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OLDER PATIENTS: THE UNIVERSAL GAP IN MEDICAL TRAINING

Can doctors trained to treat 50-year-olds provide the right care to 80-year-olds? The answer is an unqualified no, though many doctors do not fully understand why.

Pediatric Medicine ✓

Adult Medicine ✓

Geriatric Medicine ?



Pneumonia in a 50-year-old, for example, causes fever, cough, and difficulty breathing; an 80-year-old with the same illness may have none of these symptoms but just seem “not herself”—confused and unsteady, unable to get out of bed. With these symptoms, she may end up in a hospital where a doctor will prescribe a dose of antibiotic that would be right for a woman in her 50s but is twice as much as an 80-year-old patient should get, so she develops kidney failure and grows weaker and more confused. In her delirium, she pulls the tube from her arm and the catheter from her bladder.

Instead of re-evaluating whether the tubes are needed, her doctor asks the nurses to tie her arms to the bed so she won't hurt herself. This only increases her agitation and keeps her bed-bound, causing her to lose muscle and bone mass. Eventually, she recovers from the pneumonia and her mind is clearer, so she is considered ready for discharge—but she is no longer the woman she was before her illness. She is frailer and needs help with walking, bathing, and daily chores.


This scenario is far from uncommon but can be avoided. Just as no doctor would treat children without having specific training in pediatrics, all doctors who care for older adults need a foundation in geriatrics.

The principles of geriatric medicine, the conditions evaluated, and the care that follows differ from those of general adult medicine. Often, conditions and symptoms in our oldest patients are not due to a single cause, but to interactions of a multitude of abnormalities that build up over a lifetime. A crack in the sidewalk may cause a younger person to trip and lose his balance for a moment, but he


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easily rights himself. In an older person, the same faulty sidewalk may lead to a fall and possibly a fracture. Why? Small problems with vision, balance, leg strength, a touch of arthritis, and certain medications, which individually will rarely cause a fall, together reach a literal tipping point. For many elders, mobility is restricted because they have seen the effects of falls on others and have developed a fear of falling, particularly of having a hip fracture. After a hip fracture, almost half of people are unable to return to living independently.

Doctors who are trained in care of older adults know how life-changing a fall can be. These doctors routinely ask patients if



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they have fallen; watch them get up from a chair and walk; or ask them to stand on their heels to see if they lose their balance. They check for the presence of risk factors, initiate treatments to decrease them, and determine whether a cane or walker might restore the patient's ability to navigate the streets safely.

Physicians also need to regularly monitor older patients for memory problems. They should know that confusion can be due to bladder infections, heart attacks, or medications, and that heart attacks in those over 80 usually present without chest pain. They need to be aware of which community resources can help elder patients live safely at home rather than in a nursing home. Doctors with training in geriatrics make a habit of discussing patients' goals of care; doctors without such training often recommend time-consuming, uncomfortable tests and treatments, even when patients are not going to live long enough to reap the benefits.

If physicians throughout the world are to truly care for older adults, they must learn and apply what we have discovered over the past several decades about how 80-year-olds differ from 50-year-olds. This new body of knowledge must be an integral part of their medical school training. Although this seems intuitively obvious, it is not happening.

Medical student-training in geriatrics is more the exception than the rule. According to a 2002 World Health Organization (WHO) global survey, 40 percent of countries with national, medical student-training standards make no mention of geriatrics in these standards. Countries such as Spain, Greece, Germany, Austria, Portugal, Ukraine, and Bulgaria—where 20 percent of the population was already

over age 60 in 2000—have weak geriatrics training in their medical school curricula.

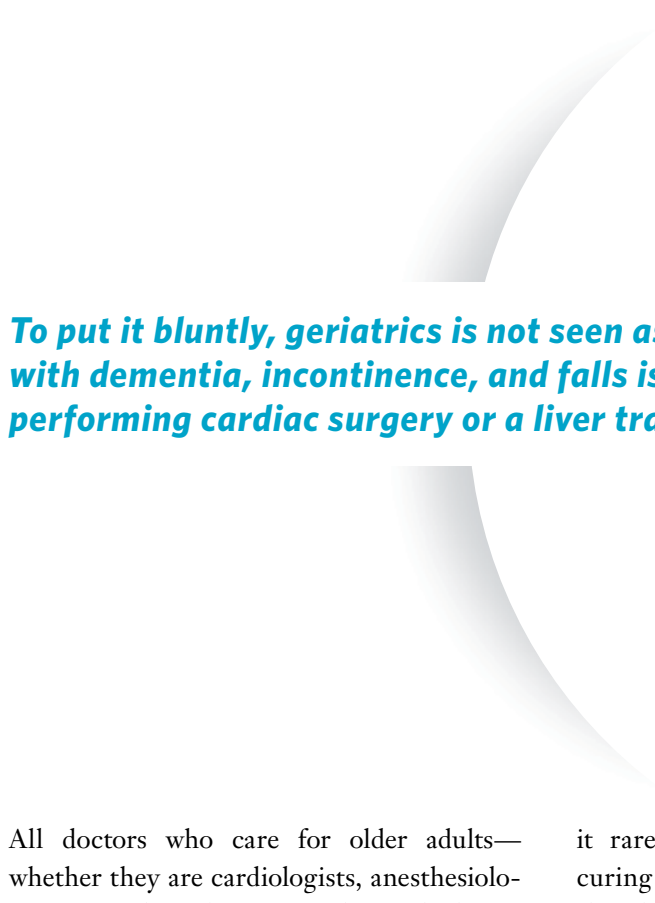
In the United States, there is no nationwide requirement for geriatrics training, even though patients 65 and older account for 32 percent of the average doctor's workload in surgical care and 43 percent in medical specialty care, and older adults make up 48 percent of all inpatient hospital days. Medicare, the national health insurance for people 65 and older, contributes more than \$9 billion a year to support training, but it does not require that training partially focus on the unique health care needs of older adults.

The age boom is happening throughout the world, not just in developed countries. Life expectancy in developing countries is now around 73 years, a 20-year increase since

1950. Life expectancy in 38 percent of all countries in the world is at least 75 years, and in 10 percent of countries it is over 80 years. As Harry R. Moody, Director of Academic Affairs for AARP, puts it, "More than half of all the human beings who have ever lived beyond the age of 65 are alive today."

Geriatrics is the branch of medicine most attuned to the changes in health care countries will experience as they become more prosperous: the switch from treating and curing acute infectious disease to managing chronic diseases; understanding "geriatric syndromes" such as falls, frailty, and confusion, and how these are often the result of interaction among many conditions; and the need to help people living with multiple chronic diseases maintain their independence and prevent further functional impairments.





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All doctors who care for older adults—whether they are cardiologists, anesthesiologists, or orthopedists—must know the basics of geriatric medicine. For this to happen, every medical school must employ faculty competent to teach geriatrics.

But geriatricians are rare in most countries. Of the schools surveyed by WHO, 20 percent of those without geriatrics in their curriculum reported that they had no faculty qualified to teach geriatrics. The field is relatively new, and many faculty received no training when they were medical students. This makes the task of educating medical students daunting—the teachers must learn geriatrics before they can teach and model it for their students.

Why aren't there more geriatricians? Many students view the field as frustrating because

it rarely offers the satisfaction of totally curing a patient of all ailments. Much of the physician's time is spent arranging and coordinating the patient's care, work that is better done by an interprofessional team with social workers, therapists, and nurses. But physicians in many societies do not have access to a team.

To put it bluntly, geriatrics is not seen as a sexy field—dealing with dementia, incontinence, and falls is not quite the same as performing cardiac surgery or a liver transplant. Geriatricians are also paid less than physicians in other disciplines. In the United States, geriatrics is the only subspecialty where one spends additional years of training to make a lower income than peers without a subspecialty.

Despite these impediments, geriatricians' job satisfaction is consistently very high,

ranking first or second among physicians in the United States. Many doctors love the complexity of caring for older people. There is rarely a single right answer to a patient's problem, and even when there is, patients have a lifetime of wear-and-tear, diseases, procedures, and medications that can make therapeutic decisions a challenge. Small adjustments can result in big benefits for patients and their families. Patients and doctors often enjoy their relationship, and truly therapeutic alliances are forged.

Health care system changes that make it easier to practice geriatrics and provide patients with needed services, as well as appropriate reimbursement for geriatricians, would go a long way toward inducing students to enter the field, resulting in more faculty to train those students who may not necessarily specialize in geriatrics, but will be caring for many older adults.

Progress is being made. Through the generosity of foundations, such as the Donald W. Reynolds Foundation and the John A. Hartford Foundation, educational and training materials have been developed and made available, free and worldwide, on the Portal of Geriatric Online Education (POGOe) website at www.pogoe.org. Medical school faculty can access this site and find off-the-shelf products and ideas for teaching the essentials of geriatrics to medical students and trainees in every discipline of medicine. For medical students in the United States, Canada, Australia, and some other countries, standards have been developed to identify the knowledge, skills, and behaviors required for geriatric care. In the United States, similar competencies have been identified for internal medicine, family medicine, emergency medicine, and surgery.

How can we foster better support for geriatrics training? More training resources help, as do system reforms. But more can be done. Nations could require that doctors demonstrate basic geriatric competence in order to get a license to practice medicine.

We need to increase awareness of the need to train doctors in geriatrics. This would not be a special interest lobbying effort—nearly all of us will eventually need care from doctors who understand that the care of 80-year-olds differs from that of 50-year-olds. **A**

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