

Invited Address to the Canadian Geriatrics Society,
October 13, 2001, Toronto

CANADIAN GERIATRICS: FROM WHERE, TO WHERE?

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I was present at the first meeting of the Society (Canadian Society of Geriatric Medicine) in Toronto in 1981, only a few weeks after immigrating to Canada, and have been pleased to be a member since then. When I see all these geriatricians in front of me, I immediately search for a collective noun. I have two for other disciplines: a rack of physiotherapists, a battery of neuropsychologists. The best I have heard for geriatricians is a wrinkle of geriatricians.

I want to focus on two questions: a) *where have we come from in Canadian geriatrics?* and b) *where are we going in Canadian geriatrics?*

WHERE HAVE WE COME FROM?

By this I want to ask you why you became a geriatrician? Why have you stayed a geriatrician? Do you remember the last time a patient or a relative asked: "Aren't you a bit young to be doing geriatrics", as if they expected a white-haired old gentleman with a cane. In fact, it's a sign of ageing in a geriatrician *not* to be asked that question. It is over 15 years since someone said that to me. Before we answer why become a geriatrician, may I say that a geriatrician is defined as that intimate amalgam of wary paranoia and, almost foolhardy, enthusiasm: a mixture of masochist and evangelist!

There are two common answers given to explain why people become geriatricians. The first reflects a close experience with old people when that person was much younger: often grandparents lived with them or they lived with grandparents. A second

influence has been that of an example or rôle model perhaps when one was a medical student or resident, or even a health-care bureaucrat. Two young health-care bureaucrats were assigned to evaluate the very first geriatric service in Canada – that initiated by Duncan Robertson in Saskatchewan. They became so impressed with this geriatrician that one of them went off and became an MD, obtained the FRCPC and later the Special Certificate of Competence in Geriatric Medicine of the Canadian Royal College – Ken Rockwood; and other continued research in health-care delivery to old people and obtained a PhD – Paul Stolee. Both are leading researchers in health-care delivery to frail old people in Canada, and both derive their "conversion" from working with Duncan Robertson.

May I suggest three answers to the question: **Why become a geriatrician?**

The first is that it is *intellectually challenging*. Although this might seem surprising to some of our non-geriatrician colleagues, it is true. By this, do we mean that we can produce longer lists of differential diagnoses than those practising General Internal Medicine? Clearly, the answer is no. What I mean is the way whereby we grapple with that wealth of information about our patients. At times, there seems to be too much pathology: physical, mental, social. Many of our colleagues in the rest of medicine when faced with this mass of information turn to the Addressograph for inspiration! They find age to be the unifying principle and it then becomes the only explanatory variable, perhaps attractive because it is unalterable. I would suggest that focusing solely on age leads to consequent ageist behaviour.

Into this morass of information came the notion

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of frailty, in one of the most important papers of our specialty¹. Two of the authors are here this evening. You will remember that this paper introduced the notion of a balance which was liable to perturbation. It provided a way of analyzing all these data and gave us a route through the maze of information. It helped us to identify what we knew and also what we did not know about a patient. It identified factors which validly predicted adverse outcomes. It reminded us that, on occasion, frailty can be reversible (the balance tips the other way). It affirmed that frailty can be measured and that frailty is researchable. We should recollect that before that paper, when posed the question: can frailty be researched?, the common answer was a resounding **no** – for two quite opposite reasons. No, because the notion was too complex, and there were too many variables and too many factors. No, because the notion was too simple; it was merely a surrogate for disability or ADL function.

Yes, our job is intellectually challenging, although it would be a little easier if only our patients had the foresight to read the medical textbooks and know how to present to us their illnesses! Thus, we are specialists for those patients who have not responded to “usual care”. Ken Rockwood put it quite bluntly: “We are doctors for those for whom ‘usual care’ has failed.”

It is also *emotionally rewarding*. Our patients and their carers give us enormous job satisfaction. My own practice after perhaps 2 hours of a Medical Advisory Committee meeting is to arrange a home visit. This is both relief and therapeutic for me. It is always rewarding to meet real people with real problems, and it helps restore one’s faith in our species. Geriatrics is emotionally rewarding, and that can include being emotionally exhausted. Remember after that “difficult family” conference: when it is skilfully undertaken, then families will recognize that they have been listened to, perhaps, for the very first time. Patients have been treated as adults. During the conference, one soaks up a lot of emotion and social pathology and it is exhausting. As an aside, it is one of the rôles of a team social worker to debrief the geriatrician and colleagues after such a conference.

It is also emotionally rewarding to be the patient’s advocate. By this, I do not mean in a patronizing or controlling way. Remember, old people have a lot of inside information about ageing. Indeed “there is nothing we ask patients to do or allow them to do,

that they have not already done, totally independently using their own judgement, at an earlier stage of their lives”. I regret that I have not traced the source of this quote but it is very true. Many of our patients do suffer the triple jeopardy of being old, female and poor. If we do not fight for them, who will? Many do not have an articulate, demanding, middle-class daughter to take on the system!

It is emotionally rewarding and this includes fun too. A few weeks ago a 92-year-old patient of mine declared: “I’m a V.O.N.” When I said to her: “What do you mean, you’re a VON?”; she replied: “I’m a Very Old Nurse!”

We became and remain geriatricians also because it is *collegially satisfying*. Geriatricians are always talking about teamwork. Indeed, the team conference is sometimes seen as the ultimate geriscope – if only they paid us as ostopists. Building up and developing a geriatric team takes time and energy, and I have been privileged to do this in three places: Liverpool, Winnipeg and Halifax. It is salutary to see how a team handles conflict. You remember the “difficult discharge” where one team member will assert: “It’s too risky, I cannot support this discharge”: what does the team do next? How does the team handle this controversy? Will it degenerate into resentful dispute? Another question is how does the team welcome newcomers, whether they are visitors or new members? Is this team a clique which repels outsiders, or is it a catalyst which welcomes and enables outsiders? It is truly rewarding to see team members develop mutual respect for each other’s professionalism and personality.

WHERE ARE WE GOING IN CANADIAN GERIATRICS?

It is instructive to look at two jurisdictions both of which have contributed greatly to Canadian geriatrics, but perhaps now we should be wary of following where they are going. I refer to the United States and the United Kingdom.

In the United States, there are profound differences with our health-care system – in spite of Mr. Klein’s efforts. American geriatricians have essentially espoused the primary care route. They have set up in direct competition with family doctors and general internists and have seen themselves in an age-related specialty much as paediatricians do. Thus, the entry into the specialty south of the border is both via Family Medicine or General Internal

Medicine. They have effectively established certification and recertification, and as a general rule their specialists undertake primary care with only a small subset left as “trainers in teaching hospitals”.

In the United Kingdom, almost the opposite has happened. There has been a major shift towards acute care, as Geriatric Medicine has, in many ways, filled the vacuum left by the disappearance of General Internal Medicine as it fractionated into its subspecialties. The largest group of medial subspecialties in the London Royal College is that of geriatricians. The general internist with a special interest in geriatrics has been created. The effect of this drift towards acute care has been complete withdrawal from long-term care and virtual withdrawal from rehabilitation. This has been particularly marked in England and far less so in Scotland. The comprehensive modern geriatric service, which was the gift of the British Isles to formal health-care delivery for older adults, has come under severe strain and almost disappeared in some places. Some British colleagues have talked of the need for another Marjorie Warren! I do hope you know who she was and what she did for our specialty.² There have been some good effects from this reorientation. The traditional antagonism between General Internal Medicine and Geriatric Medicine has greatly improved. This was virtually never a problem here in Canada. I well remember soon after arrival at St. Boniface Hospital in Winnipeg, the Head of Medicine inviting me to attend on the CTUs. He commented: “It will show everyone that you’re one of us...a slightly strange one of us...but one of us!” Certainly the English change of emphasis has increasingly resolved the pejorative labelling of second-class beds, containing second-class patients and looked after by second-class doctors and nurses with second-class resources. Nevertheless, my sense is that the cost of this change in the specialty has been destruction of the former comprehensive service.

I regret I have no information from Australia and New Zealand, other jurisdictions from which I am sure we could learn. So the question for *Canadian geriatrics* is should we follow the American course or the British course. I would strongly suggest neither. We cannot go the United States route because we just don’t have the numbers. In Canada, we have wholeheartedly accepted that geriatricians cannot and should not look after all the over 65s, or indeed all the over 85s. The geriatrician is a catalyst so that

after his or her arrival, homemakers should be doing a better job caring for older people and at the other end of the spectrum, the Chief of Medicine should be doing a better job looking after older people. The geriatrician is a resource and not a substitute for a family doctor (remember the family doctor’s rôle is, on occasion, to protect his/her patients from specialists).

I was at the first *CSGM* meeting, and shortly after that we were plunged into a long-running, disruptive antagonism between those in the *CSGM* who thought geriatricians should be solely those approved by the Canadian Royal College and those, following the approach of the American Geriatrics Society and the British Geriatrics Society, who welcomed any doctor showing any interest in health-care of old people. Happily, we have come a long way since then, and the renaming of the *CSGM* to *Canadian Geriatrics Society (CGS)* is an excellent time to reaffirm that all doctors are welcome as members! Indeed, we may even consider going where the American Geriatrics Society has led, in establishing a non-MD section. We must continue to work hard at what unites us by whatever route we came by into geriatrics: whether we are family doctors, psychiatrists, internists, public health doctors, indeed any of our colleagues.

This leads me to a major issue facing the Specialty, that of *recruitment*. We heard at the AGM earlier today of the desperate plight of the Royal College program and, to a lesser extent, the Health-Care of the Elderly Certificate/Diploma programs. Ken Rockwood has wondered whether this is a “missionary blip”, by which he meant an earlier cohort of young doctors who were attracted perhaps by the evangelist/masochist flavour of being a geriatrician. However, medical students in the hard light of financial realities and those crippling student loans, clearly are now opting for remuneration in this world rather than recompense in the next.

The advent of the Wade Report³ just published provides a real opportunity for reasonable remuneration. I draw your attention to a page from it in my hand: Chapter 7, Page 5: Determining Physicians’ Work. Every item of the tariff will be subjected to a weighting reflecting the following characteristics: communication and interpersonal skills, knowledge and judgement, risk and stress, and technical skill. Thus, perhaps there will be, at least, an Ontario solution to our national recruitment problem. Undoubtedly, one early objective of Canadian geri-

atrics must be reasonable remuneration.

The second objective of Canadian geriatrics must be the continued affirmation of the academic basis for our discipline. Recently, one of my mentors died at age 86 in June 2001: Sir Ferguson Anderson. He held the first endowed chair in Geriatrics in the world, being appointed David Cargill Professor of Geriatric Medicine at the University of Glasgow in 1965. I was privileged to be his Senior Registrar (Fellow) for 2 years. I quote from a recent obituary: "Fergie was utterly convinced that the only way to promote health-care of older people was to make geriatric medicine an academic discipline and ensure undergraduate teaching in the subject".⁴ We still have a long way to go. At the University of Manitoba, the time assigned for medical undergraduates in Geriatric Medicine was half of that at the University of Liverpool. In Dalhousie University until a year ago, it was about half of that assigned at the University of Manitoba.

My third objective for the future of Canadian geriatrics is not to forget "the well elderly". These are older adults who perhaps are much less likely to become our patients. They can be powerful allies and friends and indeed powerful enemies as Mr. Mulrone discovered when he tried to de-index their pensions. Within 8 weeks the seniors of this country totally reversed a major government initiative. Our own experience in Nova Scotia in effecting an Alternative Payment Scheme for the Geriatricians and funding rural geriatric clinics reflects effective intervention by seniors on our behalf. I commend the "mobilization" of seniors to

help us in both our remuneration-recruitment and in our academic-education endeavours. Seniors can do what we cannot do. They can tell provincial Departments of Health that "we need geriatricians" (and geriatric specialist nurses and all the rest of our gang). Similarly, they can say to Deans of Medical Schools: "what are you teaching medical students and doctors-in-training about us?"

I conclude with a personal vignette about how I became Ferguson Anderson's senior registrar. At the critical interview he was not present but the late Dr. Bernard Isaacs was. Bernard Isaacs asked me one question: "In one word, what are you trying to get across to medical students about health-care of older adults?" I replied: "Enthusiasm", saw his smile and immediately realized I had got the job. 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.

I give you the health of the Canadian Geriatrics Society in the traditional geriatricians' toast: "D.L.R.O.W."

REFERENCES

1. Rockwood K, Fox R, Stolee P, Robertson D, Beattie L. Frailty in elderly people: an evolving concept. *CMAJ* 1994;150:489-95.
2. Matthews DA. Dr. Marjory Warren and the origin of British Geriatrics. *J Am Geriatr Soc* 1984;32:253-8.
3. Resource-Based Relative Value Schedule Commission of Ontario: Draft for Comment, September 2001.
4. Williams B. Sir Ferguson Anderson: obituary. *Bull Roy Coll Phys Glasg* 2001;30:5.