Geriatric Medicine and Medical Unemployment

MICHAEL LYSE, MD, MRCP(UK)
Senior Lecturer and Consultant Geriatrician,
Department of Geriatric Medicine, University of Manchester

There are two major problems facing the medical profession in the UK. The first is the inevitable consequence of demographic changes that will be sustained until well after the turn of the century[1]. The continuing increase in the proportion of old people, and especially very old people, is apparent in society generally, and particularly in any Health Service institution. As health needs are age-related, the consequence for medicine is obvious. There will be an increase in demand for our services by the elderly, and this increase will be maintained until the retirement from practice of our present medical undergraduates.

The second problem seems to bear a paradoxical relationship to the first. Medical unemployment is now a looming spectre, not least in the minds of individuals within the training grades. The development of inflexible training programmes, including mandatory vocational general practice training, requires that overall manpower planning decisions must be made at least ten years before any change is actually required. An individual’s career plans need about half this time, but changes demand wasteful back-tracking.

Unless the profession itself makes an attempt to solve these two problems of unmet demand and inappropriate use of medical skills, it seems obvious that others will attempt to impose a perhaps unsatisfactory solution. I feel that these two problems can be refined and an integrated solution found if the so far incompatible relationship between geriatric and general medicine can be resolved[2].

Demographic and ‘Geriatric’ Problems

A shrinking NHS is being swamped by increasing numbers of old people. The misplacement and almost inevitable mismanagement of old people in environments unsuited to their needs sets up a vicious downward spiral and breeds the ‘bed-blocker’[3,4]. Thus, the old person in a residential home cannot be admitted for urgent medical management because the hospital ward is full of treated individuals awaiting a place in that home. It is well known by geriatricians, but perhaps not by all other doctors, that delay in meeting the medical needs of the elderly is liable to lead to increasing disability, which, in turn, precipitates and potentiates dependency, the root cause of ‘bed-blocking’[5,6]. We have the skills, we have the facilities (in part at least), but we cannot use them appropriately.

The specialty of geriatric medicine suffers from a poor image and fails to recruit from the ablest within the profession[7,8]. The situation can best be summed up by the calumny, which I have heard more than once, that ‘Geriatric medicine is a second-rate specialty, looking after third-rate patients, in fourth-rate facilities’. When this statement is made, or this attitude is held by the chairman of an Area Health Authority, a professor of medicine or a senior physician, the situation is unlikely to change and takes on the nature of a self-fulfilling prophecy.

General and Specialist Medicine Problems

‘Granny bashing’ is an increasingly common event in our violent inner city society[9], but I suspect that it takes place, more subtly perhaps, but with just the same effect, in general and specialist medical wards. It is manifest in the attitude that relegates the six elderly patients with strokes to the bottom of the ward and the bottom of the geriatric waiting list. After each and every ward round the ward sister rings the secretary of the Department of Geriatric Medicine to enquire as to their patients’ progress on the waiting list. The answer seems always to be the same. In the meantime, the patients slowly deteriorate, while managing to generate more and more frustration all round[3].

Lack of appropriate skills and lack of facilities to deal with problems arising from elderly patients forces the generalist at all levels to withdraw into ‘specialisms’ for which he has the appropriate skills and in which resources to deal with a more circumscribed demand are available. The result of this trend is more and more specialisation occurring at an earlier stage of training. The inflexible nature and extreme narrowness of most specialty training programmes produce a specialist apparently unable to manage ‘a simple geriatric problem’[3,10,11].

Specialist medicine training programmes are training too many individuals to take too few consultancies. Surveys of career opportunities make depressing reading for a registrar or senior registrar in gastroenterology, neurology, nephrology, and other specialities[12]. Personal discussion with junior doctors suggests that the ratio of potential candidates to potential posts in many sub-

Journal of the Royal College of Physicians of London Vol. 16 No. 2 April 1982 129
specialities is of the order of 10:1. Most candidates for consultant positions go for those jobs described as ‘with a special interest in’[13]. Many of these embryonic specialists will be disappointed and become very frustrated when, having completed training, there are no openings in their field. It would be naive to expect a financially constrained Health Service to create vast numbers of new consultant posts. Indeed, a number of realistic senior registrars are changing career in mid-stride. This must surely represent a terrible waste of time, talent and expertise.

Some Solutions for Debate

There is nothing unique about geriatric medicine. The positive attitudes, management and treatment skills and their deployment in a holistic manner are relatively easy to learn, develop and apply. Unfortunately, many doctors have never had the opportunity of looking at the discipline and even fewer have had any first-hand experience of modern geriatric medicine. Ignorance allows calumny to abound[14,15]. With the expansion of geriatric academe this unfortunate situation may change, but will take many years to do so and we require at least interim solutions now.

Educational deficiency was identified by the Royal College of Physicians’ Working Party on Medical Care of the Elderly[16] as the main stumbling block to the evolution of geriatric medicine. The Working Party recommendations unfortunately concentrated on compulsory general medical experience for geriatricians and only suggested geriatric medicine experience for physicians. This failure to recommend true reciprocal training programmes condemns the Royal College of Physicians’ Report in the eyes of many. The Royal College of General Practitioners were more forthright and unequivocal in their recommendations for vocational training[17].

There is an urgent need to transfer resources, especially manpower, from highly specialist areas to generalist areas that are heavily involved in dealing with the medical needs of the expanding elderly population. Some would say that there is little difference between acute general medicine and acute geriatric medicine[2], and, in the case of many elderly patients, this is true. Equally, there is evidence of many general or specialist physicians being totally unable to cope with the geriatric ‘bed-blocker’, while geriatricians can take the same patient and discharge him back into the community[10,11]. It is not, as some non-geriatricians suppose, a matter of geriatricians providing long-term care on a tertiary basis. If it were, the problems could be solved simply by giving non-geriatricians access to long-term care facilities.

Although there is a hard core of ‘geriatric’ patients, most sick, elderly patients do not come within this definition. Either a general physician or a geriatrician can deal with their needs, provided the former has some training and experience in geriatric medicine. When, or preferably before, the general physician reaches an impasse and is unable to cope with the patient’s discharge, he calls the expert—the geriatrician.

What kind of geriatrician do we require? As his job is to diagnose, treat and manage sick old people, I believe we need a doctor[6,18,19]. He will be called upon to advise his colleagues on the management of their elderly problem patients. He will need to spend time organising, integrating and leading a district geriatric service, but these activities, though important, should not blind him to the fact that his professional home is within clinical medicine, not in management, nor in liaison with housing managers, nor in social work. He thus needs general training in clinical medicine and specialist training in geriatric medicine. In order to reinforce, maintain and develop his medical skills, I believe that, like the general physician before him, the geriatrician needs to develop an interest in some special aspect of clinical medicine and become ‘a geriatrician with an interest in’.

The geriatrician with such an interest would join and complement his physician colleagues with other special interests. This arrangement would allow the coverage of virtually all medical skills within the district. I can foresee that within each district at least one geriatrician will have a special interest in rehabilitation[19]. There is no reason why the geriatrician’s interest should be restricted to the old—young patients have ‘geriatric’ problems. Emphasis upon clinical skills would certainly enhance the status of the geriatrician in the eyes of his colleagues and also, I suspect, in his own, when he is seen to be a proper clinical doctor and not a provider of on-demand disposal facilities[18].

What facilities will the geriatrician with a special interest require? I do not believe he requires vast numbers of beds. I suspect that overloading spells doom to both the whole-time geriatrician and that strange species ‘the general physician with an interest in the elderly’[16]. No whole-time geriatrician can, for any length of time, maintain high clinical standards with 150 or more inpatients, many with urgent medical problems. Similarly, the general physician with an interest in the elderly shares medical facilities with physician colleagues and also looks after 60 or more geriatric beds. I suspect that the geriatric overload problem is a reversal of the more usual multum in parvo.

From where do we recruit all these geriatricians with special interests? From the blocked ranks of potential physicians with special interests? It does seem an obvious solution. So why hasn’t it worked in the past? The DHSS is in favour and indeed will even provide money for senior registrars in general (specialist) medicine to spend a year or so training in geriatric medicine. There is, however, a reluctance among physicians in training to change, because they believe that they will not be able to practise to any extent the specialty for which they have trained. Appointment as ‘a geriatrician with a special interest’ would certainly recognise their expertise. But they would have little chance to practise their special interest with 150 geriatric in-patients to look after. Increasing the number of geriatricians will go some way towards removing this obstacle to good clinical practice. It is likely that consultant expansion in geriatric medicine could be sustained—indeed there are already a number of unfilled vacancies in the specialty.
Should the number of patients be reduced? Can we not reduce the non-medical, non-clinical components of geriatric medicine and, at the same time, remove what seems to many doctors a barrier to the recognition that geriatrics is proper medicine? I naturally believe that we can and should. I would suggest two main strategies—reduce community commitment by hospital doctors and reduce long-stay care responsibilities. As far as the former is concerned, I suspect many geriatricians fail to rely sufficiently upon their local general practitioners, which wastes their own efforts and also tends to frustrate the efforts of the general practitioners themselves. I believe that the care of the elderly provides the best arena for the development of good hospital/community teamwork, but there must be support on both sides. The general practitioner wants his ill, old patient in hospital quickly and will be much more willing to accept responsibility following discharge if he knows that the next crisis admission does not require long-term residence on a waiting list.

What is the role of the doctor in long-term care? I suspect that it is illogical, irrational and wasteful to use Health Service facilities (hospitals) and Health Service personnel (consultants) to provide a homely environment for long-stay disabled young or old people. The profession has a vital role in assessing individuals for long-term care after a full period of rehabilitation but use of clinical consultants on a day-to-day basis is wasteful. Long-stay care responsibilities may be behind the reluctance of many young doctors to change to geriatric medicine. The attitudes and proclivities that cause us to seek a career in medicine are not those required for long-term care. Why not, therefore, turn over the running of long-term care facilities to those nurses and social workers whose attitudes and skills are more in tune with long-stay requirements? National Health Service Nursing Homes, perhaps?

I am suggesting that in order to cope with the increasing demands made by elderly patients, a skilled medical response is required. Good medical treatment and management of disease in the elderly will often remove the so-called ‘social problem’ which the disease itself is generating. This is not to belittle the role of social workers, home helps, and so on; their supportive contribution is valuable, but we should not lose sight of the medical aspects. I see a promising clinical future for potentially unemployed hospital doctors if we can adapt general and geriatric medicine along the lines I have suggested. The distinction between geriatric and general medicine would inevitably become more blurred but I feel this would be to the benefit of hospital doctors, general practitioners and our elderly patients.

Acknowledgements

It is a pleasure to be able to record my thanks to many colleagues for their advice and discussion over many years. I have attempted to be provocative in order to stimulate discussion, and therefore opinions, sweeping generalisations and 

References

1. Editorial (1979) British Medical Journal, 2, 952.
2. Leonard, J. C. (1976) ibid., 1, 1335.
3. McArdle, C., Wylie, J. C. and Alexander, W. B. (1975) ibid., 4, 560.
4. Editorial (1980) Lancet, 2, 1013.
5. O’Brien, T. D., Joshi, D. M. and Warren, E. W. (1973) British Medical Journal, 4, 277.
6. Bagnall, W. E., Datta, S. R., Knox, J. and Horrocks, P. (1977) ibid., 2, 102.
7. Editorial (1980) British Medical Journal, 280, 426.
8. Faragher, E. B., Parkhouse, J. and Parkhouse, H. G. (1980) Health Trends, 12, 101.
9. Coakley, D. and Woodford-Williams, E. W. (1979) Lancet, 2, 1066.
10. Burley, L. D., Currie, C. T., Smith, R. G. and Williamson, J. (1979) British Medical Journal, 2, 90.
11. McApline, C. J. (1979) ibid., 2, 646.
12. Medical Manpower Division: Medical Staffing and Prospects in the NHS in England and Wales 1979 (1980) Health Trends, 12, 51.
13. Houghton, J. and Richings, J. (1981) Journal of the Royal College of Physicians of London, 15, 28.
14. Brocklehurst, J. C. (1974) Age and Ageing, 3, 3.
15. Caird, F. I. (1978) Journal of the Royal Society of Medicine, 71, 711.
16. ‘Medical Care of the Elderly’. Report of the Working Party of the Royal College of Physicians of London (1977) Lancet, 1, 1092.
17. Joint Working Party of the British Geriatrics Society and the Royal College of General Practitioners: ‘Training General Practitioners in Geriatric Medicine’ (1978) Journal of the Royal College of General Practitioners, 28, 355.
18. Webster, S. G. P. (1979) Journal of the Royal College of Physicians of London, 13, 113.
19. Williams, T. C. P. (1981) ibid., 15, 45.
20. Royal College of Nursing (1975) Improving Geriatric Care in Hospital.