Geriatrics: the "sexy" specialty

There are fewer than 200 geriatricians in Canada, but the estimated need is over 600, a number that is expected to skyrocket as the number of people over age 65 doubles in the next 25 years. Elderly baby boomers "will just expect" complex medical needs to be met, says Dr. Laura Diachun, a geriatrician at London, Ont.'s Parkwood Hospital and associate professor and geriatric medicine program director at the University of Western Ontario.

Diachun and her Parkwood colleagues have implemented several novel approaches to stimulate interest in elder care among medical students. At Spring Galas young medical students escorted seniors to formal dances. Medical trainees have also golfed, bowled, played cards, done aerobics and socialized with seniors at Parkwood.

"We really try to make it a lively endeavour for [students] to link up with older patients," says Diachun. "Since then, we've had a 10-fold increase in the number of students doing an elective in geriatrics." Many may eventually choose family medicine or other areas of practice, but exposure to the care of older persons is invaluable.

"It needs to be clear to [medical students] that unless they go into pediatrics, they will spend 50% of their time working with patients over the age of 65," says Diachun. "We have to show what's fantastic about caring for older people."

"We need to be proactive as a society," she adds.

"Geriatrics is totally sexy," insists Diachun. "It's the intellectual challenge of it. It's the chance to put all the pieces of the puzzle together for the family that's been to doctor after doctor after doctor. To put it all together, to be a detective, to be with people at their really intimate moments, to really make a difference ... to have tremendous job satisfaction. I think those are the things that make it sexy."

Diachun recently coauthored *Improving Recruitment into Geriatric Medicine in Canada* (*J Am Geriatr Soc* 2006;54: 1453-62). The report contains 6 recommendations, including considering feedback from both the "converted" (i.e., geriatric medicine trainees and geriatricians) and "not-yet converted" (residents and medical students); implementing and integrating local, provincial and national mentorship programs; implementing advocacy, recruitment and incentive campaigns to increase attractiveness of geriatric medicine as a career choice; decreasing duration of geriatric medicine training and increasing training opportunities in geriatric medicine to international medical graduates. — Lynne Swanson, London, Ont.

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Tim Bourgard, St. Joseph's Health Care, London, Ont.

Medical students, such as Jackie Nelson, are encouraged to socialize with seniors.

Manitoba physicians consider DNR guidelines

The College of Physicians and Surgeons of Manitoba is circulating draft guidelines for withdrawing medical treatment in cases where doctors and families clash over whether to continue life support.

The guidelines, believed to be the first of their kind in Canada, would stipulate exactly what a physician must do before withdrawing medical treatment. The guidelines also clarify options for families who wish to continue medical treatment against a doctor's recommendations.

"We felt there needed to be more of an understanding by all parties involved in making decisions in an end-of-life case," says Dr. Terry Babick, deputy registrar of the Manitoba college. "These are very sensitive, difficult issues."

The draft guidelines were, in part, based on the findings of a 2003 report of the Manitoba Law Reform Commission that studied the legal implications of disputes over the withdrawal of life support.

A 12-page document outlining the draft guidelines was provided to the province's physicians in June 2006 for comment. The college does not have a firm timetable for implementing the guidelines.

Babick said despite the fact that almost all physicians face the possibility of having to withdraw life support from a patient, there are no consistent policies outlining how a decision like that should be reached and what must be done in advance to ensure the patients or their families are adequately consulted.

The guidelines state that physicians can withdraw life-sustaining medical treatment in cases where it is believed the patients will not be able to meet a minimum goal of recovering or maintaining a "level of function that enables the patient to achieve awareness of self and environment and to experience his/her own existence."

In these cases, the guidelines state the physician may determine that further treatment is "not medically indicated" because the patient does not have a "realistic chance" of meeting the minimum goal, or, that treatment is "not