More Seniors, Fewer Geriatricians: Shifting Demographics Pose Challenges for Medical Education

—By Aliyah Baruchin, special to the *Reporter*

The statistics tell the story: By 2025, the number of Americans over the age of 65 will nearly double, making them the fastest-growing age group in the country. Providing quality medical care for these seniors will require a certified geriatrician population of 25,000 according to The American Geriatrics Society, but as of 2014, there were fewer than 7,500 geriatricians in the United States. Only eight of the country's 145 academic medical centers have full geriatrics departments, and only 44 percent of the nation's 353 geriatric fellowship positions are filled.



While geriatricians are part of the overall physician shortage, their numbers lag for more specific reasons. Geriatricians actually rank above most other specialties in career satisfaction, yet theirs is not a popular area of interest. "People in geriatrics are called to it," said Dr. Mitchell Heflin, associate professor of medicine at Duke University School of Medicine. "It's one of the few specialties where the more training you get, the less you make—the opposite of most procedure-based specialties." The median salaries of geriatricians are lower than those of internists and family physicians despite the extra year of training required in geriatrics. In addition, visits with older adults typically take twice as long as with other patients, which cuts into reimbursement levels.

With geriatrics already one of medicine's underrepresented subspecialties, the coming demographic shift poses enormous challenges for the future of medical education. Older adults soon will surpass pediatric patients in the percentage of practice time devoted to them, and they bring a set of needs that are both specific and highly complex. Currently, however, geriatrics rotations are still elective in most internal medicine, family medicine, and psychiatry programs.

"Gerontologizing" medicine

Most robust geriatrics curricula today focus not only on enhancing training within the specialty, but also on what William Moran, MD, professor of medicine and director of general internal medicine and geriatrics at the Medical University of South Carolina, calls "gerontologizing" the rest of medicine—training medical students, residents, faculty, and non-geriatric specialists to provide higher-quality care to older patients. "Current projections are that South Carolina needs 300 geriatricians today and will need 400 in a decade—and we have 88," Moran said. "We have to integrate geriatrics into internal medicine and primary care."

The gerontologizing process has to start with acknowledgment of the relevance and importance of geriatrics as a specialty, advocates say. "Other disciplines almost see us as irrelevant. Because they all have older people as patients, the common perception is that they are all geriatricians," said Laura Diachun, MD, director of Eldercare Clerkship, in the Division of Geriatric Medicine, at the University of Western Ontario Schulich School of Medicine & Dentistry. "And I like to counter that with, 'Well, all my patients have hearts, but I don't claim to be a cardiologist.'"

In Canada, Diachun noted, students typically spend a total of about 80 hours on geriatrics through all of the undergraduate medical education years; by contrast, the average in the United States for pediatrics training is seven weeks per year. Yet within the next two to three years, patients over 65 will begin to surpass the number of children needing care in both the United States and Canada.

"We spend six weeks training people to deliver babies, and they may never do it again, but they're going to see older patients every day," said Rosanne Leipzig, MD, vice chair for education of the Brookdale Department of Geriatrics and Palliative Medicine at New York's Icahn School of Medicine at Mount Sinai.

In fact, specialized training time is needed because geriatrics requires a specific knowledge base and skill set, Heflin emphasized. "One domain is understanding geriatric syndromes—the variety of conditions that don't necessarily fit into a disease construct but become very important to recognize and treat," he said. "Dementia and cognitive disorders, gait instability and falls, incontinence—those are conditions for which we have a particular training in terms of evaluation and differential diagnosis."

Teaching those skills requires that faculty outside geriatrics have the ability to pass them on in the first place. Yet physician educators in a variety of programs across the country find faculty members lacking in geriatrics-specific skills and knowledge—everything from communication skills to the ability to properly assess falls in older adults. "They can't teach it because they weren't taught it themselves," said Leipzig. "Faculty recognize that they need more training."



At Wake Forest School of Medicine, the Geriatrics Principles for Specialists (GPS) curriculum takes a train-the-trainer approach to faculty development. "We asked what other specialties need to deliver the best care for older adults," noted Hal Atkinson, MD, director of the internal medicine residency program at Wake Forest Baptist Medical Center and associate professor at Wake Forest's J. Paul Sticht Center on Aging. "For example, in a rheumatology clinic, where patients are often on strong medications to suppress the immune system, should we be assessing their cognitive function to get a sense of whether they'll be able to adhere to that kind of a regimen?"

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Complexity is the watchword

Specialty boundaries aren't the only lines that geriatrics education deliberately crosses. Around the country, academic programs are focusing more on interprofessional training—teaching students and residents to work in care teams that include health professionals from pharmacy, physical therapy, social work, and other disciplines. The prevalence of comorbidities, the simultaneous use of multiple medications, and more frequent care transitions make coordinated team care a necessity for older adults.

Interprofessional teams of health care providers offer patients and families a complete package of care—not just treatment for the disease or one organ, said Anna Chang, MD, an associate professor of medicine in the Division of Geriatrics at the University of California, San Francisco, School of Medicine (UCSF). The school's program takes a particularly aggressive approach to interprofessional training, and Chang believes the program's goal is nothing short of a fundamental shift in the culture of medical education.

"Medical students think that if they study hard enough, everything will be perfect," Chang continued. "But in the real world, there are so many patient safety issues that it actually does take a team. And that training has to start in medical school on day one. Our students, when they see the power of an interprofessional team early on, they get it."

For residents and interns, whose entire learning environment focuses on doing, the program is changing the unwritten rules about how they do things day to day, Chang added. For example, how can a resident plan a complicated discharge for a vulnerable older adult to ensure the best outcome? "The way you take care of patients today can be so much better if you sit in the same room as the social worker who's also trying to plan the patient's discharge; if you talk about the medications with the discharge pharmacist before you write the orders; if you hear from the physical therapist before you plan the location of discharge," she said. "These are the 'Aha' moments that residents will never forget."

This team approach is crucial because older adults so often have multiple comorbidities. Navigating those conditions requires specific skills because tapping one condition makes the others respond. "I call it Newton's Law of Medicine: Every action has an equal and opposite reaction," said Diachun.

Another important area of focus is polypharmacy, which "becomes a syndrome in itself," said Heflin. "It's become an epidemic that contributes to other geriatric syndromes and to functional decline." At UCSF, Chang's program puts polypharmacy issues front and center from the first year onward. "We don't tell residents what a pharmacist is; we change the way they do things in taking care of patients to show them the power of what a pharmacist can do," she said.

The issue of care transitions across settings and systems is key, too. Older adults experience these transitions more frequently than other patients, which can contribute to further comorbidities and polypharmacy complications. "Geriatricians are typically not bound to a particular setting, and our training and, frankly, our work takes us from a clinic to a hospital to home care to long-term care," said Heflin. "We want to teach not just an understanding of how to work in those different settings, but how to get (patients) safely between them."

Complexity may be the watchword in the future of medical education. "We talk about clinical practice guidelines, but in geriatrics, we need to merge all the individual guidelines, which typically are based on studies of young adults with single-system disease—not frail elders who also have diabetes, heart and liver disease, and have had a stroke," Diachun said.

Medical educators are anticipating the demographic shift and trying to prepare a provider workforce that can manage that level of complexity. Will that be enough? By integrating geriatric medicine and a collaborative systems approach, geriatrics is betting on that prospect.

Ultimately, said Heflin, health care systems have to ask who is best equipped to care for older adults. "Rather than someone trained in just one disease or system, it's more likely to be people who understand complexity and communicate across systems."