The New Frontier: Increasing Geriatrics Expertise in Surgical and Medical Specialties

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In this issue of the *Journal*, there is an article titled "A Statement of Principles: Toward Improved Care of Older Patients in Surgical and Medical Specialties." This statement was generated by representatives of the leadership of 10 such specialties working with leaders of the American Geriatrics Society (AGS). It identifies 10 essential objectives and the steps recommended to meet them. The overall goal of the statement and of the collaborative project from which it springs is to pave the way for improvement in the day-to-day care of older patients when they are the responsibility of surgical and medical specialists.

The Statement of Principles emerged from the Increasing Geriatrics Expertise in the Surgical and Medical Specialties project. It is one of several important initiatives developed during the 1990s by the American Geriatrics Society in collaboration with The John A. Hartford Foundation, whose philanthropy is now focused largely on aging and health. Planning for the project began in 1992, and it was launched in 1994 under the inspiring leadership of the late Dennis Jahnigen.

The project's timing could not have been better. The accomplishments of the geriatrics renaissance, which began in 1975, have accelerated to the present and continue. Geriatrics fellowship programs are numerous, have a well crafted structure, and are finally recruiting effectively. In most teaching hospitals, residents in family practice, internal medicine, psychiatry, and neurology now receive excellent basic training in the enlightened care of older people. Medical schools are gradually increasing geriatrics content in their curricula. Thousands of physicians have become geriatrics specialists, hundreds have become faculty in academic departments and divisions of geriatrics, and a clinical science base has been developed.

Building from this foundation, the time is ripe to infuse the principles of good geriatric care into the basic training of residents in general surgery, the surgical specialties, gynecology (which is both a surgical and a primary care specialty), and other relevant specialties, such as anesthesiology, emergency medicine, and physical medicine and rehabilitation. This step outward represents the next frontier of geriatrics, and the resultant improvement in patients' outcomes promises to be as great as it has been in internal medicine, family practice, psychiatry, and neurology.

BASIC TENETS OF THE PROJECT

We believe that surgical and medical residents can learn the principles of good geriatric care with only a modest addition to their already bulging residency training curriculum. The basic principles are straightforward and well supported by research findings and clinical experience. Application of these principles creates a positive feedback loop because the initial result is favorable enough to reinforce their adoption and dissemination. Further, as curricular emphasis on geriatrics in medical schools increases, specialty residents are likely to enter training with some of the necessary knowledge in hand and with more receptive attitudes.

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Geriatricians need no introduction to the key principles we are trying to inculcate into the day-to-day practice of surgical and medical specialists. They are second nature now: functional assessment, prevention of predictable disasters, identification and treatment of multiple coexisting problems ("the management of complexity"), seeking cumulative small gains in function, aggressive rehabilitation, interdisciplinary team care, careful attention to social support status, guarding patients' autonomy in end-of-life decision-making, and understanding the effect of varying degrees of dementia on the clinical setting.

Our shared goal is that a vulnerable older patient on any inpatient service should receive general medical care of consistently high quality. Before, during, and for a short time after surgery, the surgeon is the primary care physician. This is appropriate, in fact necessary, because day-to-day decision-making must be done by the person with direct responsibility, the one closest to the patient who is able to make decisions most rapidly. Because an increasing number and proportion of surgical patients are older and many are vulnerable or frail, the surgeon must be able to apply the above principles of good geriatric care if their patients are to reach their goals of rapid recovery and maximum benefit from the surgery. Outstanding competence in surgery is necessary but not sufficient to guarantee favorable outcomes in the older population.

It is clear that favorable outcomes cannot be achieved through geriatric consultation alone. Certainly, geriatrics consultation should be available and utilized in the care of particularly complex perioperative and postoperative problems, but the crucial day-by-day steps in care must be "home-

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grown." Many of these steps can be managed by establishing enlightened protocols. For example, the secret to high-quality geriatric care in the acute hospital is the prevention of, or, if necessary, the treatment of urinary tract infection, delirium, depression, pressure ulcers, falls, functional decline, malnutrition, dehydration, and so forth (see full list in the "Statement of Principles"). Many of these setbacks are best prevented by standardized nursing-physician protocols that can be developed with the advice of geriatricians and applied as usual care except where special conditions require individualized approaches.

STRATEGIES

From the beginning, the stated objectives of the project have been to improve the amount and quality of geriatric education received by surgical and medical specialty residents; to identify and support specialty faculty in promoting geriatric training and research within their own specialties; and to assist professional certifying bodies and professional societies in improving the ability of their constituents to care for older patients.

Ten surgical and medical specialties were invited to join in the project. Five (emergency medicine, general surgery, gynecology, orthopaedic surgery, and urology) did so in 1994. Five more (anesthesiology, ophthalmology, otolaryngology, physical medicine and rehabilitation, and thoracic surgery) began in 1997 when the first renewal grant was funded. The emphasis is on surgery, with general surgery, five surgical specialties, gynecology (both a surgical and a primary care specialty), and the inseparably linked specialty of anesthesiology making up four-fifths of the total effort. A total of 27,539 residents were in training in the 10 specialties in 1999.

We have pursued the stated objectives using several approaches, sometimes in parallel, sometimes convergent. First, we established contact with leadership of the major academies, associations, and societies and began to sponsor symposia and other educational programs at their annual meetings. We encouraged the development of special interest groups, task forces, and, ultimately, standing committees on aging within the various specialty organizations. In some instances, we have supported research awards presented at the annual meetings of the leading specialty organization.

As another approach to education in the specialties, we have supported publications on aging in specialty journals. The most extensive example of this was devotion of the entire Winter 1998 issue of the *Archives of the American Academy of Orthopaedic Surgeons* to a series of articles on caring for the aging patient. Several specialties have developed outlines of educational objectives regarding geriatric care, and some have gone on to create core curricula. Currently the project is about to publish a core syllabus, which will be a succinct treatment of key information in geriatrics relevant to practice in the specialties. Within the roster of AGS publications, its length and coverage will fit somewhere between *Geriatrics at Your Fingertips* and *The Geriatrics Review Syllabus*. From the viewpoint of the specialists, the first is a bit too cryptic and the second is too detailed to meet their particular needs.

The principal editor of the new core syllabus is Paul R. Katz, MD, with an editorial committee consisting of George T. Grossberg, MD, Jane F. Potter, MD, and David H. Solomon, MD.

Upon receipt of the 1997 renewal grant from the Hartford Foundation, we invited one major organization in each specialty to nominate a leader to be a member of the project's Interdisciplinary Leadership Group (ILG), which has met annually since 1998. The other members of the ILG are the directors and key staff of the project and a small group of leaders of the AGS. At these meetings, views and experiences are exchanged and plans are drafted for the future.

Armed with core curricula in a number of the specialties, we are establishing contact with residency review committees, education committees within the major specialty organizations, and their boards. Our aims are to encourage the residency review committees to mandate geriatrics education in specialty residencies and to influence education committees and boards to increase content relevant to the care of older patients in in-service and certifying examinations. We are also working with the National Board of Medical Examiners to assure high quality and relevance of geriatric questions in the United States Medical Licensing Examination.

All of these are initiatives at the national level. Another important sector of the project, the Outreach program, is rooted at the local level. We have invited well reputed residencies in each of the 10 specialties to apply for small grants to facilitate increased geriatrics education and experience in residency programs. At present we are supporting 22 residency programs in 20 institutions with a range of from one to four programs per specialty. Each year the directors of the specialty residencies join with an equal number of geriatrics mentors as partners at a retreat. Reports of progress are given; common problems are identified; communication is established among the residency program directors within each specialty; and plans for the coming year are discussed.

CHALLENGES

The state of the geriatric art in many surgical and some medical specialties is relatively primitive. It is at a stage of development comparable to where we in the specialty of geriatrics were around 1980: limited to the few centers where geriatric enthusiasts are located; groping for learning objectives and basic curricula; exploring new territory; seeking experience; and fearing failure. In 1998 we conducted a survey of residents in the 22 Outreach program sites before the program had had any impact. Since there was neither a knowledge nor an attitude assessment in the survey, the interpretation is difficult, but the results are somewhat encouraging. We learned that 59% of specialty residents devoted less than 50% of their time to the care of patients 65 years of age or older, 37% devoted between 51 and 75% of their time, and only 4% devoted between 76 and 100% to the care of these patients. When asked what was troubling about caring for older patients, 57% of respondents noted "patients often lack resources for self care," and 32% said that "older patients take more time." On the other hand, when asked what is rewarding, residents cited patients' gratitude for care (78%), improvement of function (63%), and patients' life stories (49%).

The major challenges are that funding for increasing geriatrics expertise in the specialties is limited thus far to that provided by the Hartford Foundation; faculty both in geriatrics and in the specialties are in short supply and feel chronically overburdened; and there is usually a signal lack of support from deans, hospital directors, department chairs, and division chiefs. Other challenges are addressed in the

Objectives and Recommendations columns of the "Statement of Principles".

ACCOMPLISHMENTS

Table 1 summarizes the steps taken thus far in each of the 10 specialties. Those that entered the project in 1994 are naturally farther along than those in the 1997 class. A complete list of activities in each specialty is available in the project office at AGS. However, it is difficult to evaluate progress in concrete terms because the mission is nothing less than to trigger a revolution in the quality of care available to older patients in some surgical and medical specialties. As was the case when a similar revolution occurred in geriatrics itself, concrete measures of success will be lacking until randomized controlled trials demonstrate that some interventions do make a difference. As such findings accumulated in geriatric medicine, it became obvious that older patients were having better outcomes than with usual care. Therefore, well designed clinical research performed collaboratively by geriatricians and specialists is absolutely essential if we are to determine whether application of geriatrics principles has a beneficial effect on the outcomes of older patients in the specialties.

FUTURE PLANS

In pursuit of scientific assessment of the effect of geriatrics interventions in the specialties, the Interdisciplinary Leadership Group and its geriatrics partners will focus on the development of clinical research. The need for some studies is obvious: e.g., the search for risk factors for poor surgical outcomes, and intervention trials directed at the major risk factors. However, we believe that the field would benefit from a broader and deeper approach and, therefore, we are planning to initiate a formal process to develop a research agenda for the selected surgical and medical specialties. The process will include a comprehensive analysis of clinical research literature and an opinion survey, followed by a working conference. In parallel, we are attempting to develop a research career development program for junior faculty in the non-primary care specialties who are interested in inventing a special academic field revolving about how to improve the care of older patients within each specialty. The awardees would become the new cadre of leaders absolutely essential to implementing the objectives of the AGS/Hartford project. To succeed, the research career development award program must be accompanied by assurance from department chairs that a career focused on the care of older patients will lead to advancement in their specialty.

We are also planning to launch a series of steps to expand and deepen the role of the Interdisciplinary Leadership Group. It is appropriate, indeed essential, that the penetration of geriatrics into the specialties be monitored and guided by committed leaders in each specialty and by the specialties collectively. We anticipate that in the not-distant future the surgical and medical specialties themselves will become responsible for increasing geriatrics expertise within their fields, with AGS leaders providing advice and perhaps oversight. As helpful and collaborative as we in geriatrics may be, the force must be generated within the specialty if improved care of older patients is to become an intrinsic part of the practice of surgery and other specialties.

In summary, a new era has begun, initiated by the AGS with creative philanthropic support from The John A. Hartford Foundation. It promises to spread the application of the new geriatrics to fields of medicine not touched earlier by the geriatrics renaissance. By this means, we can anticipate a revolution in the care provided to older patients in many surgical and medical specialties, where the average age of patients is rising rapidly and where health outcomes will be strongly influenced by the quality of care provided to the older population.

Table 1. Geriatrics Activities in Non-primary Care Specialties Before January 2000

Specialty	National Symposium	Committee, SIG* or Task Force	Publications	Curriculum	Research Award	Outreach Program	Residency Review Committee	Board	In-Service Exam
Anesthesiology	X	X	X	P	X	X		C	
Emergency Medicine	X	X	X	X	X	X		C	
General Surgery	X	X	X	X	X	X			
Gynecology	X	P	P	X	X	X	G		
Ophthalmology	X	X	P	X&P		X		C	C
Orthopaedic Surgery	X	X	X		X	X		X	X
Otolaryngology	X	X	X			X		C	
Physical Medicine & Rehabilitation	X	X				X		C	
Thoracic Surgery	X			X		X			
Urology	X			X	X	X		C	

*Special Interest Group
X = Completed/Scheduled
P = Planned
C = Contact Made
G = Guidelines in Place