

Old News: Why the 90-Year Crisis in Medical Elder Care?

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North American and European demographic projections indicate that by 2030, persons aged 65 and older will outnumber those younger than 15 by a ratio of 2:1. Curiously, principles of geriatric care have not taken strong hold among nongeriatric specialties, even as we approach the time of greatest need. To explore historical precedents for the current crisis in elder care, this article revisits the prescriptions of G. Stanley Hall's *Senescence: The Last Half of Life* (1922), a text widely recognized as one of the founding texts in the medicalized study of aging. It presents in brief three of Hall's major concerns—paucity of knowledge of nongeriatric specialists, the need for individualized care of elderly adults, and the prevalence of attitudinal obstacles in medical professionals caring for older persons—to demonstrate how little the language and content of modern appraisals have evolved since 1922. This disconcerting sense of paralysis is presented as an opportunity to advance important questions aimed at stimulating a more-comprehensive research agenda for addressing the future of medical elder care. *J Am Geriatr Soc* 60:1357–1360, 2012.

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The aging population is changing the face of health care. In 1958, North American statistics showed that children outnumbered persons aged 65 and older by a ratio of 5:1. By 2008, that ratio had shifted dramatically, to almost 1:1. The same year, 13.7% of Canada's popula-

tion was aged 65 and older, and 16.8% were younger than 15. Projections for 2030 indicate that those aged 65 and older will outnumber those younger than 15 by a ratio of 2:1.¹ The most recent figures from the United Kingdom demonstrate similar trends in population growth and demographic distribution.²

The healthcare needs of elderly adults can differ significantly from those younger than 65, and it seems reasonable that the expertise of healthcare practitioners and services available should adjust to suit the needs of the population, but healthcare training and resources have not followed demographics. Recent studies from the United Kingdom report that considerably fewer medical schools have mandatory rotations in geriatrics than in recent decades.³ For example, in 1981, geriatrics was formally taught as a separate discipline in all but two of 30 UK medical schools. A similar survey conducted in 2006 found this trend reversed; geriatrics is taught as a separate discipline in only two of 23 medical schools throughout the United Kingdom.^{4,5} That said, it is important to recognize that, in recent years, discussions concerning how best to implement teaching in geriatrics in the United Kingdom have taken place; geriatrics represents the largest specialty in internal medicine throughout the United Kingdom,⁶ and recent placement numbers demonstrate that, since 2008, all UK geriatrics trainees have secured consultancy appointments.⁷ By contrast, the situation in North America is considerably more discouraging. In 2006, Canadian medical students received on average 79 hours of geriatric content during their 4 years of medical school, as opposed to more than 300 hours of pediatric content.⁸ In the United States and Canada, geriatric residency and fellowship training slots have remained unfilled for almost a decade, and in Canada between 2008 and 2009, pediatric residents outnumbered geriatric residents by more than 14:1.⁹ There are fewer than 200 practicing geriatricians throughout Canada.¹⁰ Although there has been considerable growth in geriatrics-oriented content in medical publications over the last two decades, this growth has not translated into correspondingly improved recruitment of residents or mandatory training hours for undergraduate medical students. Given current deficits in recruitment and training, it will be impossible to provide a sufficient number of geriatricians to meet the needs of an aging population.^{11,12}

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These statistics will not surprise anyone in medicine. Not only is this article not advancing a new idea, it is echoing a very, very old idea. This article shines an uncomfortable spotlight on this strange sense of disciplinary déjà vu and asks: Why have the principles of geriatric care not taken stronger hold among nongeriatric specialists? To explore historical precedents for the current crisis in elder care, one can return to the discipline's early documents. G. Stanley Hall's *Senescence: The Last Half of Life* is widely recognized as one of the founding texts in the medicalized study of aging.¹³ First published in 1922, *Senescence* has been called "a prophetic book" and critical to understanding the broader contours of the history of aging as a social and medical phenomenon.¹⁴ Rereading Hall's text in 2012 affirms just how predictive—and, disconcertingly, how descriptive—its insights remain concerning medical elder care. To emphasize: a comprehensive review of the obstacles to integrating principles of elder care into general medical practice is not presented in this article, nor does it describe all of the important accomplishments that individuals, organizations, and professional societies have realized in this regard. Instead, this reading of *Senescence* is used to highlight important questions motivated by three specific areas of concern originally articulated by G. Stanley Hall in 1922: questions it is hoped will help to frame a more-comprehensive research agenda directed at addressing the future of medical elder care.

PAUCITY OF GERIATRIC KNOWLEDGE IN NONGERIATRIC SPECIALISTS

Drawing from medical, philosophical, and literary documents from the classical period to his own day, Hall states, "This hygienic survey reinforced what I had realized before, namely, that physicians know very little of old age. Few have specialized in its distinctive needs, as they have in the diseases of women and children and the rest."¹³ Today, the paucity of geriatric knowledge in nongeriatric medical and allied health professionals continues to generate much discussion. Physician knowledge of aging has been found to be limited; in one study it was no greater than that of undergraduate students.^{15,16} In the Canadian context, "healthcare professions are experiencing problems in preparing a workforce sufficiently well trained to deal with our aging population."¹⁷ Why has such little progress been made in this area? Why are geriatric medicine and the principles of elder care not a mandatory part of undergraduate medical training? Although the specialty's increasing evidence base has resulted in the implementation of some new care and practice guidelines (e.g., major funding initiatives aimed at improving the geriatric training of nongeriatric physicians and medical students, such as the Hartford Foundation \$5 million infusion to the American Geriatrics Society in 2007), this has not resulted in a deep or lasting influence on medical education. At least one recent study found that "Many students and faculty believe that, because students see older adults in most clinical rotations, the students are acquiring the knowledge and skills needed to work with older adults."¹⁸ Mandatory geriatrics teaching for all medical students is rarely if ever explicitly required for accreditation of undergraduate

medical schools: a circumstance that probably generates, and is reflective of, the pervasive belief that "further specialized training [is] redundant."¹⁸ Does this lack of formalized exposure to geriatric medicine and the principles of elder care contribute to the fact that "Recruitment into the field remains a major challenge"?¹⁹

NEED FOR INDIVIDUALIZED CARE

Hall writes, "The old most of all need personal provision and suffer most from mass treatment, for they are not a class but are hyperindividualized...there is the greatest diversity in food, regimen, and in most bodily and psychic needs. To say nothing of disposition...or temperament."¹³ In 2006, as expert evidence presented to the National Advisory Council on Aging in Canada, Richard Dobie states, "Seniors are not a monolithic group of poor, frail, sick or dependent persons. The 65 plus group presents considerable diversity in terms of life experiences, economic status, health status, and resources for independent living."²⁰ Although individualized care approaches to older persons has remained an ideal for almost 90 years, it is still not fully realized in general practice. Despite recent patient-centered initiatives (e.g., Dementia Care Mapping),²¹ "Data show that the medical care that older persons, especially frail older persons, currently receive is suboptimal."²² Because studies have shown that "mass treatment" and inflexible adherence to clinical practice guidelines remain a problem, especially for older adults with multiple comorbidities,²³ such promising initiatives will be unable to effect widespread improvement in elder care if they are not disseminated beyond geriatricians and taken up by the nongeriatric specialists who encounter older adults in their daily practice. Individualized, patient-centered practice is a firmly established principle in medical disciplines such as women's health. Why has individualized care not become an axiom of general medical practice, especially among nongeriatric specialists whose patients include those aged 65 and older? If pediatrics reflects an integrated person-centered model that regularly addresses the individualized functional, social, cognitive, and medical development of children, why has patient-centeredness not taken hold to this same degree as a guiding principle in the primary care of older adults?

ATTITUDINAL OBSTACLES TO ADVOCACY FOR OLDER PERSONS

Hall writes, "Two prevalent traditions must be ruthlessly broken and destroyed. The first is that old people's hold on life is so precarious that medical care is less likely to be rewarded with success than at earlier stages of life....The other vicious tradition is that retirement or marked abatement of activity should occur at a certain age. This ought to be always a personal matter and all who can really 'carry on' should do so with all the powers they possess as long as they are fully able."¹³ Hall's frustration is echoed in a *British Medical Journal* editorial written in 2000, in which Marion McMurdo states that "The crucial distinction between the effects of age alone and the effects of disease do need to be reinforced in the minds of both the public and health professionals. Finally laying to rest the

pervasive misconception that all the ills of old age are ‘just your age’ would represent a major breakthrough for health care of older people.”²⁴ To be fair, comprehensive initiatives such as the National Service Framework for Older People²⁵ or the Vital Visionary Collaboration (sponsored by the U.S. National Institute on Aging) have shown commendable commitment to addressing ageism in clinical practice, but ongoing concern regarding ageism in health care—as reported in professional and lay publications—suggests that, between 1922 and 2012, little meaningful change has occurred; to wit, deep-seated social and professional biases against older persons continue to trouble the medical profession at large. In an era marked by advances in social and professional attitudes toward traditionally marginalized groups, it is remarkable that ageism persists in the care of elderly adults. Why has the notion that “it’s just your age” remained an acceptable mind-set in Western health care?

SUMMARY: IS THE DISSEMINATION OF GERIATRIC CARE PRINCIPLES FROZEN IN TIME?

It would be remiss not to mention concrete examples of progress. The clinical and public relations success of the UK National Dementia Strategy—an exemplary collaboration between multiple stakeholders in politics, public policy, and the medical profession—which has generated lively discussion regarding the genesis of similar initiatives in Canada and Ireland should cheer readers. There is little doubt that further study of the reasons behind transnational differences is needed to address the concerns raised in this article and elsewhere. Moreover, other concerns pertaining to practicing geriatric medicine (e.g., compensation, prestige, and lifestyle) have been suggested as potentially significant factors affecting recruitment into the field and may in turn affect how successfully principles of geriatric care can be disseminated throughout the medical profession at large.¹⁰ As described at the outset of this article, the purpose of this short article is to focus exclusively on three concerns that G. Stanley Hall identified, as problems that have continued to manifest as obstacles to providing the best medical care to older adults, especially by nongeriatric specialists. In place of a comprehensive overview of the underlying causes of this situation (a study that would exceed the limitations of a single brief report), the intention is to generate—that is, revive—this essential discussion by highlighting one pertinent moment in the intellectual history of medical elder care.

Despite the opportunities for optimism mentioned above, the 2005 American Geriatrics Society Task Force on the Future of Geriatric Medicine concludes on a grim note: “The consequences of inaction will be profound. The combination of a burgeoning number of older persons and an inadequately prepared, poorly organized physician workforce is a recipe for expensive, fragmented health care that does not meet the needs of our older population.”¹⁹ The sense of crisis associated with contemporary medical elder care has persisted since the publication of Hall’s *Senescence* almost 90 years ago. Although individual practitioners; organizations such as the Hartford and Donald W. Reynolds foundations; government initiatives such as the Veterans Health Administration’s creation of Geriatric

Research, Education, and Clinical Centers; and the respective professional geriatrics societies of Britain, United States, and Canada have been working hard to address problems associated with medical elder care, the overall sense of paralysis in the dissemination of important principles of geriatric medicine—particularly among nongeriatric specialists who treat older adults on a day-to-day basis—is astonishing.

Given the indisputable projections of Western demographics, it is no longer possible for physicians, researchers, and policy-makers simply to acknowledge the existence of a healthcare crisis concerning older adults and an aging population. The ongoing acknowledgment in the absence of meaningful action is rather like yelling “fire!” and then settling down with a glass of wine inside the burning building. As we have seen, little to no advancement of these critical problem areas in medical elder care (especially among nongeriatric specialists) has been made despite Hall’s recommendations in 1922. Moreover, it is unlikely that healthcare stakeholders around the globe will be granted another 90-year reprieve of the sort evinced over the twentieth-century. Will the dire contemporary findings of task forces and studies of deteriorating medical education in elder care sound more loudly if we are forced to recognize that these crises were not only foreseen, but ignored?

This article is intended to expose the irony of a geriatric crisis in the discipline itself. More importantly, directed research is urgently needed to identify and elaborate the systemic factors underpinning this paralysis. In an attempt to redress the faltering medical elder care agenda, the following initiating questions are proposed for immediate consideration and investigation:

- How does the twenty-first-century medical school culture influence the perception of medical care of elderly adults?
- Is the paucity of geriatric content at the undergraduate level promoting an unintended hidden curriculum that is unavoidably ageist in nature?
- In an outcomes-based healthcare system, how can the skills specific to medical elder care—and by extension, the subspecialty itself—be defined and understood as value-added by nongeriatric subspecialties and their practitioners?
- What are the sources of important transnational differences that exist when considering large-scale approaches to caring for elderly adults?

Such research is a necessary step toward energizing and fortifying the discipline of geriatric medicine, which may in turn improve how the medical profession might better care for elderly adults in the clinic and beyond.

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