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CORRESPONDENCE

Correspondents are urged to write briefly so that readers may be offered as wide a selection of letters as possible. So many are being received that the omission of some is inevitable. Letters should be signed personally by all their authors.

Can geriatrics survive?

The letters printed below, some in necessarily abbreviated form, represent only a selection of the many we have received on this subject.

SIR,—Dr J C Leonard's topic for debate (29 May, p 1335) comes at an opportune time, as the British Geriatric Society is at present attempting to define the role of the geriatrician in relation to general medicine. As a member of that society who almost certainly holds a minority view that is broadly in agreement with Dr Leonard's, I consider that many of his suggestions, were they to be adopted, would land us in an even worse plight than that in which we already are. "Why," he asks, "is geriatric medicine necessary as a separate discipline?" Alas, the answer is simple, the same one to the question of why any specialty is necessary. It is that general physicians do not know *enough* about the elderly ill.

Those of us who practise geriatric medicine have no difficulty in defining what we are about, and to argue that the lack of definition is probably the basic reason why geriatrics has failed to establish itself as an attractive discipline suggests the most superficial knowledge of the subject. True, it has no unique techniques, but good geriatric practice is founded on the same "firm foundation in clinical processes" as good general medicine. Here are some of the basic reasons why geriatrics is not an attractive specialty. The elderly are not attractive because they are a constant reminder of our own fate. We know little about them medically because we have been trained to deal well with acute, short-term problems and to deal even better with them if their solution holds promise of personal kudos. Such an approach leaves us short of sympathy for the elderly, and short of a philosophy for coping with their chronic illnesses. Working with the elderly is unlikely to gain one entrance to the higher echelons of professional success. Geriatrics is frequently practised in second-class accommodation with second-class equipment and by second-class doctors. Junior staff note all these disadvantages and naturally look elsewhere when planning a successful career.

Staffing of geriatric units is indeed a problem, and integration will go a long way to solve it. General physicians and their junior staff certainly see many elderly patients and they are adequate in coping with emergencies; but they fail when the acute problem is past and they fail because they do not know what to do next. They cannot gauge the possibilities for rehabilitation, they cannot plan a rehabilitation programme, and while they order ancillary help as a routine they seldom discuss the problems with the staff involved. Clinical experience in geriatric units is essential for junior staff. They will be dealing with elderly patients all their working lives, and if they are to practise better medicine than the present generation of physicians specialised experience is necessary, and they will not acquire it in general medical wards.

We are agreed on reintegration, then, but not on the methods. Dr Leonard seems to suggest that all future consultant appointments should be at the subspecialty level so that a specified commitment may be made to the care of the elderly in addition to a recognised interest—for example, in cardiology. If this is his meaning he is ignoring the fact that this is the age of specialisation and it is the general physicians who are in the minority. On the other hand, if he is suggesting that general physicians should all become better geriatricians, leaving the specialists in their chosen fields after persuading them to release the beds previously occupied by patients not requiring their expertise, we are nearer agreement than I appreciate. His ideas of how the care of the elderly might be accomplished, however, perusades me that there is still a wide gulf—geriatricians "might be integrated into the specialty of rheumatology and rehabilitation"; or "physicians might . . . divide their geriatric responsibilities on a rotational basis" or "might . . . reserve some sessions each week for this work." All this conveys that geriatrics is not only a non-specialty in Dr Leonard's mind but a non-existent specialty. The elderly will get the worst medicine possible from this casual approach. Good geriatric care involves hard, painstaking work based on knowledge and experience which is unlikely to develop in this style of practice.

In this teaching hospital geriatrics is integrated with general medicine to the extent that the geriatricians hold combined appointments, taking their turn on emergency call, and doing ward rounds and clinics, and all junior staff in the department rotate through general medicine. God and the DHSS willing, our new hospital will open next year with three fully integrated medical-geriatric units of 60 beds each and it is expected to provide a better service. Given tha there is no shortage of good applicants for our posts and that this pattern may not be suitable for other regions, any device that gets the geriatrician into the acute ward on day one of the elderly patient's admission is likely to improve the standard of care he gets. The obstacles that must be overcome to achieve this are mainly the attitudes of the people concerned. Geriatricians must enter the medical wards as equals and with the confidence that they have much to offer there. This will remain an insurmountable obstacle for some. Physicians must face the fact that the elderly patient is here for the forseeable future and will not go away if they hide their