


Do We Need More Geriatricians or Better Trained Primary Care Physicians?

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The demand for more specialists in general geriatric medicine is intensifying as the proportion of people above the age of 65 years is expected to increase exponentially. Some estimates predict that in less than 20 years, about 20% of the U.S. population will be above the age of 65 years. The question, however, is, “Do we need more specialists in general geriatric medicine or do we need primary care physicians better trained in geriatric medicine?”

There is no good reason for general geriatric medicine to be a specialty different from general internal medicine or family practice. In fact, it makes much more sense that the internist or family physician who has provided medical care to the patient throughout adult life continues to provide care after the age of 65 years. Throughout the years that physician has established a position of trust with the patient (and often family) and is intimately knowledgeable about the patient’s condition as well as psychological make-up, sense of values, stressors, and spiritual and social background. Such knowledge is an asset as the medical management strategy for older patients is not only dictated by the pathology, but is often modulated by the patient’s individual circumstances: physical, mental, spiritual, and social.

It is quite traumatic for the person who reaches the age of 65 years to be told by the primary care provider—who has been providing medical care for a number of years and is considered a “friend”—that another physician should take over medical care, especially as around this time, the person experiences a number of losses associated with retirement including sense of identity, physical abilities, and financial status.

There is no doubt general geriatricians have developed a special expertise at handling atypical presentations of diseases, multiple pathologies, polypharmacy, often ill-defined “normal” levels, and the need to develop a management strategy that takes into account the patient’s physical, mental, spiritual, and social background. However, shouldn’t internists and family physicians be able to do that?

It is unrealistic to expect to produce enough geriatricians to provide medical care to all people above the age of 65 years or even 75 years. And if this were possible, there would be significantly less work for internists and family physicians as the bulk of the patients they see is above the age of 65 years. It may be argued that general geriatricians would focus only on older patients who have multiple complicated chronic problems that require the “expertise” of a geriatrician. Is that “expertise,” however, a true expertise peculiar to general geriatric medicine or is

it a perceived expertise by other health care professionals who are reluctant to manage complicated medical problems and are happy to transfer their “difficult” patients to the care of a general geriatrician claiming that they do not have the required “expertise”?

At this stage, it might be relevant to reflect on how the specialty of geriatric medicine started. In England, after the end of the Second World War, Dr. Marjorie Warren was appointed as a consultant physician (attending physician) at the Middlesex Hospital in London. For reasons beyond the scope of this article, she was assigned to the “long-term wards” where mostly older patients with chronic diseases and poor prognosis were kept because they could not be discharged. Rather than accepting the status quo, Dr. Warren did what should have been done in the first instance with these patients: She took a meticulous history, examined them thoroughly, diagnosed a number of conditions that had not been diagnosed earlier, and treated many of these diseases. She also discontinued some of their psychotropic medications. To everybody’s surprise, many of these patients improved sufficiently to be discharged back to the community.

Other hospitals noticed this and more and more consultant physicians (attending physicians) with a special interest in older people or geriatricians were appointed to specifically provide health care to older patients. Other physicians avoided these patients because they felt it was beyond their expertise to integrate the patient’s mental and social backgrounds into their treatment strategy: They were “physicians,” not psychiatrists and certainly not social workers. They were experts at diagnosing physical illnesses and treating them and did not feel comfortable tailoring their treatment strategy to the patient’s mental and social background. They also often felt uncomfortable handling the complexity of illness in old age and the often associated impairments such as impaired hearing, impaired vision, and impaired dentition, as William Shakespeare stated, “sans everything.” It is also possible that the frailty of these older patients reminded the treating physicians of their own frailty and mortality. These physicians therefore were glad and relieved to let the “geriatricians” provide care for older patients and encouraged the appointments of more “geriatricians,” although at this stage, most did not have any formal training in geriatric medicine.

As time went by, the number of geriatricians was large enough to form a medical society: the British Geriatrics Society. Soon, other similar societies were spawned in other parts of the world. Annual meetings



were held, scientific papers were presented, journals were born, and books entirely devoted to geriatric medicine were published. Soon, university chairs in geriatric medicine were established, and the specialty took off. It is important, however, to remember that unlike other specialties, geriatric medicine developed out of a social need and not as a result of a unique body of knowledge. That came later. There is, however, nothing unique about the body of knowledge, expertise, and *modus operandi* of general geriatric medicine. There is nothing a general geriatrician does that a good internist or family physician cannot do.

Subspecialists, however, such as cardiologists and endocrinologists further specializing in geriatric medicine are a different issue. They are not general geriatricians, as they are already subspecialists and further specialize in the application of their expertise to older patients. The scientific body of knowledge of these sub-specialists is considerable and growing. The geriatric cardiologist for instance would be better experienced at treating older patients with certain types of arrhythmias than a general cardiologist. However, it must be acknowledged that the contribution a general geriatrician can make to the management of an older patient with a rare arrhythmia is minimal at best, unless he or she happens to be a cardiologist.

So, how can physician trainees learn about the peculiarities of managing disease in older patients? At present, the accepted standard in many residency programs is a 1-month rotation in a nursing home. This is not adequate training for internal medicine or family practice residents or any other resident or fellow wishing to acquire a basic working knowledge of geriatric medicine. In fact, this experience is often negative and counterproductive as patients in nursing homes do not represent the "average" older person: The nursing home population represents less than 5% of the older population, and most of them have a number of chronic diseases with a rather poor prognosis. Unfortunately, older people in nursing homes or other similar institutions have not aged successfully and are not representative of the older population by-and-large. If the 1-month experience in a nursing home represents the totality of geriatric medicine training, then the young physician trainee is

likely to have as the reference for older patients the bedridden, disabled, incontinent, and cognitively impaired patients residing in nursing homes or other institutions. This is not representative of the average older person.

The teaching of general geriatric medicine should be fully integrated in the undergraduate curriculum and should be an integral part of the training of residents, and fellows. The trainee physician must be exposed to people who have aged successfully. The reference standard of the young trainee for instance should be the older person who comes to the office because he has sprained his ankle playing tennis with his grandson, or the one who just comes for a refill of Viagra; although it may be argued that if he needs this medication, then he too may not have aged very successfully.

General geriatric medicine is therefore best taught in general internal medicine and family medicine clinics and wards where patients who have aged successfully are seen, diagnosed, treated, and able to resume their daily activities. There is therefore a need for all clinicians providing primary care to be familiar with the main issues of geriatric medicine.

This is one of the goals of our Journal: Provide readers with practical, unbiased, and state-of-the-art information on problems pertaining to the care of older patients. We would like to emulate the qualities of a good friend: available, knowledgeable, unpretentious, and unbiased. We hope we will earn this reputation. We would also like to emphasize that *Gerontology & Geriatric Medicine (GGM)* is our readers' journal, and we welcome an interactive relationship with readers commenting on published articles, making recommendations regarding topics that would be of particular interest and asking questions concerning particular clinical problems, which we will be happy to forward to our experts. We hope you enjoy *GGM* and look forward to hearing from you.

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