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EDITORIAL

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Proving the Geriatrician's worth

Since the dawn of geriatrics in America in the second half of the 20th century, the discipline has tried repeatedly to demonstrate its value in health care and how it is different than just taking care of older people.

The campaign got its first toe-hold with studies of comprehensive geriatric assessment, which has shown benefits for some groups of patients with some models.[1] Other approaches to demonstrate geriatricians' worth have been calculating downstream revenue of a geriatrics practice,[2] identifying patients most likely to benefit from a geriatrician's care,[3] evaluating the benefit of geriatric co-management (e.g., of surgical patients),[4,5] and comparing quality of care (e.g., end-of-life care)[6] between geriatricians and other physicians.

In this issue of the *Journal*, Vandergrift et al add to the evidence in the last of these categories.[7] The authors report comparisons of potentially inappropriate, by 2015 American Geriatrics Society Beers Criteria,[8] medication (PIM) prescribing rates and, conversely, appropriate alternative medication prescribing rates between American Board of Internal Medicine certified geriatricians and matched general internists during the years 2013 to 2019. They found that geriatricians were 17% less likely to prescribe a PIM. Although the absolute difference was small (7.2% of geriatricians' patients versus 8.7% of general internists' patients), the authors note that if all general internists prescribed like geriatricians, 92,641 fewer beneficiaries with Part D coverage would be prescribed PIMs annually. Geriatricians were also more likely to prescribe alternative appropriate medications but the relative difference was even smaller, 2.7%. This well-conducted study adds another piece of evidence to the argument that geriatricians provide different and better care for older people.

Yet, the sum of the prior efforts have not been enough to turn the tide in favor of growth of the specialty.[9] Over the last two decades, the number of certified geriatricians has dropped by 28%[10] and, in 2022, only 43% of geriatrics fellowship positions were filled, although this may be an undercount; a recent AGS/ADGAP survey of fellowship programs participating in the match found an increase of 110 positions and fill rate of 70% after the Fellowship Match closed.[11] Compensation and ageism, even among medical students and trainees have been cited as contributing factors to the unpopularity of geriatrics.[9] Some headway might be achieved in mitigating these factors but, honestly, the compensation for geriatricians in clinical, teaching, and research roles will never be high enough to draw physicians into the specialty. Nevertheless, efforts, such as the research conducted by Vandergrift et al, and other approaches to boost the stature of the discipline should continue. However, there is another strategy that may be more persuasive in recruiting new physicians into geriatrics.

Perhaps it is time for geriatricians to shift their attitudes towards this seemingly hopeless struggle. Despite the decline in physician autonomy,[12] the intrusiveness of the electronic health record,[13] and other regulatory demands (e.g., burdensome documentation for billing), medicine remains a great profession. Physicians spend their entire clinical practices helping people in need. Those who are in academics can leverage their contributions to the greater good of humankind by teaching the next generation and by conducting research and quality improvement efforts that extend their impact beyond the patient in front of them.

In prior surveys of career satisfaction among specialties, geriatricians were the most satisfied with their careers in 2002[14] and second most satisfied, behind only pediatric emergency medicine, in 2009.[15] What then accounts this discrepancy between satisfaction and popularity of geriatrics? Insight may be gained by asking why physicians select geriatrics? Although "inspirational" older persons may play a role,[16] more important may be the fit between the work of specialty and what is satisfying to physicians who choose it. Perhaps more than any discipline in medicine, geriatricians manage complexity in determining the best course for each patient. Many of our patients get better and many do not. Yet we are there for each of them, wherever they may be. I remember singing "Moon River" with the family of a patient on her deathbed, probably the last gesture of love that she was aware of. Conversely, I recall a first follow-up visit of one of my patients after he sustained a hip fracture. I had advocated successfully for him to get more intensive rehabilitation. He walked into my office, albeit with a walker, without assistance; shook my hand; and said,

This Editorial comments on the article by Vandergrift et al in this issue.

"Thanks, doc." Geriatricians need to take daily joy in what we do, which is holistic and, above all, patient centric. We should celebrate the meaningfulness of our professional lives and perhaps the compassion of being a geriatrician will be contagious.

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