

Commentary

The following commentary is excerpted from an August 12, 2008, blog "Taking Note, A Century Foundation Group Blog." The full blog can be read at: <http://www.healthbeatblog.org/2008/08/the-geriatricia.html>.

The Geriatrician Shortage

by Niko Karvounis

In a 2006 *New York Times* article, Dr. Amit Shah, a physician at Johns Hopkins, recalled how other doctors looked down on him during his residency because of his chosen field, one of whom would shake his head and say "waste of a mind," Shah said. Dr. Shah's sin? He had chosen to become a geriatrician.

You'd think that Shah would be applauded by his colleagues for choosing geriatrics, given that the US is in the throes of a major geriatrician shortage. Since 2000, the number of geriatricians in the US has fallen by a whopping 22% to a mere 7100. According to a May Institutes of Medicine report, the outlook for the future isn't much better. By 2030, there will be just 8000 geriatricians, despite the fact that the US will need about 36,000 to cover the workload as the number of Americans 65 years and older mushrooms.

Clearly, we need more geriatricians. Yet the reason we don't have more stems from the mindset of the doctors who scoffed at Dr. Shah: both our healthcare system and our medical schools devalue the kind of care that geriatricians provide.

What's more, our fee-for-service system, set by Medicare and mimicked by most private insurers, places a greater value on procedures than it does on the type of care geriatricians provide. As Dr. Laura Mosqueda, a geriatrician from the University of California-Irvine, told MSNBC in 2006, "you'll get reimbursed better if you remove a wart than if you take the time to talk about how somebody's doing after her husband passed away."

So geriatricians, who do a residency in internal or family medicine and then a fellowship in geriatrics, find themselves near the bottom of the medical income ladder, averaging \$150,000 a year.

Ultimately the financial incentives to be a geriatrician are very low, and so it's not a popular specialty for medical students. According to the Association

of Directors of Geriatric Academic Programs, the number of fellows enrolled in second or later year positions in geriatrics fellowships decreased by 55% since 2002. And as of October 2007, 64% of those enrolled in geriatrics fellowships in the US were international medical school graduates.

According to the *Times*, "of 145 medical schools in the United States, only 9 have departments of geriatrics. Few schools require geriatric courses. And teaching hospitals graduate internists with as little as 6 hours of geriatric training." This dearth of geriatrics programs stems in part from the same mindset that drives Medicare reimbursement: the idea that the only medicine of value is procedure-based.

So what can be done? The most obvious solution is adjusting reimbursement rates so that geriatric care can get a little financial respect. The American Academy of Family Physicians thinks this can be done by relying, in part, on "a per-beneficiary, per-month stipend for care management, paid directly to the patients' designated personal physician" (this capitated approach is meant to encourage efficiency, as opposed to volume, in care delivery).

But it's not all about the money. The perception is that geriatrics isn't "real" medicine because it's not super-technical and procedure-based. This is a dangerous bias. A good way of indicating the value of geriatrics is by institutionalizing geriatrics within our medical schools—after all, it's hard for doctors to think highly of geriatrics when they don't see it well-represented in their educational institutions. Curricula can include mandatory rotations in geriatrics for students and residents; institutions should expand linkages with nontraditional medical sites like nursing homes or home visit programs; and Medicare can reserve more money within its graduate research education fund for geriatric residencies (currently Medicare spends less than 0.5% of its dollars on training physicians to care for elderly patients). Perhaps most important, medical schools need to make the conscious decision that geriatrics isn't just a second thought, and they need to get serious about securing funding, professional connections, mentorship programs, and all the other components that make for a successful and permanent academic department in medical school.

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