Evolution of Geriatric Medicine: Midcareer Faculty Continuing the Dialogue

> "*Never believe that a few caring people cannot change the world. For, indeed, that's all who ever have*".
>
> *Margaret Mead, Cultural Anthropologist*

We read the article by Tinetti[1] and accompanying editorial by Kane and colleagues with great interest.[2] During our careers as Geriatricians, these and other remarkable dedicated physicians drew us into this challenging field and continue to motivate us as clinicians, educators, mentors, and scientists. Close colleagues and friends for almost 2 decades since we met through the American Geriatrics Society (AGS) Junior Faculty Research Career Development Special Interest Group, the four of us meet at the annual meeting of the AGS, doggedly united in our hope that, when we retire, we will be able to say that the lives of older people have improved because of the work we did. So when Dr. Tinetti wrote 'to stop whining', it caught our attention and inspired us. James Macgregor Burns, a historian and a political scientist famously said: "*Transformational leadership occurs when one or more persons engage with others in such a way that leaders and followers raise one another to higher levels of motivation and morality*[3]." Motivated by Dr. Tinetti's article and after many heartfelt e-mail and telephone conversations, we feel compelled to contribute our thoughts from "mid-career."

We agree with Dr. Tinetti that Geriatrics is a 'metadiscipline', we do not market ourselves well and Geriatricians are elite. However, we disagree with the notion that our field should be narrowed to be considered experts in multimorbidity and complex medicine.

GERIATRICS AS "METADISCIPLINE"

We love the concept of geriatric medicine as a "metadiscipline." Core principles of geriatrics are now applicable to all areas of clinical, research, and training enterprise. Numerous leaders have been rapidly "geriatricizing" the healthcare delivery and policy systems[4] first by designing innovative, scalable, sustainable models of care such as Care Transitions Program[5] and Hospital-at-home;[6] second by developing tools, processes, and strategies to rapidly implement evidence-based healthcare solutions into the local community such as INTERACT tools[7]; third by leading major healthcare delivery and health insurance organizations as effective healthcare administrators; and fourth by guiding the national healthcare policy agenda at the federal and state levels such as through the Centers for Medicare and Medicaid Services.

Several other medical and surgical specialties have infused their fields with innovative models to enhance the safety and quality of the aging population that they serve. Geriatric emergency departments are a testament. With a rapidly aging complex patient population, the need to provide emergency care, often without enough resources or surrogate decision-makers, is a challenge. Geriatric emergency departments, supported by research led by collaborative teams including emergency physicians, geriatricians, educators, social workers, and palliative care and advanced nursing practitioners, have revolutionize urgent care.[8,9] Collaborations between the fields of Infectious Diseases and Aging have revamped the approach to preventing and managing infections in an aging population.[10–12] New research has revolutionized our approach to managing chronic diseases such as hypertension and dementia in primary care.[14,15] Seminal studies by multidisciplinary research teams have led the way in identifying and reducing adverse events such as delirium,[16] functional decline,[17,18] frailty,[19] falls,[20] infections[10–12], polypharmacy,[21] and pressure ulcers. Geriatricians have led or been a major partner in each of these initiatives.

These successes have inspired a generation of junior physicians in various medical and surgical subspecialties to pursue careers in research and program development that enhance quality of care and improve health outcomes in their clinical practices. Geriatricians mentor these young, energetic physicians brimming with ideas about how to better serve aging adults in their practices.[22–25] Numerous medical and surgical subspecialists now attend the annual AGS meeting and consider it to be a vibrant venue at which to present their research findings and receive peer review and mentorship from a broad range of expertise. We, as mentors, have to promote not only geriatrics fellows and junior faculty, but also subspecialists engaged in clinical care, research, training, and policy development for an aging population. To accomplish these goals and for Geriatrics to be considered a metadiscipline, it is critical that we accelerate the pace at which we develop, enhance, and sustain connections with other specialty and subspecialty societies by forming research clusters that includes Geriatricians and subspecialists, disseminating research at various venues and developing collaborative funding priorities.

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ENHANCING OUR VISIBILITY

Aging is often viewed in a negative manner, so short- and long-term marketing measures need to be designed and implemented to change societal and cultural mores. We strongly agree with Drs. Kane, Callahan, Morley, and Pacala that, rather than "rebranding" our field for ourselves, we need to extend our influence through collaborative partnerships with businesses and policymakers.[2] We understand Dr. Tinetti's frustration that her fellow Geriatricians are being timid about taking credit for their accomplishments. Just as Sheryl Sandberg, Chief Operating Officer of Facebook, is justified in urging women to "lean in"[26] and change the conversation from what women cannot do to what they can do, Dr. Tinetti is equally justified in encouraging us to focus career discussions on the effect our elite field is having on clinical care, health system transformation, healthcare policy, and improving the lives of older adults—to be more active in promoting our work. Thus, it is critically important that the AGS engage in rebranding Geriatric medicine as a metadiscipline, a broad-based marketing strategy deployable to a wide audience, and partnering with companies like Google and other supportive organizations to raise the intellectual and financial capital necessary to enhance societal awareness.

Equally important is to engage social media in promoting research. With 34,550 scholarly journals publishing 2.5 million articles every year, obtaining recognition of a research article requires careful crafting of the article's message and promotion in social media. Although impact factor measures citations of a particular journal over the previous 2 years, Altmetrics™ provides a new way for an individual article tracked in social media promotion and the attention it receives in real time. These emerging tools are critical to promote research to our peers, translating the incredible progress made into practice and being recognized for these contributions.

NARROWING OUR FIELD WILL TRIM OUR INFLUENCE

We respectfully disagree, nevertheless, with Dr. Tinetti's suggestion to endorse multimorbidity as our defining condition. Multimorbidity should be one condition we are known for being expert at addressing, but if we focus on this single "defining condition," not only will we risk burnout and drive away potential Geriatricians who are drawn to the field out of a passion to promote "healthy aging," but we will also miss out on a unique opportunity to improve the lives of older adults in other domains who may not have multimorbidity.[26] Individually and collectively, we need to relentlessly disseminate scientific knowledge about the best ways to prevent all aspects of physical and cognitive decline while enjoying a good quality of life.

Besides teaching and promoting the principle of geriatrics to all health professionals, our expertise as clinicians, educators, and scientists committed to caring for older adults positions us to have a tremendous effect on virtually every sector of society. We need to engage with the community at large, educators, and policy-makers to improve educational attainment and physical health in underresourced communities. Collaborations with entrepreneurs and engineers are critical to create age-appropriate products to allow individuals to age-in-place. Television and move industries can use our expertise to deploy entertainment products that are relevant to older audiences and promote healthy aging. As experts in Geriatric medicine, it is our responsibility to have a loud voice in the "anti-aging"world. We disagree with a concise description of Geriatrics: instead, we embrace a broad and encompassing description of Geriatrics that not only allows, but also encourages diverse career paths and interdisciplinary collaborations to expand our influence far beyond our small community.

WAY FORWARD

We should take on this challenge and break it into practical applications. First, we should ask ourselves: Do we want to promote the field of aging, promote ourselves as geriatricians, or both? The answer is "both." Promoting the field of aging is perhaps intuitive—all of us are aging. We should tirelessly make the case to devote resources to train and mentor future experts in Geriatric medicine.

The competencies of our current "influencers" need to be translated into effective, scalable mentorship programs that the AGS and its partner organizations (e.g., the Hartford Foundation) sponsor and nurture. The Aging and Healthcare Policy fellowship is a salient example of such a national mentorship program. Having a clinical executive leadership coaching at the annual AGS meeting for early- and midcareer physicians who are interested in becoming the next generation of influencers can magnify the effect of this fellowship. It is critical that Geriatricians be engaged in hospital administration as members and leaders of committees to ensure that healthcare systems are designed to meet the needs of an aging population. Furthermore, although developing and evaluating new models of care is complex, *it behooves us to strive for simplicity in programs and tools* that frontline clinicians use to enable faster and broader adoption.[28]

To achieve these goals, it is critical that our fellowship programs be redesigned to prepare our fellows to be local and national leaders, be clinical and research mentors to other specialists, be disruptors of today's healthcare system and innovators in redesigning for tomorrow's. It is crucial that our training incorporate research, quality improvement, dissemination, public policy, advocacy, and leadership development.

The personality of our entire field can be summarized in a single word: patience. Geriatricians have the patience, understanding, bandwidth and passion to be able to discuss complex medicine, healthy aging, end-of-life care, challenge existing systems, develop new models of care and are able to view each patient as an individual with a story to tell. *Let us be passionate and not patient in defining ourselves within this rapidly evolving healthcare landscape.*

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