Geriatrics at a crossroad: 'farming' or 'embroidering'?

EDITORIAL

TW Auyeung MD, FHKAM (Med)
Co-Chief Editor

One day I was asked by my colleague: "Should we go for quality or quantity in geriatrics?" Or in Cantonese slang, 'farming' or 'embroidering'? The answer in his mind was 'embroidering'. He later said we could not recruit trainees because this specialty is a farming one. Geriatrics holds no appeal for the new generation. Embroidery products are glamourous, attractive, and expensive, but rice, although a staple food, is too ordinary and cheap. Most doctors do not wish to be humble peasants all their life.

I have witnessed the change in geriatrics over the past three decades. We started as a minority in the late 1970s. At that time, the population in Hong Kong was not that old. We could afford embroidering and have been criticised because of that. I heard that nurses in the geriatric wards had time to peel an orange and feed the patients. We did not take acute cases and only took patients from general medical wards with good potential to recover. Some people may still miss this 'golden era' of geriatrics in Hong Kong, but those were the days.

Today in general medical wards, we see patients who are bed-ridden, with nasogastric tubes in-situ, being put in restraints, developing pressure injury, and/or yelling in a delirious state. Geriatric teams are fighting for or struggling to keep a small geriatric cubicle. Many of us can find no place, particularly in the acute hospitals. Geriatricians are busy visiting patients outside of the hospital in old age homes (OAH). We are farmers.

Despite all these unfavourable developments, there is some good news. Never before have I felt that ageing is a priority agenda of the government. Recently some senior geriatricians were invited by The Chinese University of Hong Kong to join a project 'Quality of care for elderly in Hong Kong' commissioned by the Food and Health Bureau to look for new service strategies. At the same time, within Hospital Authority, in the face of the escalating influx of older patients into public hospitals, new service initiatives are explored, including expansion of Integrated Discharge and Support Programme, ortho-geriatrics, dementia community support scheme, revisiting geriatric day hospital role, Community Geriatric Assessment Service (CGAS) end-of-life care, geriatric support in accident and emergency department, the new enhanced CGAS model (sick bay within OAH) in the future mega OAH in Lam Tei. In addition, dementia was chosen as a pilot project: a database for dementia research is being compiled as part of the big data strategy enforced by the government. Opportunities ahead are plentiful, but we lack the infrastructure to integrate all these scattered services. More importantly, we lack people to build and run this structure. We lack conductors and players.

I could not agree more with most of the opinions and suggestions in a recently published article written by Tinetti.[1] We share the same problems. We fail to recruit adequate trainees. Nonetheless, unlike the US, geriatricians in Hong Kong are hospital-based, not nursing home-based. This is our burden but at the same time our gift.

In Hong Kong, you have no influence on health organisation without beds. More importantly, I believe that older patients with an acute illness benefit more and be in safer hands under the direct care of geriatricians. Of course, we still need help from other specialists. I can appreciate the merit of "teaching geriatric principles to others".[1] Nonetheless, if that is all we are, we will become 'verbal geriatricians' rather than clinicians. We will gain no respect from our partner specialists. If we are not respected, the special

need of older patients will be neglected. The diffusion of geriatric principles to other specialties can only be possible by having influence on acute patient management.

Another dilemma is collaboration with primary care. Perhaps primary care is the perfect platform to teach geriatric principles to others. On the one hand, we can see the volume of services beyond our capacity. Primary care can help. On the other hand, we may fall into the trap wherein geriatrics is considered equivalent to primary care. We shall then become marginalised, and expelled from acute hospitals. The balance is very delicate and easily upset.

The revamp of special interest groups of The Hong Kong Geriatrics Society has helped to augment this delicate balance. We have to be super-specialised to facilitate teaching of geriatric principles while protecting our specialty from extinction. We must sharpen our swords in treating various complex geriatric conditions, including neurocognitive disorders and delirium, falls, syncope and gait disorders, bone health and ortho-geriatrics, spasticity and injection therapy, swallowing disorders and fibreoptic endoscopic evaluation of swallowing, sarcopenia and frailty syndrome, continence and bladder or bowel dysfunction, and end-of-life care. We can no longer survive by focusing on the three geriatric giants or merely on geriatric principles. We have to transform these concepts and principles in the management of specific clinical conditions and organ-specific diseases in older patients. We must arm ourselves with knowledge, experience, and skills if we aim at embroidering.

I hope, though difficult, this will help us to become a hybrid of 'farmer' and 'embroidery artist'.

REFERENCE

1. Tinetti M. Mainstream or extinction: can defining who we are save geriatrics? *J Am Geriatr Soc* 2016;64:1400-4.