

Why geriatric medicine? Q&A

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The article was published in the January 2013 issue of the Newsletter of the Hong Kong Geriatrics Society. Reprint with permission from the Society.

Q: "I am just waiting for a post in internal medicine," a green medical officer (who had no exposure to geriatric medicine in his undergraduate curriculum) frankly told the consultant geriatrician in-charge during a recruitment interview.

A: "Never mind, just stay on and see if you like the specialty. Some doctors may not like working with elderly patients who are incontinent of urine and faeces.... We see and care for elderly patients as a multidisciplinary team." Having witnessed how geriatric medicine was practised and how elderly patients were cared for in the geriatric unit, the doctor stayed on, finding the specialty both intellectually challenging and emotionally rewarding.

Q: "Why geriatric medicine?" A geriatrician was asked in a talk on behalf of his society to invite trainees to consider a career in geriatric medicine upon passing the MRCP.

A: "Geriatric medicine certainly keeps you humble. Be prepared for unexpected passionate kisses.... It is a 'whole person' specialty considering psychological, social, and spiritual dimensions, together with functional and environmental assessments.... To be successful in geriatric medicine, you need to be a detective and enjoy taking time to tease out key clinical features. We rejoice in complexity. Many of our patients have multiple morbidities, and assessing and prioritising their problems can be intellectually fulfilling. A survey of 12 000 American clinicians from 33 specialties found that geriatricians, belonging to 'cognitive' specialties, were the specialists most satisfied with their career choice, whereas prestigious 'procedural' specialties scored badly in terms of job satisfaction.¹"

Q: "Why geriatrics as a career choice?"

A: "Geriatrics is the most challenging and exciting area of patient care. The patients are the most ill, most complex, and most dependent on our skills and wisdom for their persistence as independent living people. The opportunities for research in geriatrics are essentially unlimited."²

Q: "Is there any difference between geriatrics and general internal medicine?" A geriatric trainee, pondering whether he should continue to pursue geriatrics in his career, asked a visiting professor in geriatric medicine.

A: "It depends on whether you are happy to stay in geriatrics.... There has been much discussion on whether geriatrics is just general internal medicine and nursing, or whether it is a specialty in its own right. The question will become superfluous when all doctors and nurses are as confident managing the 'Giants of Geriatrics' as they are in dealing with other diseases and disabilities.... The 'Giants of Geriatrics' embrace the 'common final pathway' of the clusters of acute and chronic diseases which frequently afflict very old people, with gigantic impact but yet often ignored."³

Q: "But we have been attending to so many elderly patients. We are all geriatricians." A general physician and endocrinologist exclaimed.

A: "Are you implying there is no need for specific geriatrics services? It boils down to how responsibilities should be divided between geriatricians and general physicians. Geriatricians should focus on the biologically aged elderly with whom they have most experience and whom they manage best. Integration may lead to the neglect of older patients as geriatricians are 'seduced' by younger ones. Having said this, it is important not

to pretend that there can be a single blueprint for the division of responsibilities between geriatricians and general physicians. The pressure on services (which depends on the age structure of the population, levels of morbidity, and social variables) and the allocation of resources (beds, medical, nursing, and paramedical staff) between geriatrics and general internal medical services and (above all) personal relationships are important local determinants of successful collaborative work.... It is important also to appreciate that geriatric patients present in many other settings than medical wards: a successful geriatric service should be able to reach patients in surgical wards (general, orthopaedic, and gynaecological) and also those who are managed in the accident and emergency department without being admitted."⁴

Q: "In one word, what are you trying to get across to medical students about health care of older adults?" a consultant geriatrician asked during a recruitment interview for senior registrar in a university hospital.

A: "Enthusiasm," replied the candidate and he got the senior registrar post. He later wrote, "One needs more than enthusiasm to be a geriatrician. One needs expertise, and I carefully distinguish that from experience; however, without enthusiasm, without fire in the belly, we won't do the job as well as we could, and our patients will suffer."⁵

Q: "Are there any interesting procedures to learn in geriatric medicine?"

A: "For the wavering medical student or resident coming to grips with the often merciless optimism of procedure-focused medicine, there is much in the book *Blue Nights* to show how our patients gradually come to know better than to believe what we tell them, no matter how artfully we might hedge the final outcome.... Didion describes how the evaluation of a seemingly straightforward syncope resulting in an injurious fall can demoralise the patient even as it frustrates the staff. She suffered a sudden loss of consciousness, and then being caught up in the medical machine. She notes the resentment of some team members when 4 days of heart monitoring failed to reveal a cardiac cause for her syncope; their view was that "because I had been given a bed on the cardiac unit I must

have a cardiac problem". To a Canadian sensibility, the ensuing level of investigation (4 days of cardiac monitoring, magnetic resonance imaging, magnetic resonance angiography, positron emission tomography) seems extravagant. That it proved unrevealing does not surprise. Didion describes a sudden fear of falling as she tries to arise from a folding chair at a rehearsal of the off-Broadway play based on 'The Year'.⁶

Q: "Ah, you are a geriatrician. What do you specialise in?" a dermatologist asked.

A: "Geriatrics offers a wide range of clinical interests. To be a good geriatrician, one should know something about everything and everything about something. The something we need to know everything about might be stroke, syncope and falls, Parkinsonism and other movement disorders, dementia, incontinence, or orthopaedic geriatrics."¹

Q: "Are geriatricians those doctors who care for residents of aged homes?" asked a home-dwelling elderly person who heard about geriatrics for the first time.

A: "A parent wishes his child to be treated by an expert paediatrician. A child wishes his parent to be treated by an expert geriatrician."³ "Specialised geriatric medicine with multidisciplinary care can prevent functional decline and reduce nursing home utilisation for frail older patients in their own homes and in the acute hospital setting.... However, instead of getting to grips with how service is provided to complex patients, modern health care system wants the frail old people to 'go away', to some more 'appropriate' place."⁷

Q: "Why geriatric medicine? How should we 'package' the consultant post in the vacancy notification?" A hospital chief executive asked when urged to fill up the vacancy upon the resignation of a consultant geriatrician.

A: "G-E-R-I-A-T-R-I-C-S: G stands for general, E for excellent, R for restorative, I for individualistic, A for artistic, T for total, R for respectable, I for intelligent, C for caring, S for scientific!"⁸

Q: "Geriatrics has become a 'convalescent' specialty

nowadays”, a hospital chief executive said during an interview board for recruitment of consultant geriatrician.

A: Geriatric medicine is the treatment of underprivileged patients by underprivileged doctors in underprivileged buildings.... A geriatrician is a doctor with a soft heart, a hard head, a thick skin and a chip on the shoulder. With his soft heart he feels, with his hard head he decides, with his thick skin he fights, with his chip on the shoulder he suffers.”³

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