# Challenges in Geriatric Medicine: Geriatric Services and Education

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Ignatz Nascher first proposed disease and medical care of the aged as a separate specialty and invented the term "geriatrics" in 1909.[1] However, the growth of geriatric medicine and healthcare of the elderly is often attributed to the pioneering work of Majorie Warren who successfully treated and rehabilitated seemingly hopeless elderly patients in the UK in the 1930s.[2] British geriatric medicine flourished and the first chair in geriatric medicine was set up in Glasgow in 1965.

In Singapore, Dr F J Jayaratnam established the first Department of Geriatric Medicine in Tan Tock Seng Hospital in 1988 in response to challenges posed by a Ministry of Health report on the ageing population.[3,4] The model adopted was that of an internal medicine specialty with admissions based on age related conditions, as opposed to a purely aged defined model using a particular age as cutoff. This allowed 'younger olds' with geriatric syndromes like instability, immobility, incontinence and intellectual impairment – the Giants of Geriatrics as described by Bernard Isaacs – to receive geriatric input. At the same time, 'older olds' with predominantly single organ diseases gained easier access to organ based specialists by being admitted directly to general medical departments.

The British Geriatric Society defines geriatric medicine (geriatrics) as "that branch of general medicine concerned with the clinical, preventive, remedial and social aspects of illness in older people" and the goal of geriatric care is "to restore an ill and disabled person to a level of maximum ability and wherever possible return the person to an independent life at home."[5] The wide definition necessarily implies that geriatric care must be delivered in both hospitals and community, requires a multidisciplinary approach and shares overlapping philosophies with preventive, rehabilitation, palliative and family medicine. Comprehensive geriatric assessment remains the cornerstone of good geriatric care.

The model of acute geriatric care continues to differ in settings worldwide. In addition to the aged related and age defined models, some settings have integrated geriatric medicine with internal medicine, and internal physicians with a special responsibility for the elderly provide geriatric expertise. One school of thought argues for anchoring centres on ageing in departments of internal medicine, with internal physicians equipped to deliver high quality geriatric care[6] as opposed to separate departments of geriatrics.[7]

It is increasingly recognised that care of the elderly is a responsibility of all clinicians who attend to elderly patients in their practice, whether medical or surgical.[8] Just as principles of diabetic or cardiac care should be applied to all diabetic or cardiac patients regardless of their setting, principles of geriatric medicine – comprehensive assessment and management of medical, functional and social needs of the elderly – should be applied in all settings where the elderly are cared for. In line with this, the American Geriatrics Society recommends that gerontology and geriatric medicine be integrated into the curriculum for each year of medical school, allowing for age related changes to be integrated into basic science courses and clinical aspects of ageing integrated into clinical science courses and rotations.[9] Optimal care of the elderly should be in the mainstream of specialty care of the adult and Solomon et al[10] described the infusion of good geriatric care into the basic training of residents in surgical and medical specialties as a new frontier of geriatrics.

The ideal of comprehensive and continuous care of the elderly has been challenged by the development of services built around economic factors and funding mechanisms. Casemix funding by disease related groups promote early discharge of the elderly into step-down facilities to reduce length of stay in acute beds. This has led to a new category of subacute or intermediate care evolving in community settings in addition to rehabilitation services, nursing homes and home care. Transitional care units to assist patients just discharged from hospitals are a growing trend.

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In the course of one illness, an elderly person would receive care from multiple physicians, nurses and therapy teams in multiple healthcare settings. A new medical record would be created in each setting and should he need to be transferred between settings, confusion over medications and treatment plans invariably occur. The problems of physician and nursing discontinuity, medical errors, adverse events and delirium in susceptible elderly arising from multiple transfers are well discussed by Gillick.[11]

Redesigning a service and revamping funding systems to support it requires greater effort than designing services that are best supported by existing funding systems. The economic value of geriatrics is hard to demonstrate under current funding systems. It is certainly not a revenue generator. Geriatric care costs more[12] as elderly patients have more chronic illnesses and functional impairments, more medications, more social issues that need to be addressed and geriatrician attempts at comprehensive assessment in one sitting are translated into longer consult time and fewer patients in a clinic session. From the viewpoint of a cost centre, it is economically more attractive to see patients over multiple short visits. Likewise, inpatient casemix funding based on disease related groups do not favour elderly care. To overcome economic issues, project funding is often tapped on to try out new models of elderly care on a small scale. However, even effective demonstration programmes tend to "vanish after the initial enthusiasm and funding for the project dissipate."[13]

Another area of growing interest to both healthcare professionals and the public is the concept of "successful ageing", contributed no doubt by more educated and affluent baby boomers faced with increasing life expectancy. There is no clear definition of "successful ageing" and its similar terms (healthy ageing, productive ageing, effective ageing, elite ageing) but it certainly involves more than just longevity, freedom from disease or disability,[14] high independent functioning and active engagement with life. Phelan and Larson[15] proposed successful ageing as a fluid concept that may vary substantially by birth cohort, gender, ethnic subgroup and presence or absence of chronic disease. They believe that a patient centred definition will be more useful and will allow determination of predictors truly relevant to persons who are ageing. Proponents of successful ageing are in some ways opposed to "anti-ageing medicine", which suggests that ageing is a disease, for which anti-ageing treatments must be prescribed. To date, there is very little local data on frailty and functional aspects of ageing. While there may not be major differences between western and Asian societies in biomedical aspects, cultural beliefs and practices do influence perceptions and attitudes in ageing. Geriatric services need to incorporate geriatric health promotion as a key focus and likewise emphasis on this should be given in medical education.

Geriatric medicine in Singapore has come a long way in the last 15 years. The theme papers in this issue of Annals reflect the diversity of geriatric medicine. There are papers on aged care services, clinical issues (incontinence, dementia, falls, chronic pain), palliative care, ethics and ageing research. Delivering good geriatric care continues to be a challenge in this new healthcare landscape.

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