

Commentary: Aging America: Meeting the Needs of Older Americans and the Crisis in Geriatrics

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Abstract

The aging of the United States population will offer unprecedented challenges and opportunities for the health care system at large, and particularly medical education. In this issue of *Academic Medicine*, three articles provide opportunities for medical educators and others to ponder anew how we can address this so-called “age wave” as the baby boomers become senior boomers. Leipzig and colleagues

describe their process for identifying 26 recommended geriatrics competencies for medical students. Reuben and colleagues examine the results of the first cohort of Reynolds Foundation geriatrics education grants, and Bernard and colleagues discuss the benefits of committing to developing departments of geriatrics at academic health centers. In addition, the recent Institute of Medicine (IOM) report, *Retooling for an*

Aging America: Building the Health Care Workforce, highlights many of these issues. In this commentary, the authors discuss implications of selected articles from this issue and the IOM report, in hopes of provoking discussion and consideration of solutions to address the challenges faced by medical educators and by those who make public policy.

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Editor's Note: This is a commentary on Leipzig RM, Granville L, Simpson D, Brownell Anderson M, Sauvigné K, Soriano RP. Keeping granny safe on July 1: A consensus on minimum geriatric competencies for graduating medical students. *Acad Med.* 2009;84:604–610; Reuben DB, Bachrach PS, McCreath H, et al. Changing the course of geriatrics education: An evaluation of the first cohort of Reynolds geriatrics education programs. *Acad Med.* 2009;84:619–626; and Bernard MA, Blanchette PL, Brummel-Smith K. Strength and influence of geriatrics departments in academic health centers. *Acad Med.* 2009;84:627–632.

Over the years, there have been numerous reports by the Institute of Medicine (IOM), various professional societies and academic bodies, and even citizens' groups about the need to expand geriatric education. The recent IOM

report, *Retooling for an Aging America: Building the Health Care Workforce*,¹ highlights many of the issues facing medical schools and academic health centers. As cited in the report, today there are approximately 7,100 geriatricians, and the numbers are declining—even as the U.S. population rapidly ages.

Faced with these realities, it is evident that geriatricians will not be providing care to the majority of older adults; rather, the majority of older Americans will increasingly receive care from generalists. Further, future physicians will be providing care to older adults, regardless of which specialty the physicians have chosen. Even pediatricians need to be able to recognize conditions, such as early signs of Alzheimer disease, as more grandparents raise grandchildren.

should residency programs expect a recent graduate to be able to do when they walk in the door for their first day of postgraduate year one training?” The process assumed that if, on July 1, a new resident could perform these tasks at a minimally competent level, then at least he or she wouldn't “kill granny.”

It is a testimony to the authors' organizational skills that more than 450 experts in geriatric medicine and medical education participated in the development and evaluation of the competencies. The originators included geriatric educators in medical schools, residency program directors, and deans. Although not all specialties had a chance to comment, 44% of U.S. medical schools and several major medical education organizations had some input into the process.

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Educational Efforts to Address the Need

Because the vast majority of physicians, regardless of specialty, will be caring for older adults at some point in their careers, it makes sense to provide a solid foundation for caring for older adults during medical school. In this issue, Leipzig and colleagues² describe the development of basic competencies that should be expected of every graduate of a U.S. medical school. The guiding philosophy in the development of these competencies was the question, “What

The authors were able to achieve a remarkable degree of agreement across multiple disciplines—94% from geriatricians, more than 80% from internal medicine, family medicine, and neurology, and 69% from surgeons. Attaining this level of agreement, including almost 70% of surgeons, is impressive.

The result of all this work is a list of 26 competencies in eight domain areas. On the face of it, the domains are clearly of major importance to geriatric care. We'd certainly refer our own grandmothers to

any doctor competent to perform these 26 functions!

The question we have with the competencies is not their validity—it's about their implementation. There will be many challenges getting all medical schools to commit to providing the learning experiences necessary for all students to develop all of these competencies. Where will the training be provided in an already overcrowded curriculum? Even in those schools fortunate to have a required geriatric rotation (only 11% of U.S. medical schools), it seems unreasonable to think that all 26 suggested competencies could be addressed in one rotation. Still, the Liaison Committee on Medical Education (LCME) could go a long way toward improving health care for older adults by requiring a rotation in geriatrics. It's long overdue.

Many of the 26 competencies will need to be addressed in other rotations and classes. Perhaps a subsequent consensus panel should suggest where in the curriculum specific competencies could be addressed, with an eye on spreading the experiences across all clinical rotations. This approach would help to negate the common experience of the student "acting" like the specialist while completing the rotation and then dropping those approaches when he or she moves on to the next rotation. Elderly patients are one of the most common factors across all rotations and can provide schools with the opportunity to assess cross-specialty education.

The authors also note another challenge—the development of evaluation tools. The recent change in the Association of American Medical Colleges Graduation Questionnaire (GQ) geriatric items is a good example of this problem. On the positive side, the GQ geriatrics-related items are now framed as competency statements. However, just because a student says he or she is capable of performing in a certain manner does not mean he or she can demonstrate that behavior in a clinical test. Even if students can demonstrate a behavior in an OSCE, they may not necessarily use the behavior when not being tested. Ideally, the observation and evaluation of "real-life" behaviors would occur in unexpected places. For instance, perhaps the best place to measure

competency in functional assessment would be on a surgery rotation, both because it would reflect students' true behavior and because of the well-established connection between functional problems and surgical outcomes.

In summary, the development of 26 key competencies is a major step toward improving the geriatric education of physicians. If implemented, these competencies will likely lead to improved outcomes of care, though there is ample opportunity for research to validate our assertion. If our students have the necessary competencies to care for older adults when they walk through the doors on their first day of residency, our grannies will all breathe sighs of relief!

A second article in this issue, by Reuben and colleagues,³ presents the initial results of perhaps the largest national initiative to enhance geriatric medical education—the Donald W. Reynolds Foundation grants for Aging and Quality of Life. Their report addresses outcomes of funding geriatrics education endeavors at 10 medical schools during a four-year period. A total of about \$3 million (\$2 million in grant money and \$1 million in institutional match) was awarded to each institution. On average, each institution trained more than 1,000 medical students, 500 residents, 100 faculty, and 700 nonfaculty community physicians. What was the "return on investment" for the Reynolds foundation? Was it more successful than other programs which preceded it?

It appears so. Medical students received the greatest "dose" of interventions (63% of funded learners were medical students). All institutions were able to institute structural changes in their curriculum, 80% revised their residency curriculum, and 90% reported changes in infrastructure. Importantly, graduating students reported learning more geriatrics.

It will take time to measure the real impact of this grant program. Thirty more schools subsequently received Reynolds grants, expanding the influence of the project to almost 30% of U.S. medical schools. The fourth cohort of awardees will begin their programs soon. We will need evidence that the interventions actually change the way that graduates behave to truly evaluate the long-term impact of the program.

Changing Organizational Structure to Meet the Need

A third article by Bernard and colleagues⁴ provides us with examples of how developing departments of geriatrics may influence the education of multiple types of learners to better meet the needs of our aging population. The authors point out that, analogous to departments of pediatrics, the presence of a department of geriatrics lends credence to the importance of both the population served and the specialty. It puts the clinical/health care delivery decision making, research program development, and education/training activities on par with other primary care specialties, and it allows for "a seat at the table" in decisions regarding budgets, allocation of resources, and strategic planning that are often lost when geriatrics is contained within another department or division or relegated to the level of a section.

However, there are many barriers to creating separate departments of geriatrics, including academic or health center politics and budgetary considerations. Bernard et al's article provides those who may want to consider developing a separate department of geriatrics three different case studies to consider. Although the jury may still be out on the final outcomes of departments versus divisions of geriatrics, the authors provide convincing arguments that committing to having a department of geriatrics can have significant advantages, including access to undergraduate medical education through a required clerkship in geriatrics.

Questions for Academics and Policy Makers

As we considered the articles from this issue and the IOM report, several questions arose. Why should it be left to private foundations to advance the state of geriatric education to improve the care of older people? Why are there not more stringent LCME standards about geriatric training in medical school? Why do so few residency and fellowship programs have requirements for geriatric training? The Reynolds Foundation and the John A. Hartford Foundation have tried extensively to improve the care provided to older adults in the United States. Now it's time for the governing bodies of our discipline, and those financing education and training, to do the right thing.

Larger Issues: It Will Take a Lot More Than a Village

If improving the care of older persons is to be considered a national priority (and who among us cannot wish for more effective and compassionate care of our parents, grandparents, and, eventually, ourselves?), then many other changes must take place.

Why, after more than 30 years of warnings, studies, and reports, do we still not have sufficient geriatric training for all medical students and sufficient numbers of geriatricians? Why are the numbers of geriatricians dramatically declining even as our population ages? There are numerous reasons, but foremost is the strong financial disincentive for entering the field of geriatrics.^{5,6} Medical students are economically driven to seek out higher-paying specialties as a result of increasing educational debt. In geriatrics, the situation is actually perverse—students who complete an extra year of training in geriatrics can expect their earning power to actually *decrease* compared with those who do no additional training and enter practice.^{5,6}

Further, high-quality geriatric care focuses on prevention, reducing iatrogenesis, and promoting function; these are poorly reimbursed compared with procedures that may be less important for the care of the older person. In fact, we believe there are financial incentives to provide diagnostic testing, high-tech interventions, and/or

treatment that either has not been studied, has been shown to have little benefit, or is actually harmful in the older adult population. The focus on high-tech medicine and unproven treatments diverts resources away from more cost-effective approaches and from education and training. The links between education and training, patient-care services, and financial incentives or disincentives must be realigned to promote excellent care for older adults.

The IOM report and a recent editorial by Fried and Hall⁷ supports the view that we can and should make changes that will result in training all generalists and an additional 20,000–25,000 geriatricians during the next two decades. This goal will require a concerted and coordinated approach. Changes must be made to the reimbursement system to create financial incentives for those who enter geriatrics. Further, incentives to create additional training programs in geriatrics by changing GME reimbursement should be made to encourage both the expansion of existing fellowship programs and the creation of new ones that will be needed as more students and residents seek to enter the field. Presently, only about 50% of geriatric fellowship positions are filled, so expansion of fellowship slots by itself would not be a solution. A major expansion of research to focus on areas that are most likely to reduce disability, loss of function, and promote healthy aging can provide evidence of the most (and least) effective treatments for the older adult population. And last, but by

no means least, health care reform offers to change the current fragmented, inefficient, and costly system to one that promotes prevention, reduces needless or harmful diagnostic testing, and makes use of evidence-based medicine. Such changes offer the potential for reducing costs while improving quality.

It is only through a concerted effort that we will be able to make the needed changes. Failure to do so will hurt our grandparents, parents, and ourselves.

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