TALKING POINT

Survey of recently appointed consultants in geriatric medicine

WILLIAM H BARKER, JAMES WILLIAMSON

> "There is much to recommend geriatrics as a specialty comparable to paediatrics. The creation of such a specialty would stimulate those with a leaning to this type of work and raise the standard of the work done."[1]

Forty years after Dr Warren's prophetic statement geriatric medicine, which originated with her work in a former Poor Law institution, is well established and is among the largest hospital based clinical specialties in Great Britain, with consultants located in virtually every health district.[2] Standards for facilities and professional staffing of geriatric services have been developed by the British Geriatrics Society and adopted by the Department of Health and Social Security,[3] and standards for postgraduate specialist training in geriatric medicine have been promulgated by the Joint Committee on Higher Medical Training.[4] Academic departments with professorial chairs have been established in half of the medical schools in the country and education in geriatric medicine was required in the curriculum of all but two medical schools as of 1981.[5]

Despite these manifestations of successful development, geriatric medicine remains for some a poorly understood specialty whose existence has been the subject of lively debate, including suggestions that it is best considered as part of general medicine.[6-12] The latter notion has led to the creation of several consultant appointments in general medicine with special responsibility for the elderly.[13]

As one approach to defining the current status of the specialty we conducted a survey of physicians recently appointed to consultant posts in geriatric medicine or in general medicine with responsibility for the elderly. We thought that a profile of modern geriatric medicine derived from the experiences of its most recent consultant recruits would help health policy planners, medical educators, and medical students and trainees, both in Great Britain and in other industrialised countries, all of whom are aware of the growing need for training doctors to respond adequately to the "geriatric imperative."[14] Furthermore, the study afforded an opportunity to compare the career paths of those appointed in full time geriatric posts with those appointed to posts in general medicine with responsibility for the elderly, as recommended by the Royal College of Physicians in 1977.[9]

Methods

A self administered questionnaire was pilot tested among approximately 20 recently appointed consultants and senior registrars in geriatric medicine. Information to be collected included certain basic demographic facts and descriptions of professional education and training; major factors involved in the decision to pursue a career in geriatrics; selected descriptions of geriatric units in which respondents were currently working; current teaching and research activities; and, finally, recommendations for improving various aspects of geriatric career development.

A letter sent to all regional health authorities in England and Wales and health boards in Scotland yielded a list of 182 consultants appointed in the five year period 1978-82. Responses to the mailed questionnaire were received from 147 of the 182 (81%); 17 respondents were judged ineligible because of misclassification. Of the 130 included in the study, 101 were appointed as physicians in geriatric medicine and 29 as general physicians with responsibility for the elderly. The two subgroups were compared in the analyses.

Results

Respondents were well distributed throughout the country, roughly reflecting population distribution (fig). Median age at time of appointment was 35 and approximately 15% were women. Selected aspects of medical education are shown in table I. A greater percentage of general physicians qualified in medical schools in England and Wales (other than London), while greater percentages of physicians in geriatric medicine qualified in Scotland or overseas. The median year of medical qualification and of attaining the membership of the Royal College of Physicians were similar for the two groups (1969 and 1974 for the physicians in geriatric medicine and 1968 and 1976 for the general physicians).

TABLE I—*Qualifying medical school*

Medical school	Physicians in geriatric medicine (%)	General physician with responsibility for the elderly (%)	Total (%)
London	27	21	25
England and Wales	17	38	22
Scotland	16	10	15
Overseas	41	31	38
Possession of MD	11	14	12

CAREER DECISION MAKING

From a list derived during the pilot study respondents were asked to mark the three most important reasons for their career decision (table II). The most frequent response, offered by over 60% in both consultant subgroups, was "preference for working with a wide range of medical problems." The second and third most common selections were "good opportunities to obtain a hospital consultant post" and "positive experience in geriatrics during postgraduate training."

Geriatrics was the first career preference of 49% of physicians in geriatric medicine compared with 35% of general physicians (table III). Medical subspecialty was the most common initial career

Department of Preventive, Family, and Rehabilitation Medicine, University of Rochester, New York
WILLIAM H BARKER, MD, associate professor

Department of Geriatric Medicine, University of Edinburgh, Edinburgh EH8 9AG
JAMES WILLIAMSON, MB, CHB, professor

Correspondence to: Dr Barker, Department of Preventive Medicine, Box 644, University of Rochester Medical Center, Rochester, New York 14642.

preference among general physicians. Respondents in both subgroups decided to pursue a career in geriatrics most frequently during the registrar and senior registrar stages of training. The relatively high figure of 28% of general physicians who decided during the senior registrar stage reflects a diversion away from medical subspecialty tracks. Over half of both subgroups indicated that their decision was strongly influenced by working with a specific individual who provided a positive role model in geriatric medicine during postgraduate training.

EDUCATION AND TRAINING

Only 20% of respondents had received theoretical and 10% clinical education in geriatrics during medical school, most having qualified by the early 1970s before the widespread incorporation of geriatrics as a required part of the medical school curriculum in Great Britain.[5] Respondents averaged between five and six years' total postgraduate training in general medicine or geriatrics or both before assuming their current posts. This included an average of three years of senior house officer and registrar and two and a half years of senior registrar training. Eighty eight per cent did most of their senior registrar training in geriatric posts. Participation in National Health Service management courses offered either at the University of Manchester or at the King's Fund College in London was reported by 71%. This represented 80% of physicians in geriatric medicine but only 42% of general physicians. Graduate training in geriatric medicine was rated as moderately or very good by 95% of respondents. Management and administration, various medical subspecialties, psychiatry in old age, and various aspects of rehabilitation were listed most frequently as areas in which further training would have been helpful. Forty eight per cent of general physicians gave no response to this question.

TABLE II—*Reasons for choosing career in geriatrics*

	Physician in geriatric medicine (%)	General physician with responsibility for the elderly (%)	Total (%)
Wide range of medical problems	68	62	67
Consultant opportunities	50	41	46
Postgraduate experience	44	38	43
Multidisciplinary work	31	35	32
Societal needs	25	10	22
Hospital and community work	21	21	21
Family considerations	13	14	13
Research potential	8	10	9
Medical school exposure	5	7	5
Teaching opportunities	5	3	5

Note: Respondents were given a list of the above answers and requested to select up to three most important to their career decision.

TABLE III—*Priority and timing of career decision making*

	Physician in geriatric medicine (%)	General physician with responsibility for the elderly (%)	Total (%)
First preference:			
Geriatrics	49	35	46
General medicine	22	21	21
Medical subspecialty	14	38	19
Other	16	6	14
Time of geriatric decision:			
Senior house officer (geriatrics)	13	3	11
Senior house officer (medicine)	6	10	7
Registrar (geriatrics)	12	—	9
Registrar (medicine)	24	17	22
Senior registrar	10	28	14
Geriatric locum	3	10	5
Research post	4	10	6
Other	27	20	25
Influenced by specific person	52	55	53

One hundred and thirty consultants appointed 1978-82 by health region.

GERIATRIC UNITS

Geriatric units in which respondents were based averaged eight to nine beds per 1000 population over 65 years of age, with an average of two to three beds per 1000 located in district general hospitals and four to five beds per 1000 in long stay hospitals. Day hospitals, available in all but a few instances, averaged 1·3 places per 1000 over age 65. All of these provisions, which were essentially the same for both subgroups of consultants, are at levels approximately, but slightly below, the standards recommended by the British Geriatrics Society in 1982.[3]

Over 80% of consultants in both subgroups reported having admission beds in district general hospitals. Important management elements found in almost all units included a central office for coordinating bed use, the conduct of regular multidisciplinary case conferences to review patient progress and care plans, and the use of a small percentage of the unit's beds for scheduled respite admissions of community dwelling patients with heavy care needs.

Median number of domiciliary visits per week was five for consultants in both subgroups. On average, the consultants reported spending slightly less than one day a week in direct care of patients in long stay beds. Regularly scheduled geriatric consultative liaison with general medicine departments was reported by 46% of physicians in geriatric medicine and 69% of general physicians, liaison with orthopaedic departments by 55% of physicians in geriatric medicine and 41% of general physicians, and liaison with psychiatry departments by 41% of physicians in geriatric medicine and 17% of general physicians.

Table IV lists ways in which consultants would change or improve their local geriatric services. The most common suggestions included increasing acute beds and increasing other facilities (including rehabilitation and long stay beds and day hospital places), followed by increase in social services, rehabilitation therapists, and medical posts. General physicians were as a group less responsive to this inquiry than physicians in geriatric medicine.

TABLE IV—*Areas for changing or improving geriatric service*

	Physicians in geriatric medicine (%)	General physician with responsibility for the elderly (%)	Total (%)
Increase acute beds	30	17	27
Increase other facilities	24	3	19
Increase social services	18	14	17
Increase rehabilitation therapists	16	14	15
Increase medical posts	17	10	15
Liaison with other departments	12	7	11
Psychogeriatric unit	10	3	8
Other	16	10	15
No response	4	24	8

Note: Respondents were given a list of the above answers, including "other," and requested to select up to three most important.

ACADEMIC AND ADMINISTRATIVE ACTIVITIES

Table V summarises selected teaching, research, and administrative activities. Roughly one third of respondents in both subgroups reported regular participation in medical student teaching, a half or more teaching house officers, and a fifth teaching general practitioners. Many reported participation in one or more areas of research, with clinical research reported most commonly. Finally, half to two thirds represented geriatric interests by serving on either hospital or community administrative or advisory committees.

TABLE V—*Selected teaching, research, and administrative activities*

	Physicians in geriatric medicine (%)	General physician with responsibility for the elderly (%)	Total (%)
Teaching:			
Medical students	38	31	37
House officers	45	62	48
General practitioners	22	14	20
Research projects:			
Laboratory	21	14	19
Clinical	71	45	66
Epidemiology	17	7	15
Health care	16	3	13
Committees:			
Hospital	70	69	70
Community	55	38	52
National	6	3	5

A final openended question asked what advice might be offered to medical students or house officers with respect to pursuing a career in geriatric medicine. The answers, largely reflecting reasons that the consultants gave for their own selection of geriatrics, included exposure to a wide variety of medical problems, good career prospects, a challenging career, and multidisciplinary and community involvement. Excellent opportunities for research was listed by 21%.

Discussion

On the basis of this survey, recently appointed consultants in geriatric medicine or general medicine with responsibility for the elderly have received sound postgraduate training, approximating standards established by the Joint Committee on Higher Medical Training,[4] and participate in a full array of medical services for the vulnerable elderly as called for in guidelines established by the DHSS in consultation with the British Geriatrics Society.[3] Virtually all consultants routinely include domiciliary visits, multidisciplinary team case conferences, and scheduled respite admissions as strategies for meeting their patients' needs. Approximately half conduct regular consultative liaison services with departments of medicine and orthopaedics and somewhat fewer with psychiatry. Clearly the role of the consultant in geriatric medicine has evolved from its origins managing long stay patients in chronic care institutions to a complex and dynamic practice of hospital and community medicine, much in keeping with the models proposed by several of its academic leaders.[10 11 15]

Postgraduate training was generally rated well; nevertheless, a desire for further training in rehabilitation, psychiatry, and management, three areas of particular importance in medical care of the elderly, were mentioned by several respondents. These special issues are being addressed in part with the recent introduction of annual short courses on rehabilitation and psychiatry in old age, organised with British Geriatrics Society cosponsorship by several departments of geriatric medicine.

In comparing those appointed as full time consultants in geriatric medicine with those appointed as general physicians with responsibility for the elderly, the major differences included a somewhat later time of career decision and smaller response to questions regarding suggestions for improvements among the general physicians with responsibility for the elderly. Outweighing these differences were the striking similarities between the two groups of consultants with respect to the array of facilities and routine practices in their current consultant posts. This finding suggests that it is the special mix of medical and related needs of the elderly patient population, rather than the job description, that prevails in determining the outcome of a choice of a career involving geriatric medicine.

While this survey, like an earlier study of medical careers conducted by Hutt and colleagues,[16] found that the decision to pursue a career in geriatrics occurred relatively late and usually not as a first preference, developments pertinent to current cohorts of medical students and trainees suggest marked improvements in recruitment to and enthusiasm for the specialty. These include nearly universal exposure of British medical students to formal education in geriatrics, with some evidence that this experience directly influences students towards choosing a career in geriatric medicine[17]; the expanded number of opportunities for medical house officers to rotate on geriatric medicine units and to work with geriatricians in district general hospitals; and the continuing decline in consultant opportunities in other medical and surgical specialties relative to the number of aspiring applicants.[18]

Surveys of physicians entering geriatric medicine training programmes in the past few years have found that an increasing percentage are graduates of British medical schools, that decisions to enter geriatric training are occurring at an earlier stage of career development, and that a majority prefer to practise full time geriatric medicine as opposed to practising general medicine with special responsibility for the elderly.[19 20] Under these circumstances, one estimate suggests that the current rate of entrants into geriatric training as senior registrars will yield about the right number to fill the stated requirement of approximately 800 consultantships in Great Britain by 1990.[19]

We should like to thank regional health authorities in England and Wales and health boards in Scotland for supporting the project; the respondents who participated in the survey; and Ms Audrey Hogg for administrative help. Dr Alex Kalache at the London School of Hygiene and Tropical Medicine provided valuable advice on the design of the survey. The study was supported partly by a World Health Organisation fellowship awarded to WHB in 1983.

This work will appear as part of a book by Dr Barker entitled *Organized Geriatric Services in Great Britain* to be published by the Johns Hopkins University Press in 1987.

References

1 Warren MW. Care of the chronic sick. *Lancet* 1946;i:841-3.
2 Brocklehurst JC, Andrew K. Geriatric medicine: the style of practice. *Age Ageing* 1985;**14**:1-7.
3 British Geriatrics Society. *Memorandum on provision of geriatric services*. London: British Geriatrics Society, 1982.
4 Joint Committee on Higher Medical Training. *Training handbook and third report 1980*. London: Royal College of Physicians, 1980.
5 Smith RG, Williams BO. A survey of undergraduate teaching of geriatric medicine in the British medical schools. *Age Ageing* 1983;**12**(suppl):2-6.
6 Gale J, Livesley B. Attitudes towards geriatrics: A report of the King's survey. *Age Ageing* 1974;3:49-53.
7 Leonard JC. Can geriatrics survive? *Br Med J* 1976;i:1335-6.

LMC scheme to help sick doctors

The existing model local medical committee scheme to provide informal help to sick general practitioners was drawn up in 1983. Since then several schemes have been introduced for other sections of the profession and the General Medical Services Committee's advice has been amended in the light of experience gained in the past three years.

The principal changes are:

(*i*) The need for follow up support for at least 12 months after a sick doctor has had treatment and, in particular, support with the organisation and running of his practice. This may be provided either by the counsellor or by the local medical committee secretary, whichever is deemed to be more appropriate.

(*ii*) The British Doctors and Dentists Group has a panel of doctors who are recovered alcoholics or addicts who have offered to act as special advisers if appropriate. The names of these doctors may be obtained direct from the group (tel 092084 309).

The model scheme is set out here.

Introduction

"The following model scheme is to provide informal help to the sick general practitioner who is not seeking medical attention and is at risk of having a formal complaint made against him by a patient. The scheme is quite informal and non-coercive, and intended to be highly confidential. It is hoped any locally agreed scheme will regularly be drawn to the attention of all general practitioners, their families, and professional colleagues.

Referees

"Respected general practitioners should act as referees in the scheme. In general it is suggested that there should be five referees in each local medical committee area representing both sexes. The numbers involved will need to reflect local views and needs. The local medical committee (medical) secretaries should keep the list of general practitioner referees.

"A psychiatrist or another appropriate clinician can be brought in at any stage of the informal help procedure and can be the first to contact the sick general practitioner, to contact him jointly with general practitioner referees, or at the second stage following the general practitioner referee's initial contact. The psychiatrist nominated in each case may often be from a locality other than that of the sick general practitioner. A list of psychiatric referees is available from the Royal College of Psychiatrists (tel 01 235 2351).

"The chosen general practitioner referee may contact the GMSC for the name of a special adviser who will be a recovering alcoholic/addict nominated by the British Doctors and Dentists Group.

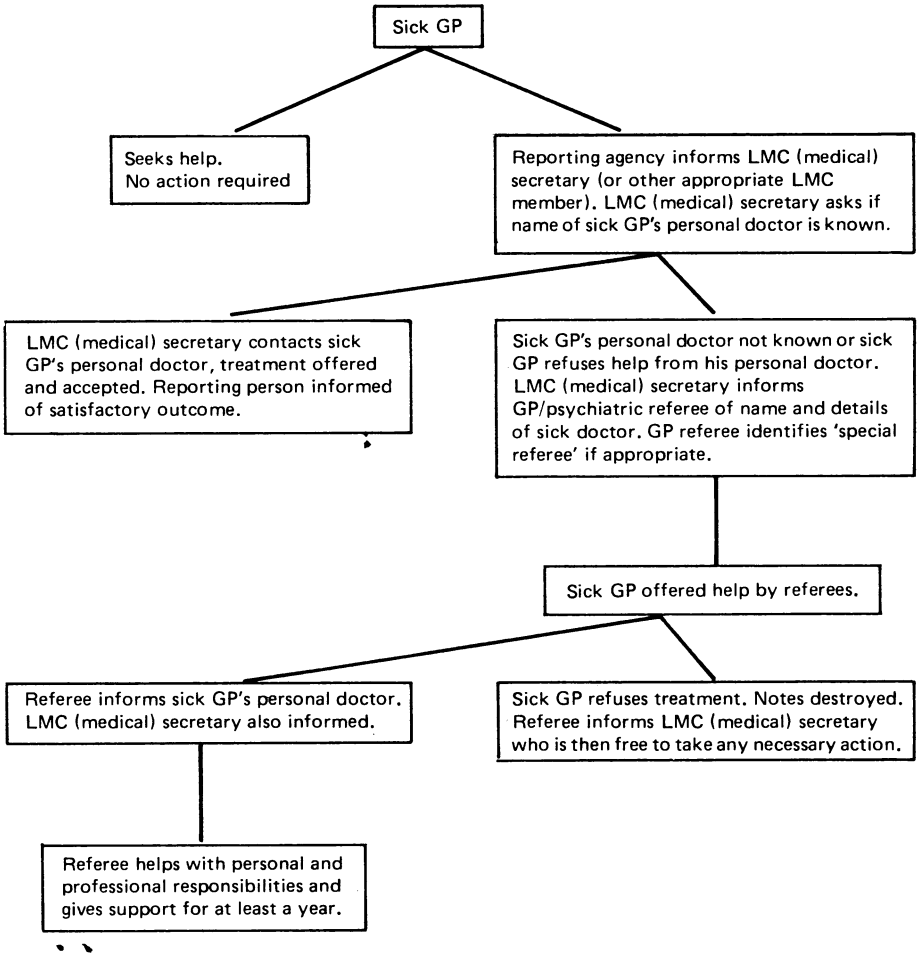
"Minimal notes should be kept by the referees during the period while help is being given and should be destroyed once action is completed. Most contact should be made on a personal basis or by telephone rather than by written word.

"It is suggested that telephone, travelling, and out of pocket expenses of the general practitioner referee and/or psychiatric referee should be met by the sick general practitioner's local medical committee.

Procedure

"When the reporting person—that is, professional colleague or members of the sick general practitioner's family—becomes aware of the failing health of the sick general practitioner, they should contact the local medical committee (medical) secretary in the first instance. (However, a senior member of the local medical committee would be appropriate if in choosing the local medical committee (medical) secretary it was felt that there could be a conflict of interests should service committee proceedings arise and the identity of that member should be publicised.)

"The local medical committee (medical) secretary should find out if the name of the sick general practitioner's personal doctor is known, and if known discuss the condition of the sick general



Survey of recently appointed consultants in geriatric medicine—*continued from p 898*

8 Cross VH. Geriatric medicine—death and rebirth. *Br Med J* 1977;ii:816-7.
9 Hazzard WR. Three views on geriatric medicine: 2. An American's ode to British geriatrics. *Age Ageing* 1979;**8**:141-3.
10 Williamson J. Geriatric medicine: whose specialty? *Ann Intern Med* 1979;**91**:774-7.
11 Anonymous. Career prospects in geriatrics. *Br Med J* 1980;**280**:426.
12 Royal College of Physicians of London. Medical care of the elderly. *Lancet* 1977;i:1092-5.
13 Graham JM, Playfair HR. General medicine with special responsibility for the elderly. *Health Trends* 1983;**15**:66.
14 Somers AR, Fabian DR, eds. *The geriatric imperative*. New York: Appleton-Century-Crofts, 1981.
15 Pathy MS. Operational policies. In: Coakley D, ed. *Establishing a geriatric service*. London: Croom Helm, 1982.
16 Hutt R, Parsons D, Pearson R. The timing and reasons for doctors' career decisions. *Health Trends* 1981;**13**:17-20.
17 Peach H, Pathy MS. Attitudes towards the care of the aged and to a career with elderly patients among students attached to a geriatric and general medical firm. *Age Ageing* 1982;**11**: 196-202.
18 Lye M. Geriatric medicine and medical unemployment. *J R Coll Phys Lond* 1982;**16**:129-31.
19 Brocklehurst JC. Conference on vocational training in geriatric medicine. *Age Ageing* 1984;**13**:179-80.
20 Donaldson M. Career aspirations of geriatric medicine trainees. *Age Ageing* 1985;**14**:8-10.

(Accepted 16 July 1986)