

Challenges and achievements in caring for the elderly

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Anyone in health care knows the Canadian population is aging. The number of patients older than 75 years of age with complex health problems is increasing dramatically. On the inpatient geriatric rehabilitation unit where I work, it is common to have 25% of beds occupied by people older than 90 years. In Canada, it is estimated that there are more than 4000 centenarians, and the older-than-80 age group is the fastest growing demographic.¹ Given the aging population, how are family physicians managing to deliver high-quality care? There are enormous challenges, but also many successes to build on.

Clearly there is a shortage of geriatric specialists in Canada. What is less obvious is the crucial role family physicians play in the care of older people. Family physicians in clinics, hospitals, and emergency departments are experiencing the changing demographics. Canadians are not only living longer, they are also independent and active later in life—and they are advocating for themselves more than earlier generations of seniors did. Although family physician shortages have improved in parts of the country, older patients rely heavily on the availability of family physicians. Many remain hard hit by family doctor shortages. Further, access to family physicians with additional training in care of the elderly (COE) is rare.

Competencies, training, and education

In response to the growing elderly population, some medical schools and residency programs have increased trainees' exposure to geriatric care. But advocacy is still needed to improve exposure at all levels of training, and considerable variability remains in geriatric curricula.²⁻⁵ Larger class sizes have made clinical experiences with specialized services less likely, given the small number of clinicians with expertise to act as preceptors. I have found, however, that practising family physicians and trainees are more motivated to provide the best care possible than was the case at the start of my career. We have a long way to go before *all* medical students and residents have experience and knowledge in the principles and practicalities of COE, but things are improving.

Because of the curriculum variability, the Canadian Geriatrics Society (CGS) developed national core competencies for medical students.⁶ These will be the foundation for learning objectives for family medicine (developed by the CGS and the College of Family Physicians of Canada's Health Care of the Elderly Program) to ensure that residents are exposed to a range of geriatric issues under the CanMEDS-family medicine competencies. These objectives

should provide impetus for ensuring that all family medicine residents work with skilled clinicians in a variety of settings including nursing homes.

A position paper by the Health Care of the Elderly Program⁷ stressed the need for academic family medicine departments to hire faculty with recognized expertise in geriatric care or additional training in COE, and for family physicians—who play a primary role in caring for seniors—to be involved in developing undergraduate and postgraduate curricula in geriatrics. The importance of training residents in a variety of settings was also emphasized, because clinical exposure guides career paths and improves confidence. It is difficult to tell how many of these recommendations have been implemented, but the Health Care of the Elderly Program needs to continue working with family physician educational leaders to ensure departments act on the recommendations.

Barriers to recruitment

Recruitment to fields focusing on care of seniors is poor in almost all disciplines. Of special concern in family medicine are the shortage of family physicians providing care in nursing homes and the very small number of physicians with additional training from accredited COE programs. Attracting physicians is a challenge for nursing homes across Canada. Those who do work in nursing homes are often at later stages of their careers,⁸ and given the increasing "very elderly" population,¹ improving physician recruitment is crucial. Increasing medical residents' exposure to positive experiences in long-term care is relevant, but financial incentives to recruit and retain physicians have been identified as a primary strategy.

Although the College of Family Physicians of Canada does not keep a list of family physicians with COE training, there are fewer than 200 such physicians. Despite this, COE-trained physicians have assumed leadership roles in education, research, and clinical care.⁹ There are many reasons why family medicine residents go directly into practice rather than doing additional training, but the biggest barrier is financial, as the training develops skills and knowledge that might require more time with patients without providing financial incentives such as specific billing codes. Further, departments of family medicine do not always stress hiring physicians with COE training, and the potential for work within divisions of geriatric medicine or specialized geriatric services is limited by "competition" with internist geriatricians. Certainly, the roles of geriatricians and family physicians with COE training complement each other, and both need to work together rather than at cross purposes to meet health human resource needs.

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Funding restrictions often limit COE physicians from independently developing care models such as consultation services, home visiting programs, or innovative models within comprehensive care practices.

Practising physicians wishing to augment their training in COE might need to find coverage for their practices and face a substantial decrease in income during training. In addition, many provinces have return-of-service requirements for re-entry positions. I have had excellent candidates forego COE training because of underserved area work requirements. This is especially frustrating given that geriatric care is underserved in most centres! The Geriatric Education and Recruitment Initiative, a national multidisciplinary collaboration sponsored by the CGS, is working with seniors' organizations to lobby governments to decrease these barriers to additional training in COE.

Reform and collaboration

Across Canada, primary care reform has had important effects on the care of elderly patients. In traditional fee-for-service models, complex geriatric patients do not fit the 1-problem-per-visit goal, and flexible approaches to billing can help compensate physicians more appropriately for dealing with complicated problems. Interdisciplinary care is crucial for frail elderly, and access to other disciplines offers more services to seniors without referral to specialized services until absolutely necessary. My colleagues have commented that primary health reform allows them to practise as they have been trained to: providing comprehensive care with links to necessary resources.


Many family health teams in Ontario have collaborated with specialized geriatric programs to optimize health promotion, systematic screening, and access to home care for seniors. Successful collaboration is crucial but is hobbled by challenges of communication, a lack of common electronic records, and fragmentation of prescribing systems. Although things are improving, much remains to be done for integration, collaboration, and coordination of care.

Seeing beyond the wrinkles

Given the increasing age of the population and the relatively small increase in the number of family physicians, we need to do a better job preventing frailty and common conditions of aging. This should start long before the "magic" age of 65. Determinants of health factor considerably into healthy aging, and family physicians can affect these through advocacy and health promotion. Promoting healthy lifestyles in the young, the middle-aged, and even the "young old" will affect aging decades later and potentially compress morbidity, which is the unspoken goal of geriatric care. Unless we change the aging process for the baby boomers, we remain at risk of being swamped—even with better recruitment to family medicine and COE.

I asked colleagues with focused and comprehensive family medicine practices how care of seniors could be improved. Overwhelmingly the comments related to

"seeing beyond the wrinkles" and enjoying the interactions as a special part of medical care. Many stressed good communication with families. The role of family in geriatric care is sometimes viewed negatively, but it is important and usually satisfying, when addressed skillfully. Good communication skills are essential and will improve outcomes and decrease frustration for families and patients. My colleagues also stressed the importance of medication review in optimizing health and minimizing iatrogenic illness. Even with the problems family physicians face keeping track of what patients are actually taking, they are well placed to decrease iatrogenic illness from medications.

Several family physicians with special interest or certification in COE have developed a series on geriatric care for *Canadian Family Physician*. Starting with the articles presented this month (page 1115 and 1123),^{10,11} the series attempts to provide practical approaches to common geriatric problems. When I went looking for authors, not one person turned me down because of other commitments or lack of interest, and all volunteered with enthusiasm. This enthusiasm is our greatest hope for the future of COE. Increasingly physicians are aware of the need to optimize their ability to care for older people, and there is an increasing cadre of family physicians with passion to improve care locally, provincially, and nationally and to be leaders at various levels. This passion comes from the intellectual challenges of geriatric care, the pleasure of working in teams, and the satisfaction of improving function or quality of life for an older person. We need to harness this passion for geriatrics to influence policy and curricula and ensure that all family physicians can provide the best care to their older patients. 

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Competing interests

None declared

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