Canada's seniors: The doctor will see you now

By Lisa Priest, Globe and Mail, Monday, Apr. 11, 2011

Seniors are the fastest-growing segment of the population, with 4.8 million Canadians aged 65 and older. The figure that will double to 10.4 million in 2036 and by 2051, one in four will be older than 65.

But who will be their doctors?

Today, there are only 238 certified geriatricians in Canada, and experts say an additional 500 more are required, plus more family physicians to treat the elderly.

Inferior pay is partly the reason this field is suffering. Perhaps more important, though, is the way it attracts future physicians. Few medical students see the elderly at their best – in their own homes. Instead they are often tended to in a full-fledged medical crisis in an emergency room or chronic care ward.

The answer for the future may be the past. Reviving the old-fashioned house call is one way to entice more doctors – and improve the system.

Jeff Turnbull, president of the Canadian Medical Association, said bringing care to elderly, frail patients often results in better care for less money, adding that "we have to bring the resources of the hospital into the home."

In Canada, at least, the geriatrics field does not have the sporty glamour of orthopaedics, the pay of cardiology or the excitement of surgery. Nor the acclaim: A geriatrician wouldn't likely garner headlines for treating delirium or restoring a senior's cognitive function.

Michael Gordon, one of Canada's first certified geriatricians, remembers the difficulty in attracting physicians when he became a specialist in 1981. "It was a hard sell," said Dr. Gordon, medical program director of palliative care at Baycrest Geriatric Health Care System in Toronto. "Because the first thing you have to get is people who like old people and if you didn't find that, you couldn't sell it to them at all."

Three decades later, the recruiting situation is equally dire. Almost half of the 31 spots to train doctors in the specialty across Canada sit empty – heightening concerns that elder care has become a dying field. According to Canadian Resident Matching Service data, only 3 per cent of doctors selected geriatrics as a first choice for medical specialty training, which starts this July. Last year was no better when 12 of 25 geriatrician spots went unfilled.

Becoming a geriatrician requires significant training: three years of internal medicine training, plus two more years in geriatrics, for a total of five years. Geriatricians look at the medical, social and psychological issues affecting older adults and deal with memory loss, urinary incontinence, osteoporosis and multiple-medication issues.

“What those numbers tell me is that geriatrics doesn't have status,” said Angela Juby, president of the Canadian Geriatrics Society, of the 15 out of 31 unfilled spots. “If doctors think they will be doing a job and always be second-class citizens, they will be less likely to want to do it.”

Even the Special Senate Committee on Aging noted in its 2009 report that geriatrics suffers from an “image problem.”

Though largely shunned in Canada, it is popular among British doctors – a finding that should prompt policy makers here to probe the differences.

In Britain, pay of geriatricians is not a problem – they are on par with other medical specialties – which explains part of why the field is so vibrant.

In Canada, however, exposure to the elderly in hospital can be a demoralizing experience for medical students and fledgling physicians, who see it as futile, end-of-life care.

“They don’t have the opportunity to see healthy aging geriatrics because they are not the ones who end up in hospital,” Dr. Juby said.

Conversely, a house call can be deeply satisfying for physicians, who are not only appreciated but can troubleshoot: fall problems, medication errors and even providing direction in the form of a Do Not Resuscitate Order on the fridge. They can head off a medical crisis before it hits.

Samir Sinha, director of geriatrics at Mount Sinai and University Health Network, points out few trainees do house calls – he only did one during medical school and none during his residency – so they never get to see how fulfilling it can be to look after the elderly.

“House calls therefore are seen as these exotic concepts of care rather than essential ways of caring for patients,” Dr. Sinha said.

It’s also practical: Many of these elderly patients are frail. Getting to the doctor’s can be onerous task for them, as many have to arrange for transportation.

Remuneration for a house call is hardly an incentive: a simple house call, which takes less than 20 minutes, is about $60; one hour of end-of-life care is about $180, one hour of mental health care in the home is about $130. Plus the doctor has to do the driving and is only paid for “face time” with the patient.

It’s far easier for a physician to stay put – and have rooms full of patients – waiting for their minor assessments.

David Hogan, inaugural director of the Brenda Strafford Centre on Aging at the University of Calgary, said the growing aging population is something to celebrate – but Canada needs to prepare. “People should be aware there are challenges, but there’s time to plan this out and think it through.”

The Canadian Geriatrics Society has made several recommendations: providing more resources for affordable community care such as home care and supportive housing, which would keep more patients out of nursing homes.

They also suggest that hospitals be more elder friendly to maximize recovery. Once in hospital, seniors are hooked to machines of low benefit and prescribed medications that worsen their cognitive function. They lose strength with every day.

No matter how well intentioned the medical care, it can hurt the elderly – who need things done for them, not to them.

It’s no wonder then that students and interns find caring for the elderly unpalatable. Plus, it has perverse incentives.

The health-care system is built around hospitals, so much so that when Kenneth Rockwood – a professor of geriatrics at Dalhousie University in Halifax – works in emergency, it can take twice as long to discharge patients to another facility or home with supports than to admit them.

That’s because it’s easier (but more costly) to keep patients in hospital, than to find them less costly, better care elsewhere. The health-care system simply isn’t set up for it.

“You can imagine why we admit so many people; that is always the easiest thing we do,” he said. “What makes my blood boil is when you see administrative documents with terms like ‘bed blockers’ in them.”

Bed blockers are those thousands of patients who, on any given day, occupy an acute-care bed in a Canadian hospital. They are awaiting placement in a nursing home or assisted living, or cannot go home simply due to lack of supports.

“It's very common [for elderly patients] to be on eight or nine drugs,” Dr. Rockwood said. “More than six drugs, the chance they are going to have a drug problem is very high.”

But when doctors go to the home of seniors, they can become trouble-shooters, helping to fend off medication problems, reduce their chance of falls and make dramatic changes to the quality of patients’ lives that help make for a gentle, dignified ending.

“It's a really fun specialty. One of the things which is fun is that you get to deal with people at a stage in their lives where there's no pretence for most of them,” Dr.

Rockwood said. “You have very meaningful conversations in a very short period of time.”

Reactions to the above article

Aging at home

Re Canada’s Seniors: The Doctor Will See You Now (April 12): This is a timely and crucial call to make “aging in place” essential in caring for the elderly in Canada. Kudos to those geriatricians who still make the effort to see their patients in their own homes. But, as pointed out, there are fewer than 250 of these specialists across the country, and they can’t begin to meet this need.

Other countries, such as Denmark, spend 80 per cent of their seniors’ health budget on keeping the elderly in their homes, whereas, in much of Canada, often less than 10 per cent is designated to providing home care.

Yes, GPs and their co-workers need to rethink how to bring the care to the patient, and they must be reimbursed adequately to do so. This is respectful of our elderly and would go far to freeing up hospital and nursing home beds for those who really have no other options.
Bryan Cummings, MD, Calgary

We really have to wake up to the reality of the future and treat today’s seniors more like we’d want to be cared for at that stage of life. Now working as a physician at the other end of the spectrum, newborn intensive care, my early training years in Europe included many months spent in internal medicine, some in geriatrics.

Visits to nursing homes and house calls were part of that. The encounters with the elderly were an endless source of reflection – on life’s challenges and human beings’ weaknesses and strengths. In addition, some of the patients displayed the directness your article mentions, a lack of fear and often a delightful sense of humour.

These patients’ care is complex, and the people who do the work described are worthy of our greatest respect. Financial compensation should be in line with any other specialist, or more, since they may well indirectly save millions of dollars for the system.
Birgitta Samuelson, MD, Vancouver

In 17 years of practice as a geriatrician, I have had the privilege of caring for the frail elderly in various settings. I also teach geriatric skills to residents and interns.

Your article brings up a lot of important points about the current state of affairs in Canada. But I was disappointed by a comment made by Angela Juby, president of the Canadian Geriatrics Society: “If doctors think they will be doing a job and always be second-class citizens, they will be less likely to want to do it.”

I’ve never been treated as a second-class doctor by colleagues from other specialties, by patients or their families. When a frail elderly person gives me a hug of gratitude or a strong handshake with his arthritic, wrinkled hands, I feel as first class as one can ever feel.

Caroline Petrossian, MD, University of British Columbia