’Geriatrics’ - an old problem

On seeing the debate around the word 'geriatrics' in the last issue of the BGS Newsletter, Dr Tak-Kwan Kong, Editor-in-Chief of the Journal of the Hong Kong Geriatrics Society sent us this editorial on 'packing geriatrics'. It was published in the HK Society's Journal in 1996 - twenty-two years ago - which only goes to show, some controversies die hard!

Jean Martin Charcot (1825-1893) of France, Ignatz Leo Nascher (1863-1944) of America and Marjory Winsome Warren (1897-1960) of Britain, have often been credited with being the pioneers of modem geriatric medicine in the West. The term "geriatrics" was coined by Nascher, an American born in Vienna. When he was a medical student, he observed an incident in which an old woman, limping up to his clinical tutor with complaints of aches and pains, was sent away dissatisfied. The tutor said, "She is suffering from old age. There is nothing to be done *to* her."

In a visit to an old people's home in Vienna, he was impressed by their good health and longevity and was told, "It is because we treat our old patients in the same way as paediatricians treat children."

This statement inspired Nascher, in 1909, to create a special branch of medicine that he called geriatrics, a name recommended by his friend, Dr. Jacobi, who had managed to get paediatrics accepted as a specialty after a long struggle.

"Geriatrics, from *geras*, old age, and *iatri.kos*, relating to the physician, is a term I would suggest... to emphasise the necessity of considering senility and its diseases apart from maturity, and to assign it a separate place in medicine."

Recently, there has been much debate concerning the name "geriatrics", in relation to the future direction of geriatrics as well as the perceived negative connotations this name has acquired. In the United Kingdom, attempts have been made to "rehabilitate" the term "geriatrics" by changing its name. Thus a plethora of bewildering names have been coined as alternatives to "geriatrics" or "geriatric medicine", e.g. *geratology* (Greek for the study of ageing); *gerocomy* (Greek for old, tending); elderology and its variants (Care of the Elderly, Health Care of the Elderly, Medicine for the Elderly, Elderly Care Medicine), *eld* health (archaic / poetic old, health) and lastly *frailtology* (to emphasise that the targets of care are frail older people). It seems that heterogeneity is the hallmark of geriatrics, whether in terms of the patients served, the styles of practice, or even the names of the profession. Our American colleagues have packaged their "geriatric evaluation and management" programs as GEM, though whether they can convince their policy-makers that their programs are as valuable as a "gem"

is another matter.

Ever since the establishment of geriatric service in Hong Kong 21 years ago, the term "geriatrics" has been in use locally up to now. This year, our society name has just been rejuvenated from "Hong Kong Geriatric Society" to "Hong Kong Geriatrics Society". Sixteen years from its birth, our Society is certainly not "geriatric", and in fact has just passed the growth spurt.

In a culture in which the marketing orientation prevails, modern men's happiness consists in the thrill of looking at the shop windows. "Attractive" usually means a nice package of qualities which are popular and sought after on the market.

There is a Chinese saying, ”Fear not a bad birth, but fear a bad name”. To Nascher, ”geriatrics” must be a good name.

Has the spirit of Nascher been changed since the birth of the name "geriatrics" 87 years ago? Can the fate and fame of "geriatrics" be changed by simply packaging it with another name? Whatever title we would like to call ourselves, be it geriatricians, elderologists, or physicians for the care of older people, the substance of our profession will remain the same. Thanks to the dedication and efforts of our predecessors, a special knowledge base in geriatric medicine has been built up to meet the needs of our older people. Instead of changing the name of our profession, it is much better to change the fame of geriatrics by educating our medical fraternity, the general public and policy makers about the content and substance of geriatrics.

We all know the Hans Christian Andersen fairy tale of the Emperor who fell for the con that the material from which his new clothes were made was of such a quality that it was invisible to all but the wise. So, what is geriatrics without clothes? To quote Professor Peter Millard, past president of

the British Geriatrics Society, "Geriatrics spearheaded the attack on bed rest and transformed wards full of bed-bound patients into active treatment units. Geriatrics developed treatment services where there were none...Think of the health care state you would not want in your old age. Old, alone, unwanted, sick, confused, incontinent and catheterised in a cot sided bed in a general medical ward or lying on a trolley in an accident and emergency department. Or continually falling at home, faecally incontinent and a strain on your family and friends. This is our stock in trade, this is the very reason for our being."

A similar echo has been provided by Professor William R. Hazzard's response to the question "What is the typical geriatric patient?": "Think of your oldest, sickest, most complicated and frail patient." The number of disease processes and interactions which can result in these geriatric presentations are enormous and their detection and management intellectually challenging. The complexity of the deficits, however, inspires anxiety rather than interest in those not trained in the trade so that these frail older patients are too easily rejected as "incurable", mislabelled as "social problems" or "bed-blockers", and finally dumped in nursing homes or infirmaries. The commitment of a geriatric service to its patients actually begins where that of traditional medicine seems to end. Only geriatricians, equipped with the special knowledge, skills and attitudes, can provide an answer to meet the needs of these frail older patients. I believe that "geriatrics" will survive as long as our culture has not degraded to one in which "gerontophobia" and "geriatricide" prevail; but rather life is respected and valued from beginning to end.

Tak-Kwan Kong
Editor-in-chief, Journal of the Hong Kong Geriatrics Society

BGS Wales Update

The following report was delivered at the July meeting of the BGS Board of Trustees:

Formal links with Welsh Assembly Government

A National Speciality Advisory Group (NSAG) was set up around five years ago for each speciality to report to government. How useful and productive this has been is hard to determine but we will persist with this group. The current chairperson rotates into this role.

Regional Meetings

BGS Wales has held two regional meetings each year, alternating between north and south. The last meeting in North Wales was well attended. The next meeting is in Cardiff. Meetings last for one and a half days and provide a forum for good educational, professional and social networking.

The national BGS meeting in Cardiff (again) in Spring 2019 is high on our agenda and likely to be well attended by Welsh colleagues.

Workforce Issues

There are 88 Consultant geriatrician (stroke) posts in Wales. Most HBs have unfilled posts.

There are 45 whole time trainees (registrars) in geriatric medicine in Wales. Seven mature every year and the majority remain in Wales. Absolute number of vacant posts is small but due to a fairly low denominator, there can appear to be large percentage of absence in posts (especially North Wales).

Wales needs to fill 10 -15 posts per year

Key problems facing older people in Wales

A service reconfiguration is occurring in Stroke nationally and at HB level for several HBs - predominantly to a hub and spoke based model. The stroke reconfiguration has not moved on substantially since the last report. Like all UK stroke services, thrombectomy will be challenging but there is central government acknowledgment of its importance.

There is central government interest in PROMS and PREMs, this is beginning roll out, especially in Welsh stroke care.

There is a lack of capacity for frail older people including people with dementia. There are various reasons for this (delays in providing community services, myth that older people do not need assessments in hospitals, reduction in care home beds etc.) The continued divide between health and social care also remains an issue.

There is a growing interest in frailty across speciality and with some higher level engagement. There are some national moves to implement a comprehensive and Wales wide frailty scale, most likely the seven point CFS.

Demographic facts

Wales has a population of around 3.15 million (as opposed to 53 million in England, 5.3 million in Scotland and 2 million in Northern Ireland). 8.6 per cent are above the age of 75, 2.5 per cent are aged over 85.

There are seven health boards in Wales (replacing the 22 LHBs).

There are two medical schools located in Cardiff and Swansea.

Jonathan Hewitt
Chair, BGS Wales