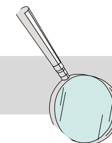

My Love Affair with Geriatric Medicine

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Key words: geriatrics, work satisfaction, medical education, holistic medicine

IMAJ 2001;3:618–620

"Geriatrics is fun!" This astonishing remark was made by one of my new colleagues at the Geriatric Department of University College Hospital, London, where I had just begun a sabbatical. He went on to tell me why he had abandoned internal medicine for geriatrics: "In internal medicine," he said, "you diagnose diseases and treat them, whilst in geriatrics you go one step further: you diagnose the patient's problems and try to solve them." He provided the following example: A local practitioner wanted to place an elderly lady with severe arthritis in an institution as she could no longer cope on her own. My colleague visited her in her home and tested her proficiency in performing household chores. Despite her deformed hands, she managed to carry out all his requests until he asked her to prepare tea. This she could not do as she was unable to turn on the water at the kitchen sink. So, instead of sending her to an institution, he arranged for the installation of a faucet with a handle that can be operated with the elbow.

I had applied for the sabbatical because I felt that as head of a general medical ward where most of the patients were over seventy, I ought to know more about treating them. At the time I held the usual view that geriatric medicine is dull and depressing. Soon after the sabbatical began however, my prejudices vanished and I decide to follow in my colleague's footsteps and become a geriatrician myself.

The story of the faucet intrigued me. It made me understand how attention to small details together with a basic knowledge of geriatric medicine may enable a doctor to solve difficult problems or, at least, to convert a big problem into a smaller more tolerable one. My own first-hand experience of this kind was the case of a resident in a home for the aged who had become bedridden and incontinent. The nurse requested his removal to the nursing department. I examined him and reached the diagnosis – a low bed! Raising the bed on blocks enabled him to get out of bed and reach the toilet without help. In addition, I arranged for him to have exercises to strengthen the extensor muscles of the hips and knees. I have seen countless cases of this kind. The most absurd case I ever encountered was a hospital patient who was disoriented after recovery from an acute illness. I had been called in to approve his transfer to custodial care. I found him to be perfectly coherent, but I noticed that his spectacles were coated with dirt. His sense of orientation was fully restored with the help of a little soap and water... Here is an interesting example that was published recently [1]. A geriatrician was conducting a study of dehydration among his patients and asked the nurse to prepare a list of those who refused to drink. He examined the individuals and found that in many cases the cup had been placed beyond the patient's reach!

The holistic approach of the geriatric rehabilitation team impressed me. The doctors, nurses, physiotherapists, occupational therapists and social workers met once a week. As the patient came up for discussion, each member of the team presented his or her report. Later on, when I led a geriatric rehabilitation team myself, I learned a great deal from the meetings and felt they were invaluable. I always had a deep sense of satisfaction each time we saved an aged person from the living death of custodial care.

My preconceived idea had been that geriatrics consisted of the internal medicine of old age together with the care of the demented and disabled. So I was surprised by the broad scope of the subject. I found myself lacking knowledge in rehabilitation, neurology, fractures, nutrition and preventive medicine, as well as in specific geriatric subjects such as osteoporosis, incontinence and falls. One of the highlights of my sabbatical was a visit to St. Christopher's Hospice, where I heard a lecture by the legendary Cicely Saunders [2] that changed all my ideas about the care of the dying.

Psychiatry attracted me and I spent a month working in a psycho-geriatric department. I soon realized that the commonest diagnostic error in the care of old people is the failure to recognize depression. Later on, I found that many of my own patients who seemed to lack motivation began to cooperate after

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treatment for depression. Depression can exist in many guises [3]. I was once called in to see a Moroccan woman who had been labeled "demented." I was asked to confirm her suitability for custodial care. However, she refused to cooperate with me and I was at a loss until an idea suddenly came to me. I told her that I had recently attended a Moroccan wedding and that the food had been wonderful. I shall never forget how her face suddenly lit up and she began to boast about her own prowess at cooking. Her depression was treated successfully and she evaded life imprisonment in a nursing home.

I must add that my decision to become a geriatrician was influenced by the fact that I had become deeply disillusioned with internal medicine. I had toiled for many years to reach the coveted position of head of a medical department; yet, when I finally achieved this goal, I began to hate my work. My job was to admit patients from the Emergency Room, but the turnover was so rapid that it was impossible to get to know the patients, let alone think about their problems. I looked back with nostalgia at internal medicine as it was practiced before the technological revolution. I agree with Shoenfeld [4] who recently pointed out that the abuse of technology and the downgrading of the clinical skills of history taking and physical examination, together with the heavy workload, have led to a drastic shortening of the time that the doctor actually spends with his patients. To my surprise, I have found that geriatrics has much in common with the clinical medicine of old. The typical patient who requires the skill of the geriatrician has already been investigated and treated. Science and technology have little more to offer him and so geriatricians have to rely on their ears and eyes, hands and brain – just like the clinician of bygone days. Solving a tough geriatric problem gives me the same deep satisfaction that I derive from making a good clinical diagnosis. Like all medical specialties, geriatrics has its dull side. In particular, the care of chronic patients in a nursing facility may become monotonous and doctors may find themselves in a rut.

Glick [5], calling for a change in the basic attitudes of doctors toward their patients, maintains that it is not enough to change the formal curriculum of medical schools; that in addition to the overt curriculum, there is also a hidden one. This is my feeling too. Even if a student gets a good training in geriatrics, this does not necessarily immunize him against the influence of teachers who sneer at geriatrics and other "soft" branches of medicine.

I remember from my own student days in London, fifty years ago, the contrast in attitude between the older clinicians and some of their younger scientifically orientated assistants. One of the veteran physicians would deliberately chose an "uninteresting" case and discuss it with us at length. I also remember an outpatient session, where, to our disappointment, there were no "good teaching cases." The young doctor in charge apologized, "I am sorry," he said, "all I have today is this rubbish!"

Here is an example of the "hidden curriculum" from my own ultra-short academic career at Tel Aviv University. Some years before I retired, I was appointed Senior Lecturer in Geriatric Medicine; this was the first time that such an appointment had been made at the Medical School. However during the five years in which I held the appointment, I gave only one lecture to medical students. As the subject for my lecture, I chose medicine's greatest challenge in the years to come – How to prevent disability in the very old. In all my years of lecturing experience I never encountered a more apathetic audience. They did not look at me at all. In despair, I changed the subject and began to talk about internal medicine in the elderly. Diseases interested them and they began to listen. The students were in their final year and had doubtlessly heard the same sentiment that I myself used to hear from senior faculty members: "Why geriatrics? Every good doctor can look after the elderly."

Although our medicine is scientifically based, there is one branch of science that our medical establishment prefers to ignore – demography. Life expectancy increases from year to year and the number of very old people is rising rapidly. How will medicine cope with this population explosion? Medical educators should ask themselves this question: why are so very few doctors interested in geriatric medicine? How can we attract physicians to geriatric medicine? Many doctors get frustrated with their elderly patients for they feel that nothing can be done for them. The myth of "senility" is still widely believed. Even today, it is not generally accepted that most of the disabilities of old age are not due to the aging process itself but to diseases, many of which can be prevented or treated [6]. The more a doctor knows about geriatric medicine, the greater will be his interest in treating the elderly. If all doctors who deal with elderly patients were to have a grounding in this field, everyone would benefit: elderly patients would at last find that their special problems were receiving serious attention, doctors would gain more satisfaction in their work, and the Ministry of Health would save the many millions that are being wasted on the care of disabled old people whose disability could have been prevented [7,8]. There is a long way to go. Even today, geriatric medicine is still not regarded as important enough to be an obligatory subject for doctors who wish to specialize as internists or as family doctors.

Now that I have reached my eightieth year, my love for geriatric medicine has not waned. My only regret is that I did not discover its fascination when I was younger. It still keeps me busy; I try to keep up with the literature, I write articles on old age in the lay press, broadcast on the radio and lecture at old-age clubs. However, one thing worries me. If I become seriously ill, will I come under the care of doctors who take no interest in the problems that beset the very old?

References

1. Spencer B, Pritchard-Howarth M, Lee T, Jack T. Won't drink? Can't drink. *Age Ageing* 2000;29:185–8.
2. Saunders CM. The symptomatic treatment of intractable pain in terminal cancer. *Proc R Soc Med* 1963;56:195–8.
3. Rollman BL, Reynolds CF. Minor and subsyndromal depression: functional disability worth treating. *J Am Geriatr Soc* 1999; 47:757–8.
4. Shoenfeld Y. The revolution in medicine toward the third millennium. From a lecture to medical students on their first exposure to clinical medicine. *Harefuah* 2000;139:109–10 (Hebrew).
5. Glick S. A paradigm shift – consequences and implications. *IMAJ* 2000;2:250.
6. Fiatarone MA, O'Neill EF, Ryan ND. Exercise training and nutritional supplement for physical frailty in the very old. *N Engl J Med* 1994;330:1769–75.
7. Schen R. Misplacement of the elderly in chronic care institutions. *Med Law* 1985;4:385–8.
8. Feldman Y, Peleg P, Yaretski A. Comprehensive geriatric assessment – its clinical, social and economic consequences. *Harefuah* 1999; 136:933–5 (Hebrew).

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