

Geriatric Rounds: Why Now?

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Why begin a series dedicated to geriatric medicine in *Hospital Physician*, and why now? Over the next 50 years, a profound change in the demographics of our society will necessitate that our health care system and, in particular, the primary provider prepare for the unique health care needs of the older adult.¹ As the baby boomers age, the number of Americans older than 65 years is projected to increase from the current 35 million to 78 million in 2050.² In addition, the number of centenarians will multiply manifold from the current population of 70,000 over the course of the coming decades. The principles of geriatrics and gerontology must be further disseminated and incorporated into medical practice to address these needs. Geriatric medicine does far more than simply apply the concepts of internal medicine, surgery, or psychiatry to the older adult; rather, geriatric medicine utilizes an interdisciplinary or multidisciplinary approach in coordination with the primary care provider to provide optimum benefits to the older adult.

To prepare for the task ahead of us, knowledge of some of the characteristics of the geriatric person will be helpful. First, as a consequence of advancing years, several disorders that are infrequent in the young become common in the older adult. Examples include—but are not limited to—coronary artery disease, cancer, cerebrovascular disease, musculoskeletal disorders, Alzheimer's disease, and hearing and visual impairments. Second, diseases may present atypically or may even be silent in the older adult. For example, rather than the classic chest pain of angina radiating to the shoulder and arm, the older patient with angina may have no pain at all or may present with vague manifestations such as abdominal discomfort, delirium, or a fall, thereby confounding and delaying diagnosis and treatment. Missed diagnoses, and delay in surgery, as in cases of appendicitis and cholecystitis, are therefore not uncommon. Third, older patients tend to have multiple comorbid processes; these may be concurrent or occur at intervals. Fourth, polypharmacy is highly prevalent in the elderly; inappropriate and excessive use of medications is particularly concerning. A greater potential for iatrogenic disease exists in the elderly.

Every drug must be considered a potential toxin, and not every symptom needs to be treated by a medication. Fifth, as a consequence of comorbidities, functional impairments are typical and affect activities of daily living. The goals of treatment of elderly patients must be focused far more on quality of life and maintaining function than on prolongation of life. Ethical issues often cloud judgment and render decision-making difficult. Although a *cure* may not be possible, *caring* is of paramount importance.

Geriatricians are often confronted with the unique question by the patient or caregiver, "Is it aging or disease?" The answer may not be easy to ascertain. Certain changes defined in time can clearly be attributed to aging; a perfect example of *normal* aging is the menopause in females, which is inevitable at a certain stage in life. Several disorders typically associated with older age are referred to as *usual* aging, for example, coronary artery disease.^{3,4} On the other hand, it is hard to say whether diverticular disease, so common in the geriatric population, is a result of disease or aging.⁵ Is loss of memory inevitable with aging, or is it an early manifestation of dementia? Finally, certain disorders are often incorrectly attributed to normal aging. For example, depression, insomnia, and anorexia are clouded by myths that link these conditions to the aging process.

Given the unique features of the geriatric individual, as well as the expected increase in the older population over next few decades, geriatric medicine is expected to play a major role in health care in the foreseeable future. Academic programs are being created with the recognition that geriatric medicine is central to missions of internal medicine in health care.⁶ Requirements for accredited fellowship programs were defined by the American Board of Internal Medicine and the American Board of Family Practice in 1988.¹

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Presently in the United States, there are more than 100 fellowship programs in geriatric medicine.

Nevertheless, available medical resources for the elderly will be far from sufficient. The number of certified geriatricians (currently estimated at approximately 9000 of the 650,000 licensed US practicing physicians) will fall well short of the projected requirement of 36,000 geriatricians in 2030, a shortage expected to persist for decades.⁷ There is also a scarcity of academic leaders in the specialty, a problem unlikely to be resolved in the near future. The lack of training in geriatrics may herald devastating consequences for the elderly and a looming crisis in health care for the geriatric population.^{7,8} Medical students, residents, fellows, and clinicians must be prepared for the increasing amount of geriatric care that they will be forced to provide. Other than fellowship programs, options for educating the health provider in geriatric medicine include CME programs, books, and journals. Case discussions that focus on the geriatric patient are an additional means of developing and enhancing the necessary skills for geriatric care.

With the goal of familiarizing physicians with the complex needs of the geriatric patient, *Hospital Physician* in this issue initiates the *Geriatric Rounds* series. The feature uses a case-based format to focus on the characteristics of geriatric medicine. Older patients typically present with multiple comorbid conditions rather than a single illness; cases will be presented to reflect this. Those interested in submitting a manuscript for publication in *Geriatric Rounds* should contact the editorial staff of *Hospital Physician* (hp@turner-white.com).

We begin with a case of an older adult who has loss

of memory, atrial fibrillation, and additional comorbid processes. As the discussion demonstrates, small steps go a long way in helping this patient. In such situations, a single approach is not necessarily ideal; opinions may vary considerably with regard to the extent of investigation and treatment. Key points are highlighted and tables are provided to ease the learning process. The next case in the series will appear in an upcoming issue of *Hospital Physician* and will discuss a frail old person with failure to thrive. We hope that *Geriatric Rounds* will help to prepare physicians for the complex task of caring for the elderly.

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