RCPE Casenotes: Past & Present Podcast - Geriatrics Transcript

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[introductory music]

Welcome to the Royal College of Physicians of Edinburgh's Casenotes podcast. Over the next few months we're going to delve into the different physician branches or specialties.

Just to start off with, what is a physician? Most people know what a GP is, and what a surgeon is, but not everyone knows exactly what a physician does. Well the formal description is specialists in internal medicine, so diseases and complaints that happen inside your body.

And even if that sounds unfamiliar, you have almost certainly heard of a lot of the areas that this covers, like cardiology, diabetes, allergies, palliative care, infectious disease and neurology. These are all branches of medicine, or specialties, that physicians are responsible for.

In each coming episode of Casenotes we will pick one of these specialties and delve into its history, looking at its development over hundreds of years, and some of the interesting stories and cases from the past. We'll also talk to a current physician working in that area, to find out what it is like to be working as a specialist physician in the twenty-first century.

[musical interlude]

In this episode of our Casenotes podcast we are exploring geriatric medicine. We'll be looking at the history, and then talking to Dr Martin Wilson. We don't have a historical case study today, instead Martin is going to tell us more about some of the fascinating patients he has met in his work.

Before the twentieth century there was very little support or treatment for elderly people. As a result, they often ended up spending years, or even decades, in asylums, hospitals or workhouses.

One such eighteenth-century institution, the Newcastle dispensary, said in its regulations that while “decay from age” meant that "death be inevitable”, that “humanity will prompt a Physician to contribute every aid from medicine, in order to alleviate the most painful symptoms”. Although it did conclude this statement by saying that one disadvantage in treating elderly patients was that these particular “sufferers, are almost always persistent; and apt to complain”.

During the nineteenth century urbanisation removed people from traditional support networks, making it harder for them to care for the sick or the aged. This meant a growing number of individuals suffering from conditions like dementia were placed by their families in asylums.

Diagnosis and treatment did also take place outside the forbidding walls of the workhouse and asylum, though. One seventeenth-century book on the subject was written by Dr Tancred Robinson, who was a Fellow of the Royal College of Physicians of London. Robinson was a friend of the British Museum founder Hans Sloane and a physician to the king. This book detailed the story of Henry Jenkin, a man who had allegedly died in 1670 at the age of 169. Or perhaps not – Jenkins was born before parish records were maintained so his remarkable claim cannot be verified. He put his unusually long life down to a diet which included raw onions, nettle soup and tar water. The book said that “‘tis to be wished that particular enquiries were made and answered concerning the temperament of this man’s body, his manner of living and all other circumstances which might furnish any useful instructions to those who are curious about longevity.”

Another book, published in the early eighteenth century by John Floyer and titled *The Art of Preserving Old Men’s Healths*, was the first book in English purely on the subject of geriatric medicine. The author recommended cold plunge baths although he did note that “Physicians oft find it a difficult task to conquer the aversions of nice patients…I expect to find an aversion to cold bathing”.

Another important work on geriatric medicine was published around the same time. Its author, George Cheyne, was a Scottish doctor, originally from Aberdeen. Cheyne was a very popular and fashionable doctor in the eighteenth century – his service was sought after by many wealthy members of high society. His book was called *An Essay of Health and*

Long Life and in it he gave his rules for a healthy life, covering diet, exercise and sleep.

Finally, we come to the nineteenth century, and two important studies of geriatric medicine. The first of these is the first clinical description of the disease known as Parkinsons. James Parkinson was a physician and geologist practicing in London. Parkinson wrote his most important work, titled *An Essay on the Shaking Palsy*, after years of observing people with this condition on the streets around Hoxton Square in London where he practised and lived. He made careful notes on their condition and deterioration over the years and, although unable to offer a cure, decided to publish his observations to, as he put it, "excite the attention of those who may point out the means of relieving a tedious and most distressing malady."

The signs and symptoms of the disease had been noted by physicians before Parkinson, but he was the first who recognised that they represented a single disease. His observations, although without the advantages of any post-mortem examinations, were so accurate that most of the *Essay* remains relevant to the description of patients with Parkinson's disease today.

The second major nineteenth-century text on diseases of the elderly was the work of the English physician Barnard van Oven. Van Oven wrote a book titled *On the Decline of Life in Health and Disease*. In this he wrote that "it will readily be seen that a vast number of those who attained a very old age passed through life remarkably free from disease; many were never ill, never took medicine, retained the powers of body and mind…until the…latest period, and seemed to sink suddenly into the arms of death without passing through any period of decay and decrepitude."

In an appendix, van Oven provided a series of tables, showing the names of 1500 men and women who had attained ages from 100 to 110; 331 between 110 and 120; and 47 who were said to have exceeded even that age. Like the story of 169-year-old Henry Jenkin from two centuries earlier, the desire to believe in remarkable longevity remained.

[musical interlude]

Daisy: Welcome to the podcast. We have here with us today Dr Martin Wilson. I just wondered if we could kick off with you just telling us a little bit about yourself, who you are and where you work?

Martin: Hello, I'm Martin Wilson, a consultant, I work in care of the elderly. I'm based in Inverness in Highland. I trained initially in Glasgow where I was born and raised and did training in various parts of Scotland and eventually found myself in Inverness and I cover that and parts of Ireland [Highland?]. I've been involved with both the Colleges, and particularly Edinburgh for the last few years.

Daisy: Thank you very much. So we're going to start off with a little bit of a horrible question, which is – how do you define geriatric medicine? What is it?

Martin: So, unlike lots of other specialties that's actually quite tricky! So if I was a cardiologist I would say I deal with hearts and if I was a renal physician I would say I deal with kidneys and if I was a surgeon I would say I operate on things. Geriatrics is a bit difficult because there is an element of function to it. So we deal with older adults, adults who are at least seventy-five if not older than that, but adults who also have an age-related problem associated with it, that their age is in some way impacting on them. So I will get people who are eighty-five who are not geriatric at all, some of whom are in the royal family running around and they're all doing wonderful things, and they're not geriatric at all, they've got no functional problems related to the elderly, not very many medical conditions and that's fine. But I've got some people who are much younger who have functional problems related to age, often we define that as frailty, and that's how we define it. So it's not just your age, it's an age plus something that affects your day-to-day function, and that's kind of why geriatrics exists.

Daisy: Thank you. So I think geriatric medicine is maybe one that people are at least somewhat aware of, and I think increasingly so. But I was just wondering, you know, are there any sort of stereotypes around geriatric medicine, any myths you could dispel or equally anything that would surprise people about what your work involves?

Martin: Yeah, I think the biggest thing about it is just trying to get that difference between it not just being old people, it being something functional, so we will deal with younger people as well. I mean, one of the misnomers, so one of the things is that very few people decide to do medicine cause they want to do geriatrics, it doesn't sound particularly dynamic, you know, and I'm not going to name other specialties but compared to some other things as well it's something people tend to come to a bit later. The misconception is that it is quite dynamic and it is quite good for people with short attention spans, so if I'm dealing with an older individual who's not functioning very well, the determination of whether we as a team have done well or not is do they feel better and do they function better within a relatively short period of time. So a lot of other conditions, you're dealing with people with conditions for ten, twenty, thirty years, to try and make small changes over a long period of time so that they get better at a later stage. I love all my patients but very few of them have got twenty or thirty years left to live, OK, I need to make things better for them soon, and now, and that immediacy of it I think is quite attractive, and people don't really, I don't think people necessarily recognise that, they think that it's kind of maybe a bit slow, but you've potentially got to do things a bit quickly.

What, the other general misconception is that how much about geriatrics is about problem solving. So often, if you get an older adult who's in hospital, they've got some functional problems, they've got some medical problems, and typically they're on a lot of different medications, that can involve an awful lot of problem solving. I have to work out exactly why they've unravelled in the first place and how to put them back together again, and that unravelling is a bit of a detective challenge often, there's often a mix of social things and functional things and medical things, and ironing all of that out is quite a fascinating process, really, and potentially quite rewarding, and I think a lot of people maybe don't recognise that. So you feel a bit like detectives an awful lot of the time, the crime being the old person falling apart and the solution being, you know, in what direction is that going in.

Daisy: So you've talked about this already but, you know, what have been the significant changes, do you think, in geriatric medicine over the course of your career, your working career?

Martin: So the biggest thing has been the lack of, so, that we don't tolerate things in the way we used to, things that were considered as part of the just general doing business are no longer accepted as part of general doing business. So when I started in 1996, pressure sores would be extremely common, horrible things, so, and they would occur in hospital so, there was a while where everyone I admitted to rehab after fracturing femurs, almost all of them would have pressure area damage, and it was just considered, that was just what happened. And there was a lot done to try and make sure that that was not seen as, that was seen as preventable and avoidable and remediable and it could be fixed and it could be avoided. And now pressure sores in hospital are almost seen as a crime, you know – if they occur there's some investigation response, we work out why that occurred. It's not really that you never see them any more out in the community and things, but that business of that you see something that just take as being part of doing business, part of what happens to old people in hospital, is now not seen as acceptable.

Things that are getting work on now are people that become acutely confused, delirium, this business that people get acutely confused in hospital, it's again, has been, you know, if you look back far enough it's just seen as the sort of thing that happens, but now it's seen as something that we need to address, try and avoid where we can, and I think that's where things in elderly medicine are going to go forward. That an awful lot of the changes with age are not irreversible, people's loss of function is not necessarily irreversible, sometimes it is but it's not a general thing, and I think that going forward is where we're going to see a difference. The expectations of what people can expect when people get older will go up and that's a good thing and will drive improvements.

Daisy: That's really interesting, thank you. So we're now getting on to my personal favourite bit which I'm really interested in, in the history of medical specialties and especially in the history of geriatrics. So I'm interested in, you know, your perspectives on the history of your specialty. Are there any moments from the past that sort of – or figures from the past of your specialty – that stand out as important or influential for you?

Martin: Yeah, so geriatrics is easy cause we have an undoubted medical hero, and that's Marjory Warren who basically got geriatrics going in the first place. So she was born 1897 and started doing her medicine in the thirties and the forties, and she was the one that identified that elderly patients needed a specific way to look after them, and need to be looked after by people who were specifically interested in that. And what's terrific is that some of her findings are just extremely relevant now. So she wrote articles in the 1940s, one that she wrote in 1946 and she was talking about the problems of the ageing population, and that was in 1946 when average life expectancy was about sixty-two, sixty-three and we'd just come out of a world war. So what she did, she was medical director in a wee hospital in England, and they at that moment, that time, had lots of what they would call long-stay, whereas back in those days it would still be called poorhouses, and had hundreds of people in them and she would review them, and find out why they were there, get them rehabilitated and often get them home.

Now what was interesting, those wards were full of people with everything – people with dementia; people who have had strokes; people that had falls; people that had just got stuck, and were being ignored, even down to, she was finding people in there who were single mothers, who got stuck in hospital with a child and could not then support themselves. So the single mothers she helped get jobs, got them jobs, got them independent, got them out again and showed that you could get these things moving, and that was really very important.

You've got to be careful reading some of her articles, because they are written with a 1940s style, but some of her quotes are incredible, some of her statements are awesome, and so, she was one of the ones that detected early on that women have a much bigger problem older age than men, still the case. Women look after their men, their men die, there's nobody left to look after them. Women tend to live longer, they tend to be fitter, and that's still the case. If you're a woman in Scotland now you're twice as likely to have a care home as your location of death than a man, and that is purely dynamics. So, because the women will be left on their own there'll be nobody there to look after them.

She also talks greatly about the different issues about, a bit about status and a bit about what it's seen to be. So a lot of things that are useful when you're old are people to care for you and look after you, hands-on

care, people to look after care homes, people to look after nursing and they're typically historically associated with female workers. And as we know that anything that's historically associated with female workers are paid less and have less status, OK, and that's well recognised. So obviously we have male carers now, male nurses and male people working at care homes, but largely if you look at a society point of view, they're seen as largely female roles, and if you have any roles which are female roles, they, it will be paid less and it will have less status, and she was recognising that all the way back in the forties. And all those lessons now are valuable now. So to fix society going forward, all the things that help fix old people like care and attention, have to be seen as as valuable as older heroic things, like building britches and doing operations and fixing things, and valued as that and trained as that to have any way of going forward. So her articles now are just, it's amazing how much has changed, but in some ways how little has changed. So that would be my hero.

Daisy: So we're coming towards the end now but there's one question which we can't really entirely avoid. So we're talking at the end of March 2022 and – COVID. So essentially, you know, I'm interested to know, hopefully less now than it was a year or two ago, but presumably still some impact on the work that you do, so what has been the impact of coronavirus on your work?

Martin: So COVID's been catastrophic, you know, it's been, for the whole of society, but it has been disproportionately felt by anyone who was in anyway on the edges of society. So if you're in a deprived postcode or a deprived area you're much more likely to get sick, much more likely to die. If you're old and you're frail you're much more likely to get sick, you're much more likely to get die. Anyone that was on the edges of society in any way it was catastrophic for. And indeed in some ways that reflects what the issue with older people is in general. So I mentioned earlier on there was a functional issue, and I often, I always used to think that care of the elderly was related to just people weren't fond of old people and didn't like that, and actually that's not true. I worked in paediatrics for a while and I – you know, long story short – I ended up working in paediatrics and thought "oh it's going to be brilliant in paediatrics, everybody loves children, they will be drowned in money and love" and all the rest of it so, and that's not true either. It was, and I found in paediatrics the kids that struggled the most of the whole service

were the kids that were at the extremes of society – kids in foster care; kids that had trouble; kids that had difficult parenting; and they struggled just as much to get what they needed as my older people (who are on the edges of society) struggled and it looked that their problems were different but it looked very similar, and that has been reflected and totally amplified in COVID.

So if you were an older person that was in any way isolated from society and outwith society, you struggled dramatically and a lot of these people lost enormous function, amounts of function. Whereas older people who were well into society and had relatives around them and people that were supporting them, they still struggled but they did an awful lot better. And it really reinforced my idea that a lot of problems we've got with older people, and actually younger people as well, is social isolation. If people drift away from the centre of society and society's attention span they tend to do really badly. So I worry about the funding of care homes and care at home. If I was a paediatrician I'd probably be talking the same about children's homes.

You know, it's not, you know, that, it's not, age isn't the issue, it's how peripheral you get to what society counts as being important, who's going to shout for you. And people who have people with political muscle and, you know, are getting all the rest of it to shout for you, will do better. So if my kids are ill, I'll fight like hell to get them better, OK? If my parents were unwell – they've now gone away – I'll fight like hell to make sure they get what they want. A lot of older people don't have people to shout for them like that, and actually sadly a lot of children are in the same situation [unintelligible] wise and COVID has really amplified that.

I'm going to talk, I'm going to have to talk a bit more about this because it's been difficult. So the first thing that happened is an awful lot of people died. I sadly was involved with care home outbreaks in the pre-vaccination phase where thirty to forty per cent of residents died. Unbelievable numbers on a ward, initially pre-vaccinated again but the fatality rates were about the same. It's almost inconceivable what it's like to work in that environment. I know there was a Channel 4 programme *Help* that was on about that recently, even it didn't touch the absolute magnitude of that and what that has done, both now and onwards to our care home sector if they were affected. The psychological impact on the

staff, some of whom just can't work anymore, and the patients. You know, the patients who survived, even if they were cognitively impaired, saw that horror which was largely in closed doors and not seen going forward. And that's really affected the care home sector, the viability of the care home sector has been really deeply hit by that, and we need a care home sector. At some point in your life you may well need to be in a care home – you might not want to be there, but you equally might not want to be in an intensive care unit, but equally you would want there to be a local intensive care unit that's functioning should you need to have it, and that's going to take an awful lot of long time to fix.

The other thing that's going to get an awful lot of long time to fix is that, for years and years and years I would be talking to patient groups and going "eat, drink and be merry, OK?" Eat well, drink – don't drink alcohol but drink enough fluid – and be merry. Get out, see people, get out your house as much as you can, interact with as many people as you can, because that is what makes life worth living, but it also has such a positive impact on the individual, and try and fight against this idea of people being socially isolated and stuck. But for two years now we've told older people to stay in their house, not see anybody, and a lot of people have done that and survived, it was a necessary thing to happen, but are struggling to get out and about and they have lost years worth of function, because they've just not got out, they've not got exercise, and society over the next couple of years, once COVID has passed (it's still raging in the background as we're talking just now, if a much less severe form, it's still raging in the background) is to get that population out and about and moving again.

And it will not just be true for the elderly, it will be true with people that suffer from social isolation in all ages and that's going to be the big fight. And every day in clinic now, I'm talking to people who have not been out – literally out their houses – in years and we've got a lovely day outside, so I'll say "just walk to the end of your driveway and back", you know, do something to get out and about, and that would be the biggest thing that we need to do going forward.

Daisy: So we're coming to the end now, really, but I just wanted to ask before we finish, is there anything that you haven't been asked that you wish you'd been asked, is there anything else that you would like to say?

Martin: No, I think we've kind of covered it. I think, you know, I think it was going to take, I think I was just trying to get an overview is that geriatrics as a specialty, it's not unique but the social aspect of people's care is as important as the medical aspect, and that's partly why some of my answers have drived [?] down more larger society issues about deprivation and social isolation and things like that as well, because – and there'll be other specialties that see this, but I can just talk about my own – you just see it every day, the importance of the wider social elements are as important as medicine and the pills that people take, and for the big improvements in health in general that's well recognised, that the big improvements in health don't come from medication and pills, it comes in differences in how society lives and how society operates.

So things like improved housing is one of the reasons why life expectancy improved in the UK, it was nothing to do with pills. You know, life expectancy in the UK was improving before antibiotics came along, it came, you know, people had decent houses that didn't leak and weren't mouldy and, you know, all the rest of it and so on, the air wasn't polluted and, you know, all of these public health measures, that people exercise a bit more and for elderly people it's just I would highlight the things that, you know, I really don't want a pill to fix older people, I would just want them to be part of society and interacting well and getting exercise that they enjoy would be the thing that I think would make the biggest difference. And you'll find a lot of geriatricians are a bit political, and you know, political with a small 'p', you know, I don't mean Labour or Conservative but you know, the wider aspects of how society operates. It's just so core, and it's just as I was just saying in my answers already, but it's completely core. So if you've got a family who care for you, you will do, and look after you, you will do much better. I mean, it's not for it [?], there were studies done years and years ago that patients who get visitors in hospital live longer and do better than people that don't get visitors. Isn't that astonishing?

Daisy: Yeah

Martin: You know, that level of that, and they've done cohort studies and things like that in the London area, and people who are isolated from society have worse morbidity and mortality, you know, whereas people that are involved in society do better and that, you know, that being just

such a major task, particularly with this bulging, ageing population. So a third of older people past seventy-five will, the prediction is, will be living on their own and have no family to look after them. You know, and that's, you know, going to 2035 now, that's quite staggering, and we need to do something about that.

Daisy: Thank you so much, Martin, this was really fascinating, thank you for joining us.

Martin: And thank you very much indeed.

[musical interlude]

Today, instead of a historical case study, Martin is going to tell us a bit more about some of the patients he's met under his care.

Martin: You go through a care home, you will meet people who have vivid recollections of times that are now, you know, gone to us. You know I've met people who have been on D-Day beaches, people that have been in battle, but I remember speaking to an old lady who flew into Europe as part of the SOE in the second world war and was determined to go home, even though she was unsafe to do so, and you are not going to be able to talk down somebody who parachuted into occupied France, you know. I mean a lot of those are dead now, but they have, they are just walking history and it is, you know, it's just, you know, I have the most fascinating patients. I mean sometimes on a Friday afternoon I'll speak to my colleague – I share an office with her – you know, "this is the wonderful top trump, wonderful interesting person I bumped into this week, you'll never guess what this one did" and it inspires me as well, you know, I think I should have a bit more of an interesting life than I do, because at some point in a care home somebody asks you what you did with your life and a lot of these folk have done phenomenal things. I speak to my new [?] recruits and I say, "look, everyone has done something interesting in their life, right?" If they've lived to eighty or ninety, and even if they've done nothing interesting, that in itself is fascinating! If you've managed to do nothing interesting in eighty or ninety years, that's remarkable! And I just quietly all these, you know, all these wonderful stories, yes, so yeah I would highlight, I agree with my palliative care colleague there.

One of my favourites is occasionally you'll meet old women, it's usually women, who were premature children. So I met one who was a pound and a half, or something you know, ridiculously small when she was born. Doctor comes along and says baby's going to die, and again, eighty, ninety years ago lots of babies died, very tragic and that's how it was, but the family went "Oh no, no, no, no". So they were used to dealing with premature sheep the whole time, so they put her in the oven, left the door open a wee bit, wrapped her up, did what they did with sheep and that woman lived until she was nineties, she was called the miracle baby of Hoy. And I was like going, that's a story and a half, you know, wouldn't you have just loved to be able to get in your time machine and show her parents – look (you know it was actually her granny that sorted her out), this is what's going to happen, she's going to live for another, wouldn't the doctor that was involved loved to have known that this person was going to live to be ninety odd, you know.

There are some wonderfuls, and that is what keeps us going day to day, and it's one of these things that encourage people into home care, encourage people into care homes, is it gets them over that fear of it, being old. Cause if we don't spend a lot of time talking to people in different generations, it feels a strange thing to do, whereas if you're forced in some way to do that, you get it really quickly and go, "oh actually, you're just an old version of me", you know, and actually an old version of me who was much cooler than I was when you were my age, you know, and did all, you know potentially, did all these things and lived through, you know, I mean, all sorts of things.

[musical interlude]

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