FOR DEBATE...

The future of geriatric medicine in an era of patient choice

DAVID H. METZ, SUSAN J. LABROOY

1 Centre for Ageing and Public Health, London School of Hygiene & Tropical Medicine, Keppel Street, London WC1E 7HT, UK
2 Care of the Elderly Directorate, The Hillingdon Hospital, Field Heath Road, Uxbridge, Middlesex UB8 3NN, UK

Address correspondence to: D. H. Metz. Fax: (+44) 20 7681 8040. Email: david.metz@lshtm.ac.uk

Keywords: geriatric, patient, choice, elderly

Introduction

The speciality of geriatric medicine is well established in Britain, exceptionally so by international standards. This has taken place over the past 50 years within a National Health Service (NHS) that offered only limited choice to older patients. Now that we are moving into a new era in which patient choice will become of increasing importance, there is a risk that geriatric medicine could become sidelined. We discuss how the speciality might be re-oriented, both to avoid those aspects that might be felt to be stigmatising and to address the new challenges that arise from increasing life expectancy.

Patient choice

An important current theme in the development of health service policy in Britain is that of ‘patient choice’. Initially, choice is being made available for elective surgical procedures when the waiting time has exceeded 6 months. In future, the intention is that patients should be able to choose how, when and where they get treated, on the basis of good information and a partnership of respect between them and their clinician. The main aims of patient choice are to reduce waiting times, personalise the delivery of healthcare, improve standards of care, and enhance efficiency, through the introduction of an element of contestability into service provision [1]. It is intended that patients should take a substantial role in shaping the care system’s development. One possible instance where this could happen is in the area of geriatric medicine.

Specialist geriatric services developed in Britain as an integral part of the NHS, following pioneering work in the 1930s on the assessment and rehabilitation of elderly disabled people [2]. The first consultant geriatrician was appointed in 1948, the year the NHS came into existence. Currently, there are over 1,000 consultant level posts in the UK, and geriatrics is the largest medical speciality by this measure [3]. However, Britain is exceptional in the size of the speciality of geriatric medicine. While in most parts of Europe there are physicians with a special interest in older people, the numbers are much lower than in Britain. In the USA, the numbers of qualified geriatricians have been declining such that, in the opinion of one observer, ‘Geriatricians are in danger of extinction’ [4], while another, less pessimistic, commentator is of the view that ‘the vigor and progress of geriatrics have reached a plateau’ [5].

It is arguable that one factor contributing to the success of the speciality of geriatric medicine in Britain has been the lack of choice offered to patients using the NHS. Geriatricians were willing to take on the medical care of elderly patients with complex morbidities in acute and long-stay hospitals, whom other specialists and general physicians were willing to hand over. Three main kinds of approach to the acute care of elderly patients resulted: admission to specialist geriatric wards on the basis of age; integrated care, in which specialists in old age medicine work with physicians in specialities in an integrated team; and admission to specialist wards for older people based on clinical needs such as complexity or frailty [6]. In addition there are a variety of other kinds of provision, such as ‘day hospitals’ and stroke units. All this developed in the context of a monolithic health service in which the medical professionals were pre-eminent in decisions about service provision, and in which patients were offered little choice.

Although geriatricians championed the care of older people in Britain and made a huge impact on the equity of care, the numerical strength of the speciality alone could not eliminate discrimination against older people in the provision of NHS services [7]. Indeed, it is arguable that the existence of a discrete speciality made it easier for such discrimination to take place, since putting the old in a ghetto permitted adverse decisions on resource allocation.

Geriatricians have been debating the future development of their speciality. Issues include the involvement of geriatricians in the acute unselected medical take, in the
planning and delivery of services for older people outside of hospital, and their role in delivering hospital-based sub-speciality services such as those for stroke, continence, movement disorders, falls and orthogeriatrics [8, 9]. However, the likely wishes of the patient do not explicitly inform this debate.

What might now develop if patients are able to exercise choice, for instance between acute hospitals offering different approaches to the care of older people, or between treatment based in primary care and treatment in secondary care? A number of considerations could influence decisions:

- The relative benefits, as perceived by the patient, of (a) treatment of the main morbidity by a specialist in the particular condition, hoping that co-morbidities would be managed adequately; or (b) treatment of the patient holistically by the geriatrician.
- The benefits of treatment of complex chronic conditions of older people by primary care-based multidisciplinary teams as opposed to teams led by consultant geriatricians based in hospitals. A recent large-scale study suggests that primary care teams can manage problems as well as geriatrics teams [10].
- Where patients locate themselves in their life course, recognising that health and social care for frailty and multiple morbidities occur predominantly in the final year or two before death [11, 12].
- Changing attitudes of the coming cohorts of older people, who are less likely to accept gratefully the care on offer, and may be more apt to discriminate, the better to meet their perceived needs. It is generally supposed that the ‘baby boom’ generation will be more assertive of their preferences [13].

**Responding to choice**

Given the ability to exercise choice, people who do not see themselves as frail may very possibly tend to reject geriatric medicine. There is a risk that patients will start voting with their feet, triggering a spiral of decline in which falling demand compounds the already weak academic base [14], resulting in the loss of what has been a real strength of British medicine. What could geriatricians do to prevent this? There are a number of possibilities:

- Continue the present tendency for geriatricians to take the lead in delivering hospital-based sub-speciality services of particular relevance to older people, for instance stroke, continence, movement disorders, falls and orthogeriatrics.
- Redefine geriatrics as the clinical management of multiple long-term conditions [4]. There are particular challenges in managing patients with multiple conditions for which disease-specific clinical guidelines may have limited applicability [15]. The management of chronic disease is rightly a new NHS priority. People can accept having a long-term condition much easier than being geriatric. Patients are becoming more knowledgeable, even expert. Older people are heavy users of healthcare.

There is, therefore, a strong case for engaging them actively, involving them in decisions, helping to identify and achieve personal goals that improve quality of life. Geriatricians could be the leaders of multidisciplinary teams that provide holistic treatment of multiple long-term conditions of mind and body. While most patients would be older people, there would be no need to designate the service as solely for the ‘elderly’.

- Focus on the management of the end of life. The current main activity in this area is the palliative care of patients with advanced, progressive illness, particularly cancer. However, there are other end-of-life trajectories [16] and a hitherto neglected question is the scope for influencing outcomes. Much investigation of the determinants of healthy ageing has contributed to the current rapid increase in life expectancy, and there is some suggestion that end-of-life morbidity is being compressed [17]. But we lack understanding of preventative measures that would ameliorate the illnesses of the final 2 or 3 years of life. The research challenge is to understand how to maximise quality-adjusted life-years over both the lifetime and the final 2 or 3 years, as well as to take full advantage of the higher level of health expenditure at this time [11, 12]. In the meantime, there is potentially a big demand for options and choice at the end of life. People will prefer geriatricians for holistic care, physical and mental, from a single expert source, if that seems to be the most appropriate care to meet these particular needs.

In a healthcare system which promotes choice and in which finance increasingly follows the patient, a speciality that is seen to be less attractive will face declining demand and resources, whatever its clinical virtues. Geriatric medicine needs to reinvent itself if decline is to be avoided. Geriatricians are beginning to review their role, but need to take the lead in redefining the speciality or face the prospect of having it done for them.

**Key points**

- Geriatric medicine in Britain is numerically a strong speciality.
- This strength is arguably associated with the lack of choice that has been offered to older people by the NHS.
- The development of patient choice may put at risk the success of geriatric medicine, unless the speciality can present its virtues persuasively.
- Key opportunities include the management of complex long-term conditions and of the end of life.

**References**