

## Why choose a career in geriatric medicine?

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In this issue, Briggs *et al* examine why doctors choose a career in geriatric medicine.<sup>1</sup> Their large survey of current consultants and trainees provides a useful insight into the factors which motivate (and demotivate) doctors from deciding to work in this specialty.

### Recent problems with recruitment

The disappearance of senior registrars with the Calman reforms meant that many new specialist registrar (SpR) posts were created on the basis of 'history or equity' rather than on their capacity as good training slots. As a result, some registrar posts, previously not considered suitable for training, were incorporated into SpR rotations, exposing several deficiencies:

- the lack of research opportunities or a need to rotate to a research oriented department
- the inadequacy of services to offer exposure to the specialty elements now required for accreditation, and the new service elements emphasised in the National Service Framework for Older People (NSFOP) such as falls, stroke care, acute assessment and geriatric specialisation within acute services.

The demands of acute medicine compounded by the dramatic effects of the European Working Time Directive (EWTd) are widely believed to be detrimental to the quality of specialty training and hence may adversely affect recruitment to the specialty. Most obviously, the majority of SpRs in geriatric medicine (and other specialties involved in emergency medicine) have been forced into partial or complete shift work in the service of acute emergency medicine, with a detrimental effect on specialty training and continuity of medical care. These changes are deeply unpopular with trainees.<sup>2</sup>

Modernising Medical Careers (MMC), designed to accelerate postgraduate medical training, is to be fully implemented by the summer of 2007. Concerns have been expressed about its principles as well as the rapidity of its introduction.<sup>3</sup> As Briggs and colleagues point out,<sup>1</sup> with the implementation of MMC, the requirement to choose a specialty at an earlier career stage may well reduce the potential market for geriatric medicine which previously relied heavily on 'late converts'.

The strictures imposed by the EWTd have led to consultant expansion in other acute medicine specialties, for example cardiology, gastroenterology and respiratory medicine, so geriatric medicine faces competition for trainees with other specialties which are expanding as fast or faster than itself. A recent survey of recruitment of SpRs in geriatrics gives cause for concern.<sup>4</sup> In 2005, certain areas of England (Yorkshire, Mersey and North West Thames) noted a sharp rise in the number of unfilled SpR posts although in Scotland, Northern Ireland and Wales there appeared little difficulty in recruitment.

Academic opportunities are an attractive feature in career choice and this aspect has been an issue for geriatric medicine. In its recent submissions to the Royal College of Physicians (RCP) Workforce Unit,<sup>5</sup> the British Geriatrics Society (BGS) Workforce Committee noted that only 91 out of 965 posts were academic appointments (9.4%) compared with a 16.3% average for medical specialties. As Briggs notes,<sup>1</sup> undergraduate teaching in geriatric medicine has a low priority in many medical schools and the specialty has never been an attractive target for mainstream research funding. Thus there is a low proportion of consultant posts in teaching hospitals: the RCP census in 2000<sup>5</sup> showed that only 273 posts out of 965 (28%) existed for geriatric medicine, compared with other medical specialties such as cardiology (38%) and gastroenterology (37%).

### A career choice with a bright future

Despite the problems presented above, a number of factors give hope about the future of the specialty.

The power of demographic change and increasing numbers of older people have been recognised and reflected in the year-on-year increase in the number of consultants in the specialty, with a 43% increase in the UK (excluding Scotland) between 1993 and 2004.<sup>6</sup> As many organ specialists withdraw from involvement in 'general' medicine, geriatric medicine has often been described as its last bastion.

The government has also recognised the need to rapidly increase the number of consultants in the specialty not only to improve compliance with the EWTd but to address important health targets such as reducing deaths and morbidity from heart disease and stroke, and to improve detection, speed assessment and also to improve outcomes from treatment

of an array of cancers. Thus the current expansion and creation of UK medical schools is welcomed but will take 10 or more years to have an impact on consultant numbers.

A positive effect of MMC in terms of specialty recruitment may be the release of funds from a number of discontinued senior house officer posts which could be used to fund new specialty training posts, an idea which the Joint Committee on Higher Medical Training has recently indicated a willingness to explore (January 2006), provided the specialist training capacity can be found.

In previous years, strict controls or 'ceilings' were imposed on specialties to curb the unbridled expansion of popular ones at the expense of others. Encouragement by provision of some central funding was given to unpopular specialties which were either politically sensitive (eg psychiatry) or necessary for key health targets such as cancer (requiring an infrastructure in specialties such as histopathology and radiology). As the impact of the EWTD on doctors' numbers became apparent the restrictions on SpR numbers has been eased especially in acute medical specialties. In geriatric medicine, 80 new SpR posts were allowed in 2003 and a further 30 in 2004.

In the past, geriatric medicine had some difficulty in convincing others of its 'specialty' elements. In the late nineties, an important independent report on the deficiencies of care of older people in our acute hospitals,<sup>7</sup> led directly to the March 2001 launch of the NSFOP.<sup>8</sup> As well as raising the profile of the care needs of older people, the NSF has had a beneficial effect on helping the specialty to re-define itself. The political strength of NSFs, coupled with a growing evidence base on the efficacy of assessment and treatment of major clinical problems in old age – such as osteoporosis, falls, stroke, Parkinson's disease and geriatric rehabilitation – has led to an expansion of 'geriatricians with a special interest'. Recent internal surveys by the BGS have shown a rapid expansion of consultant posts especially with

stroke and falls as a sub-specialty interest. At the same time, the increasing demands of emergency medicine have led to an expansion in consultant numbers in all specialties (including geriatric medicine), as indicated above.

The specialty has every reason for an optimistic and expanding future. Young doctors, hopefully inspired by good role models in their undergraduate and early postgraduate training, would do well to consider a career in geriatric medicine with a core interest in 'frailty' but with the opportunity to specialise in an expanding number of 'special interests' for example acute care, stroke, falls, rehabilitation, movement disorders and the interface with mental health.

## References

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