Should Geriatrics Be Reserved for Geriatricians?

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It is projected that one of eight persons in the United States will be aged 65 years or older by the year 2000.[1] Recently, several recommendations have been offered for meeting the current and future medical demands of the aged as a result of this population change.[2,3] Two divergent approaches have been suggested for providing primary care: (1) increasing the number and quality of geriatric specialists, and (2) increasing the competence of primary care physicians (ie, family physicians, internists, and general practitioners). This discussion explores the need for training more geriatricians as recommended by some sources,[4,5] and attempts to determine whether geriatrics is a valid medical specialty or a general approach to primary care.

The Question of Geriatrics

Several sources indicate that the aged have been poorly served by the medical community in the past. Kane et al[6] have found that the average length of an encounter between physician and patient declines with age, especially as the aged are institutionalized. According to their study, primary care physicians have generally failed to take responsibility for the medical care of the elderly. Portnoi[7] suggests that institutionalization is too readily regarded as a solution for treating aged patients. It has also been noted that the cost of medical care for the aged has grown phenomenally without attendant improvement in health status.[8]

These factors suggest to some that geriatrics should be given specialty status. This development would be accompanied by a broad array of options including the proliferation of training programs in geriatrics and expansion of the number of geriatricians in primary care practice. If geriatrics attained board-certified specialty status and broader recognition in the medical community, it is assumed that higher quality care for the aged would result. There is also the issue of whether geriatrics is a specialty meriting such status. Advocates of this position present a number of arguments: (1) care for the medical problems of the aged should not be limited to specific areas of medicine, (2) a holistic approach is most appropriate, and (3) among the aged there is no singularity of medical requirements; rather, there exists a plurality of medical and social needs. The primary issue is whether geriatrics is a unique science (or specialty area) or a general approach to medical care.

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In addressing whether geriatrics is a valid specialty worthy of expanded development or a general approach that should be limited to primary care, the fundamental reasons for and against increased specialization should be considered.

Geriatrics as a Specialty

The development of geriatrics as a specialty can be supported from the perspective that the medical needs of the aged are not being served adequately by the present medical care system.[9] Physicians are not solely responsible for the diverse social factors that prevent the aged from gaining access to medical care, but they could be more responsive in modifying their practice patterns to facilitate delivery of services to the aged. Some special consideration may be necessary (eg, aid in billing, responsiveness to social changes such as living or marital arrangements, aid in transportation).

A second reason for increasing specialization in geriatric medicine involves the generic nature of medical care for the aged. The medical problems of the aged—senile dementia, nutritionally based systemic changes in physical and psychological function, general physical and mental deterioration, cancer (eg, prostate), and other problems prevalent in the aged—are complex. Although basically primary care physicians are trained to treat these problems, frequently insufficient attention is paid to the scope of the problems, the potential for adverse reactions, and the length of rehabilitation.

A third reason for expanding geriatric specialization relates to the projected oversupply of physicians in urban areas. Analyses of the geographical distribution of physicians have shown that oversupply is accompanied by an increase in specialization in urban areas (with concomitantly higher expense and overutilization by patients).[10,11] It may be appropriate to channel the oversupply into the greatest area of need, such as geriatrics.

A final reason for expanding geriatric specialization concerns the dissemination of information on geriatric medicine. Who will instruct physicians (ie, in continuing medical education) in the needs of the aged and the treatment methods most conducive to improved mental or physical status? Internists, family physicians, general practitioners, or other primary care specialists all need training from specialists to improve the delivery of medical care to the aged. This training is most easily accomplished when a large body of specialists are to provide instruction.

Geriatrics Through Primary Care

A principal reason why there should be no further development of a geriatric specialty is that medical diagnoses and treatments for the aged may not be sufficiently different to require specialization. The delivery of primary medical care to the aged can best be managed by existing primary care physicians who are responsible for the provision of medical care to all patients. The older patient, as much as any other patient, may require specialist care, but the mechanism already exists for the referral of primary care patients to specialty treatment.

Second, further specialization will contribute to a disjointed medical care system. That system is already excessively fragmented, and the proliferation of geriatricians to serve primary care needs is the wrong means for achieving a desirable end. There is little question that generalists and specialists both want patients to receive the best treatment possible, but this does not necessarily call for additional specialization.

A third reason why geriatric medicine should be provided by primary care physicians, rather than geriatricians, involves the delivery of care. Diagnoses and treatments that are most appropriate for the aged patient are those arrived at by use of a holistic approach, with emphasis on economic, nutritional, psychosocial, and rehabilitative circumstances not normally addressed by the individual specialist. Maintenance of wellness and treatment of disease in the aged necessitate a diverse range of skills from a team of medical and nonmedical experts coalesced into a functional whole. This approach can be rendered effectively through primary care medicine.

Finally, the additional training of geriatricians may also be unnecessary in view of greater patient segregation in specialty medicine.[12] A geriatrics specialty singles out the aged patient receiving primary care. This separation of the older patient from younger patients may be inimical to the belief that geriatric patients should get better. They are viewed as special cases, contributing to the belief that the aging are different—that their deterioration is somehow acceptable.

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NITRO-BID® Ointment (nitroglycerin 2%)
BRIEF SUMMARY

INDICATIONS: This drug product has been conditionally approved by the FDA for the prevention and treatment of angina pectoris due to coronary artery disease. The conditional approval reflects a determination that the drug may be marketed while further investigation of its effectiveness is undertaken. A final evaluation of the effectiveness of the product will be announced by the FDA.

CONTRAINDICATIONS: In patients known to be intolerant of the organic nitrate drugs.

WARNINGS: In acute myocardial infarction or congestive heart failure, nitroglycerin ointment should be used under careful clinical and/or hemodynamic monitoring.

PRECAUTIONS: Symptoms of hypotension, particularly when suddenly arising from the recumbent position, are signs of overdosage. When they occur, the dosage should be reduced.

ADVERSE REACTIONS: Transient headaches are the most common side effect, especially at higher dosages. Headaches should be treated with mild analgesics, and nitroglycerin ointment continued. Only with untreatable headaches should the dosage be reduced. Although uncommon, hypotension, an increase in heart rate, faintness, flushing, dizziness, and nausea may occur. These all are attributable to the pharmacologic effects of nitroglycerin on the cardiovascular system, but are symptoms of overdosage. When they occur and persist, the dosage should be reduced. Occasionally, contact dermatitis has been reported with continuous use of topical nitroglycerin. Such incidence may be reduced by changing the site of application or by using topical corticosteroids.

DOSAGE AND ADMINISTRATION: When applying the ointment, place the specially designed Dose Measuring Applicator supplied with the package printed side down and squeeze the necessary amount of ointment from the tube or pouch onto the applicator. Then place the applicator with the ointment side down onto the desired area of skin, usually the chest (although other areas can be used). Spread the ointment over a 6x6-inch (150x150-mm) area in a thin, uniform layer using the applicator. Cover the area with plastic wrap which can be held in place by adhesive tape. The applicator allows the patient to measure the necessary amount of ointment and to spread it without its being absorbed through the fingers while applying it to the skin surface.

The usual therapeutic dose is 2 inches (50 mm) applied every eight hours, although some patients may require as much as 4 to 5 inches (100 to 125 mm) and/or application every four hours.

TUBE: Start at ½ inch (12.5 mm) every eight hours and increase the dose by ½ inch (12.5 mm) with each successive application to achieve the desired clinical effects. The optimal dosage should be selected based upon the clinical response, side effects, and the effects of therapy upon blood pressure. The greatest attainable decrease in resting blood pressure which is not associated with clinical symptoms of hypotension, especially during orthostasis, indicates the optimal dosage. To decrease adverse reactions, the dose and frequency of application should be tailored to the individual patient's needs.

Keep the tube tightly closed and store at room temperature 59° to 86°F (15° to 30°C).

FOIL POUCH: The 1-gram foil pouch is approximately equivalent to one inch as squeezed from a tube and is designed to be used in increments of one inch. Apply the ointment by squeezing the contents of the pouch onto a specially designed Dose Measuring Applicator supplied with the package printed side down.

PATIENT INSTRUCTIONS FOR APPLICATION: Information furnished with Dose Measuring Applicators.

HOW SUPPLIED: NITRO-BID® Ointment is available in 20-gram and 60-gram UNI-Rx® Paks (six tubes per pack); in individual 20-gram, 60-gram, and 100-gram tubes; and in Unit Dose Identification Paks of 100 1-gram foil pouches.

Consult full product disclosure before prescribing.

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A Proposed Solution

The problems in providing medical care to the aged result from a system in which reimbursement mechanisms have favored incremental care and eventual institutionalization. The system is excessively fractionated. Creating a primary care model that is specialist dependent is not a solution for the problems of the aged patient. First, care for the aged should not focus upon use of a single provider, since the diversity of needs can be approached feasibly only by individuals competent in a variety of disciplines. Second, medical school curricula should include more course work in gerontology, and primary care physicians should be given continuing education in the area of gerontology. These approaches will result in the delivery of services by the most appropriate providers.

There can be little argument about the need for the medical care field to continue discourse over the future of geriatric medicine. It is also apparent that a timely resolution should be reached on which course to follow. To the authors, the arguments on the side of primary care seem more persuasive.

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