



# The aging of family medicine

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*Every disadvantage has its advantage.*

Johan Cruyff

A recent editorial in *The Globe and Mail* claimed that the issue of reining in Canada's health care costs was mostly ignored by politicians in the recent federal election campaign.<sup>1</sup> Furthermore, *The Globe* argued that fixing Canada's \$192 billion health care system should begin with the elderly—the fastest growing segment of our population, with almost 5 million people aged 65 years and older now and more than 10 million expected by 2036. One of the solutions called for in the editorial was to train more geriatricians—Canada currently has only 238 of them and experts say that 500 more are needed.<sup>1</sup>

It has been very difficult to interest medical students, residents, and practising family physicians in the care of the elderly.<sup>2</sup> There are many reasons for this. There is evidence, for example, that family medicine residents do not understand the demographics of the future in which they will practise. In a US study by Helton and Pathman,<sup>3</sup> family practice residents reported very positive attitudes toward elderly patients, yet only two-thirds of them thought that elderly people would make up a substantial part of their practices. Another factor, cited by Weiss, is the possibility that geriatric medicine as currently taught in medical school and residency programs is seen as overwhelming, depressing, or both.<sup>2</sup> To quote Weiss:

In a typical geriatrics rotation, residents and students spend time in nursing homes seeing debilitated elders. They spend time in geriatric assessment clinics seeing older people whose health is failing, in hospice programs where people are dying, and working with underfunded social services agencies to deal with elders who are having trouble getting along in the community and who may or will ultimately end up in nursing homes because they can't get the support they need at home. These patients often have multiple medical problems that are difficult to treat in combination and from which they will not "get better" in the course of a month-long rotation or a 1-day experience. Such rotations and experiences don't provide residents or students with the opportunity to develop satisfying long-term relationships with patients or to see what they can do for these patients that makes a difference over time for patients or to patients' families. It is likely that few of these experiences are inspiring or fun.<sup>2</sup>

Dr Weiss is describing the US situation, but it should sound familiar to Canadian medical students, residents, and family practitioners as well.

In every disadvantage there is an advantage. It is unlikely that Canada is going to be able to miraculously train the 500 or more geriatricians that health services researchers say are needed. *The Globe and Mail* editorial described geriatricians

as "trouble shooters who spend time with patients, going over medications, dealing with memory problems and helping avert medical crises."<sup>1</sup> That sounds a lot like the work that family physicians across the country do.

There is an opportunity for family physicians to take on a greater role in providing care to the full spectrum of aging Canadians, as well as to model both the joys and challenges of caring for the elderly and to be more innovative in the way we train residents.

Most of the older patients in our practices are healthy, active people, and we need to emphasize this to trainees. In order to make just that point, Dr Weiss' family medicine program at the University of Arizona had residents go hiking with seniors' hiking groups of the Southern Arizona Hiking Club. Not surprisingly, many of the 30-something residents had trouble keeping up with people in their 70s and 80s.<sup>2</sup> Perhaps Canadian family medicine residency programs need to be similarly creative.

In November 2010 *Canadian Family Physician* launched a series of practical Clinical Review articles focusing on care of the elderly. This month's issue features 2 more practical reviews—one by Dr Robert Lam on assessing gait disorders in older people (page 765)<sup>4</sup> and one by Dr Tareef Alaama on fall prevention (page 771).<sup>5</sup> Both articles should help family physicians to more comfortably assess and manage these common problems among frail elders.

This issue also features 2 interesting research articles that highlight the problems of applying disease-oriented clinical practice guidelines (CPGs) to elderly patients. The first, by Mutasingwa et al, examines the applicability of CPGs to all elderly patients (page e253).<sup>6</sup> The second, by Cox et al, focuses on the relevance of CPGs to our oldest patients (page e263).<sup>7</sup> What both articles highlight is that when it comes to looking after older people, disease-oriented CPGs only take you so far. The rest depends upon the things that family physicians do so very well: being patient-centred in our care and managing clinical uncertainty in partnership with our patients and their families. 🌿

#### Competing interests

None declared

#### References

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Cet article se trouve aussi en français à la page 755.