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The Doctor and the Elderly

James Williamson

Abstract

Specialism in medicine is an inevitable accompaniment of modern life and one of the newest specialties is Geriatrics (or as many of us would prefer — geriatric medicine). Medical specialties develop for a variety of reasons, for example, the specialty of renal diseases has grown out of the great technical advances in diagnosis and treatment in recent years. Other specialties have developed more gradually as the total body of relevant knowledge has accumulated, for example, cardiology and neurology. Other specialties have appeared as a direct response to the needs of the community, and this is the category into which we place geriatric medicine. With the increasing numbers of old people consequent upon the much higher proportion who survive to old age, the needs of the elderly have escalated and it has been necessary to attempt to deal with this crisis in different and sometimes novel ways. At the same time as numbers of old people have been increasing, many of the traditional family patterns of care have been eroded by social alterations, and so we have both demographic and social reasons for a "geriatric crisis". It is commonplace now to find that the married daughter (in her 30's or 40's) is unable to afford her mother more than token support because she herself is in paid employment and only available for housewifely and family tasks in the evening.

The result has been a great increase in declared demand for services for the elderly. Nor is this the whole story, because many studies in different areas of the Western World have shown that old people's needs are often unknown until a crisis occurs (a fall, an acute infection, a stroke, or sometimes simply illness of a custodial relative or neighbour) and the situation is then found to be very advanced and perhaps irreversible and preventable sequelae have occurred.

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THE DOCTOR AND THE ELDERLY

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Specialism in medicine is an inevitable accompaniment of modern life and one of the newest specialties is Geriatrics (or as many of us would prefer — geriatric medicine). Medical specialties develop for a variety of reasons, for example, the specialty of renal diseases has grown out of the great technical advances in diagnosis and treatment in recent years. Other specialties have developed more gradually as the total body of relevant knowledge has accumulated, for example, cardiology and neurology. Other specialties have appeared as a direct response to the needs of the community, and this is the category into which we place geriatric medicine. With the increasing numbers of old people consequent upon the much higher proportion who survive to old age, the needs of the elderly have escalated and it has been necessary to attempt to deal with this crisis in different and sometimes novel ways. At the same time as numbers of old people have been increasing, many of the traditional family patterns of care have been eroded by social alterations, and so we have both demographic and social reasons for a "geriatric crisis". It is commonplace now to find that the married daughter (in her 30's or 40's) is unable to afford her mother more than token support because she herself is in paid employment and only available for housewifely and family tasks in the evening.

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It is against this background of increasing demand, unreported need and limited facilities that we have to try to take stock and assess the present situation. It is often suggested that these are "mainly social" problems and therefore the doctor's role is a limited one. But the profession cannot wriggle off this particular hook so easily because when we examine these "social" difficulties many turn out to have an important (even exclusively) medical basis. Thus we find the old lady who lives in the top flat in a tenement and is becoming more and more disabled, unable to climb stairs and thus shopping becomes perfunctory, her social life and diet suffer, and she is in danger of loneliness, isolation and all the sequelae of such a state. A social problem? But what if the reasons for her increasing disability is dyspnoea associated with congestive cardiac failure and this is due to a rapid, unknown, uncontrolled

atrial fibrillation. This now becomes a medical problem, readily amenable to standard therapeutic measures with excellent results (and at almost negligible cost to the N.H.S. and the community). I have an old patient who presented in such a state eleven years ago and who still lives on in her old family flat and has done since the diagnosis and appropriate therapy was instituted. Unfortunately not all the problems of elderly patients are quite so simple and straightforward and the majority present with multiple pathology. In many cases traditional medical measures are only partially successful, and we are left with significant residual disability. In these cases modern rehabilitation techniques must be employed — assessing the functional deficit in stroke cases, for example, and using physiotherapy and occupational therapy to restore lost function. Where irrecoverable disability remains, then the patient's environment must be altered to suit. Thus family or neighbourly support can be mobilised. Home helps can take over household management tasks and the house itself can be adapted to suit the old person's disabled condition (provision of ramps, handrails, wider doors in W.C., etc.). In this way the doctor's skill is employed to establish an accurate clinical diagnosis; traditional therapies are then employed to cure or alleviate those disease entities which are uncovered, and the doctor then has to invoke the rehabilitation team to restore lost function or to make up for the loss when full restoration is not feasible.

Geriatric medicine can claim great success in many fields over the last twenty years or so. More and more it is realised that early diagnosis and appropriate treatment will enable an increasing number of old people to remain longer in their own homes, thus staying out of institutions and costing the rest of us less in terms of money and trained staff to look after them. Despite increased efficiency however, the increasing numbers of old people in many areas continue to swamp the community services, and in this case the old people "overflow" into hospital beds where they often are seriously misplaced. Thus every general ward in Edinburgh has its quota of "blocked beds" occupied by old ladies who should be somewhere else, for example, in sheltered housing (which virtually is non-existent in Edinburgh) or in old folk's homes (which themselves are occupied to a large degree by old people who could be in sheltered housing if this existed). These old ladies are often pathetic creatures —

disabled, frequently demented, bereft of family support and guiltily aware that they are not very welcome in the "acute" ward situation in which they find themselves. They are led to understand that they are "blocking a bed", that the bed "is needed for a more urgent case", etc. This leads to frustrations among the medical and nursing staff, and if there are students in the ward, this is communicated to them. The student thus gains the idea that somehow old people are "uninteresting", that they are "therapeutically unrewarding" and that their care scarcely impinges upon the activities of doctors (or at any rate "proper" doctors). It is not all surprising therefore that the young graduate often emerges from the Edinburgh Medical School with a highly negative view of his role in relation to elderly patients. This may last him a lifetime, although fortunately many manage to achieve a more useful attitude towards their older patients as they go through their professional career. If anyone doubts the accuracy or truth of this statement, let him ask a representative sample of final phase students or young graduates what are their views of the care of elderly patients, or the function of the geriatric services. I know what the response will be because I have asked these questions.

Another sad fact is that the student's contact with old age in his curriculum is almost exclusively in the wards of the teaching hospital and he remains largely ignorant of the huge majority of other old people. The importance of this is emphasised by the fact that 94% of elderly persons are in private households and only 6% in any form of institution. Of this 6%, only a tiny fraction are to be found in teaching wards, most being in old folk's homes or old-fashioned psychiatric hospitals, well away from the medical student's accustomed territory.

The result of this is that many students manage to become doctors with only a very incomplete and highly distorted view of the ageing process and the common problems which beset the older members of the communities he will be attempting to serve. This is particularly serious in view of the fact that these doctors (if they are to practise in a developed country) will be spending an increasing proportion of their time with elderly patients.

THE FUTURE OF GERIATRIC MEDICINE

It has been pointed out that the specialty of geriatric medicine arose initially out of the pressing community need. This declared need,

combined with a general lack of interest and unwillingness on the part of most doctors, led to the setting up of special departments and a small number of pioneers in the profession showed what could be done to help the apparently "hopeless cases" of old people with multiple and complex needs. Gradually geriatric hospital units have evolved and now there is some sort of service for each area of the Kingdom. It is, however, readily seen that there are stresses and strains, and it is necessary to review the present situation and to try to devise more satisfactory plans for the future. There is no denying that geriatric units are difficult to staff — there are well over thirty vacancies at consultant level in England and Wales alone, and it is commonplace for posts to be advertised over and over again with failure to obtain satisfactory applicants.

It is therefore proposed by many responsible geriatric physicians that the present arrangements should be reviewed and that the recent trend for separation of geriatric medicine from general medicine should be reversed. This idea has much to recommend it, and some of us who initially were not too enthusiastic are now prepared to change our stance on this issue. After all, Geriatrics is defined as "that branch of general medicine which deals with the clinical, social and psychological problems of elderly persons", so that it is an integral and increasingly important part of general medicine. Indeed, some would go further and claim that geriatric medicine is by far the largest part of general medicine since so much else of the general field has been pirated by narrower specialisms. It would thus seem likely that we should encourage geriatric units to come closer to general departments, to share junior staff (either in joint appointments or in rotational schemes), to share expensive diagnostic and treatment facilities. Thus we might envisage the medical division of the future having as one of its constituents the consultant in Geriatrics who would deal with the "purely geriatric" cases and at the same time be available for advice on other elderly patients who were receiving treatment from other specialisms in the division. This "loose specialism" could extend outside the hospital into general practice where some general practitioners would be encouraged to develop special interests in the diagnosis and management of elderly patients. These specially interested general practitioners would be those who had spent some time in the geriatric department and many of them would retain an

active role in the local geriatric unit. This general plan would reverse the recent drift towards establishing a separate service for older patients — in my view such a trend would result eventually in two standards of service — a good and a bad — and there is little doubt which would be which! There will, of course, always be a need for specialist geriatric units, especially in large centres where large numbers of very difficult cases will occur. In addition there is a great need to encourage the establishment of academic departments in geriatric medicine, and it is difficult to escape the conclusion that until a medical school has a Department of Geriatric Medicine it cannot be said to be matching up to the demands of the late twentieth century. Ten years ago it could with justification be argued that the total body of knowledge on ageing and geriatrics was so scanty and disorganised that it could not justify being described as an academic discipline. The great advances in recent years in the practice and theory of medicine in relation to old age and the success of research has changed this and there are now as good arguments for academic departments in this subject as there were twenty or thirty years ago for academic departments of Paediatrics (or more properly Child Health).

These things, of course, cannot be done at the stroke of a pen, and the first essential is to provide undergraduate instruction in geriatric medicine. The Edinburgh Medical School is well-known in Scotland for having been extremely slow to develop such instruction — indeed, it only started on any scale in January, 1972! Even now the time allocated — two sessions in fourth year and the same in final phase — is so brief that it is quite difficult to know where to start.

It is therefore suggested that the following should be aimed at:

PRE-CLINICAL YEARS

The student should have an introduction to age topics immediately he enters medical school. The biology of ageing is a fascinating and rapidly growing subject and should be taught in the biology class.

Similarly, physiological changes of senescence should be taught in the physiology and anatomy courses. Visits to geriatric units should be arranged at this stage so students can see the significance of what they are being taught in a clinical setting, for example, the ageing of bone tissue could be demonstrated in a dra-

matic fashion by showing students the skeletal changes in elderly patients.

Psychological aspects of ageing require to be taught in the behavioural sciences class, and again visits to geriatric departments should be arranged in collaboration with consultants in geriatric medicine.

In the studies on community health, the place of the elderly and the stresses and strains they experience (and generate) would be included.

In this way the student would be made to realise from the start that senescence is something that will affect him personally and that a large part of his professional life will be spent on dealing with its effects. If we believe that "normal" life span is three score years and ten, then we must accept that senescence is a normal part of human development and hence justifies study just as much as embryology, infancy, childhood and adolescence. At present our attitude to human development tends to suggest that once we reach maturity, nothing changes until death!

CLINICAL YEARS

In the teaching of clinical methods there are great advantages to be had in bringing students to the geriatric department: a) there is a wealth of "clinical material" —heart murmurs, palpable masses, skeletal changes, malignant disease, cataracts, etc.; b) it is important that the student should have an opportunity to realise the special problems of clinical examination and history taking in the elderly, c) the distinction between "normal" age changes and pathological ones. Here attempts should be made to show students healthy octo- and nonagenarians in order to counteract the dismal impression he obtains of old age in the wards.

For the teaching of geriatric practice we need a good deal of experiment with different methods. If lectures are an important part of the course, then there should be lectures on geriatrics. But it is not, I think, a subject which lends itself readily to treatment in large formal lectures. It is better to develop topic teaching by concentrating upon specially important aspects. A good example is Stroke, which should be taught by a multidisciplinary approach — pathology, epidemiology, diagnostic procedures, management of "acute" phase, and finally assessment of functional loss and planning of rehabilitation. The special contribution of the geriatric teacher would be in the last two items, but there is much to be said for involving other specialists in the same teaching session, (And, of course, physiotherapists, speech therapists and nurses as well). There is a great scope for developing better teaching methods in these fields.

Lastly, some students should be encouraged to do "in depth" studies of ageing problems. The field of gerontology and geriatrics bristles with opportunities for special enquiry, and a keen young student could even at undergraduate level readily provide new evidence on old problems which might lead to better ideas on management. Much of this could be done in the community, away from the restrictions of hospital-bound medicine, and this in itself would be valuable (and also in line with much current student aspiration).

In these ways I believe it is possible to bring geriatrics back into the mainstream of general medicine before the separation has gone too far. Psychiatry drifted away from general medicine in the 19th century, and it has been a slow and painful struggle to bring it back; let us not allow this to happen to geriatric medicine.