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Prepare for your retirement, doctor, by investing in ...?

THE proposed changes affecting PEPs, Tessas, and the new ISAs (Individual Savings Accounts) may be presenting unexpected challenges to doctors preparing for retirement, whether this is imminent or not. There is, however, another form of investment that should not be overlooked if retirement is to be enjoyed and not become an anxious time. It has the big advantage of having virtually no cost but, as the adverts say, 'act promptly'. Indeed, this opportunity only came to the fore at the end of last year when some 100 medical journals from over 30 countries published an issue devoted to ageing.[1] No, you do not need to invest in another dietary or exercise regime but you do need to answer just two questions and, for these, it may be helpful to have some background information.

In three years' time, two million more pensioners will have joined the ten million pensioners already in the UK.[2] Why then, you may ask, with an eye on your retirement, are elderly people excluded from being subjects in clinical research?[3] When you retire will you be one of them – excluded, I mean, not just elderly? This is serious because, as you know, retired people are not merely older young people who can be safely given the same drug dosages.

Moreover, while illnesses common to young people also occur as commonly in those who have retired, illnesses in the young commonly follow textbook descriptions, whereas, after retirement age, similar illnesses present in an atypical manner. Indeed, in younger people a coherent account of symptoms can be quickly elicited to enable a proper provisional diagnosis to be made well before a full physical examination is contemplated. Any outstanding questions can be pursued with the aid of well-directed ancillary and other specialist investigations. In this way the clinical problems of young and middle-aged patients may be swiftly solved when the process of trained vertical thinking is propped up by pattern recognition of common complaints. This has given rise to what has been described as 'Hi! Doc' medicine.[4] Examples of this include: 'Hi! Doc. I have a pain in my chest and it goes down my arms. It is worse when I hurry (especially in cold weather) but is relieved by rest', and 'Hi! Doc. I am losing weight unexpectedly and passing large volumes of urine.'

But for those who become ill after retirement the same vertical-thinking process may not help with diagnosis and even less with management. Many textbooks do not help either. The reason is that the classical accounts of illnesses given in standard general medical texts were first written when the majority of our population was very much younger. For years the undergraduate medical curriculum has continued to be set as though this is still the case. Even professional examinations for postgraduate medical and surgical diplomas, as well as programmes for continuing medical education in all adult specialities, have not been sufficiently responsive to the changing needs of our ageing population.

There is no doubt that the increased numbers of the retired population have brought new clinical problems that have been ill understood. Indeed, their difficulties have been regarded by many as though they are 'simply social problems' and too readily associated with the dismissive diagnosis of 'just old age'.[5] Under these circumstances, the concept that medical or surgical treatment for those in retirement has little to offer can become a self-fulfilling prophecy and not allow the real causes of the presenting problems to be identified and corrected.

Invariably in young people one diagnosis is the outcome and one body system is all that may be diseased. Moreover, illness slows younger people down and readily distinguishes them from their more physically active peer group. Older people, on the other hand, do not usually have such a physically demanding lifestyle. Disease can therefore make a greater encroachment on the retired person's body reserve before even exercise-induced symptoms appear. Frequently, also, in the older person more than one organ is affected, either by separate diseases or by a disease in one system affecting others (e.g. the results of erstwhile silent heart failure and atrial fibrillation impairing cerebral perfusion). The gradual onset of such illness is accompanied by reduced physical activity that not only predisposes a person to secondary muscle atrophy but also silences symptoms dependent on exercise. At this time anything untoward can be easily overlooked (especially since diagnoses such as 'It is just your age' and 'what else can you expect at your time of life?' are, unfortunately, far too common).

Furthermore, in retirement, social isolation may be compounded by easily treatable visual impairment, deafness, and increasing immobility whose significance may not be discerned by the untrained observer. Any or all of these may pave the way for the elderly person to drift from unrecognized disorientation to overt mental confusion when acute illness occurs. Under these circumstances the elderly patient (one day, it may be you, doctor) will not be able to present in the 'Hi! Doc' manner of the young because the very organ (the brain) that would make the 'Hi! Doc' statement is involved in the disease process, especially when the acute phase occurs. At this stage the readily available clinical diagnoses of 'senile dementia' or even 'Alzheimer's disease' can rob retired people and their medical practitioners of the opportunity for effective diagnosis and management. Ignorance about, and adverse medical and societal attitudes towards, old age (ageism) may lead to clinical neglect and the failure to diagnose and treat even simple conditions (e.g. heart failure, pneumonia, etc). The problems may be compounded when increasing social support and an adverse environment may so restrict lifestyle that older people (and their carers) do not realize that they are failing to cope because they are becoming ill.

One of the intellectual challenges in clinical practice today is that effective diagnosis in elderly people is often a complicated process. This is because various factors mask the presentation of illness in old age. Stated briefly these are: Reduced body reserve;

Atypical presentation; Multiple pathology; Polypharmacy; and Social adversity — all easily remembered by the mnemonic 'ramps'.

Now, what were those two important questions you needed to answer? The first is this: 'When you retire will your general practitioner, A&E surgeon, or specialist be able to respond appropriately to the clinical problems of your old age?'[2] To ensure they can, what additional low-cost investment do you need to be making now? Simply this, in the new commissioning contract for *all* of their hospital adult services, insist that your primary care group[6] include the need for appropriate training of medical, nursing, and paraclinical staff in the diagnosis and management of elderly patients. Then ask your Royal College representative to make sure that syllabuses for professional qualifying examinations and continuing medical education are updated so that 'they', i.e. your younger colleagues, will be able to manage effectively the clinical problems of elderly people by the time you retire!

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