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Why Geriatric Medicine? A Survey of UK Specialist Trainees in Geriatric Medicine

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ABSTRACT (250 words)

Background: There is global concern that there are insufficient numbers of geriatricians to meet the needs of the ageing population. A 2005 survey described factors that influenced why UK geriatricians had chosen to specialise in the field - in the decade since, UK postgraduate training has undergone a fundamental restructure.

Objective: To explore whether the reasons for choosing a career in geriatric medicine in the UK had changed over time, with the goal of using this knowledge to inform recruitment and training initiatives.

Design: An online survey was sent to all UK higher medical trainees in geriatric medicine.

Methods: Survey questions that produced categorical data were analysed with simple descriptive statistics. For the survey questions that produced free-text responses, an inductive, iterative approach to analysis, in keeping with the principles of framework analysis, was employed.

Results: 269 responses were received out of 641 eligible respondents. Compared with the previous survey, a substantially larger number of respondents regarded geriatric medicine to be their first-choice specialty and a smaller number regretted their career decision. A greater number chose geriatric medicine early in their medical careers. Commitments to the general medical rota and the burden of service provision were considered important downsides to the specialty.

Conclusions: There are reasons to be optimistic about recruitment to geriatric medicine. Future attempts to drive up recruitment might legitimately focus on the role of the medical registrar and perceptions that

geriatricians shoulder a disproportionate burden of service commitments and obligations to the acute medical take.

INTRODUCTION

The global population is ageing at an unprecedented rate. The number of people living with multi-morbidity and frailty is rapidly increasing [1]. There is compelling evidence that Comprehensive Geriatric Assessment (CGA) is the most effective way to provide healthcare services for this population [2, 3]. Geriatricians – medical specialists with expertise in the healthcare of older people – have a key role in delivery of CGA; however, there is global concern that there are insufficient numbers of geriatricians to meet this need [4, 5]. In Europe, there is wide variation in the number and density of geriatricians [6] and in some countries, geriatric medicine is not even recognised as a specialty [7]. In the United Kingdom, a modest growth in demand for training in the specialty has failed to keep pace with the increased demand within the National Health Service (NHS) for fully-trained geriatricians [4]. This may, in part, be due to negative perceptions towards the specialty, and the patient cohort for which we provide care, reported in surveys of both junior doctors [8-10] and medical students [11-12].

In 2005, a survey of members of the British Geriatrics Society (the UK specialist society for healthcare professionals with an interest in the medical care of older people) [13], described factors that influenced why UK geriatricians (both trainees and consultants) had chosen to specialise in the field. The most frequently stated influences were an affinity for the clinical work of the specialty and the effect of inspirational senior colleagues. 39% of consultant geriatricians had chosen to specialise in geriatric medicine later in their careers, frequently having worked in other specialties prior to moving into the care of older people. The authors suggested that this might represent either a process of maturation, or be related to the fact that geriatric medicine could only be fully appreciated with insight into the aspects of care which other medical disciplines fail to offer, but which are enshrined in the principles of CGA.

In the UK, geriatric medicine is a physicianly specialty with training conducted under the auspices of the Royal Colleges of Physicians. There is however wide variety in how geriatric medicine training is coordinated and delivered elsewhere in the world [7]. In the decade since the 2005 survey was published, UK postgraduate training has undergone a fundamental restructure. Modernising Medical Careers (MMC), and the creation of the Foundation Programme, aimed to provide trainees with a wider range of experience during their early career, thus enabling them to make more informed career choices. At the

same time, trainees have less flexibility to move between specialties or to delay progress through training whilst they decide on a medical specialty.

Against this background, we aimed to explore whether the reasons for choosing a career in geriatric medicine in the UK had changed over time, with the aim of using this knowledge to inform recruitment and training initiatives both in the UK and beyond.

METHODS

Guidance was sought from the NHS Newcastle and North Tyneside Regional Ethics Committee which advised that formal ethical approval was not required. The project was supported by the Joint Royal Colleges of Physicians Training Board (JRCPTB) and their Specialty Advisory Committee (SAC) for Geriatric Medicine. An online survey was developed taking account of previous research into career choices in geriatric medicine [10, 13]. The survey was piloted with local higher medical trainees - in light of their suggestions changes were made to the phrasing of questions, the page structure within the survey and to the logic flow of the online survey. A final version of the survey is included in an online appendix. A link to the survey was then sent to all UK higher medical trainees [doctors, typically 4-9 years post-graduation, who have completed core medical training and are undertaking a five year programme to achieve consultant geriatrician status] using the comprehensive list of contact details held by the SAC in geriatric medicine and used by them to administer training. The survey was available online for a six-month period (01/10/2015 to 31/03/2016) with reminder emails at two and four months. After completion of the survey, trainees were invited to enter a draw to win a book token to acknowledge their contribution.

Responses were collected anonymously. Survey questions that produced categorical data were analysed with simple descriptive statistics. For the survey questions that produced free-text responses, an inductive, iterative approach to analysis was employed that consisted of two phases. For the first phase a pair of researchers were assigned to each question and were provided with all the free-text responses to their allocated question. Each researcher, working in isolation, then identified code(s) that reflected the theme(s) contained within each free-text response. The second phase involved researchers, working in their respective pairs, sharing and comparing their coding frameworks. Coding frameworks were discussed, challenged and refined. Data were analysed using the principles of framework analysis [14]. Framework analysis provides a structure for systematic analysis of qualitative data – it is recognised as enabling in depth exploration of data whilst also ensuring that the analysis process remains transparent, thus enhancing the rigour of the analytical process [15].

RESULTS

269 responses were received out of 641 eligible respondents. 10 responses were excluded on the basis that they were not UK Higher Medical Trainees in Geriatric Medicine (1 associate specialist, 3 other training grades, 4 overseas doctors, 2 completed training). The response rate was thus 40.4%.

1) What is your current stage of training?

Respondents' stage of training is summarised in Table 1.

2) When did you decide to do specialty training in geriatric medicine?

The majority of respondents made the decision to train in geriatric medicine during core medical training (CMT) (153, 58.7%), 63 (24.3%) did so during Foundation training (FY), 25 (9.7%) during undergraduate training. 19 made the decision at another point: during a locum appointment (n=7), whilst on another specialty training programme (3), during a sabbatical (3), during a research post (2), whilst working overseas (2) and whilst working in a residential care home before university (1) [one respondent left blank].

3) Did you have a post in geriatric medicine during training?

The majority of respondents (250, 96.6%) had worked in a post in geriatric medicine prior to opting for a career in the specialty. Over half of respondents (142, 54.8%) had a geriatric medicine post in both FY and CMT training; 27 (10.4%) had a post in FY alone, 64 (28.6%) in CMT alone. A small number (7, 2.8%) had a post in geriatric medicine outside 'usual' training pathways: these included locum appointments (n=5), overseas (1) [one respondent left blank]. Only 9 respondents (3.5%) did not have a post in geriatric medicine prior to applying for higher specialty training in geriatric medicine; of note, geriatric medicine was the first-choice specialty for all but one, and none reported regretting their choice.

4) Was geriatric medicine your first-choice specialty?

242 respondents (93.4%) described geriatric medicine as their first-choice specialty. Of the 17 (6.6%) of respondents who did not, 14 would have opted for a physicianly specialty: respiratory (n=4), neurology (2), palliative care (2), cardiology (1), dermatology (1), endocrinology (1), gastroenterology (1), haematology (1) and infectious disease (1). 3 respondents would have opted for a non-physicianly specialty: ophthalmology (1), paediatrics (1) and psychiatry (1).

5) Do you regret choosing geriatric medicine?

The majority of respondents (254, 98.1%) did not regret choosing a career in geriatric medicine; five respondents (1.9%) regretted their decision.

6) What (if anything) might have deterred you from choosing geriatric medicine?

The most frequently cited deterrent to a career in geriatric medicine was commitment to the general (internal) medicine (GIM) on-call rota (n=99, 38.3%). Perceived low prestige of the specialty was also commonly cited (61, 23.4%). Deterrents, and the proportions of respondents agreeing with each are shown in Table 2.

7) Why did you choose geriatric medicine?

The coding structure representing data derived from this question, along with exemplar quotes, is presented in Table 3.

8) Is there anything you do not enjoy about geriatric medicine?

138 respondents (53.3%) identified factors about geriatric medicine that they did not enjoy. The coding structure representing data derived from this question, along with exemplar quotes, is presented as an online appendix [please see the table Appendix 1 in the supplementary data on the journal website http://www.ageing.oxfordjournals.org]

DISCUSSION

The main findings of this research are that, compared with the last survey of BGS members about career choices undertaken in 2005, a substantially larger number of respondents regarded geriatric medicine to be their first-choice specialty and a smaller number regretted their career decision. A greater number chose geriatric medicine early in their medical careers. These are positive findings and suggest, if anything, that the current cohort of UK geriatricians in training were drawn to their specialty sooner and more directly – and are more content with their career choice, than earlier cohorts surveyed. This is particularly striking at a time when morale amongst UK doctors in training has been recognised as being particularly low in response to service pressures and strained industrial relations within the NHS [16]. Whilst these results may not necessarily be directly applicable to doctors in other countries, they do demonstrate a genuine appetite for a career in the specialty amongst junior doctors – this finding may add weight to arguments for the development of the specialty in territories where it is not yet formally recognised.

These findings run contrary to fears stated prior to the restructuring of UK medical training that, by forcing doctors to make career decisions earlier, fewer would have the opportunity to realise the potential benefits of a career in geriatric medicine [13]. The qualitative data give some insights into possible contributory factors towards this trend. These include a specialty that may be recognised as rising to address the challenges of modern healthcare – meeting the demographic imperative posed by a greater proportion of older, frailer patients head on. Deeper understanding of the reasons why doctors are attracted to a career in the specialty may help inform recruitment initiatives in countries that struggle to recruit sufficient numbers of trainees. The perception, amongst respondents, of good work-life balance within the specialty might be an important effector of recruitment and retention in an era when many doctors in training are disenchanted with new contract arrangements and the prospect of more intensive rotas following recent contract renegotiation.

Perceptions amongst respondents about the strengths and weaknesses of the specialty reflect those previously identified in surveys of UK undergraduates [11]. Prominent amongst the strengths described were the intellectually stimulating nature of dealing with complexity and the sense of a worthwhile job done well – being on a mission. Prominent amongst the weaknesses were the perceived lack of status associated with the geriatrician's role and a disadvantageous position regarding private practice when compared with procedural specialties. As the authors of the previous undergraduate surveys identified, these probably represent a realistic appraisal of the specialty and are not something that can be glossed over or minimised in the attempt to attract more recruits.

Commitments to the general medical rota and the burden of service provision – which, in turn, were perceived to lead to reduced academic and training opportunities – were considered important downsides to the specialty. These are compatible with data from other surveys of UK-based general medical registrars which suggest that the role of the medical registrar is one which is increasingly associated with high levels of stress, limited opportunities for high quality training and is a disincentive for doctors to train in physicianly specialties who contribute to medical registrar rotas [17, 18]. Furthermore, these surveys revealed that medical registrars across the spectrum of medical training programmes had considered giving up GIM [17] and that many were actively exploring how potential future consultant posts might avoid a GIM commitment [18]. Unlike private practice, and perceived low status, this aspect of the geriatrician's role is readily amenable to interventions around how training is structured. It is possible that recently proposed reconfigurations of postgraduate training, which will seek to emphasise more training in general medicine and a broader distribution of the service burden of the medical registrar role

across all physicianly specialties [19], may lead to geriatric medicine being placed at less disadvantage when it comes to attracting potential recruits. Recently developed national quality criteria for core medical training programmes also have the potential to increase recruitment to geriatric medicine training. These were developed in response to a 2013 national survey of UK CMTs that highlighted dissatisfaction with training [20], and include a call for all CMTs to undertake a placement in geriatric medicine. At present, this remains a 'best practice' criterion and is not mandated; it is however recognised that the posts that foundation doctors undertake have a significant impact on their future career choices [21] – this may, in time, help to attract more junior doctors to the specialty. The strengths of this survey lie in: the use of a carefully piloted questionnaire which used questions comparable to those contained within prior surveys, enabling trends in perceptions to be considered over time; the use of a national contact database used for administration of training, meaning that all higher medical trainees in geriatric medicine were approached; and the rigorous methodology taken to evaluating the open response questions so that these data were explored in full and in depth. The survey response rate is comparable to similar studies undertaken elsewhere. The limitations of the study, as with all surveys, lies in possible response bias, although it is not clear whether this would select for those more, or less, likely to be content with the specialty. The survey did not capture data on gender, which is recognised as an important factor in relation to workforce planning. The gender distribution of geriatric medicine registrars has changed dramatically in recent years, with 40% being female in 2002, rising to 56.7% in 2011 [4]. It is important to note, when comparing responses over time, that the cohort sampled in the 2005 survey included consultants in addition to higher medical trainees. Data, specific to trainees, was however available from the 2005 study, meaning direct comparison between cohorts was possible for all questions except for "Was geriatric medicine your first choice?". We acknowledge this as a limitation that may potentially affect the ability to draw conclusions about the specific opinions of training grade doctors with regards this particular question.

CONCLUSIONS

There are reasons to be optimistic about recruitment to geriatric medicine. More trainees are selecting the specialty sooner and more are content having done so. Future attempts to drive up recruitment might legitimately focus on the role of the medical registrar and perceptions that geriatricians shoulder a disproportionate burden of service commitments and obligations to the acute medical take. Issues

around perceptions of prestige and status will be more difficult to overcome – but with such high levels of enthusiasm amongst future consultants, the future in this regard is potentially brighter than ever before.

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CONFLICTS OF INTEREST

None declared.

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TABLES

Table 1: Responses to Survey Questions 1-5, with comparative data from 2005 survey [13] (Briggs et al.) where available

			2015 % (n)	2005 % (n) [where available]
1) What is your current stage of training?	St3		24.3 (65)	21.4 (59)
	St4		20.8 (56)	21.7 (60)
	St5		18.9 (51)	17.0 (47)
	St6		8.9 (24)	17.4 (48)
	St7 or above		15.4 (41)	20.3 (56)
	OOP	Research	4.1 (11)	
		Maternity	3.3 (9)	
		Leadership and management fellowship	1.5 (4)	
		Teaching	1.1 (3)	
		Stroke	0.7 (2)	
		MA in Humanitarianism and Conflict Response	0.4 (1)	
2) When did you decide to do specialty training in geriatric medicine?	StR in other specialty		1.1 (3)	7.0 (19)
	CMT (or equivalent)		58.7 (158)	81.0 (224)
	Foundation (or equivalent)		24.3 (65)	8.6 (24)
	Under-graduate		9.7 (26)	4.0 (11)
	Other	During a locum appointment	2.6 (7)	
		During a sabbatical	1.1 (3)	
		During a research post	0.7 (2)	
		Whilst working overseas	0.7 (2)	
		Whilst working in care home	0.4 (1)	
3) Did you have a post in geriatric medicine during training?	CMT alone (or equivalent)		54.8 (147)	43.0 (119)
	CMT + FY (or equivalent)		28.6 (77)	
	FY (or equivalent)		10.4 (28)	26.0 (72)
	None		3.5 (9)	
	Other		2.8 (8)	
4) Was Geriatric Medicine your first-choice specialty?			93.4 (251)	57.1 (158)$
5) Do you regret choosing geriatric medicine?			1.9 (5)	10.1 (28)

$quoted value includes both trainees and consultants

OOP = Out of Programme; StR = Specialist Trainee; CMT = Core Medical Traning; FY = Foundation Training

Table 2: Deterrents to a career in Geriatric Medicine, with comparative data from 2005 survey [13] (Briggs et al.) where available

Factors that deter people from doing Geriatric Medicine	**2015 % (n)**	***2005 % (n)***
Commitment to GIM on-call rota	38.3 (99)	5.4 (15)
Perceived low prestige	23.4 (61)	1.8 (5)
Desire to do more procedures	13.0 (34)	
Desire for more acute illness	10.0 (26)	
Lack of academic opportunities	8.6 (22)	
Limited potential for private practice	6.3 (16)	
Negative experiences of older people pre-medical school	5.9 (15)	
Not feeling comfortable with uncertainty	4.1 (11)	
Lack of undergraduate exposure*	2.3 (6)	
Dealing with cognitively impaired patients	2.3 (6)	
Complexity of geriatric medicine patients	1.9 (5)	
Social issues*	1.5 (4)	
Dealing with chronic disease	1.5 (4)	
Therapeutic Nihilism*	0.4 (1)	
Challenging Family Interactions*	0.4 (1)	
Lack of intellectual stimulation*	0.4 (1)	0.7 (2)
High local competition ratios for posts*	0.4 (1)	

**coded from free-text responses to respondents who selected 'other'*

Table 3: Why respondents chose geriatric medicine

Category	Code	Exemplar quote
Personal characteristics	Affinity for patient group	“Older adults are a fantastic set of patients - entertaining, stoic and varied”
	Sense of advocacy / altruism	“I like to represent the underdog group of patients who typically get a raw deal from a health system not designed to look after them”
	Suited to personality	“I found a bunch of doctors who I seemed to fit in with: similar ideas and approach to patient”
Career characteristics	Continuity (acute to chronic)	“Generality of the specialty - acute medicine but also chronic issues and the challenge of balancing them”
	Lack of procedures	"I was never really particularly bothered about procedures so had excluded more organ-specific specialities from that respect”
	Involvement in acute medicine	“Complex patients with acute medical problems - front line medicine and being the pts advocate.”
	Varied career options / ability to subspecialise	“The job offers a wide variety of sub-specialisms and huge variety of places of care delivery i.e. general and acute wards, ED, clinics, community and residential homes, surgical wards, intermediate care etc.”
	Career flexibility	"The fact that a lot of them were female and managed to have a family whilst training also made me feel less intimidated”
	Developing field of medicine / expertise	“As the population ages the need for medics who are experienced and skilled in managing multi-comorbidity increases and geriatrics is right at the forefront of this”
Job characteristics	Complexity	"I enjoy the complexity of looking at multi-morbidity and working out (together with the patient and relevant parties) what we can treat, what we should treat and what will offer the most improvement for that individual patient”
	Holistic approach	“Holistic care for patients, looking at what they want and what is achievable, rather than single organ focus”
	Pragmatism	“There is a lot of ‘thinking outside the box’ required, and there is a lot more scope for individualising treatment plans compared to other specialities”
	General medicine / variety	“It is the only true general medical speciality left. There is a massive variety of patients and conditions and each one is unique in the interaction between their healthcare and social problems”
	Rewarding	“Really enjoy variety of work. Find building up a relationship with patients and families very rewarding.”
	Multi-disciplinary / teamwork	“I enjoyed the feeling of being part of a team - I got this more in my geriatrics placement than any other job”
	Pleasant working environment	“I realised as I was getting to the end of CMT that I needed to look at the consultants working in different specialities and think about whether I wanted their life for the rest of my career. Geriatricians tend to be caring and friendly people who have a good work-life balance and I liked the idea of becoming one of those people”
	Emphasis on patient and family involvement	“I like the communication and interaction with the family and friends as well as our patients, this is still the core skill we rely on rather than being too driven by tests and investigations”
Experience	Role modelling	"I was inspired by some Geriatric medicine registrars and consultants who I worked with when I was a core medical trainee who were just excellent clinicians, excellent communicators and teachers. I thought that if i could be like them one day, I would be doing a good job as a doctor”
	Previous positive experience in geriatrics	“I had really enjoyed all my attachments in geriatrics, both as a student and house officer”

[Online Appendix 1: Factors about geriatric medicine that respondents disliked]

Category	Code	Exemplar quote
The Discharge Process	Decreased Social Care Provision	"The amount of patients who are in for prolonged periods awaiting social issues - mainly package of care/new placements… this is so depressing for both the staff and the patients"
	Delayed Transfers of Care	"Not being able to send people out of hospital in a timely manner because of limitations in community resource"
NHS Resources	Perceived Underfunding	"Geriatric wards are not well funded... old people are perceived to lose the hospital money"
	Fragmented care	"I find the lack of integration between primary health care, social care and secondary care extremely frustrating and burdensome"
	Insufficient staffing levels	"Geriatric Medicine seems to not have enough junior doctors compared to other specialties… doctor to patient ratios can be appalling"
Perceptions about the specialty	Lack of evidence base	"It can be frustrating at times working in a speciality that often has a lack of consensus... due to the lack of trial evidence for interventions in our age group it can be difficult to get a definitive answer regarding best management"
	"Dumping ground"	"I have come to realise that you are undervalued by other specialties and they tend to try and use the geriatric wards as a 'dumping ground' for patients they no longer wish to look after - even my own family don't seem to value what I do"
	Percieved non-specialist	"I think we are still considered in some way non-specialist by our organ-specific colleagues. This can lead to a perception of geriatrics as a low-value speciality in the hospital"
Working pattern	Lack of challenge and/or variety	"Sometimes I feel that I need more of a challenge. I just feel like I'm going through the motions some days, especially with a ward of medically stable patients awaiting discharge. I'd like more variety and turnover sometimes"
	High work load	"The only problem is the very large number of patients... and the increasing strain being put on the speciality as it expands"
	Burden of Paperwork	"Paperwork can be inundating"
Training Experience	GIM On-call Commitment	"Understaffed GIM rota (with)constant pressure to work more shifts"
	Lack of Educational Opportunities	"Service commitment is higher than other specialities, less protected time for academic interests"
	Dissatisfaction with ePortfolio	"The curriculum changes often and it can be difficult to keep up with all parts - new areas are not always developed in your area so difficult to gain experience i.e. surgical liason"
	Negativity re. specific sub-specialty areas	e.g. "Stroke"
Complexity	Complex Legislation	"The new legislation on DOLS have made it ever more difficult to look after our older patients with cognitive impairment or dementia. It seems the policy makers are not aware of the practical impact of these decisions"
	Dealing with challenging families	"The constant, regular and lengthy discussions required with increasing numbers of families which is extremely time consuming"
Practice of seniors	Insufficient quality of locum consultants	"Locum consultants not trained in Geriatric Medicine working as consultant geriatricians"
	Demand on Geriatricians from other specialties	"A 'default' feeling that patients should be managed by geriatrics when they are of a certain age… refer all to geriatrics"
Attitudes towards older people	Ageism amongst Healthcare Professionals	"The attitudes of other medical professionals towards our patient population sometimes frustrates me... the priority is "meeting targets" rather than caring for each individual in a personalised manner depending on their needs, not the needs of the service providers"

Online Appendix 2: Survey Content

1) What is your current stage of training?

[select from the following]

St3 / St4 / St5 / St6 / St7 (or above) / OOP (free-text) / Other (free-text)

2) When did you decide to do specialty training in geriatric medicine?

[select from the following]

During CMT / During Foundation Training / During Undergraduate Training / Other (free-text)

3) Did you have a post in geriatric medicine during training?

[select from the following]

CMT (or equivalent) / Foundation Training (or equivalent) / CMT & Foundation Training (or equivalents) / None / Other (free text)

4) Was geriatric medicine your first-choice specialty?

[select from the following]

Yes / No (plus free text - if no, what was?)

5) Do you regret choosing geriatric medicine?

[select from the following]

Yes / No

6) What (if anything) might have deterred you from choosing geriatric medicine?

[select from the following]

Commitment to GIM on-call rota / Complexity of geriatric medicine patients / Dealing with cognitively impaired patients / Dealing with chronic disease / Desire to do more procedures / Desire for more acute illness / Lack of academic opportunities / Limited potential for private practice / Negative experiences of older people pre-medical school / Not feeling comfortable with uncertainty / Perceived low prestige / Other (free text)

7) Why did you choose geriatric medicine?

[free-text box]

8) Is there anything you do not enjoy about geriatric medicine?

[select from the following]

Yes (plus free text - if yes, what?) / No