For Debate . . .

Geriatric medicine—death and rebirth

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Yet another year has gone by and the debate continues. What is the role of the geriatrician? Why do so many students and doctors fail to see the exciting potential? How are we going to handle the ever increasing number of elderly patients in our society? The search for relevant comparisons from which to learn lessons usually dismisses paediatrics, hesitates at cardiology, before plunging into the confusing debate of "what constitutes a specialty anyway?" The way ahead is apparent, however, if we are prepared to learn from our mistakes, accept the obvious priorities, and reallocate medical staff appropriately.

A tarnished image

Gale and Livesley¹ in a paper entitled "Attitudes towards geriatrics" concluded, "the British medical graduate's unfavourable attitude towards geriatric medicine is due to deterioration of attitude after graduation." My observations differ strongly from this. The deterioration after graduation is far less important than that taking place during the clinical teaching years. The two major factors undermining the geriatric teaching programme are the image and role of the geriatrician, and the unconcealed prejudice of hospital staff. The very existence of geriatrics as a medical specialty inhibits acceptance of the elderly patient by clinical students and qualified doctors.

Medical teachers whose job it is to produce well-educated graduates have long been wrestling with the disinterest and apathy that seem to go hand in hand with geriatrics. Their function is to identify problem areas and offer solutions during the clinical teaching years, thereby producing a freshly qualified doctor with an enthusiasm for the problems of his elderly patients. If we assume that medical schools provide a good standard of geriatric teaching the question is whether such teaching is successful. A true measure of success would be to count the number of British trained graduates who choose this specialty as a first career option. Parkhouse and McLaughlin,² in a survey of career preferences, failed to record a single example of geriatrics among 2002 graduates who responded. This indicates the challenge facing departments of geriatric medicine and is even more an indictment of medical schools for failing to respond to the health needs of the population.

Adverse factors

Present-day teaching of geriatric medicine appears reasonable, and given an average batch of students good teaching should

equal educated students. It certainly does not do so in geriatrics. Clearly, there are factors that detract from the teaching effort.

STUDENT-PATIENT AGE GAP

The student-patient age gap is well recognised and is anticipated in the teaching programme. Nevertheless, owing to the smaller family groups of today many students find it difficult to identify with the elderly. They do not know how to gain the patient's confidence, and so feel powerless to help in the fight for recovery. This aspect is underemphasised in all aspects of medical education, but is a particularly important key to communication between the young doctor (or student) and elderly patient.

IMAGE AND ROLE OF GERIATRICIAN

When students first enter university they will seize a deserving cause and pursue it with the verve and enthusiasm of the innocent. The plight of the elderly, the real work of their chosen profession, grips them—almost like argina. As the clinical years progress, their attitudes gradually change until they conform to the prevailing medical norm. The study of pathology, for example, does not distinguish age groups and there is no such thing as geriatric pathology; similarly with pharmacology. Despite warnings of decreasing drug metabolism and diminished renal clearance with age, we find no geriatric pharmacy. The same applies to acute medicine and surgery. Consequently, many students do not believe that there is such a phenomenon as a geriatric patient. The elderly are just older patients, and the need for special doctors seems illogical.

If the medical profession has fallen down on its code of practice to the detriment of the elderly, necessitating the creation of special posts to plug the gap, then be honest with the students and tell them. The original problem seems to have been disinterest in treating elderly patients. Therefore, special posts were created. These posts are now inhibiting interest in treating elderly patients, and the cycle is complete.

From the point of view of teaching, too, it seems wrong to segregate the elderly. Not only does this confuse the student but it prevents him from developing his skills with older patients because he sees their problem as someone else's responsibility. This produces a graduate doctor with an unthinking attitude towards geriatric medicine.

Students and medical staff baulk at the very term "geriatrician." I think that there should be two types of geriatrician with quite different roles. The first and most important—the pioneer of medical and social services for the elderly—could keep the title geriatrician, although gerontologist might be more suitable. He has played an essential part over the past 20 years in identifying the nature and magnitude of the problem, in organising and assembling resources to meet it, and in familiarising students with the social and medical problems of the elderly. The second type, the "doctor specialising in the management of the elderly," suffers by being labelled geriatrician,

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and the term should be discarded. He is foremost a doctor, whose role is to provide first-line medical support for the elderly in the same way that doctors treat other groups of patients.

PREJUDICE OF HOSPITAL STAFF

The student on the hospital wards soon realises that the geriatrician lacks credibility with the rest of the medical staff. Perhaps more importantly he is seen to lack prestige and glamour. The student and young doctor are, of course, lacking in experience and often incapable of differentiating priorities in the hustle of the medical "rat race." They are impressed by the trendy young registrar, the whizz-kid of medical science, and model themselves on his behaviour and outlook. Such an attitude is clearly prejudiced, especially with regard to the geriatric patient and his problems. There is often open contempt of the role and medical ability of the geriatrician, and this is not confined to junior staff.

The very existence of a clinical specialty called geriatric medicine invites comparison with other specialties, often at a superficial level. How do you rate the drama of renal transplants, the high technology of cardiac bypass units, the academic maze of endocrine studies compared with, say, problems of incontinence and dementia in the elderly? Once again their cause loses out because of the existence of the specialty that purports to help them. Students and hospital staff accept implicitly that only the academically inferior student seriously considers doing geriatrics. It is regarded as an easy route to a consultant appointment, and yet students with any degree of self-esteem would rather enter that other, often maligned, field of general practice first. The end-result is the negation of most of the teaching effort, and total loss of sympathy with the cause—before graduation.

A non-specialty

The creation of special posts to provide medical cover for the neglected elderly seemed necessary 20 years ago, and has undoubtedly paid handsome returns. Thanks to the efforts of the pioneers of geriatric medicine not only is the medical profession aware of most aspects of this increasing problem, but so too is the rest of society. This achievement alone has justified the existence of geriatricians, but we should now ask whether they have completed their work, and if the time has not arrived to hand responsibility back to the profession, which should now be well equipped to deal with it, even if it would still prefer not to. Two points arise from this argument: whether or

not geriatrics was ever a medical specialty, and the proper allocation of resources.

Geriatrics cannot be likened to any other medical specialty. Its creation was not centred on any minority patient group where there existed a lack of technical skill, nor was it justified on the grounds of providing centres of excellence to give "top cover" when the general physician felt inadequate. This being so the general physician should be able to manage the elderly patient if he wants to and is given suitable facilities. I can only conclude that geriatrics is certainly not a medical specialty, nor was it originally intended to be.

If, as we are told, 60% of all hospital admissions today are in the over-60s age group and this proportion will increase, is it not time that the geriatrician took over as the general physician, leaving the latter to look after the rarer younger patients? Do we continue to recruit more geriatricians to deal with this dilemma while the non-geriatrician has an easier time or is made redundant? Surely the resources we seem to be lacking for the elderly do in fact exist; they must be allocated where they are needed.

A solution

The confusion that exists over the role of the geriatrician and his lowly status must be dealt with urgently. The problems of the elderly are both medical and social. A geriatrician can easily be labelled a "super-social worker" if he cannot strike the right balance between these two. The general physician, on the other hand, often pays lip service to the patient's overall welfare, while dealing only with the medical problem.

The terms geriatrician and geriatric medicine should be abandoned and be replaced by more clearly defined designations (see figure). The first would be the "gerontologist" for the pioneers of medical and social change and students of the problems of the elderly. The existing departments of geriatric medicine would become departments of gerontology, and would retain their present role of teaching and research. The second would be the "physician to the elderly," who would continue to specialise in the management of the elderly in much the same way as now, but his work load would be reduced to enable him to give his patients more attention. This, of course, implies that someone else will take over a fair proportion of his beds. In fact, as responsibility for the care of many of the elderly is handed back to the general physician he can be given extra facilities in geriatric hospitals. This means that a general physician with a ward in an acute hospital will also have a ward in a chronic hospital, thus providing him with the ideal complete facility.

The problem of the self-perpetuating cycle of biased medical staff influencing students before they are mature enough to make sound value judgments must be passed back to the faculty of medicine itself. If it is accepted that one of the major objectives of the medical course is to produce physicians able and interested in treating the elderly, steps can be taken to remind teachers that unbalanced opinions and personal prejudices should be voiced with care in the presence of students.

Medicine of the aged must be presented to the student as it really is: difficult and frustrating, often unrewarding, but a challenge at least equal to any other encountered in medical practice. Students should be repeatedly told throughout their training that the profession has failed in its responsibility to the older patient, and that it will go on failing if it cannot manage to stand by its caring principles. They should be told of the intellectual challenge but reminded also that they must first become better than average physicians before they will be able to manage their older patients successfully.

References

- ¹ Gale, J, and Livesley, B, *Age and Ageing*, 1974, **3**, 49.
- ² Parkhouse, J, and McLaughlin, C, *British Medical Journal*, 1976, **2**, 630.

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Proposed new designations for geriatricians.