The Choices Facing Geriatrics

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DOI: http://dx.doi.org/10.5770/cgj.15.33

Key words: geriatric medicine, health services, education, clinical responsibility

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> "Ah, but a man's reach should exceed his grasp/
> Or what's a heaven for?"
> - *Andrea Del Sarto*, Robert Browning (1812-1889)

These words of Browning suggest that to achieve anything worthwhile, a person should attempt even those things that may turn out to be impossible. Canadian geriatricians have tried to abide by this dictate, but it has not always worked out as well as hoped. We have spread ourselves thinly in our efforts to both improve the lives of older persons and fulfill our academic responsibilities. As a relatively new discipline, we have striven to respond to requests from colleagues in other fields, academic leaders, health-care managers, and administrators. Our efforts at multi-tasking have likely made us less, not more effective.[1] History tells us that "to do two things at once is to do neither."[2] With our small and currently static number, we have no recourse other than to focus our finite time and energy on what is truly important and where we can, in collaboration with colleagues from medical fields and health professions, be most effective. But what should that be?

Many both within and outside our field argue that we should first attend to the care of hospitalized older persons for four primary reasons. Firstly, older Canadians disproportionally use this expensive and limited resource. In 2003–2003, the approximately 13% of the Canadian population 65 years and older accounted for one-third of all acute care hospitalizations and almost half of total hospital bed-days.[3] There is every reason to believe that these proportions will increase in the coming years. Seniors admitted to hospital are more likely to have multiple morbidities, impaired cognition, and higher levels of disability (including mobility) than younger adults.[4-7] They present unique challenges (multiple morbidity and, in its shadow, polypharmacy, cognitive impairment, and disability) that play into our particular areas of competency. Secondly, a hospital admission is a dangerous time for seniors. An acute care stay can have long-lasting deleterious effects on the functional abilities of older patients.[8,9] There is a growing body of literature attesting to the ability of geriatric programs to mitigate this danger.[10,11] Thirdly, hospitals are still the site where the lion's share of clinical teaching in internal medicine takes place. It is where we can share our expertise with students and residents, as well as excite them about geriatrics. All this speaks to the need for us to be there. The final force pulling us into acute care is not directly related to either the care of older patients or our academic mission. Departments of Internal Medicine and hospitals need physicians to care for unattached patients whose problems do not qualify them for care by other hospital services. This leads to the ticklish question of finances. Especially in jurisdictions without an alternative payment system, sessional fees, or preferential billing codes, rotations on a busy hospital service can generate enough income to allow geriatricians to support the less remunerative aspects of their work.

There is also, we would argue, a need for us to have a presence as medical directors and consultants in long-term care institutions and supportive housing settings where medical care can be suboptimal. Poor adherence to treatment guidelines,[12] limited recognition of treatable conditions such as depression,[13] and inappropriate pharmacotherapy[14] are some of the problems prevalent in these facilities. While geriatricians as medical directors and consultants can help address these issues, to deal effectively with them would require organizational changes, better funding, and improvements in the quantity, mix, and training of staff. These settings are being increasingly used to provide sub-acute and palliative care. We feel these services would benefit from the active involvement of consultants in geriatrics and linkages with specialized geriatric services.

And then there is the community, where the majority of frail and/or disabled older persons reside. Increasing emphasis on community-based care is surely the future of our health-care system. There is growing evidence that complex community-based interventions can help older patients live safely and independently for longer,[15] while the utility of targeted home visits and ambulatory consultations is confirmed by experience in this country and others.[16,17] We need to

improve support provided to primary medical and community care by offering consultation services within primary care group practices, home assessments when indicated, and timely access to traditional facility-based ambulatory care. Geriatric clinics and day hospitals (which were invented by geriatricians) assess and manage memory disorders, chronic pain, falls, incontinence, multi-morbidity, chronic pain, and other disabling conditions.[18]

But we also have our academic mission. Across the country, small divisions of geriatric medicine in collaboration with Care of the Elderly physicians and geriatric psychiatrists introduce Canada's future doctors to the care of older patients, albeit not to the depth we would wish. We teach residents in family medicine, psychiatry, neurology, and internal medicine, along with other health-care workers, while enthusiastically participating in continuing professional education and development, as well as public education. For a small specialty, our research and publication output is more than respectable, and is growing annually. Canada ranks third of all countries in the number of articles published in gerontology and/or geriatric journals.[19] We have internationally recognized leaders in areas such as Alzheimer's disease and other dementias, frailty, health services, and population research. And then there is our time-consuming, important, and often solicited involvement with policy and program development, health service evaluation, medical administration, and advocacy for seniors.

But we cannot do equal and adequate service to these competing demands with our limited numbers.

What are the solutions? It is time for bold thinking and action. We have to define those areas that are unique to us or where we perform demonstrably better than others and that are vital to our mission—where we can be the most effective given our relatively small numbers. We must ditch those areas not meeting these criteria. To use human resource jargon, because of our limited numbers we must opt for a restricted scope of practice that addresses our "core business". Whatever is not will have to be performed by others. We do not believe that we should focus all our efforts in one location (such as acute hospitals). To improve the health of seniors and the effectiveness as well as efficiency of the health-care system, it is necessary to look upstream and downstream of hospitals. We have to develop a balanced portfolio. Specifically, we feel that we should:

1. Maintain a Presence in Acute and Long-term Care: In acute care we need to demonstrate how to optimally manage older patients with complex needs through geriatric consultation teams in emergency departments and, on the wards, through geriatric evaluation and management (GAU/GEM) units, acute care of the elderly (ACE) units, and or Hospital Elder Life (HELP) Program,[20] as well as on sub-acute units in long-term care where our clinical role would be consultative. We will need to negotiate these roles with our hospital-based colleagues to ensure we are used in an effective and efficient manner. Certainly, we will need to limit the number of beds for which we have primary responsibility, and recognize that the vast majority of older persons will be cared for by others. For these patients, we will offer an active consultation service that can co-manage referred patients.
2. Expand our Presence in Primary Care: We need to foster effective partnerships with primary care professionals who will be increasingly challenged by caring for our aging population. It is essential for us to provide relevant, effective, and timely support to primary care physicians, as well as to other community-based professionals, through a balanced combination of facility-based specialty clinics and community-based consultations. There is growing evidence that a period of frailty or vulnerability precedes the onset of disability in many older individuals. We must work with primary care to help identify older people at risk and then intervene to reduce the subsequent likelihood of disability. And, we must appreciate the importance of chronic disease management. While huge strides have been made for conditions such as diabetes, heart failure, dementia disorders, and chronic renal disease, there is room for improvement in the management of multi-morbidity where the competing demands of disability, cognitive impairment, and dealing with several chronic medical conditions have to be juggled. We should embrace this area and work with our colleagues in primary care and other fields to develop chronic disease management strategies for older individuals with multiple, interacting, and summating diseases.
3. Education: We must teach as the demographic imperative demands that nearly all present and future health-care workers will have to be proficient in the care of the ever-increasing number of older patients. But which learners should we particularly target? We feel it is most important to influence medical students, internal medicine and family medicine residents, as well as trainees in other medical specialties and sub-specialties, from whose ranks will spring those caring for older persons and future specialists in geriatrics.
4. Research: We have an obligation to continue to contribute to the discovery of new knowledge, and its translation and then implementation into practice settings. Our unique perspective allows us to appreciate significant clinical issues for older patients that cut across system-based specialties. We must maintain our reputation for high-quality research while doing better in knowledge transfer.
5. Advocacy: We must advocate more strongly for the rights of older people. Our hospitals and community services must be elder-friendly. And, we need to be more effective in raising the concerns of seniors at a policy level. Demographic aging is no secret, but somehow it always seems to slide below the threshold needed for political action. Can we ensure that there is an effective aging

national strategy in place prior to large relative and absolute increases in older Canadians we can expect over the next twenty years?

We are not seeking Renaissance workers able to personally grapple with all five suggested actions, but we feel that every division of geriatric medicine must be able to deal collectively with them.

On the other side of this coin, we must declare what we can no longer do. We suggest that:

1. Decisions about how to allocate our clinical time should be driven by where we can make the most difference and not by financial concerns.
2. We have to retain, as well as recruit. Collectively we must fight against losing any of our small cadre of specialists to other clinical fields. Division Heads will need to be creative in ensuring comparable rewards and be willing to modify positions to make them attractive to potential, as well as current, members. Everyone stepping out (or students and residents "stepping away" from the field after initially expressing interest) of geriatrics should have an exit interview to discover what went wrong and how we could have prevented the defection.
3. We should not be doing things which can be done equally as well, if not better, by others. This means more than working with fellow physicians. Those of us who have worked with nurse practitioners (NP), clinical nurse specialists, and other advanced practice nurses appreciate their ability to improve our efficiency and comprehensiveness. The same can be said for the other professionals with whom we work. We must acquire the resources to establish integrated and comprehensive teams of health-care professionals that can broaden and enhance our impact.
4. Family physicians are admirably prepared to provide primary medical care for seniors with complex needs in both facilities and the community. Specialists in geriatrics should not be providing primary care but supporting the true specialists in this field. In many jurisdictions family physicians with additional geriatric training (e.g., Care for the Elderly) have worked side-by-side with geriatricians in the provision of consultative care to older persons. We have to ensure that these physicians have employment opportunities, equitable reimbursement, and job security.
5. We must stop doing what doesn't work or is inefficient—even if we like doing it. Where is the evidence that medical day hospitals are more effective than other forms of comprehensive care?[21] If there isn't any, why do we persist in supporting them? While home or domiciliary visits are necessary for some of our patients, they are not needed by all. Domiciliary visits are rewarding and educational, but can be inappropriate and inefficient. Are we planning and performing these visits in an appropriate manner?

Redefining ourselves in the manner described is all moot if we are unable to entice more trainees and practicing physicians into the field. It is not widely known that geriatric medicine is one of the most satisfying fields of practice, yet few trainees are currently choosing geriatrics, a phenomenon not unique to Canada. This trend needs to be reversed as the baby boomers travel through the last third of their life span. It is surely time for an urgent dialogue on these matters and how to deal with them not only within our divisions of geriatric medicine, but also with our hospital and university departments, faculties of medicine, and regional and provincial health authorities. We must establish priorities for the future of our specialty but, more importantly, for the future of quality care for older persons. And if we do not, Canada will become, to borrow a film title, *No Country for Old Men* (or Women).

CONFLICT OF INTEREST DISCLOSURES

The authors declare that no conflicts of interest exist.

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