

BY ELIZABETH HEUBECK

# A BOOMING NEED



Geriatrics is the hot specialty these days, as the number of elderly skyrocket and baby boomers start pushing 60. With demand outstripping supply, it's a subspecialty worth considering.

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**L**IKE IT OR NOT, WE'RE ALL getting older. In fact, 6,000 Americans turn 65 every single day, officially joining a population dubbed the "elderly." It's an age group whose numbers will continue to soar. Currently, 35 million people in the United States are 65 or older—that's 12.4 percent of the nation's total population. According to the [Department of Health and Human Services](#), in 2030 this number will double to 70 million, comprising 20 percent of the country's population.

What's more, the elderly population of the future will no longer be concentrated primarily in the Sunbelt regions of the country. "In 20 years, the entire country is going to look like Florida in terms of demographics," says Daniel Perry, the executive director of the [Alliance for Aging Research](#). For physicians entering the work force or changing careers, this means a job market brimming with opportunities in geriatrics.

Perry says geriatrics "is where the action is and where it's going to continue to be in our lifetime. It's hard to imagine a part of the country where having training or a fellowship in geriatrics would not make you a sought-after clinician."

Presently, the demand for physicians trained in the unique needs of the elderly far exceeds the supply. (See "Supply vs. Demand," this page.) And this gap is expected to widen, according to the [Association of Directors of Geriatric Academic Programs](#). The association bases its predictions on a current trend in which there are more physicians retiring from geriatric practices than there are completing geriatric fellowships. If this trend continues, the number of certified geriatricians will fall from 9,000 to 6,100 by 2004.

Specialized training is necessary to provide proper care to the elderly for several reasons. First, as people

live longer, their risk for disease and disability increases. Second, diseases present differently in the elderly than in younger adults. Third, older adults react differently to medications than younger adults. Finally, many elderly people take several prescription drugs on a daily basis to treat various chronic ailments, increasing the risk of adverse reactions due to interactions.

The consequences of having too few physicians trained to meet the specialized needs of the elderly prove devastating. The Alliance for Aging Research reports that each year, 35 percent of people older than 65 have adverse drug reactions. A study published in the December 12, 2001 issue of the [Journal of the American Medical Association](#) found that

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#### Supply vs. Demand

##### *Elderly Population Rising*

##### **Number of persons age 65 and older, 2002–2050:**

2002: 35 million  
2030: 70 million  
2050: 78 million

Source: [Administration on Aging](#) report. A Profile of Older Americans, 2001.

##### *Geriatricians*

**In 2001:** 20,000 needed, 9,000 available  
**In 2030:** 36,000 needed, 11,000 estimated available

##### *Geriatric Academicians*

**In 2001:** 2,400 needed, 700 available

Source: [Alliance for Aging Research](#) report. Medical Never-Never Land: Ten Reasons America Is Not Ready for the Coming Age Boom (Washington AR, 2002).

##### *Geriatric Fellows*

##### **Fellowship Positions Available Versus Filled in Academic Year 2001-2002**

Family Practice & Int. Medicine:  
373 available; 259 filled (69.4%)

Geriatric Psychiatry:  
132 available; 81 filled (61.4%)

Source: Graduate medical education tables: [JAMA](#). 2001; 286:1095-1107.

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more than one in five elderly patients receives prescriptions of inappropriate drugs.

The entire country pays a high financial toll for the mishaps resulting from a lack of training in geriatric medicine. Consider this single example: The inappropriate prescribing of medications due to a lack of training in geriatric medicine leads to hospitalizations costing approximately \$20 billion a year, reported John Murphy, MD at a testimony before the [Senate Special Committee](#)

[on Aging](#) in 1998. Murphy is the director of the division of geriatrics at Brown University. The Alliance for Aging Research argues that more consistent and widely available geriatric care could reduce health-care costs by 10 percent annually, a savings of \$50.5 billion in 2000 alone.

High job satisfaction

Despite the current shortage of geriatricians—only 9,000 were available to fill 20,000 vacancies in 2001—and the far-

reaching problems it presents, those who have chosen to take up the profession report incredible job satisfaction.

A recent large-scale survey that compared career satisfaction across 33 specialties and drew data from 12,528 physicians resulted in some very telling findings. Conducted by Paul Leigh, PhD and associates from the [Center for Health Services Research in Primary Care](#), the results were published in the July 22, 2002 issue of [Archives of Internal Medicine](#). The survey found that physicians practicing geriatric internal medicine were much more likely to report professional satisfaction than were physicians in several “procedural” specialties, such as ophthalmology, orthopedic surgery, and pulmonary medicine.

Procedural specialties are associated with greater prestige and higher salaries than cognitive specialties such as geriatrics. But as this large-scale study revealed, and as practicing geriatricians will tell you, it’s not necessarily the money or the clout that brings satisfaction to a physician’s career. It’s something much more intrinsic and lasting.

So, what is it that keeps geriatricians like G. Michael Harper, MD returning to work every day? “The ability to hear the perspective of an 85-year-old who lived through the depression and both world wars—seeing pictures of grandchildren—helping patients through the toughest times they face,” says Harper.

Harper is an assistant professor of medicine at Johns Hopkins and a geriatrician at the [Johns Hopkins Geriatric Center](#). A state-of-the-art hospital and nursing facility, the center is staffed by more than a dozen geriatric-trained physicians and provides long-term and sub-acute care to the elderly—including a rehabilitation unit; a chronic medical

**Daniel Perry, the executive director of the Alliance for Aging Research in Washington, DC, says increased funding for research will expand the need for geriatric physicians. “Fifteen years ago, about \$120 million a year was the annual appropriation for the National Institute on Aging. In recent years, the aging institute has grown by leaps and bounds. This year’s appropriation is close to a billion dollars.”**



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### Health Status of Elderly

- Twenty six percent of persons age 65 and older report poor or fair health, compared to 11.5-18.5 percent of persons age 45-64
- Persons age 75 and older report an average of three chronic conditions
- Persons age 75 and older report an average use of almost five prescription drugs
- More than 25 percent of persons age 75 report at least one disabling condition
- Seventy five percent of people age 80 report at least one disabling condition

Source: *Alliance for Aging Research* report. Medical Never-Never Land: Ten Reasons America Is Not Ready for the Coming Age Boom (Washington AR, 2002).

G. Michael Harper, MD, a geriatrician and assistant professor at Johns Hopkins, says his older patients provide his motivation to practice geriatrics: **"The ability to hear the perspective of an 85-year-old who lived through the depression and both world wars—seeing pictures of grandchildren—helping patients through the toughest times they face."**

unit; skilled, intermediate, and respite care; and adult day care. It is here that Harper spends a large portion of his days treating elderly patients. At other times he can be found in the classroom, teaching medical students how to meet the specialized needs of their future elderly patients.

In a world of medicine that until recently has rarely acknowledged the

unique needs of the elderly, the large number of resources that Johns Hopkins has dedicated to its geriatrics program make it a trendsetter. Harper attributes Hopkins' strong geriatrics program to the administration's long-standing support, and the start of the [Baltimore Longitudinal Study of Aging](#), America's longest-running scientific

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study of human aging, which began in the 1950s.

That all-important support from administration continues today, trickling down from the top and touching each of the Geriatric Center patients, all of whom receive personalized treatment from staff members.

“We’ve tried to maintain a very high touch and low-tech approach,” Harper says. “When our patients call, they get a person who answers the phone. The staff knows everybody by name, they know the family members. Our nurses are wonderful. It’s not necessarily training; a lot of people see this as a mission. We don’t rush patients. One to one-and-a-half hours for an initial consultation is average,” he says.

What it takes

In the often fast-paced atmosphere of medicine, spending more than 15 minutes per patient is rarely an option. But, as geriatricians like Harper and his colleagues recognize, treating elderly patients adequately requires more time.

“Providing extra time for listening is the hallmark of a practice geared to seniors. In addition, as the primary physician, the geriatrician often fills the role of counselor who can communicate the patient’s concerns to members of the social circle, family, or to other health providers,” explains Samuel Durso, MD, Harper’s colleague at the Johns Hopkins Geriatric Center.

Dr. Eugene Lammers, an Indianapolis geriatrician, agrees. “Treating geriatric patients takes more time, more support, and more in-depth analysis than you can offer in the routine office visit,” says Lammers, also the medical director for the Center for Geriatric Medicine at [Clarian Health Partners](#).

Unlike physicians who treat acute dis-

### Disproportionately High Use of Services by Elderly

- 23% of ambulatory care visits
- 48% of hospital days
- 83% of nursing facility residents
- 25% of office visits (approximately)
- 69% of recipients of formal home-care services

Source: [Health Care Workforce: Who Cares for Older Adults? Workforce Implications of an Aging Society](#); *Health Affairs*, September/October 2002.

ease in which the goal is usually a cure, geriatricians care for patients with chronic and often multiple illnesses or disabilities. Therefore, treatment goals are multiple and, in some instance, conflicting. Ultimately, the course of treatment depends on the patient’s preferences. Attentive listening by physicians is necessary to elicit a patient’s preferences and establish goals of care.

Setting treatment goals is a standard practice used by geriatricians, and it’s well worth the time it takes. Studies published in the British medical journal [Lancet](#) show that treatment goals enhance patient adherence and satisfaction, and may even improve patient outcomes.

To elicit their patients’ preferences throughout the course of their relationship, geriatricians often communicate with family members. “In rare cases is a relationship between simply patient and doctor. There’s almost always some interaction with family: They come to the visits, we follow up with them by phone. It’s quite amazing how intimately involved family members are,” Harper says.

That interaction with family members often requires diplomacy and delicacy on the part of the physician. “You have to be willing to recognize that no matter how old people are, their loved ones don’t want them to die. And you have to

be able to provide support to their loved ones,” Lammers says.

In addition to excelling as communicators, geriatricians must be team players. When geriatricians first see a patient, they typically administer a comprehensive geriatric assessment in concert with medical professionals from other disciplines, such as physical and occupational therapy. The assessment is a diagnostic tool designed to determine a patient’s capabilities and limitations (medical, psychosocial, and functional) and, ultimately, to develop a plan for treatment and long-term follow-up. And it works. Studies show that use of the assessment helps improve function and reduce nursing home placement and hospital re-admissions. But, like any tool, it’s only as effective as the people who use it.

“It takes a team of people to assess baseline capabilities and put them on programs that reinforce these capabilities,” Perry says.

Not only do geriatricians work with multiple health professionals, they are also trained to work across multiple sites. It’s not uncommon for an elderly patient with one or more chronic conditions to require specialized care in each of the following settings at different times: acute care in a hospital, sub-acute care in a nursing home, home care for assistance with activities of daily living, ambulatory care for ongoing medical management, and hospice care.

Training requirements

Some skills, such as that of being a good listener, are inherent—although they can be improved with practice. Others, however, must be learned. [The American Geriatrics Society](#) recommends practitioners treating the elderly receive the Certificate of Added Qualifications in Geriatrics Medicine (CAQGM), offered

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by the [American Board of Family Practice](#) and the [American Board of Internal Medicine](#). Candidates must complete one year of clinical training beyond that of the required medical residency program to be recognized as geriatricians, or experts in the clinical care of older persons. Those who wish to pursue positions as “educator” or “administrator” geriatricians require two-year fellowships. “Researcher” geriatricians require fellowships of three years or more.

The training requirements to become a geriatrician are no more time-intensive than those required by other subspecialties. Physicians who enter the profession report high levels of career satisfaction. And the demand for geriatricians’ skills is clear. Why, then, do so few medical students choose to pursue this field? And what is being done to encourage more of them to consider geriatrics or, at the very least, to become skilled at caring for the elderly and the specialized needs they present?

### Changing misperceptions

Authorities in geriatrics believe that a widely held misperception prevents many medical students from pursuing this subspecialty. “Young physicians see geriatrics as depressing,” states Christine Cassel, the chair of the department of geriatrics and adult development at [Mount Sinai Medical Center](#) in New York.

Medical school administrators acknowledge that how students perceive older people presents a major obstacle to recruiting geriatricians. And they are making a concerted effort to change these perceptions.

In a program developed by the [Association of American Medical Colleges](#) (AAMC), “senior educators,” adults age 60 and older, spend recreational time paired with medical stu-

dents. The results are eye-opening.

“They [medical students] see that older people are not necessarily in nursing homes. They’re bowling, dancing, they have sex lives. It’s a different relationship than they have, say, with their grandparents,” says M. Brownell Anderson, the senior associate vice president for medical education at AAMC.

Clearly, exposing medical students to the elderly is the best way to change long-held, albeit not necessarily accurate, perceptions of this population. That’s why Mt. Sinai Medical School in New York recently moved medical students’ requisite one-month rotation in geriatrics from the fourth year to the third year of medical school.

The third-year geriatrics rotation is quickly becoming a trend at medical schools across the country. The thinking is that introducing students to geriatrics through a clinical rotation a year sooner might steer them in a direction that hadn’t occurred to them. There’s evidence that this early exposure may sway students’ decision to enter the field.

“Some of our fourth year medical students said to us, ‘I wish I’d had that [rotation] earlier,’” says Helen Fernandez, MD, an assistant professor of geriatrics and adult development and the assistant fellowship director of geriatrics at Mt. Sinai.

So might the “buddy system,” another idea developed by the Mt. Sinai Medical School and intended to introduce medical students to realities that elderly patients face.

Whereas the “senior educator” program helps medical students see older adults as vibrant members of their communities, the buddy system, in which a medical student accompanies an older patient to medical visits, sheds light on the unique concerns of elderly patients.

Fernandez explains: “They learn firsthand what happens when they [older adults] go to see doctors. This includes everything from transportation issues—how will they get to the appointment?—to what happens the moment they leave the doctor’s office. For instance, do they have the resources to fill their prescription?”

These lessons learned would not have the same impact if taught in the classroom, and it is a lasting impression that Fernandez wants to instill in medical students. “It’s wonderful when medical students get it; when they begin to think about things like how the patient is functioning at home, and if that patient has the resources to get her medication. Even if they’re not going to become geriatricians, they’re going to think about aspects of care other than giving medicine. They’re going to look at the older adult as a whole person,” she says.

### More dollars for geriatrics

By following their passion to promote a heightened awareness of the unique characteristics and needs of elderly patients, professionals like Fernandez help advance the field of geriatrics. They are increasingly joined by organizations intent on furthering this cause too.

In 1997, The Donald W. Reynolds Foundation gave \$28.8 million to the University of Arkansas for Medical Sciences (UAMS) to establish a [geriatrics program](#) at the school, the second of its kind in the nation. Housed in a 96,000-square foot building, the program includes geriatric clinical, educational, and research programs. This past July, the foundation promised an additional \$18.25 million for the program. This support has made possible expansions in UAMS’s geriatrics curriculum, allowing all medical students to spend four weeks

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in a geriatrics rotation.

In another effort to improve care to older patients, the AAMC recently collaborated with the [John A. Hartford Foundation](#), awarding grants to 40 United States medical schools to enhance gerontology and geriatric curricula. Each institution will receive a total of \$100,000 toward curriculum changes centering on skills needed to deliver high quality, compassionate care to older patients, and to manage complex issues associated with end-of-life care.

“The grants will not be used to create a separate course in geriatrics, but rather to integrate geriatrics into the existing curriculum,” explains AAMC’s Anderson.

Exposing medical students to older adults and the skills needed to care for them are two ways to recruit geriatricians. Providing practical incentives is another. The Alliance for Aging Research recognizes the importance of offering such incentives, and is lobbying hard to deliver them.

“We’re working with the Department of Health and Human Resources in the Bush Administration to push for system-wide improvement in three areas: loan reimbursement forgiveness, reimbursement for clinicians, and support for academic development,” Perry reports.

Undoubtedly, such offerings may entice students who otherwise wouldn’t choose geriatrics to consider it. So, too, might knowing that several career paths exist for geriatricians.

Several career paths

Unlike some professions in which it is easy to get ‘pigeon-holed’ by a lack of choice, geriatrics offers countless opportunities. “There are a number of things we can do: patient care, administrative positions such as director of a

nursing home, academic and research careers,” Harper says.

Thanks to significant increases in funding over recent years, aging research is a growing field for geriatricians. “Fifteen years ago, about \$120 million a year was the annual appropriation for the [National Institute on Aging](#). In recent years, the aging institute has grown by leaps and bounds. This year’s appropriation is close to a billion dollars,” Perry says.

And just what areas of aging research are gaining momentum these days? Those that explain the mechanisms behind aging are, for practical purposes, growing rapidly. With a booming aging population, it’s imperative that researchers learn how to postpone diseases of aging and deliver effective, preventive medicine to the elderly.

Clinical studies utilizing much older subjects are also on the horizon, according to Fernandez. This is only logical, as the average life span continues to rise. To date, most studies including elderly subjects draw from participants in their 70s. In the future, she foresees more studies including subjects in their 80s and 90s.

Role models in the classroom often drive necessary changes in medicine. By articulating the importance of skills required to treat the elderly, medical professors enhance the field of geriatrics and, ultimately, the care of the elderly. Strong academic role models can also help define a student’s career path.

“I was mentored by a professor who was so passionate about improving our learning so we could then take better care of older adults,” Fernandez recalls. That professor’s passion steered Fernandez to an academic career in geriatrics. In turn, she strives to foster

the same enthusiasm in her students. “The idea that I could really influence and give knowledge and skills to medical students pushed me to stay in academics,” she says.

Harper also credits strong role models with his decision to enter geriatrics. “I thought the geriatricians I met in my rotation were the most humanistic of physicians; they seemed to be able to balance judgment with knowledge,” he says. And it is this balancing act—equal parts challenging and rewarding—that Harper and fellow geriatricians perform on a daily basis.

“We can do a lot to help these folks live independently. And at the end of life, we’re there to see that they have a dignified passing and to support their families,” Harper says.

There is reciprocity in the patient-doctor relationship, however, with geriatricians receiving something from their patients as well. These elderly folks give their physicians a glimpse of a bygone era. “The most rewarding part of my job is discovering who my patients are and who they used to be. I’ve had patients from the Deep South raised in farming families with 20 brothers and sisters. They’ve lived a different life, one that we can’t really imagine,” Lammers says. ■

*Elizabeth Heubeck’s article, “Doctors Do Good,” about volunteer physicians helping the uninsured, appeared in January/February 2002.*