Geriatric Medicine in South Africa – a Cinderella subspecialty?

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Population ageing is a worldwide phenomenon and follows a decline in birth and death rates. Longevity and a greater number of people living to an advanced age are a major achievement for humankind. However, a consequence of the demographic shift is an escalating demand for health care as a result of increases in chronic and age-specific diseases and disabilities. The transition is more rapid in developing countries, which also have fewer resources than the developed countries to meet the challenges of an ageing population.

Geriatric Medicine (GM) is a relatively recent subspecialty but has been well-established in a small number of tertiary institutions in South Africa since the 1980s. The first chair of geriatrics was installed at the University of Cape Town but was frozen by the provincial government in 2000. Nonetheless, the Division of Geriatric Medicine at that institution remains the leading geriatrics focal point in the country. The University of KwaZulu-Natal has the only other chair, and only two or three other institutions, notably the University of Stellenbosch, have a geriatrics unit.

The development and expansion of GM in the country has been hampered by political and financial vagaries, or institutional priorities. Advancement of the subspecialty has been bedevilled further by a shrinkage of training posts and few career opportunities for graduates in the subspecialty. The country has only seven registered geriatricians, three of whom are in private practice. A relative lack of interest in GM among the medical fraternity and a view that the subspecialty is super uous have also retarded its growth and acceptance.

A countrywide survey of medical practitioners' attitudes to Geriatric Medicine and older patients conducted in 2004[1] showed high levels of disinterest in the subspecialty and negativity towards such patients. Although nine in ten respondents attended older patients daily or weekly, only 3.1 % had been exposed to any post-graduate training in GM. Only a minority (6.6%) had ever considered geriatrics as a speciality. Attitudes were negative in all domains of characteristics of older patients, but least negative attitudes were correlated with shorter duration of practice (<19.7 years), younger age of the practitioner (<45.4 years), private sector employment and frequent attendance to older patients. Only 15 % viewed work with older patients positively; three-quarters viewed it negatively.

The investigators concluded that South African medical practitioners' attitudes towards older patients are ageist and based on negative stereotypes. However, it is encouraging that younger doctors are more positive about GM and older patients than their older colleagues. Training in geriatrics is hardly included in undergraduate curricula at present, and the investigators recommended that an expanded GM component in curricula and more exposure to older patients at undergraduate level may improve the attitudes of future cohorts of doctors.

Specialisation in GM has traditionally been within Internal Medicine, but a trend in some countries is for geriatricians to be trained within Family Medicine. Graduate training embraces both clinical skills development and service delivery and ideally research. However, demands on tertiary clinicians' time often hamper their capacity to engage in research.

It has been argued that Geriatric Medicine should not be confined to the tertiary level.[2] A specialist with training in GM and therefore the holistic management of older patients would be ideally placed in a secondary level hospital, where he/she may also support primary level professionals. Primary care services are the most important level of care and moreso in the case of older persons; older persons' ability to retain functional independence is largely dependent on management decisions made at this level.[2] As Geriatrics Medicine is hardly included in undergraduate training, health professionals are ill-equipped to manage older patients at a primary care level. Indeed, many practitioners in these settings may attribute modifiable pathology to consequences of ageing and thus deny older patients appropriate management.[2] If a geriatrician was available at a secondary level hospital, community based professionals would benefit from the services offered, and referrals from primary to tertiary levels of care and vice versa would be improved.[2]

Geriatric Medicine in South Africa needs to be recognised as having come of age. The demographic imperative must be recognised moreover as leading to a growing demand for geriatric care. For the subspecialty to progress and expand, strong leadership with vision needs to be developed. A start in this direction would be to introduce GM more substantially in undergraduate curricula.

Articles in this Geriatrics issue discuss a number of health conditions commonly seen and treated in older patients in both general practice and tertiary services. Authors of four articles are based in academic departments while one author is a family physician. The articles and the conditions demonstrate a need for seamless referrals of older patients, where indicated, through different levels of care in the diagnosis and management of certain conditions.

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References

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