Age & Stage episode 10

Show Notes from conversation with Dr. Lucy Pollock, geriatrician and author about Elderly Care and Geriatric Medicine

Dr. Lucy Pollock, a consultant geriatrician in Somerset, shares deep insights into the field of elderly care, drawing from decades of experience. She explains how she came into geriatric medicine almost by accident, but with immediate recognition that it was the right path: “You need to know a lot about lots of different conditions,” she says. “Most of my patients have multiple things wrong with them, and I get to work with wonderful multidisciplinary teams and families.”

What Geriatricians Do

Dr. Pollock’s work is varied. She spends time in acute frailty units, hospital-at-home settings, outpatient clinics, and on-call medicine. Acute frailty units aim for quick turnaround—ideally discharging patients within 48 hours. Hospital at home, by contrast, brings hospital-level care to patients’ homes, avoiding disorienting and potentially harmful hospital stays.

“Being in hospital is not a good idea for many older people,” she notes. “We know it can worsen confusion and lead to complications. That’s why bringing expertise into the community is essential.”

Subspecialties and Complex Cases

Geriatric medicine now includes subspecialties like orthogeriatrics, onco-geriatrics, and cardiogeriatrics. Geriatricians focus on benefit vs. risk—especially important when polypharmacy (taking many medications) is involved.

“Geriatrics, when done well, prevents the wrong things being done,” Pollock stresses. “Too often we pile on medications or procedures that do more harm than good.”

Navigating Access to Geriatric Care

While most elderly care starts in primary care, a geriatrician is helpful when multiple conditions, cognitive decline, or general deterioration are involved. Dr. Pollock recommends starting by discussing this with a GP and framing it reasonably: “Would it be possible for my mum to see a geriatrician?”

Conversations Families Need to Have

Many people avoid difficult topics—driving ability, incontinence, or end-of-life wishes—due to embarrassment or fear. Pollock emphasizes the importance of open dialogue. “Common doesn’t mean normal,” she says, especially regarding issues like continence. “There are so many things that can help, from pelvic floor exercises to getting off caffeine or using the right equipment like convenes for men.”

Polypharmacy and the BRAN Test

A significant concern is polypharmacy. Dr. Pollock encourages families to lay out all medications on the table and perform the BRAN test:

- **B**enefits: What real benefit does this tablet provide?
- **R**isks: What are the downsides?
- **A**lternatives: Are there non-drug options?

- **N**othing: What happens if we do nothing?

“People are shy about saying they’ve stopped taking a medication. But if eight out of nine people don’t benefit from a drug, and it raises the risk of dementia, shouldn’t we be talking about it?”

She highlights anticholinergic drugs used for overactive bladder as particularly problematic: “They dry up your brain’s acetylcholine and can increase the risk of dementia by a third.”

Treatment Escalation and End-of-Life Planning

Pollock strongly advocates for treatment escalation plans or RESPECT forms. These clarify what treatments are appropriate—resuscitation, hospital admissions, or intensive care—and reflect what the patient values.

“Older people are often relieved to have this conversation. Families need to know what Dad wants. It’s not about giving up—it’s about living well and dying well.”

On Resuscitation and Hospital Admissions

Reinforcing the importance of context, Dr. Pollock says, “CPR has a very low chance of success in frail elderly people. Knowing someone’s wishes helps us avoid inappropriate emergency treatment.” Similarly, hospital isn’t always the best choice. “Being rushed to hospital at 4 a.m. when someone could be supported at home is something we can often avoid with good planning.”

Hospital at Home and Virtual Wards

Dr. Pollock praises hospital at home: “It’s safe, cost-effective, and often preferred. We can administer IV antibiotics, fluids, and monitor patients closely. It’s not for everyone, but for many it’s a better experience.”

Looking Ahead

Asked what she hopes for the NHS as she ages, Dr. Pollock says: “That it maintains its humanity. That care is personalised, informed by shared records, and built around what matters to each person.”

You can read our review about Lucy Pollock’s first book – The Book about Getting Older.