Canadian Geriatrics Society (CGS)

BRIEF: The Role of Specialists in Geriatric Medicine in Dementia PLUS Care

The majority of Persons with Dementia (PWD) have two or more other chronic diseases (e.g. Diabetes, Heart Failure, Chronic Lung Disease etc.). In a Senate Standing Committee on Health report on chronic diseases Dementia was identified as ‘the Godfather of chronic diseases’ due to the fact that dementia destabilizes the control of other chronic diseases (e.g. Diabetes, Heart Failure, Chronic Lung Disease etc.) – an effect described in that senate report as ‘The Dementia Domino Effect’ leading to avoidable Emergency Department (ED) use, avoidable hospitalizations, prolonged hospitalizations often resulting in Alternate Level of Care (ALC) and avoidable / premature Long Term Care (Nursing Home) placement. In line with this, ICES and CIHI have both demonstrated that Dementia is the #1 diagnosis contributing to ALC. This is resulting in wasted health care dollars and resources, hospital overcrowding as well as unnecessary suffering by PWD and their families / caregivers.

The Alzheimer Society of Canada estimates that 750,000 Canadians have dementia. We need to find better and more cost effective ways to care for PWD to keep them in the community (e.g. home or residence), out of the ED, out of hospital (or to shorten hospitalizations and get them safely back home ASAP before they deteriorate in hospital and become ALC) and to prevent / delay Long-term care (Nursing Home) placement – that is the goal of Persons with Dementia and their families – it should also be our societal goal grounding all our efforts.

Four medical specialties diagnose and care for PWD – Primary Care, Cognitive Neurology, Geriatric Psychiatry and Geriatric Medicine. These specialties all diagnose dementia but play complementary roles in dementia care; Primary Care provides longitudinal care in the community, Cognitive Neurology focusses on early and challenging diagnoses, and Geriatric Psychiatry has expertise in concomitant mental health issues (e.g. depression and anxiety) and Behavioral and Psychological Symptoms of Dementia (BPSD).

Specialists in Geriatric Medicine do not only care for persons with dementia but do play a large role in dementia care. In the context of dementia care, specialists in Geriatric Medicine (a hybridized adaptive specialty with cross-training in Internal Medicine, Neurology and Psychiatry) have a critical role to play – Dementia PLUS care (care for persons with dementia who are medically complex (often having several other chronic medical conditions such as Diabetes and Heart Failure), medically unstable (caring for such persons with dementia in hospital who are at risk for avoidable decline, long lengths of stay and ALC) as well as persons with dementia in their last stages of life who are dying. While other specialties (Primary Care, Geriatric Psychiatry and Cognitive Neurology) are also involved in Dementia Diagnosis and early care, only specialists in Geriatric Medicine are specifically trained to provide Dementia PLUS
care (an area that is costing the health care system a great deal of money as it is poorly resourced and not organized).

Some provinces such as Ontario have significant and growing numbers of specialists in Geriatric Medicine – the problem is too much concentration in academic centers and too little community and rural reach. Other provinces such as Saskatchewan and Newfoundland only have 1 specialist in Geriatric Medicine each!

With respect to recruitment to Geriatric Medicine, we are far behind and not keeping up. In Canada, we are graduating 15 – 25 specialists in Geriatric Medicine per year .... far behind other specialties that do not have as severe a Physician Resource shortage. This contrasts with the UK where Geriatric Medicine is one of the largest of the Internal Medicine specialties.

Ultimately, the numbers of specialists in Geriatric Medicine that society needs will be driven by [1] whether we can create an infrastructure to allow specialists in Geriatric Medicine to practice in the community to prevent ED visits, prevent hospitalizations and prevent premature LTC placement AND [2] how well we formally incorporate specialists in Geriatric Medicine into hospital-based Dementia PLUS care (every hospital should have a Dementia-Delirium team comprised of specialists in Geriatric Medicine and Geriatric Psychiatry focused on getting Persons with Dementia safely home and out of hospital ASAP before they decline and become ALC – this would have a huge potential to save money and prevent Code gridlock).

The attached Canadian Collaborative Centre for Physician Resources (C3PR) report highlights the pressing need to rapidly grow the specialty of Geriatric Medicine. To that we would add that there is a need to plan for the optimal distribution of specialists in Geriatric Medicine to insure all provinces and rural regions have equitable access to this expertise.

The Canadian Geriatrics Society would be willing to further explore new roles for specialists in Geriatric Medicine as well as the Physician Resource issue further.

Respectfully submitted,

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Demand for physicians and their services

The 2013 National Physician Survey focused on employment issues and among surgeons in particular there was some concern about underemployment ¹. The vast majority of physicians, however, were either employed to their satisfaction (59%) or felt they were overworked in their discipline (32%).

Of those who were overworked, 11% reported there had been a major decrease in supply of physicians in their specialty within the last two years whereas only 4% reported a major increase. Interestingly, the proportion reporting minor decreases (22%) or minor increases (26%) was similar and 35% reported no change.

Two thirds of all physician respondents indicated that the need for the services they provide had increased over the last two years, either in a major or minor way. This was particularly true in Newfoundland & Labrador and Quebec where 73% of physicians indicated an increase in demand.

There is no surprise given our aging population, that geriatric medicine leads the list with nine out of ten physicians (91%) indicating an increase in the need for their services. Selected specialties of note are dermatology (81%), emergency medicine (80%), anatomical pathology (79%), psychiatry (72%), and neurosurgery (71%). For the physicians who indicated at least a 10% decrease in the need for their services, most were in diagnostic related specialties with nuclear medicine the highest with 36% reporting decreased demand. See Graph 1 and 2.

Graph 1: Change in need for their specialty in last two years – specialties with high increased need