

HEALTH

As Population Ages, Where Are the Geriatricians?

By KATIE HAFNER JAN. 25, 2016

PORTLAND, Ore. — Ruth Miles, 83, sat in a wheelchair in a small exam room, clutching a water bottle, looking frightened and uncomfortable.

She was submitting to the tender scrutiny of Dr. Elizabeth Eckstrom, who scooted her stool so close that she was knee to knee with her patient.

Ms. Miles had broken her pelvis after tripping on an electric cord in her apartment. The weeks since then had been hellish, she told her doctor. At the rehab center, incapacitated and humiliated, she had cried for help from the bathroom. Her hands were covered with bruises from the blood thinners she was on. She winced as Dr. Eckstrom tugged slightly at a bandage that adhered stubbornly to her left elbow. “We’ll have to get that changed,” Dr. Eckstrom said softly.

Dr. Eckstrom, 51, who spends her days focused on the complex medical needs of older patients, is, like the Central African okapi, a species that is revered, rare and endangered. She is a geriatrician.

Geriatrics is one of the few medical specialties in the United States that is contracting even as the need increases, ranking at the bottom of the list of specialties that internal medicine residents choose to pursue.

“One of the greatest stories of the 20th century was that we doubled the life expectancy of adults,” said Terry Fulmer, president of the John A. Hartford Foundation, which funds programs to improve the care of older adults. “Now we

need to make sure we have all the supports in place to assure not just a long life but a high quality of that long life.”

Here in Oregon, there is approximately one geriatrician for every 3,000 people over 75. The shortage will grow more acute as the state’s population continues to age.

Oregon’s problem is mirrored across the United States. According to projections based on census data, by the year 2030, roughly 31 million Americans will be older than 75, the largest such population in American history. There are about 7,000 geriatricians in practice today in the United States. The American Geriatrics Society estimates that to meet the demand, medical schools would have to train at least 6,250 additional geriatricians between now and 2030, or about 450 more a year than the current rate.

Yet, the field is becoming even less popular among physicians in training. Oregon Health and Science University, where Dr. Eckstrom practices, had five slots open for geriatrics fellows for 2016 and filled only three.

Last year, Dr. Elizabeth White-Chu, who directs the university’s geriatrics fellowship program, said she had resorted to cold-calling residency programs throughout the Pacific Northwest in search of candidates. This year, there were so many unfilled slots around the country that Dr. White-Chu did not even bother to call. “It would have been a total waste of time.”

A geriatrician is a physician already certified in internal or family medicine who has completed additional training in the care of older adults. In addition to providing clinical care, geriatricians are skilled in navigating the labyrinth of psychological and social problems that often arise in the aging population.

“Part of the reason aging has such a negative connotation is this sense that you can’t cure older people’s problems,” said Dr. Kenneth Brummel-Smith, a professor of geriatrics at Florida State University College of Medicine in Tallahassee, Fla., a state with a particularly severe geriatrician shortage. “And yet a good geriatrician can bring someone back to functional status.”

People avoid the field for understandable reasons. Geriatrics is among the lowest-paying specialties in medicine. According to the Medical Group Management Association, in 2014, the median yearly salary of a geriatrician in private practice was \$220,000, less than half a cardiologist's income. Although geriatrics requires an extra year or two of training beyond that of a general internist, the salary for geriatricians is nearly \$20,000 less.

Since the health care of older patients is covered mostly by Medicare, the federal insurance program's low reimbursement rates make sustaining a geriatric practice difficult, many in the field say.

"Medicare disadvantages geriatricians at every turn, paying whatever is asked for medications and procedures, but a pittance for tough care-planning," said Dr. Joanne Lynn, a geriatrician and the director of the Center for Elder Care and Advanced Illness at Altarum Institute, a nonprofit health systems research organization based in Ann Arbor, Mich.

Dr. Eckstrom said she knew of several board-certified geriatricians in Oregon who, in order to avoid attracting too many older patients, went into practice as general internists, making certain not to mention their geriatrics training. "With too many Medicare patients in their practice, they wouldn't be able to make ends meet," she said.

Marie Hall, 84, who lives in Portland, knows all too well the difficulty of finding a geriatrician. A little over a year ago, several months after Ms. Hall underwent back surgery that left her with nerve damage, her longtime geriatrician retired, and the hospital did not replace her.

Eventually Ms. Hall got in touch with Marcy Cottrell Houle, a Portland author who had just written a book with Dr. Eckstrom. To Ms. Hall's relief, Ms. Houle helped get her in to see a new colleague of Dr. Eckstrom.

"I knew I needed that kind of specialized care," Ms. Hall said, "that I needed to think ahead for when the downhill slide really comes."

A Debate on Necessity

Some primary care physicians argue that geriatricians are unnecessary, that most ailments among older adults are the same as those that hit the middle-aged population, such as diabetes, hypertension and heart disease. The difference, they say, is that older patients just have more of them.

“This is simply untrue,” Dr. Eckstrom said. “Just think about dementia, or delirium caused by a medication. Those are just two conditions you seldom see in middle-aged adults.”

Dr. Eckstrom embodies both the frustration and gratification that characterize a geriatrician’s day. She spent most of her 40 minutes with Ms. Miles sweeping up after the caregivers who had preceded her: pressure ulcers, a wound dressed poorly, dehydration, depression.

She gave her patient a pep talk, urging her to be up and walking as much as possible, and to take in more fluids. She commented on her patient’s brightly colored shoes. Throughout the morning, in fact, she made a point of admiring something each patient was wearing: a bright piece of jewelry, a colorful scarf, an all-purple outfit.

Then, as if Ms. Miles were doing her doctor a personal favor, Dr. Eckstrom added, “I very much appreciate that you’re not taking too much of the oxycodone.”

At the end of the appointment, Dr. Eckstrom took Ms. Miles’s hand and said, “You can always call me.”

“You’re too busy,” Ms. Miles said.

“I’ll squeeze you in. I’ll make it work.”

Ms. Miles had arrived at her appointment defeated and anxious. By the end, she was relaxed, even animated.

“I know how lucky I am to have her,” she said as a nurse carefully removed the bandage on her elbow and replaced it with one that would not stick to the wound.

That afternoon, Dr. Eckstrom worked with three residents who were on a

rotation that included geriatrics. When the residents went in to see patients, they were engaged enough, but decidedly ho-hum about the specialty, voicing a preference for more vibrant fields like oncology, with its experimental new drugs, and cardiology, which combines good pay with the excitement of new technologies.

Young physicians in training find it difficult to muster interest in the slow grind of caring for older patients, and days filled with discussions about medication management, insomnia, memory loss and Meals on Wheels deliveries.

An old family member is often the inspiration for medical students who choose geriatrics. “My grandmother was one of my best friends when I was growing up,” said Dr. Emily Morgan, 37, who recently joined Dr. Eckstrom in her practice. Dr. Morgan said that watching her grandmother’s decline after a car accident, followed by a terribly painful death, instilled in her a deep belief “in the inherent dignity and worth of a life, especially towards the end.”

Chase West, a second-year medical student at Florida State, was present for much of his own grandmother’s decline. “Just seeing how the specialists worked with her in the last two months triggered that light-bulb moment,” he said.

Dr. Eckstrom was a general internist who practiced in primary care for nine years before returning to Oregon Health and Science University to complete a geriatrics fellowship. “I thought I was doing a good job caring for my patients,” she said. “But I wanted to do more geriatrics teaching and research.” The fellowship opened her eyes. “I had no idea what I didn’t know,” she said.

Phyllis Wolfe, 76, has been seeing Dr. Eckstrom for more than 12 years. Two years ago, she had a series of mini-strokes that affected her memory. Then she developed two small-bowel obstructions, and each surgery was followed by significant cognitive decline and delirium. Her gait was unsteady, and she was in danger of falling.

Ms. Wolfe’s health gradually improved not by virtue of drastic interventions, but from careful attention to every possible detail. Dr. Eckstrom stopped Ms. Wolfe’s prescription for Ambien, an insomnia drug that can cause confusion in older patients. Dr. Eckstrom also suggested an exercise program to prevent a fall, and put

Ms. Wolfe on a nutrition plan.

In Dr. Eckstrom's office that day, Ms. Wolfe was transformed — lively and clearheaded. "If you hadn't seen her six months ago, you'd never know she had all those problems," Dr. Eckstrom said.

Ms. Wolfe passed a standard memory test with ease, and the appointment turned into a session of helpful hints that seemed almost homespun but were backed by evidence.

"Elevate your legs for 30 minutes before going to sleep and you'll need to go to the bathroom during the night less often," Dr. Eckstrom said when Ms. Wolfe asked about needing to stay well hydrated, then having her sleep disrupted by frequent trips to the bathroom.

"Instead of iron pills, buy a cast-iron skillet, one of the best ways for the body to absorb iron," Dr. Eckstrom advised in response to Ms. Wolfe's concern about iron pills.

Ms. Wolfe said she had tried to get a few of her friends in with Dr. Eckstrom, with little luck. Her practice is full.

Dr. Eckstrom began taking care of Ms. Wolfe when she was 64. Dr. Eckstrom said she prefers to start with patients when they are still relatively young, so she can follow them into old age.

"The majority of my patients are in their 80s and 90s, but I've been seeing many of them for 20 years," she said, adding that care for these patients is less complex, as they have entered old age in better shape.

'Sick of the Whining'

While many in geriatrics have resigned themselves to their predicament, some believe the field will soon receive the recognition it deserves. New payment models that hold doctors and health systems accountable for keeping people healthy are on the rise, and geriatricians foresee a day when they are better valued and compensated.

“A lot of us are sick of the whining,” said Dr. Rosanne M. Leipzig, a geriatrician and professor at the Icahn School of Medicine at Mount Sinai, which is experimenting with a two-year program that combines geriatrics and palliative care.

And there is an emerging emphasis on training many different health care professionals — nurses, pharmacists, internal and family medicine physicians, physician assistants, and physical and occupational therapists — to see older patients through a geriatrics lens rather than focusing solely on creating more geriatricians. Mini-fellowships at teaching hospitals to train practicing physicians in geriatrics have sprung up around the country. Cardiology, urology, emergency medicine and other specialties are promoting geriatrics training and research within those disciplines.

Acknowledging an older person’s need for dignity is an important part of Dr. Eckstrom’s practice. When talking with a patient about giving up driving, she refers to it as “retiring from driving,” casting it as an act of liberation, as if driving were a job to be freed of.

It is that kind of perspective that drew the attention of trainees already attracted to the human side of medicine. Dr. Kathleen Drago grew to love geriatrics while training under Dr. Eckstrom. “I got caught in Elizabeth’s web,” she said. “You meet people who have walked these incredible paths, and are starting to reflect on their lives and focus in on what’s important in the time they have left.”

Dr. Drago, 31, left medical school with a debt of around \$270,000. “I made a decision that was distinctly against my own financial interests,” she said. “But I come to work every day, and I get to deliver the patient-centered care that I dreamed of as a med student.”

She now works as a geriatrician at Oregon Health and Science University, seeing only hospitalized patients. Recent evidence about care provided by geriatrics teams shows that with the care of such teams, the hospitalization of older adults runs shorter, costs less and results in fewer complications, including falls, pressure ulcers and urinary tract infections.

While making her rounds in the hospital one recent afternoon, Dr. Drago

introduced herself to a 79-year-old woman in the intensive care unit. The patient, who has dementia, had been found lying on the ground the previous night a quarter-mile from her home, bruised and bloodied, with three cracked ribs and bleeding in her brain. She had left the house with a Bible in one hand and an American flag in the other.

Dr. Drago sat down and began a frank yet gentle conversation with the patient and her daughter about the next steps. The doctor stayed for two hours.

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