

Preventive care of elderly people: how good is our training?

THERE were no departments of geriatric medicine in the 1940s to train my generation of medical students in community care of the elderly. It was assumed that experience of handling a relatively small number of often highly dependent old people in long stay hospital beds gave us the general grounding for care of old people in general practice whose needs often proved to be very different. Training on disease management was thorough but disability in old age was often taken for granted and rehabilitation was less active and vigorous than it is today. Attention was drawn to the contribution of social problems but we now recognize that they were not given the emphasis they deserved.

The last 45 years has seen a dramatic change in this field with the development of geriatric medicine, especially by British pioneers like Marjorie Warren, Lionel Cosin and Ferguson Anderson, dedicated to improving the management of disease and promoting rehabilitation in the elderly. It is therefore paradoxical that, while the young doctor today is much better educated than in the 1940s, community care of the elderly is still plagued by well documented shortcomings. These are:

- Underdiagnosis of certain medical disorders, notably depression, dementia, incontinence, disorders of the feet and other disorders affecting mobility¹ as well as alcoholism² and physical abuse.³
- Poor identification and management of disability^{4,5} and sensory impairment.^{6,7}
- Overprescribing.⁸
- Poor patient health education and health promotion, leading to poor use of the social and medical services by patients.⁹⁻¹¹
- Lack of attention to carer stress.^{12,13}
- Inadequate briefing of patients about disability aids, benefits and entitlements.⁹⁻¹¹
- Poor standards of record keeping.¹⁴

Despite these shortcomings it remains common to hear family doctors at conferences claiming that there are few unrecognized problems among their older patients. Such doctors are often sceptical about the value of preventive care in this field, claiming that it is intrusive, interferes with privacy, is likely to lead to increased prescribing and raised consulting rates, does not identify treatable disorders, is not of proven value and will increase workload. Only the last criticism can be sustained for there is clear cut evidence from controlled trials that screening and functional assessment reduce institutional care significantly among elderly people, and are cost effective owing to reduced prescribing and need for institutional care.^{7,15-17}

Why then is it that so many family doctors dedicated to preventive care in other fields oppose it for elderly people? It may be due to a lack of awareness of the defects of demand-led care, complacency about its effectiveness and 'ageism' with its pessimism about the health prospects of the elderly and scepticism about our capacity to influence their health status. Most of all, however, I believe that educational inadequacies are at the heart of this opposition and these inadequacies need to be examined.

The central problem is that medical student training in geriatric medicine is centred largely on hospital inpatients, often very old and disabled people undergoing rehabilitation. Training in outpatient departments tends to be more limited and the general practice setting is rarely used by teaching consultants despite its proven value in other fields.¹⁸ In addition, although 95% of the care of elderly people is provided in the communi-

ty, the family doctor's involvement in the training of medical students for community care of the elderly is restricted to some informal instruction during the students' usually brief general practice attachment. As a result, students tend to emerge from medical school with a distorted image of disease, disability and dependency in old age.

In many cases too little value appears to be attached to the importance of teaching medical students about the value of preventive care among old people in the community. Certainly I have never met a medical student or trainee general practitioner who has had undergraduate education in the planning, organization and management of either opportunistic or selective screening of older people. Contrast this with students of midwifery who would not be regarded as properly trained if they did not know how to organize and run an antenatal clinic on graduation.

Medical students also report limited contact with other health care professionals, for example, physiotherapists, occupational therapists, chiropractors, dietitians and social workers. As a result, on graduation, they are not always clear about the potential contribution of these fellow health care workers.

In the past there has also been a lack of training in the functional assessment of older people and this has been reflected in the results of examinations for the Diploma in Geriatric Medicine in which questions on disability and rehabilitation have been answered worst. Examiners have also been surprised to find how few of the examinees were familiar with the Barthel index — the most commonly used instrument for measuring disability in the elderly.

Likewise student training in the management of the patient with dementia and his or her family has, in the past, been inadequate. Thus, psychogeriatricians spend a good deal of their time carrying out domiciliary visits to assess patients thought to be suffering from dementia. Yet it may be inappropriate to suggest that a psychogeriatrician, usually quite unfamiliar with the patient, can assess him or her better in 20 or 30 minutes than a general practitioner, thoroughly trained in this assessment, who has known the patient and family for years. If medical students and trainees were better educated in this relatively simple work, the psychogeriatric service in the National Health Service could be transformed. However, it must be said that training in physical and mental assessment of the elderly has shown signs of improving in recent years.

Vocational training programmes can also be criticized for their lack of emphasis on preventive care of the elderly and the best ways of organizing opportunistic and systematic screening. It would be surprising if it were otherwise, since course organizers are themselves the product of student training in care of the elderly. It has been reported that, during their trainee year, trainee general practitioners get less experience of care of the elderly than their trainers.¹⁹ Also, since only a small minority of practices have an opportunistic or selective screening programme for the elderly, they rarely get experience of running a clinic for older people during their trainee year.

The requirements for the care of elderly people under the new contract for general practitioners have stimulated interest in preventive care among the elderly. However, the programme seems to be far too rigid and doctors are not required to have special training for this complex work. By contrast, developmental paediatric care is to be provided by 'suitably trained doctors'.

To resolve these educational defects it is necessary for medical student training to be broadened by using selected practices,

trained to do the work, as a teaching resource and for students to be better briefed about the work of other health-care professionals. Vocational training should also be more oriented to the special needs of the elderly with trainers seeking to ensure that trainees get more experience in community care of older people. Day-release courses could place more emphasis on the importance of paramedical problems in the clinical care of elderly people. They could also focus more on the importance of identifying disability and promoting rehabilitation and independence in old age. During the trainee year, attention also needs to be drawn to carer stress, better health education and improved information systems.

These suggestions for improving the training system should lead to doctors entering general practice with a more balanced view of elderly people and their problems. One hopes that it would also encourage a more active approach to the identification and management of the diverse problems mediating ill-health in old age, the maintenance of patient function and independence and the continued integration of elderly people in society. Only then can the elderly continue to be independent in their chosen setting for as long as possible, to fulfil their aspirations and to lead the best life open to them — the ultimate objectives of care in old age.

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Medical practice and the double-blind, randomized controlled trial

OVER recent decades doctors have become increasingly aware of the range of prognostic variability in patients and the sheer magnitude of the placebo response. Thus, it has been realized that determining the effectiveness of a given therapy is a rather less straightforward matter than was once supposed. The search for a scientific basis to medicine has led to the double-blind, randomized controlled trial being proposed as the 'gold standard' for the evaluation of therapeutic interventions. Clearly this represents a major advance towards a systematic and cumulative consensus for clinical management, based on criteria more objective than anecdotal experience.¹

However, the question arises as to why, if the double-blind randomized controlled trial is such a powerful technique for providing objective data, medicine still relies to a large extent on individual experience, opinion and unvalidated treatment. Does this resistance to the hegemony of the double-blind randomized controlled trial result from mere nostalgia, inertia and irrationality? Or are there good reasons for a viewpoint which sees the role of the double-blind randomized controlled trial as vital, but of restricted applicability to medicine?

We must first remember that the double-blind randomized controlled trial is only employed in conditions of clinical unpredictability. When an obviously effective treatment emerges there is no need for a controlled trial to establish its usefulness. The value is obvious either because the treatment has a predictable effect or because the disease has a predictable prognosis which can only be influenced by the new treatment. For example, if a surgeon is able to sew back and restore the function of an amputated limb, there is little doubt of the treatment's effectiveness. We can call such paradigm cases 'empirical' medicine, because they derive primarily from observation with the minimum of theory. Historically, such objectively valid treatments have been most frequently generated and explained by the system we call Western medicine, which probably explains why this is our most successful export to other cultures.

From empirical and primary observations a whole range of rational and secondary questions are derived by a process of logical extension — the optimal dose and regimen of a drug, the morbidity rate following surgery, the long-term outcome of