Introduction to the Geriatrics-for-Specialists Initiative: Geriatrics Specialty Care at the Tipping Point

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It is a special pleasure for me to be invited to speak to you tonight. You represent seven crucial specialties of surgery and three closely related medical specialties. I represent the medical specialty of geriatrics, I have also been heavily involved in the Geriatrics-for-Specialists Initiative (GSI) project since 1995, and I have an additional very personal qualification for being here—I am in many ways a classical geriatrics patient. I am not yet disabled or frail, but I carry six major chronic diagnoses in four key organ systems; my functional capacity, mental and physical, is definitely declining, fortunately very slowly. But everything takes longer to do. I take 10 medications daily. And, as a geriatrician, I am well aware of what lies ahead.

So I have a personal stake in the basic mission of the GSI to enhance the well-being of older patients who suffer from diseases and conditions requiring treatment by specialists. Should I require surgery or other specialty care in the future, I want my surgeon to "be familiar with the unique requirements of the geriatric surgical patient." Here I am quoting verbatim from the booklet of information provided by the American Board of Surgery (ABS) to all potential applicants for certification. Incidentally, this sentence was added in 2000 in an extremely welcome response to a letter sent to the ABS by the GSI.

Why was the GSI project essential? The answer is very simple. Around 1975, it became clear to all that the population of elders in the USA and elsewhere would have a growth spurt in the decades from 1980 to 2010 and growth would become explosive from 2010 to 2030 when the baby-boom generation will be passing age 65 en masse. Parenthetically, the growth spurt has far exceeded predictions because of a startling increase in human longevity in recent decades. This is dramatically illustrated in the current decade when the number of people dying at a given age is actually falling, an unprecedented phenomenon.

Driven by the demographic imperative, a renaissance of the field of geriatrics began in the late 1970s, but it was limited to the specialties of internal medicine, family practice, neurology, psychiatry and, to a certain extent, emergency medicine, anesthesiology, and physical medicine and rehabilitation (Physiatry). This renaissance led to a remarkable expansion in our knowledge of the physiology and pathology of aging and the diagnosis and treatment of geriatric patients, and this knowledge has resulted in striking improvements in their medical care.

In the early 1990s, some visionaries, led by Dennis Jahnigen (the founder of the GSI project, for whom the Jahnigen Career Development Awards are named), recognized that every clinician needs to have knowledge and skill in geriatric care and that the geriatrics renaissance would fall short unless every branch of our profession participated in it. In particular, surgery is crucial because more and more older people are undergoing operations, and they are clearly more vulnerable to perioperative problems than are younger adults.

Thus, the GSI project was essential to the full maturation of the geriatrics renaissance, and it represents a historic advance in which our profession has faced the need for improved care of its older patients across all generalists and specialists. The last time there was similar recognition of the unique needs of a subpopulation was in the birth period of pediatrics nearly a century ago.

Today you have heard about many of the specific accomplishments of this project. We all should recognize that none of this would have happened but for the wisdom of Dennis Jahnigen; the steady, inspired support of the John A. Hartford Foundation; and the quality of the people who made up the Interdisciplinary Leadership Group (ILG). This predecessor of our Council was formed in 1998. At its second meeting, in 1999, most of the important programs of GSI, including the Jahnigen Scholars, the Geriatrics Education for Specialty Residents, and the research agenda, New Frontiers in Geriatrics Research: An Agenda for Surgical and Related Medical Specialties, were suggested by ILG members. All of these suggestions were adopted and activated in less than a year.

The ILG also made the decision to place the responsibility for managing the GSI project in the American Geriatrics Society and to change itself into the Council of the...
Section on Geriatrics-in-Specialties of the AGS. I should emphasize that this was a decision made freely by the ILG, which represented all 10 of the specialties. The AGS did offer itself as a possible home for the project but made no attempt at coercion and actually suggested three other alternative affiliations for consideration. This important decision has resulted for me personally in the great joy of working with a group of outstanding specialists. We have built strong friendships on a foundation of shared goals, and I am deeply grateful for that.

Every 4 years, we have submitted a renewal grant application to the Hartford Foundation and, later, to Atlantic Philanthropies as well. In the Hartford grant for 2001 to 2005, we stated that the completion of the geriatrics renaissance would take many years and that its success would depend on a transfer of “ownership” of the project. In that grant, we laid out an explicit plan for the progressive transition of the leadership of the project from geriatricians to specialists. This led to George Drach, Joe LoCicero, and Jeff Silverstein becoming, successively, Chairs of the Section; it also led to a rule that a majority of the Executive Committee of the Council would always be specialists.

Now we are at the tipping point, where we must complete the transfer of leadership of the project from the geriatricians to specialists. A major step in that transfer will be embedded in the next renewal of the Hartford grant.

We now commit that the Program Director of the grant will be a specialist. John Burton will remain as a Co-Program Director for 1 year, but after that, the grant that has sustained the project through 15 years will be administered, for the first time, by specialists. Geriatricians will be in a consultant role. Staff of AGS will still provide strong and stable support, and AGS, through GSI, will also commit to participate in efforts to expand funding support for the project.

That is the proposed structure for the future. Our conviction is that our common aims can only be met if the specialties are committed to do the job. Our missions are the same. The AGS has done its best to help GSI get started. We have stated the specific aims and have developed programs to address each of them. Most importantly, all of us together have created an atmosphere of collaboration and camaraderie, which we hope will continue for many years. We have made dramatic progress, but much remains to be done.

It is now essential that each specialty society take over leadership in promoting geriatrics education and faculty development within its specialty and also in pressing its board and residency review committee to incorporate a necessary minimum of geriatrics knowledge into their assessment of the abilities of applicants for board certification and maintenance of certification. The consortium of 10 specialty societies and the AGS, represented here by the Council, lends great strength to the effort and must continue to be supported, because it must still perform important functions; for example, it will provide curricula for education and training in geriatrics, supervise the Jahnigen Scholars Program, guide research approaches, and push for improvement in quality of care; but, the major expenditure of energy in the future must well up from each specialty and be expressed within each specialty.

I believe that this transition of leadership and sharing of responsibility can result in an extraordinary broadening of the impact of GSI on the quality of care that older patients will receive. The project will go from a relatively obscure liaison arrangement to a vibrant effort to adapt each specialty to meet the unique needs of older patients. In the process, residency curricula and continuing education of specialists will change, and more and more faculty and practicing specialists will develop knowledge and skill in managing their older patients.

Would the increased responsibility carried by the specialty societies be accompanied by greater fiscal commitments? Undoubtedly yes. For example, financial constraints at Hartford and Atlantic have made it impossible to continue the Jahnigen program as it has been. So John Burton and others are far along in a negotiation with the National Institute on Aging (NIA) to develop a joint program whereby NIA would meet half the cost, with the rest being covered by the university of the applicant, the Hartford grant or other extramural support, and the specialty society, whose share would be 12.5%, that is $12,500 a year for 2 years for each Jahnigen Scholar in one’s specialty.

I have mentioned more than once the unique needs of the elderly patient. I want to give some specific examples. Long-neglected problems of older patients include, among others, falls, incontinence, dementia, depression, delirium, rapid deconditioning, functional decline, slow recovery from trauma, pressure ulcers, pneumonia, urinary tract infection, malnutrition, and dehydration or fluid overload. All of these are threats in the perioperative period, and all require interventions to prevent or mitigate bad outcomes.

Examples of such interventions include early but cautious mobilization; rapid catheter removal; organized efforts to orient patients to time, place, and person; early and constant psychological support; exquisitely close attention to biochemical changes and fluid balance; standard pressure ulcer prevention; avoidance of aspiration; and maximal focus on nutritional support. These are all simple things, beneficial to patients of any age, but they are very often overlooked in the busy ambience of a recovery ward. Finally, careful, considerate, continual, and communicative discharge planning is a must for older patients, but it is often missing; everyone believes the words, but somehow it often fails to lead to actions.

Before closing, I should mention another qualification I have for speaking to you tonight. Almost 2 years ago, my wife, Ronnie, and I moved into a CCRC (Continuing Care Retirement Community). As one of the few retired physicians there, I have heard a flood of stories confirming my fears that postoperative care for elders is not being tuned properly for older patients and that the transition from the surgeon to out-of-hospital care is all too often discontinuous, a prescription for disaster.

But let me emphasize again that there is nothing new about the need for specialty societies to assume direct responsibility for including the principles of good geriatric care in the training and research missions of the society. We have been talking about it for a decade, and worthwhile steps have been taken in many of the societies. We geriatricians will always help, but we are not members of any of the 10 specialties that have banded together in the GSI. In order to succeed, the real revolution must now take place within each of the member societies.
I have a final plea. May these revolutions succeed, so when I have my second coronary bypass surgery, my emergency medicine physician, my surgeon, my anesthesiologist, and my physiatrist will all understand the pitfalls that could await an old codger like me and will know the steps needed to prevent or manage the potential postoperative complications.

EDITOR’S NOTE:
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