Senior Registrars’ views on Geriatric Medicine

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The ideal relationship between geriatric and general medicine, in terms of training and service commitment, has been frequently contested[1,2]. The practice of geriatrics and its association with general medicine at present remains diverse[3,4]. This study attempts to describe the attitudes of senior registrars (SRs) in geriatrics to the specialty’s affiliation with general medicine.

Method

Questionnaires were mailed to 157 SRs whose names were obtained from the British Geriatrics Society trainee list. The questions were phrased in a pragmatic form and the replies were made anonymously. There was space in the questionnaire for additional comments.

Results

One hundred replies suitable for analysis were received; a 64 per cent response rate. The answers are detailed in Tables 1-3.

| Table 1. Length of registration and experience in geriatric medicine; job description. |
|--------------------------------------------------|
| Years registered with GMC: | Mean 7.4 | No. of people |
| Months (post-GMC registration) of experience in geriatrics prior to SR appointment | 0 | 28 |
| 1-6 | 26 |
| 6-12 | 17 |
| >12 | 29 |
| SR job description: | Full-time geriatrics | 59 |
| Integrated with general medicine | 41 |

More than half the sample had less than 6 months’ geriatric experience before being appointed SR. Although a majority (68) felt that further training in general medicine as an SR was desirable, a minority of 35 were unable to undertake it. In contrast, 62 respondents preferred the career option of whole-time geriatrician and the same number wished geriatric medicine to remain separate from general medicine.

Approximately 15 per cent of the respondents made further comments, independent of the questionnaire. Many of these views overlapped and most were related to the integration of geriatric and general medicine.

| Table 2. Accreditation and rotation with general medicine. (Number of answers received) |
|--------------------------------------------------------------------------------------|
| In training future consultant geriatricians, do you believe dual accreditation with general medicine is desirable, in contrast to training (at SR level) mainly or wholly in geriatrics? |
| Desirable | 68 |
| Undesirable | 9 |
| Irrelevant | 23 |
| Would one year’s experience in general medicine, at SR level, enable you to apply for dual accreditation? |
| Yes | 62 |
| No | 33 |
| Don’t know | 5 |
| Can you to rotate to general medicine during SR training, if desired? |
| Yes | 65 |
| No* | 35 |
| *15 in Thames Regions. 5 lecturer posts in University Departments. |

| Table 3. Career choice; future of specialty. |
|---------------------------------------------|
| Choice of consultant post: |
| Whole-time geriatrician | 62 |
| Physician with an interest | 30 |
| No stated preference | 8 |
| How geriatrics should proceed? |
| Separate specialty | 62 |
| Total with general medicine | 21 |
| Other | 17 |

Of those favouring some form of integration, several expressed some confusion at what this implied, i.e. whether it was sharing of beds, staff, or resources such as radiology. A popular view was that in rural or semi-rural areas integration would be more logical than in urban environments; however, specialist university departments should continue to exist to guide research and policy. Other people believed that geriatrics would be more viable as an age-related speciality like paediatrics, and interestingly only two respondents wished geriatrics to be a medical sub-specialty like cardiology. A further two respondents stated that other reasons for dual accreditation were to give them as wide as possible a career choice and to silence critics of the calibre of trainees in geriatric medicine.
The more entrenched 'separatist' attitude was that wholesale integration would once more lead to general physicians with neglected and unsupervised long-stay beds. Indeed, they felt that far from encouraging geriatric medicine SRs to train further in general medicine, it should be made compulsory for general medical SRs to spend a period in geriatrics. One respondent expressed concern that some senior geriatricians now seemed to believe that training as a pure geriatrician was in some way inferior to the integrated approach.

The replies of the 28 respondents who had no previous geriatric experience prior to SR appointment were examined. It transpired that 15 had integrated SR posts, 19 only required one further year in general medicine to qualify for dual accreditation (providing two years of geriatrics was also completed), and four had already claimed accreditation in general medicine prior to SR appointment. The majority (23) believed further training in general medicine at SR level to be desirable, but equal numbers were in favour of each career choice. Only nine wished geriatrics to integrate totally with general medicine.

Discussion

The response rate of 64 per cent seems small. However, the JCHMT gives an approximate figure of 120 approved geriatric medicine training posts in the UK. Some are not necessarily funded, and others may be vacant because the incumbent has moved on to another post and a replacement has yet to be appointed. Thus the true reply rate may be in excess of 85 per cent, which makes the views expressed more representative of the general SR population.

It is disappointing that there remains a minority of SRs (28) who have no previous geriatric experience on appointment. This number includes over one third of those in designated integrated SR posts and almost one half (13) of those wishing to become physicians with an interest in the elderly. They are not significantly longer registered with the GMC than other respondents nor do they necessarily wish for the integration of geriatrics into general medicine.

There are more integrated SR posts than likely consultant vacancies of this sort. Only a minority (30) wish to have their consultant practice integrated in this fashion.

The desirability of further training in general medicine appears to have as much to do with its possible political implications as with its probable training content.

In my opinion the suggestion that geriatric medicine is an ideal career option for surplus trainees from other general medical specialities[3] is fraught with difficulties. To imply that surplus-to-requirements purely means failed candidate would be grossly unfair to the many excellent recruits geriatrics has gained in this way. A recent survey by Donaldson has clearly shown that trainees who arrive by this route would still rather be doing something else[5]. Donaldson's survey had a substantially different SR population from my own study, but both show that these people wish, in the main, to keep in touch with their general medical roots by choosing a consultant post as a physician with an interest in the elderly. It is possible that applicants with longer general medical training may be considered more favourably for these integrated posts. However, as their SR training is often integrated with general medicine, their geriatric experience may not always be of sufficient duration.

It is a worrying, although perhaps an over-pessimistic view that, in suggesting all geriatric departments should be a subset of general medicine we will recruit a cadre of dissatisfied general physicians who may in the future be inclined to give a lower priority to their elderly patients. As these types of departments work almost exclusively on acute admissions with little or no home visiting it is inevitable that a high turnover of patients will be achieved. What then becomes of the difficult rehabilitation problems, who do not fall into the acutely-ill category?

I believe that closer liaison with general medicine brings benefits. However, I suggest these lie in having assessment beds in the main hospital with access to all investigative facilities and perhaps also a common pool of staff. I think that, because of its development from the chronic care wards, the very modus operandi of geriatric practice in the UK, precludes it from being treated in the same way as another medical subspecialty. If a consultant is busy doing general medical out-patient clinics, specialist clinics and practising skills such as endoscopy, there will simply be little or no time to do day hospital, chronic care and rehabilitation rounds and domiciliary assessments. Geriatricians should co-operate very closely with their general medical colleagues. Regular visits to the general medical ward, to advise on problems and not just to provide a 'take-away' service, can be particularly beneficial[6].

The majority of SRs in geriatric medicine would, for a variety of reasons, welcome the opportunity of having further training in general medicine, although at present some are unable to achieve this. Despite this, the majority of SRs in geriatrics wish to be whole-time consultant geriatricians. Therefore, such training, however desirable it may be for the trainee, should not intimate to trainers that geriatric medicine requires wholesale integration with general medicine. This represents a diametrically opposite view to that of other policy makers[7].

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References

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