From psychiatry to geriatrics and back again

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Skill in physical medicine is important in the care of the elderly psychiatric patient. The need for reciprocal training in geriatric medicine and old age psychiatry has been highlighted. This is most often undertaken at higher training level. This paper describes a six-month sabbatical from psychiatry as a senior house officer in geriatric medicine.

As old age psychiatry continues to develop, it is becoming clear that it shares much in common with geriatric medicine. Not only are the patients the same age but they often have both physical and psychiatric needs. A recent article reported that old age psychiatry patients have a high rate of significant physical illness (over 80% of cases) with over 60% of cases having multiple physical pathology (Dover & McWilliam, 1992). A certain degree of medical acumen is becoming increasingly recognised as important on old age psychiatry (Rice & Mulkerrin, 1992). The joint report of the Royal Colleges of Psychiatrists and Physicians recommended two months experience in geriatric medicine for higher training (1989).

It was with this in mind that after three years of psychiatry I took a six-month sabbatical as a senior house officer in geriatric medicine.

The six months consisted of three months as the ward doctor on a 15-bedded regional stroke unit followed by three months of acute geriatric medicine in the local district general hospital with responsibility for 40 beds. The former post had floating senior registrar cover and the latter had a full time registrar and a pre-registration house officer.

The first two weeks were the hardest. It was the interpretation of ECGs and chest X-rays that I found the most difficult. Here a combination of good supervision and sheer necessity pulled me through. My learning curve was very steep as most of the knowledge had been previously learnt, although many years ago.

The role of the junior doctor was not too dissimilar to that on an old age psychiatry post. The team functioned on multidisciplinary lines. Often the main problem was placement and longer term rehabilitation. The actual medical role was not too high powered as the patients were stabilised prior to transfer to the unit. There was a surprisingly large psychiatric role. In the first month I picked up two actively suicidal patients, a third of patients were depressed enough to warrant antidepressants, and another third showed severe adjustment reactions. At first I felt this may have been me clutching to safe areas of knowledge. Further enquiry revealed that most of these patients were known to the nursing staff. However either the nurses did not refer to the medical staff (because the depression was 'a normal understandable reaction') or the medical staff did not treat because of fears about the safety of antidepressants. The SSRIs were not well known at that time and the older tricyclics were often contraindicated in this group of patients.

In some ways the first half of the post was a dry run for the faster harder pace of acute geriatrics. With a cut-off age of 70 much of the work was similar to that on an acute medical ward. The pace of work was much faster than ever encountered in psychiatry. There were at least three emergency admissions a day. Older patients present with less classical symptoms and deteriorate quickly. The more reflective and sometimes cautious approach to psychiatry had to be abandoned rapidly. Medical knowledge was surprisingly easily remembered from the past and technical skills such as venflons and lumbar puncture seemed to return instantly. History taking, the physical examination and investigations had changed little over the years since house jobs. The biggest advances were in treatment. This was especially true in cardiac disease with newer antihypertensives, antianginal drugs and the thrombolytics for acute myocardial infarcts. In three years these areas had radically improved and at times I felt that I had come from a different time zone. Again many of the issues in acute geriatrics were similar to old age psychiatry, such as finding long term care, deciding when to stop active treatment and how to obtain good palliative care. There was one out-patient session a week. Embarrassingly, there was more time to talk to these patients than had been the case in the general adult psychiatry clinics where I had worked.

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Again there was a high rate of psychiatric morbidity on the wards and I am afraid the referral rate to my old age psychiatry colleagues for follow-up was increased markedly.

Surprisingly one of the biggest difficulties I experienced was settling back into psychiatry. I had become used to a pace where patients improved rapidly and deteriorated equally rapidly. This contrasted to adult psychiatry where change is often over weeks not days or hours.

I found the post an invaluable experience for a career in old age psychiatry. It updated my medical knowledge and helped me see how a parallel service operates. I feel now that old age psychiatry probably had more in common with the geriatric services than with general psychiatry and that the future direction should be towards one joint old age service. I can recommend such a posting for anyone considering old age psychiatry.

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