Geriatrician Shortage Bodes Ill for Care of Elderly

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WASHINGTON — The number of physicians choosing to specialize in geriatrics will not be anywhere near enough to meet the needs of the elderly patients of the future, Dr. Christine Cassel said at a meeting jointly sponsored by the American Thyroid Association and Johns Hopkins University.

In 1987, the American Board of Internal Medicine (ABIM) and the American Board of Family Medicine created a certificate of added qualification (CAQ) in geriatric medicine. To date, 7,422 such CAQs have been issued, including 263 in 2006, said Dr. Cassel, ABIM president. "That rate is not nearly enough to keep up with the predictions" of the number of geriatric specialists needed, she said.

Geriatrics is challenging because "it's not about mastering one area in great depth, but being comfortable enough dealing with a wide range of specialties—not just subspecialties of internal medicine, but other specialties [such as] … orthopedics, urology, and psychiatry—that you will be referring to," she noted.

The physician must also understand the difference between disease and aging, and know how to evaluate physiologic age.

In addition, "no geriatrician thinks you can be a solo practitioner in an office by yourself." Instead, geriatric medicine specialists need to know how to integrate advanced practice professionals, social workers, pharmacists, and others into the practice team, Dr. Cassel said. In effect, what elderly patients will need are generalist physicians.

"That generalist discipline, which is rapidly disappearing from American medicine, is necessary to solve this problem of coordination of care and reduced costs and better quality," she said.

Dr. Cassel quoted ABIM data that showed that in 1997, only 43% of internal medicine residents went into subspecialties; by 2005, that figure was 60%. The data that the board is seeing today suggest that only 15% of internists are becoming general internists, "and of that 15%, more than half are [becoming] hospitalists," she said. "It really is the very rare person who wants to do [generalist] practice in the community."

Dr. Cassel pointed out that "our health care payment system has made it virtually impossible to do that [kind of medicine]. It has put huge barriers in the way of people who want to [go into general practice], and created great incentives for people who want to do more procedural, more highly specialized work."

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DR. CASSEL

Internists who specialize in procedures will often argue that specialists "are pushing innovation. [They say], 'That's why America has the best health care in the world, because we have all these specialists,'" she continued. "But the evidence is quite to the contrary. … The United States is somewhere between 15th and 20th in the world in terms of numbers of older people and higher life expectancy."

Dr. Cassel noted that Japan, Germany, and Sweden—countries where life expectancy for both males and females is higher than in the United States—not only provide universal health insurance for the entire population, but also, within the last 10 years, have enacted universal, government-funded long-term care insurance.

"Somehow they managed to do this and still spend less money than we do," she said. "This idea that the United States provides the best quality of care is getting less and less defensible."

The lesson to be learned from these other countries "is not that we should, in a wholesale way, adopt one or another of these systems; the message is that there has to be a way to figure out how to provide comprehensive, affordable, good care with an aging population," Dr. Cassel said. "Germany, Sweden, and Japan are probably where we're going to be 15-20 years from now, so as we look ahead, we can probably learn some lessons from them." ■