While the number of seniors rises nationwide, the number of geriatricians is falling. Why is that happening? And what can be done?

BY ANDY STEINER
“In the state of Minnesota, there are 15,000 physicians. As of a couple of years ago, only 153 of those physicians were certified in geriatrics,” Pacala says. “There are about 75,000 nurses in the state. About 3,700 are nurse practitioners. Out of those, just 9 percent are certified in geriatrics. That’s the kind of numbers we’re looking at today.”

The workforce numbers aren’t any better nationwide, Pacala adds: “Nationally there are about 7,000 geriatricians in a workforce of 830,000 doctors.” Despite the looming senior population that the nation has known about for decades, he says, “In my lifetime, the numbers of geriatricians has remained flat.”

Even more concerning is the fact that the numbers of practicing geriatricians are actually shrinking.

George Schoephoerster, MD, a geriatrician at CentraCare Clinic in St. Cloud, explains it this way:

“Every year, more geriatricians retire than graduate from fellowship programs,” he says. “You can’t get around this reality.”

The problem is way too big for an obvious or quick fix. Edward Ratner, MD, associate professor of medicine at the University of Minnesota Medical School and associate director for educational evaluation and geriatric research and education at the Minneapolis VA Hospital, says that it is impossible to train enough physicians to care for the elderly living in America now, never mind the millions to come.

“There are just way too many already,” Ratner says. “Even if you started training people now you could never catch up. The problem we’re facing is at that level already. We don’t really have a pipeline to create the faculty needed to train the doctors. There are so few people going into advanced geriatrics training that we aren’t going to have enough people teach other people.”

Aging isn’t sexy

So why are there so few geriatric physicians in the United States?

The reasons for this shortage are varied, Pacala says, but can be summed up in three basic points.

The numbers are stark—and the best way to give a sense of the problem that lies ahead. All the experts agree: As millions of Baby Boomers reach retirement age, the number of physicians trained to address their unique medical concerns is shrinking; Minnesota—along with the rest of the United States—faces a looming healthcare crisis.

Talk to James Pacala, MD, MS, professor and head of the Department of Family Medicine and Community Health at the University of Minnesota and author of Geriatrics At Your Fingertips, for instance, and listen as the numbers spill out of his mouth.

“Right now, there are somewhere between 40 to 45 million Americans over the age of 65,” he says. “In 30 years, that number will double. By 2050, there will be over 80 million Americans over age 65.”

The numbers in Minnesota are similar to the rest of the nation, Pacala says. Right now, about 14 percent of the population, or some 700,000 Minnesotans, are over 65. Demographers think that number will almost double to 1.3 million, or 21 percent of the population, by 2035.

As they age, that large population of seniors will increasingly need medical care geared toward their complex medical needs. But the numbers just don’t add up. It’s best to lay it out at the beginning. There’s no way to discuss the state of geriatric medicine without talking about the numbers.
All fields of medicine are complex, but, when practiced right, geriatric medicine may be the field that involves the most complex thinking and problem-solving.

As a person ages, the number of medical concerns usually grows, and each of those concerns involves some kind of intervention.

While the media has plenty of accounts of 100-year-olds who play tennis and take nothing but Tylenol for their aches and pains, the reality is that most older adults live with multiple chronic conditions, says Schoephoerster.

“I might have a patient with 20 different problems on their list,” he says. “That might mean they are on a number of medicines. Sometimes I have patients who take as many as 30 different medicines. Each individual I see is complicated and complex.”

Older patients are harder to care for, says Pacala, and this makes their care more complex. Physicians who specialize in geriatric medicine need to take a particularly careful approach with their patient population, who tend to metabolize medicine differently than younger patients and take longer to bounce back from illness. The best geriatricians are skilled multitaskers who are carefully observe their patients for symptoms and interactions.

“You can’t make mistakes in frail older people,” he says. “You can make all kinds of mistakes in kids and they’ll get better. Middle-aged people usually have a single problem, so a physician only has to focus on one thing at a time. It’s never that easy with older adults.”

To make sure that the care they provide to their older patients will be effective, geriatricians need to slow down, ask questions, and patiently listen for answers.

“Geriatric medicine is very person-centered,” Leppin says. “It takes into consideration all of the social and psychological determinates that contribute to aging. A geriatric medicine physician has to provide whole-person care, which should be...
The right stuff

Caring for old people may not be glamorous, but it's also not for the faint of heart. Pacala, who has focused his career on geriatric care, admits decades later that his decision to enter the field felt at first like a kind of personal dare.

“I got into it as a challenge to myself,” he says. “When I was young, old people freaked me out. I was scared of them. I was frightened of nursing homes. They made me uncomfortable.”

Instead of running away from his fear, Pacala decided to face it: “I thought, ‘I’m going to turn this around and I’m going to go toward it and embrace it and take it on and overcome it.’”

He’s happy now that he took the challenge, because it turned out that he is well suited to geriatric care. “My career has been extremely rewarding,” he says. “When I see a complex old person, I am 100 percent comfortable with what’s going on and I enjoy it and enjoy the challenge. I enjoy working with old people and with their families.”

Geriatric medicine requires patience, complex thinking and problem-solving. That approach takes time, and the physicians best suited to this specialty are willing to slow down and listen to patients, addressing their sometimes-complex concerns sequentially, Schoephoerster cautions.

“I think that is one of the things my patients notice is I’m never trying to get them out the door. I’ve always enjoyed my time with them, and I’m willing to take the time required to solve their problems.”

Some people like to divide medical specialties into two categories: caring and curing, Schoephoerster says. “With curing specialties like surgery and anesthesia, you get to help your patients and then you get to leave. With caring specialties, you have to stick around. Geriatrics is most definitely a caring specialty.”

Treating older patients, especially the most vulnerable, also often requires intense interaction with their family members. Though many assume that it may be easier to work with younger family members than it is with the elderly patients themselves, geriatricians often have a special bond with their patients and a

What physicians need to know about older patients

standard at all ages of life, but is especially important with older adults.”

It’s also important when working with elderly patients for physicians to shift their attitudes about what constitutes quality medical care. It’s not always about looking for miracle cures or medical breakthroughs: It’s often about understanding each patient’s goals and helping them live a comfortable life.

This can feel like a major perspective switch for healthcare professionals trained to save lives at all costs.

“In this work I often have to ask myself, ‘What are you really trying to accomplish here?’” Schoephoerster said. “I do full-time nursing-home work, where the average lifespan of my patients is two and half years. If my patients have two-and-a-half years left of their lives, how does that change what I am doing with my treatments?”

In many ways, that reality check frees physicians like Schoephoerster to focus on what truly matters in a person’s life. Many of the old rules can get tossed out the window in favor of a focus on finding joy in life.

“When a patient gets dementia, I usually say, ‘Forget about the low-salt, low-calorie, low-cholesterol diet.’ The problem suddenly becomes getting enough calories and finding enough happiness. I almost always put my elderly patients on an ‘eat all you can eat’ or an ‘eat what you love’ diet. For many older people, it’s a welcome change.”

This approach to care doesn’t have to feel like giving up, Chebli adds. It could actually feel like a radically loving approach to care.

“We are in an era where we think everybody should live forever,” he says. “I’m all for living a long life, but in the end, what kind of life, what quality of life do you actually want? That may include not treating certain conditions because it does not benefit the patient. It may be doing less.”

Maybe doing less is a misnomer, because taking this approach to medicine requires a different kind of work, at a level that is no less intense but actually much more involved.

“Geriatrics involves working with families and patients at a highly vulnerable stage of their lives,” Pacala says. “When care is handled correctly, and the complex pieces that make up an older person’s health are aligned, he adds, “You are truly helping them improve their quality of life, affording them more time, maximizing their functioning and paying attention to their overall goals.”
unique understanding of their needs that their own family members may lack.

“When you get into nursing home care like I have, you sometimes spend more time with the family than with the person,” Schoephoerster says. “Sometimes I don’t like the family all that much, but I always like my geriatric patients. The last 10 years that I’ve spent treating them have been the best 10 years of my medical career.”

Not every physician has an innate gift for working with elderly patients, says Yasser Chebli, MD, a geriatrician with Fairview Health Systems who and serves on the board of the Minnesota Association of Geriatrics Inspired Clinicians (MAGIC).

“I really enjoy being around older adults and being able to help them,” says Chebli. “I’m from Lebanon—it’s part of my culture to respect the elderly. I have a passion to do this job well, and I find the work highly rewarding.”

**Makeover needed**

A public relations professional might say that geriatric medicine has an image problem. If we live in a society that glamorizes youth and makes admitting aging seem like a failure rather than a natural part of life, it should come as no surprise that there is a shortage of medical students interested in focusing on the treatment of the elderly.

Pacala says that that disinterest—or, more honestly, avoidance—of the inevitable reality of age is reflected in the number of unfilled geriatric medicine fellowships nationwide. “There are currently about 350 fellowship positions available in geriatric medicine,” he says. “Only about 235 of those are filled. There are simply not enough med students applying for these positions.”

What can be done to make geriatrics more appealing to medical students? There are a number of options, Pacala says: “First of all, you could try paying us more. That always helps. Some states have looked at loan forgiveness or some other type of incentive for people who have chosen those careers.”

Another, decidedly more complicated, strategy involves a makeover of sorts, he adds. “We need to rethink the values our society glorifies when we talk about medicine: In good old Mpls/St. Paul magazine, for instance, a recent cover said, ‘The Doctor Will Save You Now.’ In the article, they featured doctors doing exotic, lifesaving procedures that are miraculous—but only impact a small percentage of the population. In the meantime, we have a lot of seniors out there with multiple chronic conditions and not all that many physicians interested in caring for them.”

In some ways this shortage feels curious to Joseph E. Gaugler, PhD, the Robert L. Kane-endowed chair in Long-Term Care and Aging and professor in the Division of Health Policy and Management at the University Of Minnesota School of Public Health.

In the United States, people over 65 represent a powerful bloc of influence, he says. As a group, they have been able to use their sheer numbers and combined to advocate for renewed focus on important issues that directly impact their lives, including a recent increase in research on Alzheimer’s disease and dementia.

“I would say much of that change is due to the effective advocacy of families of people with memory loss across the U.S.,” Gaugler says. “With so many people behind that effort, the issue has gained bipartisan support in Washington. Unfortunately, we haven’t yet seen anything similar in geriatrics and long-term care.”

How can that change? Aaron Leppin, MD, assistant professor of health services research at the Mayo Clinic and a Health and Aging Policy fellow with the Minnesota Board on Aging, says that geriatric medicine needs to organize itself around a strong voice that can clarify the needs of a generation and advocate for its long-term care.

“Somebody needs to be the leader,” Leppin says. “Geriatricians can speak to the medical community in an important way about the realities of what it is like to be an older person in the country. They can talk about what’s lacking and, hopefully, rally the supports that we need.”

Maybe this new army of older people should take its cues from other distinct communities that have made noise and demanded change.

“In order for this movement to be successful, older people and their family members are going to need to demand better geriatric care,” Gaugler says. If this group stays silent, even though it is large, it will be easier to ignore. Society does that at its own peril: “Look at what we’ve seen in the disability community, where people who were silent for generations rose up and demanded better care.” Change happened there, largely in the form of the powerful Americans with Disabilities Act. Something similarly powerful could happen for seniors. MM

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