Chapter

Introductory Chapter: Geriatrics

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1. Introduction

Geriatrics has been identified as a subspecialty by virtue of a board certification since the mid-1980s by the American Board of Internal Medicine. The original core of knowledge was primarily the extension of the diagnoses and management of diseases of organ systems to the three age groups over the age of 60 years: young-old was 60–70, old was 70–80, and old-old was over 80 years of age. At that time I became interested in geriatrics by focusing on elders with renal and urology diseases [1]. At the beginning I researched the anatomic and physiologic changes of the kidney and urinary system, and then later each other major organ system of the body. My work in renal and urologic diseases led to editing my first book in the field [2]. As I delved into caring for the elderly, I became exposed to the knowledge of problems which are outside of the individual organ systems like "falls" or problems which affect every organ system like "geropharmacology." Over the decades since then, the role of the geriatrician who is the primary care provider for the elderly requires knowledge in a multitude of other specialties beyond internal medicine such as ophthalmology, ENT, audiology, neurology, orthopedics, and physiatry. I will present the earliest skills needed for the care of the elderly followed by the newest skills now incorporated into the subject matter of geriatrics. The chapters in this book mostly represent a catalog of the newer skills.

2. Previous geriatric skills

2.1 Geriatric assessment

One of the first skills I learned when preparing for practice in geriatrics was that of geriatric assessment. I saw the amazing statistics of increased diagnostic accuracy, prevention of iatrogenic problems, and improved functional status which translated to better quality of life. We developed this tool for our practice [1] and spent the next 2 years unraveling difficult diagnostic and management problems for the patients in our clinic. Our multidisciplinary team included a nurse, physician, pharm. D., social worker, mental health expert, physical therapist, occupational therapist, dietician, and speech therapist. Our day consisted of intake by the nurse, exam by the physician, sequential evaluation by each of the other team members, and contact by the physician to the patient's referring physician. After a preliminary meeting of the team, the patient and family were invited to a brainstorming session in which the findings were reviewed and additional questions were invited. Then a second team meeting finalized our findings and recommendations which were again presented to the family and patient and transmitted to the referring physician. I realized that the complex problems of the elderly with their age-related lack of compensation ability, their multiple comorbid conditions, and the large number of socioeconomic issues that influenced the quality of life of these patients could

only be completely dealt with by this tremendous manpower commitment. We literally committed 1 full day per patient.

2.2 Nutrition

I had a prior background in nutritional research and was board-certified by the American College of Nutrition (now absorbed into the American Society of Parenteral and Enteral Nutrition or ASPET). In light of the huge number of patients whose medical and socioeconomic problems and limited resources led to nutritional deficiencies, we undertook a project to provide supplements to elders involved in communal meal programs like Meals on Wheels or congregate dining at senior centers [2]. We called the program as our "Meal Mate" program.

2.3 Pharmacology

We discovered the problem of polypharmacy in many of our clinic patients. We sought not only to streamline their medications but to reach out to our rural community as well [3]. We would bring our team to community centers after announcing free consultation for medication simplification, and we offered education concerning possible adverse reactions and adverse drug interactions. The recommendations were made after consulting with their primary care providers. A written summary of recommendations was given to the patients and transmitted to their primary physicians. We were among the earliest to use the term "MedRed" program.

2.4 Nephrology

I became interested in geriatrics when I decided to focus my primary specialty of nephrology to the care of elders with renal insufficiency. My collaborators and I put together what in my opinion was the first subspecialty textbook of geriatrics [4]. My basic research team and I focused on factors which led to age-related changes in renal anatomy and physiology independent of diseases [5]. We explored the dietary and other means to slow down such aging of the kidneys.

3. Current skills

The American Geriatrics Society has published its syllabus to serve as a compendium of the core information considered as the standard data base for geriatricians to be able to successfully care for their patients in modern day practice [6]. As mentioned above, besides the "internal medicine" organ system diseases, there are large sections devoted to visual loss, hearing loss, syncope, dizziness, falls, frailty, swallowing problems, nutrition management, pressure wounds, behavior disturbances, delusions, dermatology, addiction, and gynecology.

In addition, the current practice of geriatrics requires an incredible knowledge of socioeconomic management issues such as ethics and advanced directives, elder abuse, insurance coverage and payments, mobility, and driving competence.

4. Conclusions

In conclusion, the field of geriatrics has undergone a transformation from the hospital-based application of internal medicine subspecialty care to the outpatient broader application of multiple medical specialties as deliverable by office practice.

From a solitary or episodic intervention, it has expanded to a continuous, ongoing set of interventions designed not so much to perform diagnostic studies or prescribe curative medications, but instead to improve mobility, mentation, and special senses and in that way improve quality of life.

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