Geriatricians: The Super Specialists

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Who is going to care for the growing population of older persons, especially those with multimorbidity, who are responsible for over a quarter of physician office visits? Many of my primary care physician colleagues tell me that they look after older people all the time and that they are excellent geriatricians. It is only when the child of one of their older patients brings her to me that I realize just how dangerous their belief is. As an example, about a year ago I saw an 88-year-old male with prostate cancer and brain metastases. He came to me because he was fatigued. He was on 26 medicines and his physician had told him that if he stopped any of his medicines he would die instantly. I sent him home on one medicine and he phoned me a week later telling me he was no longer fatigued. He died peacefully 8 months later. Another example was a 68-year-old lawyer whose colleagues had suggested his legal practice was not as good as it should be. His primary care physicians suggested he was getting old and should consider retirement. He was clearly cognitively impaired (Saint Louis University Mental Status (SLUMS) score of 16/30) and after asking his wife if he stopped breathing at night, I referred him for a sleep test. Six months later he returned on continuous positive airway pressure with a SLUMS of 30/30. Finally, 2 African American women in their mid-80s came to one of our screenings. They both complained of fatigue. Their home systolic blood pressures on three antihypertensives ran between 90 to 100 mmHg! Unending stories like this make the geriatrician the super specialist for older persons.

No other specialty has developed as many wide ranging, successful programs that have improved the quality of life of older persons. As illustrated in Figure 1, the geriatrician is the peripatetic clinician and administrator who is responsible to care for and respond to the older person's viewpoint. Geriatricians have demonstrated improved care for older persons in hospitals (Acute Care for the Elderly (ACE) units,[1] Delirium Intensive Care Units[2] orthogeriatric units,[3] postacute care (geriatric evaluation and management units),[4] and outpatient evaluation[5]). In addition, geriatricians have developed programs to decrease falls,[6] to improve outcomes post hip fracture,[7] to delay the rate of cognitive impairment (the FINGER trial),[8] and to reduce frailty and sarcopenia.[9–12] Geriatricians have also been leaders in top quality programs in nursing homes and calling for increased research in nursing home care.[13]

At the basic clinical care level geriatricians have focused on recognizing and treating a variety of predisability syndromes—The Modern Giants of Geriatrics (Table 1). These syndromes represent the Pandora's box of predisability conditions and the ideal focus for prevention of disability. They are virtually never recognized by primary care physicians and subspecialists. The physical phenotype of frailty as developed by Fried et al.,[14] coupled with the recognition of sarcopenia, provide treatable conditions that can prevent or delay the onset of disability. Polypharmacy and the use of newer, expensive medicines represent a situation where physicians are costing their older patients large amounts of money, with negative outcomes. There are numerous treatable causes of the anorexia of and weight loss in older persons. Early recognition

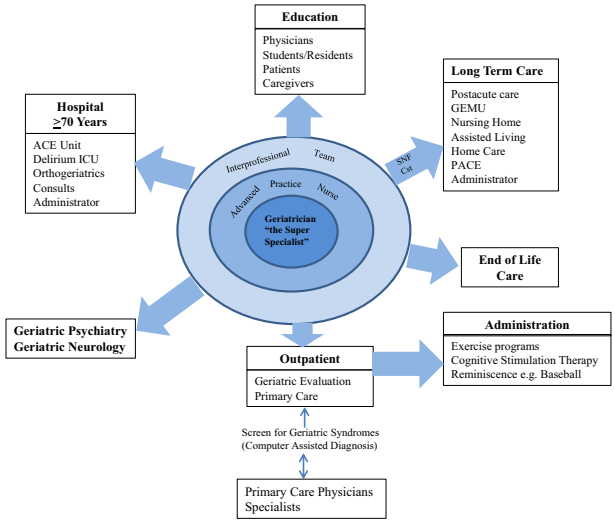

Figure 1. The multiple roles of the geriatrician. Geriatricians tend to be important in multiple sites where they work with interprofessional teams to enhance the quality of life of older persons. GEMU = geriatric evaluation and management unit; PACE = Program for All-inclusive Care for Elderly.

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Table 1. The Modern Giants of Geriatrics

1. Frailty
2. Sarcopenia
3. Anorexia of aging
4. Mild cognitive impairment
5. Delirium
6. Falls
7. Depression
8. Dementia
9. Polypharmacy
10. Fatigue

of cognitive decline is important because in some cases it has treatable causes and it is essential for physicians to be able to recognize whether or not their patient can remember and carry out health care instructions.[15]

A survey of physicians showed that geriatricians are the most satisfied of physicians.[16] Despite this and the enormous need for geriatricians there has been a decline in board certified physicians from a peak of 8,424 in 1996 to 7,428 in 2014 (Figure 2). With the increase in the older population it is estimated that from 2000 to 2050 the number of geriatricians/10,000 of the population 75 and older will decline from 4.7 to 1.5. A part of the reason for this is that geriatricians are among the most poorly paid of physicians. The average geriatrician earns approximately $184,000 compared to $383,117 for a cardiologist and $498,127 for a radiologist.[17] (http://healthcareers.about.com/od/compensationinformation/tp/PhysicianSalaries.htm).

Because the geriatric method not only improves quality of care but also decreases cost (e.g., Geriatric Patient Aligned Care Team (Geri-PACT) in the VA decreased total cost of care by 23% compared to usual care)[18] (https://ashecon.confex.com/ashecon/2016/webprogram/Paper4956.html), it would seem that paying geriatricians on a par with those who tend to increase costs would not be unreasonable.

Given the shortage of geriatricians, geriatricians must spend a portion of their time educating other physicians and putting in place systems that result in referral of the most appropriate patients from other physicians to geriatricians. Three model systems to facilitate appropriate referrals to geriatricians are the Kihon Index in Japan,[19] the Gerontopole referral system in Toulouse[20] and the Rapid Geriatric Assessment (RGA) in St. Louis.[21] The St. Louis model includes a computer assisted management system to further reduce the numbers of older persons needing to see geriatricians. At their early stages all of these systems appear to be working. Developing systems like these will be essential for the future of high quality care for older persons.

Rodney Dangerfield complained, "I get *no* respect" and this truly applies to geriatrics. It is time for geriatricians to stop being shrinking violets and to loudly proclaim to their colleagues and the public that geriatricians are the super specialists for older persons, and all other specialists need to defer to them! The American Geriatrics Society and geriatric programs should advertise on primetime television, radio and on social media. A recent half-hour primetime television program "The Science of Healing: Geriatrics" together with a commercial on the "Dancing Doctor" produced by St. Louis University has dramatically changed

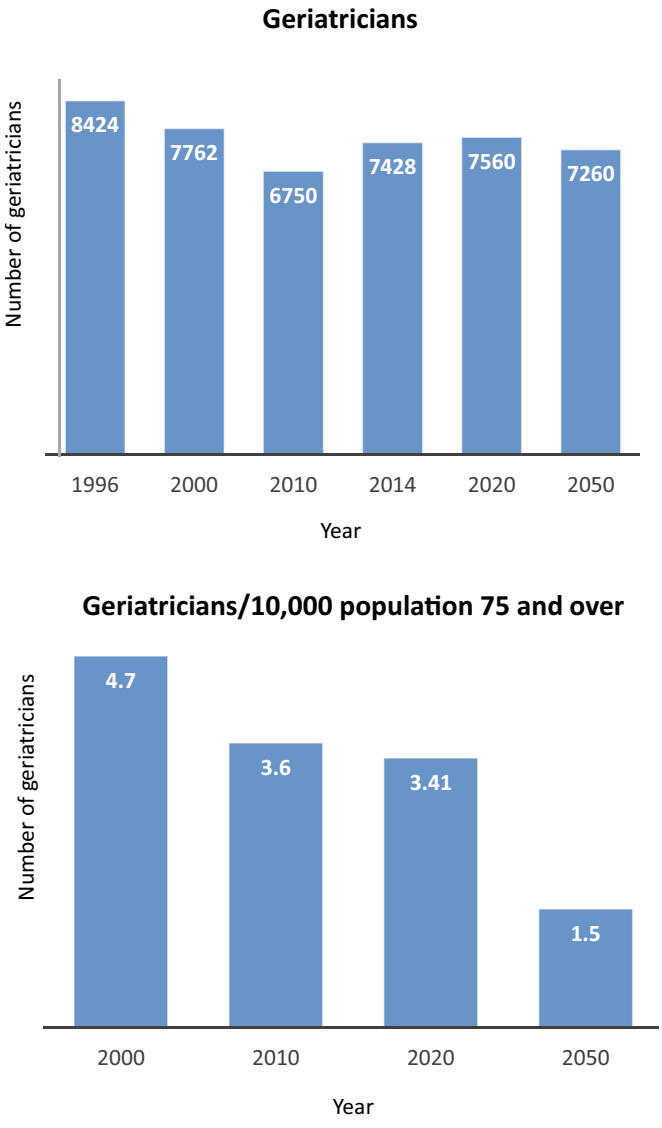

Figure 2. Geriatricians in the United States and population 75 and over. The number of geriatricians in the United States has declined since 1996 and is not expected to rise significantly until 2050. This paucity of geriatricians is put into perspective when it is realized that the baby boomers will significantly increase the population 75 and over leading to a marked decrease in geriatricians per 10,000 of the population 75 and over (numbers obtained from the American Geriatrics Society website).

both the public and health care providers' image of geriatrics in our area (both now available on YouTube). Finally, geriatricians need to continue to produce high quality research. To accomplish this there is a desperate need to return to a 2-year geriatric fellowship to allow time for the future geriatricians to develop their research skills. At all times geriatricians need to be proud to remind everyone that we are the SUPER SPECIALISTS!

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