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The Changing Face Of Geriatrics – How Training In The Care Of The Elderly Changed My Perception And Practice

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As a doctor, trained and practicing in India, my idea of Geriatrics was pretty much the same as most others – caring for patients who were the same as every other patient, just older. The first indication that this view would change came even before I left for my training in the UK. During my interview for a training post under the Royal College of Physicians, I was asked what my experience in Geriatrics was. I replied that I had a lot of experience in treating patients who were above 60 years of age. The interviewer laughed and informed me that 60 is still considered middle aged in the UK and the patient needs to be above 80 years to be considered geriatric. He also pointed out that I would be seeing a lot of patients in their late nineties and a few in their early hundreds. His words had the effect of leaving me wondering at the challenges I would face during my practice in the UK.

Having completed my training, it would be instructive to focus on the differences between care of the elderly in the UK and in India. Some of these differences arise from the difference in healthcare systems. The UK has a developed healthcare system already in place with every citizen mandatorily registered with a general practitioner (GP) in their catchment area. The role of a GP is well defined aiming to prevent illnesses by carrying out screening tests, providing clinic level care for simple ailments and home visits when needed, besides acting as the referral point to hospitals or specialists when required.

With regards to hospitals there are separate geriatric units with consultants specially trained in the care of the elderly who in addition participate in the unselected general medical take. There are special clinics run by consultants and clinical nurse practitioners focusing on specific problems in the elderly like falls, dementia, Parkinson's and fractures. Every junior doctor training in medicine has to mandatorily rotate through four months posting to the geriatric units. The geriatric units are equipped with other staffs like nurses, physiotherapists, occupational therapists, social workers who are all trained to look after the needs of the elderly. These staff ensure that the patient is fit and safe to be left alone in the isolation of their residence once he or she leaves the hospital, as it is not uncommon in the western world for an elderly person in their nineties to prefer to stay in their own homes and retain their independence.

Outside the hospital, there is a network of caregivers who look after the special needs of the patient in the community. There are systems in place where health care workers would step in a few times

a day depending on the individual needs to check on these elderly in addition to helping them with basic needs like getting washed and cleaned and getting them their meals, besides the help they receive from family members, friends or neighbours. The concept of "Meals on Wheels" especially appealed to me a lot. For emergency situations they have well equipped emergency teams available for help within minutes of placing a call. The use of pendant alarm system, in the elderly who may have problems summoning help following a fall is common. When these individuals are deemed to be unsafe in their home environments the social care workers step in to provide help in case family is unwilling to support them, which can be at the level of assisted livings to care homes or even nursing homes when completely dependent.

End of life care was an eyeopener during my training in the UK. A common misconception among doctors is that their purpose is to heal patients as opposed to alleviating suffering. A natural corollary to this approach is that a doctor would try anything in his power to keep a patient alive. Keeping a patient breathing naturally or artificially for a few extra days, whatever the quality of life may be, is considered desirable if not heroic. I appreciated the humane approach of doctors in the UK in this regard. When it is understood that a person has reached the end of his meaningful life, the focus shifts to keeping him comfortable and no further interventions to prolong life are undertaken. A decision in this regard is only taken after general consensus among the treating doctors, family and other caregivers; and the patient's opinion is sought if possible. When available, the patient's wishes carry the most weightage. In short, a clear distinction is made between prolonging life and prolonging death.

Though there are many aspects of this system which I would love to see in India; at a practical level, we are decades away from bringing in such a system. The sheer size of the country would be a major stumbling block to this sort of healthcare system ever coming up here. However, this should not stop us from aspiring to changes we can bring about with collective help from volunteers and social care organisations.

What can and should change is the individual approach of each doctor to a geriatric patient. Just as a paediatric patient is not just a young adult, a geriatric patient is not just an older patient. The health challenges that they face are mostly specific to their age. Frailty or general debility is a major concern. A simple stumble while walking could be a life altering or even a life ending event. The assessment of general condition becomes far more important in a geriatric patient and such an assessment should be thorough and comprehensive. A doctor needs to be aware of the specific problems in a geriatric patient like dementia, Parkinsonism, falls, delirium, incontinence, balance issues, visual and hearing problems to name a few. A multidisciplinary approach is vital with physical and occupational therapists, nurses and family members complementing various specialists like cardiologists, nephrologists, orthopaedicians etc.

A look at the changes in India's demographic profile will give us an idea of the vital importance in proper geriatric training for doctors. India may be a young country, probably the youngest in the world in terms of average age of the population, but we are only a few years away from a major demographic shift. Our life expectancy has gone from a mere 36.6 years in 1947 to 69 years in 2019 and the easier availability of advanced healthcare facilities across the nation will ensure that this index maintains it's rising trend. Better family planning will ensure that burgeoning population growth is stabilised. These two changes taken together means that the present age pyramid will shift to a silo with an equal number of the aged and the young. This increasingly aging population will mean that a better knowledge of their special health care needs becomes a priority in the years to come. This calls for developing a proper syllabus for geriatric training in medical schools as well as expanding the scope for geriatric specialty training for postgraduates. Eventually Geriatrics should branch out as a separate subspecialty. This can then be followed by setting up of specialty geriatric centres and separate geriatric departments in medical college hospitals. India is aging and our elderly as well as the soon-to-be-elderly deserve a chance to get the best healthcare that we can provide.