Guest Editorial

Aren’t Thirty Years Enough to Affirm the Full Maturity of Modern Geriatrics?

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THIRTY years ago, on December 27, 1984 the New England Journal of Medicine published a study by Dr. Lawrence Rubenstein and colleagues, entitled “Effectiveness of a geriatric evaluation unit. A randomized clinical trial” (1). Until then, the effects of specialized geriatric evaluation and treatment programs had never been evaluated in randomized trials: hence, the practice of Geriatrics had poor, if any, support by evidence.

In Rubenstein’s study, 123 patients aged 65+ years, admitted to the VA Acute Care Services in Sepulveda, CA, were randomly assigned to usual care or to a Geriatric Evaluation Unit. Within few days since admission, each patient received Comprehensive Geriatric Assessment by a multidisciplinary, multiprofessional team, which applied in weekly meetings the most reliable instruments and scales available at that time, to define specific, individualized treatment plans. At 1-year follow-up, the intervention arm had improved survival, cognitive, and functional status and had spent fewer days in nursing homes after discharge, at no additional cost. Improved survival and preserved quality of life, again at no additional cost, with Comprehensive Geriatric Assessment compared with usual care was confirmed by 2-year follow-up data (2).

Many other trials and a number of meta-analyses followed and, together with large observational studies (3), confirmed that, in patients selected because of some “frailty” or “vulnerability” features, the Geriatrics model of care is more effective, efficient, and cost-effective than the usual approach of Internal Medicine (4–6). Guidelines derived from such a body of evidence (7) established this as the gold standard method to treat complex, frail older patients.

Similarities and differences can be highlighted between this and other therapeutic interventions that dominate modern medicine. In 1987, again the New England Journal of Medicine published the results of the CONSENSUS study, a randomized clinical trial of enalapril in patients with severe chronic heart failure: for the first time ever, a drug was shown to reduce mortality in this deadly condition (8). The efficacy of angiotensin-converting enzyme inhibitors as a life-saving therapy in heart failure was confirmed by further studies and meta-analyses, which originated evidence-based recommendations in highly reputable guidelines (9).

Although cardiac therapy entered its own modern era 3 years later than Geriatrics, its success was greater. Nowadays, nobody would dare not to apply guidelines-recommended treatments in heart failure patients, being prosecutable for malpractice in that case. Conversely, the Geriatrics model of care, whose supporting evidence is equally strong and has an even longer history, is not applied to the same extent and with the same certainty. In 2008 the Institute of Medicine in the United States reported that, out of 180 authorized instances of Program of All-Inclusive Care for the Elderly, only 42 had been implemented, serving 10,000 older persons out of 3 million eligible (10). Even more disappointing examples of poor application of the Geriatrics model come from Italy, where less than 5% of the total number of medical beds in acute care hospitals are assigned to Geriatrics, compared with an 8%–10% estimated need (11).

Some reasons for these different destinies are straightforward: drug-based interventions are much easier to implement than a complex method of care, and both testing of new drugs and implementation of drug-based therapies into practice are tremendously boosted by more or less legitimate interests of industry. Yet, drugs are not necessarily the best weapons when facing problems of the old age, especially under the menace of the double-edged sword of polypharmacy (12). Simple answers to complexity are rarely, if ever, efficacious, at least on the long run, and treating the
elderly is a difficult and extremely challenging task, where no magic bullets, or pills, are at hand!

Although their success is only partial, geriatricians do not give up, because they know that overcoming the episodic, disease-oriented model of care toward an integrated and individually tailored approach is a compelling need for their patients and for health care systems (13), which have to face with the expanded demographics of older patients. This Geriatrics mantra is now, at least sometimes, shared also by some illuminated internists, who advocate for an “Internal Medicine able to deal optimally with the changing demography . . . to become acquainted with the tools of multidimensional evaluation. . . . This acquisition requires some degree of humility . . .” (14).

On its 30th birthday, modern Geriatrics is mature to stand up, neither with arrogance nor with complexes of inferiority, and ask for recognition of its substantial contribution to current, evidence-based Medicine.

References
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