Redefining Geriatrics

There are specialists in elder care, but increasingly important is ensuring that all medical providers are equipped to deal with the health needs of their aging patients.

By Debra Levy Martinelli

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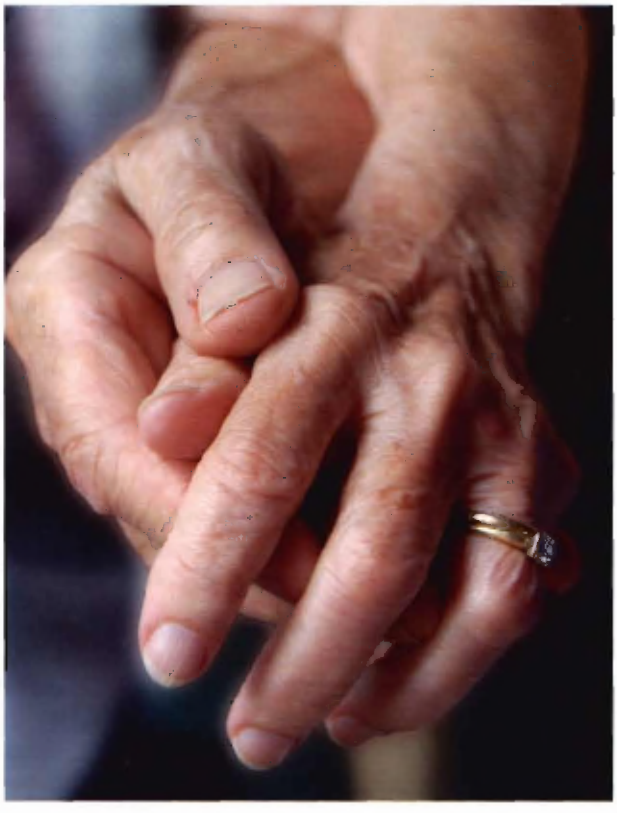

In a world in which 50 is touted as the new 40 and 40 the new 30, numerical age does not seem to mean what it did, say, 20 years ago.

Once nearly everyone started collecting Social Security benefits at 65; now the standard has been pushed up to 67, 68 or even older.

The boundary lines for acting your age, looking your age, even being your age have blurred, but say the word "geriatrics," and suddenly a very definite image comes into focus.

And here is a newsflash: Geriatrics is not a specific number, either.

"In the late 1980s, when I'd give talks about geriatrics, the image that word conjured up was of a cranky old man sitting in chair shaking a cane at you. That's not what aging is about anymore," says Marie Bernard, M.D., an internationally renowned geriatrician who until this past fall served as the founding chairman of the Donald W. Reynolds Department of Geriatric Medicine at the University of Oklahoma Health Sciences Center.

Rather than being defined by age, the need for geriatric care is increasingly defined by level of function. "It's more a matter of what illnesses older people have and what their needs are," she says. "An 85-year-old who's up and about may not be considered geriatric, while a bedridden 62-year-old would be. Geriatrics is evolving to the care of the frailest of the frail, and recognizing what needs to be done to avoid or limit the development of frailty."

The U.S. population is aging at an unprecedented pace. A Baby Boomer—someone born between 1946 and 1964—turns 60 every 20 seconds; by 2011 a Boomer will turn 65 every 20 seconds. Geriatricians call this phenomenon "the Silver Tsunami."

A major problem presented by this burgeoning segment of the population is that there simply are not enough qualified physicians to take care of them. According to the American Geriatrics Society, only some 7,000 board-certified geriatricians currently practice in this country, and those numbers are decreasing. As a result, health care providers in all specialties, as well as generalists, are being urged to become better equipped to treat their aging patients. A landmark report issued in April 2008 by the Institute of Medicine, "Retooling for an Aging America: Building the Health Care Workforce," suggests that *every* health care provider needs to have some core competency in the care of the elderly, and establishes guidelines for criteria to be met by 2030. *continued*

Marie Bernard, M.D

At OU, the Department of Geriatric Medicine is addressing this need by providing that core training to all of its medical students while educating those planning careers as geriatricians.

An $11.2 million grant from the Donald W. Reynolds Foundation in 1997 gave OU the third full-fledged university-based geriatric medicine department in the United States at that time and currently one of only 11 nationwide. The majority of the Reynolds Foundation grant was earmarked for 10 endowed faculty positions to attract and retain the best geriatric educators and researchers. In 2007, the foundation gave another $7.5 million to fund six more research positions.

"When the department was established 11 years ago, the idea was to recruit a critical mass of physicians to help train medical students, with the goal of exposing every one of them, regardless of area of specialization, to geriatric-aged individuals," Bernard explains.

That abstract has become concrete. With 20 primary and 45 adjunct faculty, the department is meeting its mission of educating future geriatricians and current healthcare providers, providing geriatric expertise to referring physicians and their patients, and advancing the knowledge of aging and related diseases through technology and research.

When Bernard departed OU in September 2008 to become the deputy director of the National Institute on Aging, she left stewardship of the acclaimed program to interim chairman David Staats, M.D., who joined the faculty in 2003. A national search for a permanent chairman is under way.

"Establishing this department has been the pinnacle of my career thus far," Bernard says. "This faculty and staff are a group of vibrant, engaged, smart people who are doing a great job educating students, treating patients and looking for new and improved ways of doing both."

To further that end, Staats plans to build relationships with other departments at the Health Sciences Center and on the Norman campus; foster the growth of the Reynolds Oklahoma Center on Aging, the research arm of the department; and promote the work of the Oklahoma Geriatric Education Center, a nationally funded program of educational outreach to health care professionals working with older persons throughout the state.

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Geriatrics has only been a board-certified specialty since 1988. Bernard was among the first to earn the certification. Trained in internal medicine, she thought she knew geriatrics but during additional geriatrics training discovered otherwise.

"I was really good at diagnosing and treating high blood pressure, diabetes and coronary problems, but I had not been trained to translate that into how people can stand and walk or feed and dress themselves," she relates. "There is a whole body of knowledge that we as physicians are not really aware of. Little by little, we're all learning and gaining more appreciation for the things that can be brought to the table by geriatrics expertise."

Because the number of certified geriatricians is expected to fall far short of the need over the next few decades and beyond, medical education is undergoing a shift in emphasis to ensure that physicians and other skilled medical professionals—nurses, physical and occupational therapists, social workers and dieticians—can help.

"Geriatricians have to get recertified every 10 years, and a lot of them are retiring or deciding not to get recertified. There are fellowship programs for geriatricians, but all of the positions aren't getting filled. And the specialty isn't as high paying as most other medical fields," Bernard explains. "So it's kind of a calling. Geriatricians are at the top of the scale in terms of professional satisfaction. We love what we do."

What they do is improve the quality of life for older people on a very individualized basis. "We have each patient tell us what's important to them in terms of quality of life: Maybe it's 'I want to be able to go fishing with my grandson' or 'I want to go back to traveling around the country in my RV.' In situations where you're dealing with an individual who isn't cognitively intact, you have to rely on what they've told family and friends or indicated in written directives. Either way, we work to achieve the quality of life as defined by that individual. Usually that means enhancing function."

Looking at aging from a functional perspective, about 5 percent of 65- to 74-year-olds have significant problems bathing, feeding and dressing. By age

85, that number increases to 25 percent. "Our job as geriatricians," Bernard says, "is to figure out how we can reverse or compensate for that."

In some cases the functional problem results from a new illness and can be turned around. In others, patients seeing multiple doctors are being overmedicated because the physicians are unaware of one another's treatment.

Bernard illustrates with an anecdote. "One of our fellows went to practice in Enid, Oklahoma. Just by cutting back medications and removing catheters, he got patients walking again. They thought he was just fabulous!"

Patients who suffer a stroke or emphysema, for example, experience a permanent change. In those situations, geriatricians work together with the patient's physical therapist and occupational therapist to enable the patient to do as many things as they can or want to do for as long as possible.

Even many diagnosed with significant degrees of Alzheimer's disease, through careful testing, can still function well, both physically and neurologically. A famous research study known as the Nun Study is further confirmation that the disease does not necessarily impact functional abilities in the elderly. The ongoing research, which began in 1986, follows a group of nearly 700 nuns through death and autopsy. Findings to date show that even when the brain showed all the pathological changes of Alzheimer's, some of the individuals' physical and neurological function remained at high levels.

For the past five years, all OU third-year medical students at both the Health Sciences Center in Oklahoma City and OU-Tulsa's Schusterman Center have incorporated into their training a compulsory one-month rotation in geriatric medicine in a hospital or acute care clinic, nursing home or home care program. This academic year, for the first time, they rotate through all of those settings.

Dr. David Staats, interim director of the Donald W. Reynolds Department of Geriatric Medicine at OU, consults with a patient. Students say Staats is a role model for connecting with patients on a personal level, which greatly enhances treatment results.

"By exposing medical students to formal training in geriatric medicine, we give them a repertory of information and skills that they can apply to all the old persons they treat, no matter what their chosen area of specialty," Staats explains.

A week and a half into their month-long rotation, third-year medical students Philip Sloan and Thomas Maliel already had concluded that establishing a connection with the patient is the key to treating geriatric patients.

"We're learning that it's more important in this population than any other to really get to know the patients and their history," Sloan explains. "Their situations are so complex. Doctors need to know the whole person so everything can be treated simultaneously."

"Dr. Staats sits down—really sits down—and talks to the patients and somehow finds common ground with each of them," Maliel says. "He does whatever he can to connect on a personal level and discover some shared experience. When that connection is made, a trust develops, and the patient is more likely to do what the doctor says. We see in these patients real respect for the physician."

Maliel and Sloan are convinced that, regardless of the field in which they eventually practice, their experience in the geriatrics rotation will give them a better understanding of how to treat other patients as well. "We'll be better able to help all of them," Maliel says. *continued*

While third-year students spend a full month in geriatric medicine, second-year students are introduced to the discipline by engaging in role playing that gives them a feel for problems that may develop with aging. They wear eyeglasses with grease smeared on the lenses to simulate cataracts; add popcorn balls and packing materials to the inside of their shoes to replicate arthritis of the foot; tape fingers together to mimic osteoarthritis of the hand; or wear an adult diaper to understand that it is an uncomfortable last resort for incontinence. In another exercise, they are given scenarios in which they are nursing home residents having to sort out bills, put on stockings while wearing restrictive adaptive equipment or listen to directions given in rapid-fire fashion. Then they reconvene as a group and discuss their experiences.

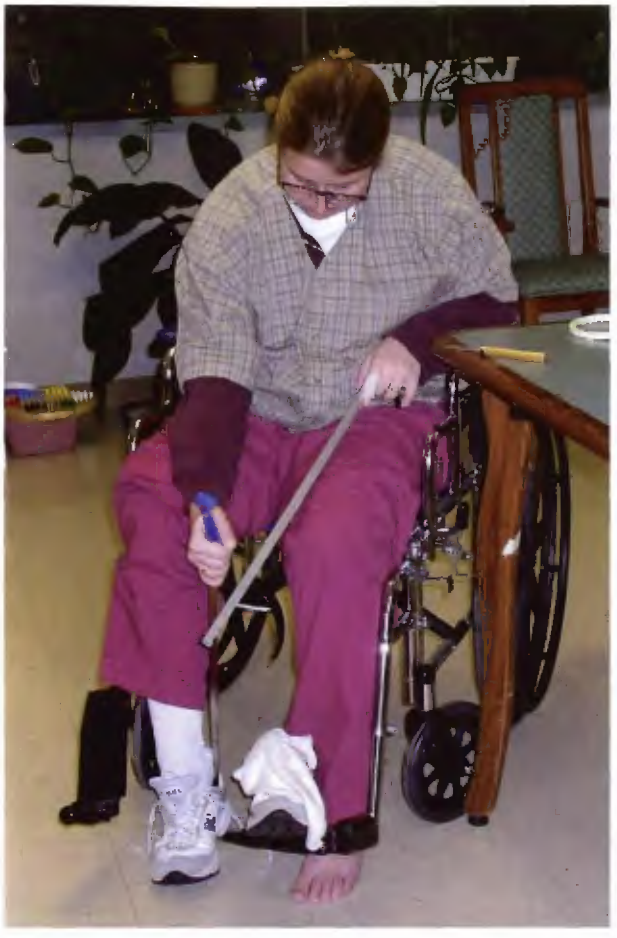
OU's Department of Geriatric Medicine is based at Oklahoma City's Veterans Administration Hospital on the Oklahoma Health Center campus. Department faculty treat in-patient and out-patient veterans and also reach the greater Oklahoma geriatric community by seeing patients at the Senior Health Center in the OU Physicians building, serving as consultants for patients admitted to Presbyterian Tower, and providing continuing care at independent living and assisted living retirement centers, skilled nursing centers and Alzheimer's facilities.

Despite the inevitability of the cognitive deficits and physical infirmities that may come with aging, Bernard contends it is not as scary as it sounds. "People are living longer and better because we know so much more about what needs to be done for that to happen."

She remains optimistic about the future of geriatric care. "If some of the barriers were removed that discourage health care professionals from pursuing careers in geriatrics—forgiving educational loans, providing scholarships and establishing a geriatrics health service corps based on

Second-year medical students at HSC and OU-Tulsa engage in role playing to help them gain empathy for the problems faced by elderly patients. Here, a student tries to follow a recipe while wearing eyeglasses smeared with grease to simulate cataracts, while another measures ingredients wearing a restrictive brace.

Medical students gain an entirely new appreciation for the challenges facing the elderly during classes that give them the opportunity to walk a mile in their shoes—stuffed with popcorn to replicate arthritis—or ride in their wheelchair, as the case may be.



OU medical students learn that even a simple task like putting on shoes becomes more difficult with limited mobility when confined to a wheelchair.

Reading the tiny print on pharmacy labels is only the beginning for students who are learning firsthand the struggles their elderly patients face. Opening bottles with arthritis or partial paralysis becomes an all-consuming task.

All third-year medical students at HSC and the Schusterman Center at OU-Tulsa take part in a one-month rotation in geriatric medicine. Dr. Staats (seated) believes that training in geriatric medicine teaches skills and sensitivity that students will use no matter what area of speciality they eventually practice.

the National Health Service Corps—this field would be enlarged and strengthened tremendously."

By 2030, the year Bernard expects to celebrate her 80th birthday, she hopes that the guidelines of the 2008 Institute of Medicine report will be met, and every health professional will have some basic core competencies in the key care of older individuals. She also expects there to be a small cadre of geriatric experts to care for the frailest of the frail.

One way for that to happen is for more medical schools across the country to adopt the model on which the Donald W. Reynolds Department of Geriatric Medicine was created.

"It takes lot of money to get a program like this up and running, and we were very fortunate the Reynolds Foundation took a keen interest in us," she says. "Together, we have shown that it can be done."

Debra Levy Martinelli is a freelance writer living in Norman, Oklahoma.