EDITORIALS

GERIATRICS IN THE NEXT DECADE

When you receive the Journal, we have already turned into a new millennium. It appears a bit shortsighted when everyone was talking about the next century / millennium and yet we just focus at the next decade. However, it will be more pragmatic for us to look at the real areas of concern so that we can plan ahead and prepare for the challenges. At this turn of the century, it is appropriate for us to review the development of geriatrics and draw vision to its future direction in the coming decade.

Geriatrics was first established in the 1940s in UK. At that time, the poor and disabled patients were sent to infirm settings. Little was done on them and patients just remained in those settings until their death. It was not until Marjorie Warren, a trained physician, volunteered herself to work in the West Middlesex Hospital then their suffering was relieved. Through appropriate medical care (including medical work up and treatment) and rehabilitation, more than 20% of the patients could be discharged back to the community. Her works were published in *Lancet*1-2. The essences of her work are a holistic approach towards patient care and appropriate medical care irrespective of age. Geriatric Medicine was subsequently established as a medical specialty in UK in the late 40s. Since then, there was expansion on medical knowledge on elderly. Nowadays, any standard textbook in Geriatric Medicine usually has more than 1000 pages.

With the improvement in sanitary conditions, advent of antibiotics and other technological advancements, life expectancy of human being has been prolonged. It is often quoted that a particular disease is cured or mortality is reduced with a particular treatment. Using the ISIS-43 and SOLVD Prevention trial studies as examples, Tan and Murphy3 discussed that the term “saving lives” commonly claimed in articles actually referred to “prolonging survival”. Coupled with normal ageing process, it is understandable that elders have multiple pathologies and co-morbidity problems. There is an absolute need to care elders with a holistic approach. Holistic not only in the usual sense of clinical, functional and psychosocial aspects, but also holistic in terms of integration of diseases management. As a clinician and in particular, a geriatrician, there is a specific need that one has good medical knowledge in a wide range of medical subspecialties. In other words, a geriatrician must at least be a good general physician. On the other hand, it is the medical sub-specialization since the late 60s that helps with the knowledge / technology explosions in the past 20 years. Along this direction, there is a need for Geriatric Medicine to embrace in-depth knowledge of individual organ subspecialty. Thus, in which direction should Geriatrics develop? Shall we develop ourselves into geriatric subspecialties such as Geriatric Cardiology, Geriatric Neurology etc? Or shall Geriatrics remains as “General Medicine with special interest in elderly care”? Or shall we develop into “Geriatrics with special interest in a subspecialty area”? It is worthwhile to look at the different developments in different countries.

In terms of service provision, how should elderly care be developed? More than half of the hospital emergency admissions are elders with age greater than 70, commonly with multiple pathologies and comorbid conditions. These patients are unique in their presentation and altered haemostatic states. Their organ specific diseases need to be identified and treated accordingly. Besides the resolution of their medical condition, they are also in need of rehabilitation or re-conditioning. Often, aspects of care such as symptom control in situation of “no cure” are also of paramount importance. The interface between symptom control or palliative care in terminal cancer and elder care is highlighted by Lo in this issue6. This concept should be extended beyond terminal malignancy to other “non curable” conditions. With the development of medical subspecialisation, how should geriatric services interface with other medical services such as General Medicine / Rehabilitation Medicine / Palliative Care Medicine. In view of the large service demand, should all primary and secondary
clinicians be trained in elderly care so that they can be equipped with knowledge, skills and attitude to look after our elders in the community?

Geriatrics is in its crossroad. It is essential that we plan ahead for the development so that appropriate training can be organised to the healthcare providers. The articles by two of the geriatricians serve as impetus for discussion. It is your input and the leadership from the Hong Kong Geriatrics Society that help shaping better elderly care in the next decade. The HKGS most welcome your voice and suggestions. You can express yourself through the Journal, HKGS newsletter or at the HKGS homepage. Let’s work together towards better elderly care in the coming decade / century.

The Hong Kong Geriatrics Society first published its own journal in 1990. Throughout the past ten years, the journal had been under the strong leaderships from Drs. YC Lee, J Woo and lately TK Kong. Special thanks should be paid to Dr. Derrick KS Au who designed the cover of the past issues and my predecessors who had helped transforming the Journal into a reputable journal in geriatric field, both locally and in overseas.

The year 2000 is the start of a millennium, a century and a decade. It also denotes the tenth year of the Journal. Taking the opportunity, the cover of the Journal is re-designed, incorporating the logo of the Society. The contents are also enriched. The original articles, audit / evaluations, viewpoints, quotations, reviews and case reports are retained. For respective sections, the usual format is in form of a formal/ complete review and a case report with detail literature review. In view of sub-specialisation and rapid advancement in medical knowledge, we welcome also papers in form of mini-review and short case report. We have added sections on Geriatrics Update, History in Geriatrics and Statistics Corner. Special thanks to my colleagues who have contributed as section editor.

Having worked through the publication of the Journal, I do understand the tremendous workload of my predecessors. The workload is even heavier now that we are to publish the Journal twice yearly in January/July. I am most happy to have a handful of experienced colleagues to help me through. They have been appointed for a term of 4 years (2000-2004). I am certain that we shall then have another generation of outstanding geriatricians who can fuel and help flourish the Journal.

May I take this opportunity to thank all members of the international and local advisory / editorial board, and reviewers of individual article. Without their contribution, the standard of the Journal cannot be as reputable.

I look forward to your submissions to the Journal.

Christopher C.M. Lum

References
2. Warren MW. Care of the chronic aged sick. Lancet 1946;i:841-843