Geriatrics, Specialism, and Primary Care

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Interest in the development of geriatrics as a specialty has waxed and waned on several occasions during the last 75 years in the United States. In each instance little momentum was gained toward establishing geriatric medicine as a specialty and today the major organizations concerned with this issue still oppose the creation of a separate specialty in this area.

A recent study by Kane and his colleagues, however, reopens the issue of geriatrics as a specialty, and makes some provocative recommendations concerning future projections and needs for geriatric manpower. They estimated the needs for geriatric medical manpower under four different models: (1) continuation of the present system, (2) academic geriatricians only, (3) academic and consultant geriatricians, and (4) academic, consultant, and primary care geriatricians. Through the use of an arbitrary set of assumptions, models, and calculations, they argue in favor of option number 4 above whereby up to 20,579 geriatricians (in full-time equivalents—FTEs) would be required to provide geriatric care for people over 65 years of age in 1990 based on current utilization levels; if geriatric care were improved to meet presently unmet needs, this projection would be for as many as 25,790 geriatricians (in FTEs). Similar projections for the number of geriatricians needed in 1990 (in FTEs) for the care of patients over 75 years of age were 10,071 and 12,780 based on current utilization levels and improved care levels, respectively. These estimates are based on an assumption of minimal delegation of patient care responsibilities to non-physicians; even if maximal delegation of clinical responsibilities was made to non-physicians, the projected need for geriatricians in 1990 to provide improved levels of care would be 15,065 and 7,977 for care of the elderly over ages 65 and 75 years, respectively.[1,2] By comparison there are presently in the United States about 6,000 otolaryngologists, 12,000 orthopedists, and 22,000 pediatricians.

Since quantitative projections may often be given more credibility than they deserve, these recommendations call for reaction. Williamson[3] suggests that there are three main reasons for the creation of specialties in medicine: (1) expansion of the body of knowledge in a field to the point that the exclusive attention of a specialist is needed (eg, neurology), (2) development of new and complex techniques, (eg, neurosurgery), and (3) extraordinary community need (eg, family practice). Although there is a distinct and important domain of knowledge, skills, and attitudes needed (and often deficient) in physicians providing care

*"Gerontology" has been defined as "the study of aging processes, originating in the biological sciences and expanding more recently into the social and behavioral sciences"[7]; "geriatrics" has been defined by the British Geriatrics Society as "the branch of general medicine concerned with the clinical preventative, remedial, and social aspects of illness in the elderly."[8]

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for elderly people, and clearly a need to upgrade the level of education and practice in these areas, the case for specialization in geriatrics is not persuasive on the basis of either of the first two criteria. With respect to the third criterion, community need, a strong case can be made for improvement of patient care, and expansion of teaching and research in gerontology, but does this require yet another specialty?

The National Institute of Aging,[4] the Institute of Medicine,[5] and the American Geriatrics Society[6] all oppose a separate specialty of geriatrics but favor gerontology and geriatrics being recognized as academic disciplines within the relevant existing medical specialties.* They favor the creation of fellowships in these disciplines for the purpose of teaching and research, and urge expansion of geriatric teaching in family practice, internal medicine, psychiatry, and other specialties involved in the care of the elderly.

Many reasons can be advanced against the creation of a new specialty in geriatrics involving both primary care and consultant roles, including the following:

1. Community needs can be well met through improved educational programs at all levels within the existing specialties (particularly general/family practice and internal medicine which were responsible for 46 percent and 37 percent, respectively, of all non-hospital and hospital encounters with patients over 65 years of age in 1976—according to Practice Study Reports from the Department of Research in Medical Education, University of Southern California, Los Angeles, 1979, unpublished).

2. Current national priorities are emphasizing the training of increased numbers of family physicians and general internists, the two fields most involved in geriatric care.

3. The widespread provision of primary care by geriatricians would inevitably involve substantial discontinuity of physician-patient relationships as patients reach some arbitrarily established geriatric age group.

4. There is now only a small constituency in favor of specialization in geriatrics compared to widespread opposition within organized medicine and academic groups.

5. It is unlikely that large numbers of medical students and residents can be attracted into an exclusive geriatric practice.

6. The development of geriatric medicine as a specialty in the United Kingdom, after 30 years of experience, is now viewed by many as a failure due to isolation from the mainstream of medicine, and recruitment and related problems.[9,10]

For these reasons, the creation of a new specialty in geriatrics would appear to be an ill-conceived "knee-jerk" response to a set of problems which can be addressed in other ways.

There is already considerable evidence that family practice can and will respond effectively to the needs for improved teaching of gerontology and improved care of elderly patients. The following examples are offered.

1. According to a recent study of US family practice residency programs, 94 percent of program directors concurred with the need for substantial geriatric training as an integral part of residency training; the general consensus was that this training should include structured geriatric rotations, concurrent training in the family practice center (including home care and outreach to nursing homes and extended care facilities for family practice patients), and other didactic teaching and small group/individual learning experiences.

2. The Residency Assistance Program (RAP) considers a family practice residency program "at risk" if any of the following situations is found in a program:[11]

A. if there are no other health care professionals (other than physicians) involved in the care of patients in the family practice center

B. if there is no provision for utilizing community health care resources

C. if there is no mechanism for the necessary assessment of the home environment

D. if there are inadequate arrangements with auxiliary care facilities for maintaining contact in order to coordinate care

3. The American Board of Family Practice considers gerontology as one of the seven major content areas for its certification and recertification examinations.

4. A recent study of medical students at three medical schools showed that medical students with preferences for the primary care specialties had significantly more positive and empathetic attitudes toward the elderly than their peers expressing preferences for the non-primary care specialties.[12]

5. Many teaching programs and community

practices in family medicine are working closely with mid-level practitioners, medical social workers, and others as they extend care to the home, nursing home, and extended care facilities; an example is the successful incorporation of a geriatric visiting nurse in one medical school's family practice program.[13]

6. Research studies are starting to focus on the needs and problems of elderly patients, as illustrated by studies of functional disability of elderly patients carried out in one university based family practice program.[14]

Family practice has begun to respond to the special needs of a growing part of the population. Much more is needed, including (1) expanded teaching in gerontology at undergraduate, graduate, and postgraduate levels, (2) increased emphasis on research in this area, (3) creation of one-year geriatric fellowships in each of the relevant specialties, particularly for the purposes of faculty development, teaching, and research in gerontology, and (4) development of mechanisms for certification of special competence in geriatrics for those who have completed these fellowships under the tripartite auspices of the American Board of Internal Medicine, the American Board of Psychiatry, and the American Board of Family Practice. A deliberate and sustained effort by the various involved specialties, particularly these three, will meet the needs of the nation's elderly for comprehensive care better than the creation of still another primary specialty.

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