-1990s general practice was in crisis. The magazines for GPs were full of stories of “burnout,” and many partnerships were empty. The reason: GPs did 40-50 consultations a day along with daily house calls and working on Saturday mornings, late evenings or overnight. This had been taken for granted for decades but was no longer compatible with family life and an increasingly female workforce. Pay was relatively poor.

However, GPs still endured snotty hospital juniors on the phone and the constant thinly veiled snipes at our ability, however jokily made. We waited months for patients to be seen in outpatient departments, and consultants often ignored our calls to their secretaries. Consultants had a protective raft of juniors, who were better paid than us, and had pensionable merit awards and private practice engagements. Many GPs resented this perceived disparity in status and pay.

But the new GP contract changed everything. GPs now find themselves better paid than many in the hospital and are free from 6 pm and at weekends (although many of us still work late evening and weekends). General practice is now considered a lifestyle choice. With consultants still working weekends and nights and having lost much of the support from their junior doctors, they have become resentful towards GPs, who they believe don’t deserve the pay. I know this, because they can’t help but tell me so.

So how do we heal these divisions? Firstly, by raising the status of GPs. General practice training needs to be extended; it is ridiculous that in an area as diverse as general practice the training programme is shorter than that in other specialties. This might ease some of the pressure in the hospital rotations. Also, all specialist training should include six months’ rotation through general practice so that we all understand the context and limitations of community practice. GPs and consultants should carry out education together, as peers not pupils. We should consider a unifying employment contract for all doctors. GPs should not participate in divisive commissioning arrangements that pitch GPs against consultants but consider forming a managing group comprising members of both groups to develop local services. Lastly, the widespread lack of respect shown in hospitals to GPs must change. Resentment is poison, and we need to find a cure.

Des Spence is a general practitioner, Glasgow destwo@yahoo.co.uk

Cite this as: BMJ 2010;341:c5343

Nemesis

It seemed to taunt me: “I am the eternal abscess. I have been your companion through the ages, adorning both knight and burgher, proud and red and ripe and rampant. Shakespeare immortalised me as ‘imposthume,’ look on my works, ye mighty, and scratch and despair.”

But the sin of Hubris is always punished by Nemesis, just back from a long weekend with Sappho in Lesbos. “I think we’d better lance this,” I’d said, although this was just foreplay, because our nurse was the true connoisseur.

“Things growing are not ripe until their season,” she murmured, half to herself, eyeing it keenly, fondling it a bit (a bit too much, I reckon; certainly more than was entirely decent), like Ernest and Julio Gallo checking out their grapes. “It will be pointing in, I would estimate,” she mused, “about three days.” And sure enough, three days later, “Macbeth is ripe for picking,” she said, purring with anticipation, her lips moist and wanton and come hither. The vorpal blade went snicker-snack, and the laudable pus came spurting out, like wandering water gushing from the hills above Glencar.

“Goodnight sweet prince; and flights of angels sing thee to thy rest,” she said, in an almost postcoital tone, after which we felt compelled, for some inexplicable reason, to nip out the back for a languorous smoke.

But this unusual consummation was only the prologue; she also took extreme offence at any pus that remained unexpressed, so she returned to combat, put Wagner’s Ride of the Valkyries on the CD player, and squeezed and squeezed like her life depended on it. As the abscess was out of the patient’s eye line, she gave a running commentary to keep the patient informed and the rest of us entertained.

“You should see the stuff coming out of it now, what a rich and glorious colour; earth has not anything to show more fair; what a vibrant and unforgettable bouquet; it’s amazing; it’s incredible; just one more squeeze; don’t worry, we’re nearly finished now; just the last wee bit; gosh, can you believe it, there’s loads more, buckets and buckets of it, where is it all coming from? Ah, look, there’s another abscess; that one’s not ready yet; you’ll have to come back next week.”

And then, aside to the audience, “Always leave ‘em begging for more.”

Liam Farrell is a general practitioner, Crossmaglen, County Armagh dfarrell@hotmail.co.uk

Cite this as: BMJ 2010;341:c5337