of relevant research to establish best practice, hopefully arising as much from within the NHS as the academic sector, through its reconfigured R&D programme including the new Dementia and Neurodegenerative Diseases Research Network (DeNDRoN).

- The fifth consequence would be the emergence of an evidence base that could properly inform the commissioning process and better define the roles of primary and secondary NHS services, along with social care and the voluntary sector. This would produce sustainable and equitable services for the future.

The move to dementia services is not about major investment, rather, a strategic step to address a public health challenge. The UK has led the world in highlighting the need to provide care for people with dementia and the efforts of older people’s services, particularly, old age psychiatry, are envied and emulated in many parts of the world—including Europe. However, at the moment, these services are under pressure, with most having undergone significant resource cuts over the last 2 years, usually to support more high-profile services elsewhere in medicine. By creating integrated dementia services, the right knowledge base can be achieved to determine what the most effective choices for people with dementia in terms of efficacy, cost and investment need to be. Avoiding this step not only leaves us disarmed in the face of a major public health challenge, it also puts dementia care in danger of joining soccer and cricket as great UK inventions that the rest of the world eventually works out how to perform better than us.

Key points
- There is a need to stop providing dementia services across multiple agencies.

This would facilitate improvements in service provision, education and research.
- Provision of integrated services would prove to be the most cost effective.

Conflicts of Interest
Steve Iliffe is Associate Director of the UK co-ordinating centre for Dementias & Neurodegenerative Diseases Research Networks.

References

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Will undergraduate geriatric medicine survive?

The decline in undergraduate geriatric medicine education in United Kingdom (UK) Medical Schools [1] follows the trajectory of a progressive neurodegenerative disorder. First there is a niggling suspicion, [2] but within 2 years something is definitely amiss [3]. Over the years, the problem worsens and after 25 years a tipping point is reached [4]. The trajectory is steep and accelerating.

What is wrong?

There are fewer geriatric medicine academics [1]. The demands of the Research Assessment Exercise [5] points to where those remaining should focus their attention. Is geriatric medicine’s decline in the undergraduate curriculum inevitable?

Thanks to UK medicine we live longer, and, thanks to geriatric medicine, morbidity has been pushed later into our lifespans. The entry point to undergraduate geriatric medicine must, therefore, be the physiology of ageing [6]. Without understanding the physiological canvas on which disease is painted, students cannot understand the picture that the patient presents. Students will learn by working with older people in general but learn more by understanding
that even healthy older people are biologically different. Is geriatric medicine’s decline in the undergraduate curriculum a failure to recognise this?

Without time spent in geriatric medicine will students understand patients’ heterogeneity, concepts surrounding frailty and that many older people are well? Geriatric medicine is messy and complex. It does not have neat boundaries to its practice and is difficult to understand unless immersed in its world. Many diseases become commoner with advancing age, are multidimensional and may coexist. Why older people experience them, how they might be managed and the roles and ways of working in the team that will do this are core to geriatric medicine. Is geriatric medicine’s decline in the undergraduate curriculum because organ-based medicine is displacing the need for individual clinicians to manage comorbidities or a failure to realise that few specialties offer such rich opportunities for solving patients’ problems through interprofessional team-working or both?

Lally and Crome [1] have added a further point [4] to the trajectory of a ‘disease’, which, if not arrested will mean the death of undergraduate geriatric medicine in the 31 medical schools of the country that invented the specialty.

Is the decline irreversible?

We must value the educational leadership academic medicine can give to our specialty. It is in all geriatricians’ interests to see strong local academic geriatric medicine units linked to a network of district general hospitals (DGHs). Research informs practice and practice is the classroom. Academics should lead from a research base that reflects our specialty’s clinical practice all underpinned by the sociology and biology of ageing.

Geriatric medicine should be learned by every undergraduate student, something too important to be left to just academics. What students need to know to practice is best taught by those in practice. The NHS Plan [7] established the potential to change the medical school/NHS relationship. Some medical schools—Bristol for example [8]—map onto a number of local geographical localities through which students rotate rather than a ‘teaching hospital’. Students are no longer ‘on attachment’ but on a number of local sites within the NHS, each with a university infrastructure. There can be few DGHs where geriatric medicine is not practised. There is an increasing opportunity for NHS teaching leads to work closely with local medical schools to change the curriculum. Moreover medical schools have within their DGH partners, colleagues pursuing teaching skills courses at many levels. NHS geriatricians expect enthusiastic medical students to follow their specialty and become their colleagues of the future. It is difficult to be a role model [9] if the students do not know that the specialty exists.

We must challenge the argument that students see geriatric medicine practised elsewhere in the curriculum. They see skilled colleagues practising their specialty on chronologically older people, but is this geriatric medicine? There is a strong case for time to be spent in our specialty based on changing demography and the needs of the doctor and wider society at qualification. So, while we want to enthuse the geriatric medicine specialists of tomorrow it is the surgeons, oncologists and anaesthetists for whom the issues of ageing will colour the backdrop against which they will operate, irradiate or intubate.

We must be more imaginative over what we include in the geriatric medicine undergraduate curriculum and how we deliver it. Medical students may better match to the learning opportunities of the NHS [7] but DGHs are merging, beds are being reduced and community hospitals are closing. Where are the elderly—are we exploiting all the learning opportunities? Many are relatively well and in their own homes. Some are very dependent and in nursing homes. In between, they inhabit varying localities satisfying rising care needs. Older people come together in community activities. Just as students in paediatrics learn about normal children in nurseries our students have much to learn in the community whether in nursing homes, the day centre or on the bowls green. Learning about older people needs to happen where older people actually are.

Most students go on to work with older people, so all must learn about geriatric medicine; that is the conclusion of the University of South Carolina (USC) [10]—a university that had never had a course in ageing or geriatrics. USC considers this so important that instead of a course it is introducing a Vertical Curriculum in Geriatrics across all 4 years. It is community focussed, based on the American Geriatrics Society curriculum [11] and involves healthy ‘free range’ senior mentors as a learning resource. Meanwhile, changing demographics in Turkey have prompted a new geriatrics course based on the British Geriatrics Society (BGS) curriculum [6] but, impressively, in a university without a geriatric medicine department [12].

The General Medical Council 5-year cycle of visits to medical schools is an opportunity for our academics and the BGS to influence faculty deans. It is though the unheard voices of the huge numbers of NHS geriatricians and other grades who deliver the teaching that can potentially make the most difference to the future of undergraduate geriatric medicine.

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Editorials
Tracking demographic footprints

Two footprints in the demography of ageing can readily be identified that are associated with improving health and longevity, namely, the funding and redefining of retirement, the other associated with burdened ageing especially the impact of neurodegenerative disease-fuelled disability, dependency and demand for long-term care [1]. A report in this month’s journal highlights the importance of tracking the footprints of social trends as well as projecting the epidemiology of diseases associated with ageing [2].

With regard to the redefinition and funding of retirement in the United Kingdom, the state pension has diminished, and future proofed final salary pensions increasingly rare. The expanding retirement population and relative contraction of the working population is undermining the sustainability of the long established practice of paying for today’s pensions from current taxation. After many years of difficult debate government has made important pension policy commitments for the future [3]. These include the delay of retirement, partial retirement and greater pension contributions.

Furthermore, in July 2005, HM’s Treasury announced that a second Comprehensive Spending Review (CSR) would report in 2007, the purpose of the review being to identify what further investments and reforms are needed to equip the United Kingdom for the global challenges of the decade ahead. Preliminary publications from the Treasury have recognised that

‘demographic and socio-economic change, with rapid increases in the old age dependency ratio on the horizon and rising consumer expectations of public services’ [4]

And

‘a particularly important driver is the sharp projected increase in the number of “oldest old” (those aged 85 years and over). The size of this group is projected to increase by 38% between 2005 and 2017, compared to 17% between 1995 and 2005. The increase in the future elderly population can be predicted with sufficient certainty to mark it out as an important trend.’ [5]

Whilst the changing demographic footprints of burdened ageing have changed, the provision and funding for long-term care has historically been used by those suffering the effects of poverty, deprivation and neglect. In the United Kingdom, long-term care is now largely fashioned on a social care model. The paradox is that whilst the social care model has been successful in promoting more domestic care settings, the needs profile of older people receiving the services have become dominated by chronic disease-related disability.

The data from a record linkage study reports findings in this journal [2] of socio-demographic factors associated with a higher ‘risk’ of living in institutional care, namely people who have chosen (or perhaps been ‘chosen’) to live alone, particularly childless women. In 2005 the number of people living alone in Great Britain had more than doubled since 1971, from 3 to 7 million. An analysis of the age of people living alone from the general household survey [6] reveals the most striking changes are occurring between the ages of 25 and 64. For men in that age range there has been a near doubling of the incidence of living alone. The trend is less marked for women and from 65 onwards a modest reduction...