

Aging, Geriatricians, Elder Care: Knot

Outliving Society's Capacity to Care

By Walter Cummins

Despite the rapidly growing number of aged in America, the ranks of geriatricians is not keeping up with the needs for old people's medical care. So reports the *New York Times*.

According to projections based on census data, by the year 2030, roughly 31 million Americans will be older than 75, the largest such population in American history. There are about 7,000 geriatricians in practice today in the United States. The American Geriatrics Society estimates that to meet the demand, medical schools would have to train at least 6,250 additional geriatricians between now and 2030, or about 450 more a year than the current rate.

Unfortunately, geriatrics is the least popular of all specialties for internal medicine residents. Even though it requires another year or two of training, the annual income averages \$20,000 a year less than that of a general internal medicine practitioner and half that of a cardiac surgeon.

Because of this disjunction between the growing numbers of people living longer and longer and the increasing lack of specialists to address their unique needs, our society faces an escalating dilemma. Better drugs, earlier interventions, more exercise, and healthier diets are increasing life spans for large numbers. The fortunate spend those added years with minor issues and pass on relatively quickly; the unfortunate require ongoing medical attention, lingering in a state of compromised health. But the fact that more and more Americans refuse to shuffle off before they get really old places multiple burdens on the system, especially given the shortage of people willing to attend to the aged.

Beyond having an intellectual curiosity about this troubling prospect, as one of the aged, I am also part of the problem because I've survived so long. The *Times* article appeared shortly before my eightieth birthday, a cautionary predictor of my future if I end up with serious health-care needs. I have been further warned—and more openly—by

recent visits to and news of age-mates, signs of the medical declines of people I've known for decades. They—we—overload the schedules of doctors, nurses, and caretakers, not to mention the nation's healthcare budget. The Centers for Medicare & Medicaid Services reported in December 2015: "Per person personal health care spending for the 65 and older population was \$18,424 in 2010, 5 times higher than spending per child (\$3,628) and 3 times spending per working-age person (\$6,125.)"

The mind fades, organs malfunction, joints creak, bones snap, the body breaks down. Here's some anecdotal evidence. Recently I received the latest report about a man in his nineties who is in a Florida rehab facility with a leaky heart valve and congestive heart failure. Not long after, at another rehab center, I visited a friend my age receiving therapy after burn surgery. It was lunchtime, and we sat in a dining room with her 97-year-old roommate, as people in wheelchairs, including a former governor, rolled past to their tables. Others on foot maneuvered with canes and walkers. A few shuffled unaided but seemed about to topple over.

Two days after my rehab visit, I drove into New York City with a 90-year-old friend to have lunch with another person, in his mid eighties, who had suffered a stroke a while ago. He has some short-term memory and mobility issues but a good command of the past, and he can hold a lively conversation. But he requires therapy and someone to drive him. Another friend from my undergraduate years called to tell me that his wife, whom I've known almost as long, had been diagnosed with Alzheimer's. She is sleeping much of the time and asking the same questions again and again. They are seeking a residential facility.

Then there are the cancer victims, primarily women friends who have had breast cancers, mastectomies, radiation, and chemotherapies; lymph nodes excised; temporary baldness. For a number of men I know, the less fatal and less complicated equivalent has been prostate cancer.

Many of my aged acquaintances have, like me, survived serious health problems, such as heart attacks, serious fractures, joint replacements, malignancies, and surgeries, conditions that at one time would have been quickly fatal. Even the healthiest of the aged tend to forget names or where they left their keys or reading glasses or why they walked into a room. Gawking at shelves, they block supermarket aisles. They dawdle when driving. It's no wonder that the young think, mutter, or shout out loud—Get out of the way, old man (or lady)!

To paraphrase Yeats, this is no country for old men and women, and yet we oldsters hang on to existence. And, despite our aches, pains, and physical and mental limitations, a good number of us enjoy dining, traveling, listening, viewing, and, when our eyesight permits, reading.

I should note that the people in my world—my reference points for aging—are for the most part educated and financially able, aware of the benefits of healthy eating and exercise and available to pay for gyms, trainers, and organic foods, along with expensive

medications. For the poor the situation is much worse because they can't afford these amenities, often limited to the cheap fat- and salt-loaded calories of fast food, as compared, say, to those in organic broccoli or Chilean sea bass. Many require a greater range of serious medical care, and thus confront more fully the shortage of gerontologists.

But what's the incentive for doctoring the elderly—people whose ailments are inevitable, whose visits provide less income, who groan and complain, who often expect medical miracles and are resentful at the failure of physicians to perform them? As Americans, we—young and old—expect every problem to be fixable, whether it's conflict in the Middle East, the loss of manufacturing jobs, destructive storms, or a malfunctioning heart. Decrepitude is defeat, and something should be done about it.

It is no wonder fresh med school graduates picking a residency specialty choose one that earns more, offers more prestige, less stress, and usually leads to feel-good results like Lasik-improved vision and wrinkle-free skin. Dermatology has become the field of choice for young physicians. According to one study, “while both dermatologists and geriatricians spend a minimum of 4 years in postgraduate training, geriatricians earn less than half of a dermatologist's income.”

Still, geriatricians bring in a median annual income of just under \$200,000, many times more than that of the workers engaged in hours of hands-on involvement with the sick and aged. Many elderly people depend on the daily care they receive from caretakers employed in assisted living, nursing homes, or home care. For little pay and constant pressure, these healthcare workers dress, feed, bathe, and change diapers. Some of their patients are dead weight, others abusive, still others delirious.

As the population ages, and especially as the number of Alzheimer's and other dementia cases grows, the need for such caretakers is booming. The Bureau of Labor Statistics has estimated that by 2022 the United States will need 48 percent more—1.3 million—home nursing and personal assistants. Beyond the handful that serve willingly—for example, helping aging relatives—the majority of such workers fall into the profession as a job of last resort, often reluctantly. They would be ecstatic to be geriatricians, who, after a day of seeing patients, are able to go home to an affluent life away from old people.

The caretakers are often immigrants or African-Americans, and are paid as little as \$10 an hour, and on average just over \$20,000 a year. Their work is demanding, often unpleasant, often frustrating. According to Alana Semuels in *The Atlantic*, “One in four live in households whose income is below the federal poverty line. . . . Unsurprisingly, the field has a high turnover rate—some estimates put it as high as 60 percent.” One in three elder-care workers do not themselves have health insurance, either because of employers not offering it or because the workers cannot afford the premiums.

It's a Catch-22. The medical community fixes many once-fatal problems and extends life expectancy, and this puts more pressure on physicians, nurses, and those in the

trenches, such as caretakers, as well as on children of the aging, who may also end up giving a lot of time and money to their parents' care.

As I enter my ninth decade, I'm functioning pretty well for my years, still working out in the gym, traveling, teaching, reading, writing, cleaning litter boxes, closing in on the post-op five years that will make me an official cancer survivor. But my remaining years most likely can be counted on my fingers—perhaps of one hand, perhaps of two. Something—a burst artery, a cell gone berserk—is bound to go awry in not too long. If I'm lucky it will be a swift process. I will quickly become one less burden for the gerontologists and the overworked, if even available, health aides. Otherwise, I may find myself one of those whose lingering, unhappy lives are occasionally interrupted by visits from more mobile friends, by drip-feedings, by being turned regularly to prevent bedsores. I'd have a title but not the wherewithal to produce the essay: *Longevity and Its Discontents*.

Sources

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