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EDITORIAL

Geriatric medicine and health care system: how can they fit together?

Medicina geriatrica e sistema sanitario: come possono lavorare in sinergia?

Western societies are currently experiencing an epidemiological explosion of the oldest age groups. This phenomenon, largely due to the scientific and economic progresses, poses a major threat to public economies, especially in countries (as Italy) which are based on models of social health care. In fact, the increasing number of retired persons (which are also those more severely burdening the health care services in terms of needs and costs) and the decreasing number of workingly active younger adults significantly affect the socio-economical stability of the system. Interestingly, the article by Mazzi [1] mentions that the mean age of patients admitted to Internal Medicine wards is 71.4 years at his institution, and even higher in other hospitals of the same region. These data may implicitly suggest an overlap of what is traditionally considered internal medicine with geriatric medicine, perhaps just because the overall population is older and elders are more likely to seek medical assistance. If the average hospital patient (independently of the specific clinical problem) has been changing (i.e., getting older, more complex, frailer) over time, the approach cannot remain as usual, but should be modified to better respond to the newly raised needs.

Typically, the frail older patient (the one, for example, responsible for the bed-blocking phenomenon; in other words, the "gold standard" geriatric patient) is not only difficult to treat because of the lack of directly applicable evidence-based guidelines, but also hard to manage from a social perspective (e.g., lack of family or community support). These two issues (i.e., the clinical complexity and the social support limitations) are closely related and largely determine the success or failure of the preventive and therapeutical interventions. In the past years, several specialties have started looking at geriatric medicine and what geriatricians propose and (try to) do with different and increased interest. Formal multidisciplinary geriatric-oriented collaborations aimed at better targeting the older patients' needs have found increasing support in literature. In fact, current evidence has consistently demonstrated that the comprehensive geriatric assessment performed by a geriatrician may significantly and positively affect both the older patient (in terms of better clinical outcomes) and the institution (in terms of cost-effective interventions). The first ortho-geriatric experiences aimed at improving the quality of care offered to acute older patients with fractures have not only confirmed to be extremely effective [2,3], but have also paved the way to further and different collaborations. For example, onco-geriatric units have recently started to take place, not only to better serve older patients, but also to expand the number of potentially eligible candidates to more aggressive interventions (previously too easily precluded due to the difficult distinction between "anagraphical" and "biological" age) [4,5]. Similarly, cardiac surgeons have just recently started proposing the clinical adoption of specific geriatric assessment tools (e.g., gait speed test) for supporting their decisions and better targeting their interventions [6].

In this scenario, O'Malley [7] recently questioned the internal medicine comanagement of surgical patients. He correctly wondered whether such interactions might be detrimental (especially on the long-term) for the quality of the medical profession because limiting and degradating the basic clinical inpatients skills of subspecialties. This risk is surely present. On the other hand, it is noteworthy that about 75 reports of trials and 11 systematic reviews of trials are published per day, about 7-fold more than thirty years ago, and this positive trend has not yet even reached a plateau [8]. Such a vast amount of scientific evidence which is exponentially and rapidly increasing every day cannot be ignored and inevitably leads to a hyperspecialization of medicine. This new approach directed towards the

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deepest molecular foundations of diseases and futuristic pharmacogenomic or staminal cell therapies may appear as strongly conflictual with the macroscopic, clearly evident, and devastating conditions of older persons such as cognitive impairment, falls, or disability. Because the geriatric patient is complex, the currently available evidence-based medicine cannot be applied to him/her. His/her conditions are not always the "same" (as learned on the medical textbooks), but the result of multiple interactions between "what is sick" with "what is old" (often a quite difficult distinction to make). The hyperspecialization of medicine has necessarily led to the birth of a novel professional figure in the last decade: the hospitalist. The hospitalist can easily be thought as a sort of case manager of the acute inpatient, responsible for giving a unique direction to the diagnostic and therapeutic process. Models of acute care based on the hospitalist have shown not only to provide positive results from a clinical perspective (e.g., shorter in-hospital length of stay without increase of readmission or mortality rates), but also to be cost-effective (at least, not more expensive than other traditional models) [9]. Nevertheless, it has been suggested that hospitalists may still benefit from formal geriatric consultations, especially for more accurately evaluating and treating the so-called "geriatric syndromes" [10].

Hospital patients are older than ever before, and it is unlikely that this trend will change because there are more elders and the health care system is saturated (consequently leading to improper admissions). To guarantee that hospitals will remain the primary setting devoted only to the treatment of acute conditions, we need to develop services and procedures (inside and outside of the traditional health care settings) that can filter requests and offer adequate and patient-tailored alternatives of care, especially to assist older frail persons. Unfortunately, a major redesign of the current system is required to optimize admissions of older patients to the proper clinical setting. If home care is not supported and expanded, families and caregivers will continue to bring their frail older relatives to the Emergency Department, consequently promoting improper hospital admissions. Similarly, if the number of beds in long-term facilities is limited and the waiting lists are too long, the acute care units will continue to improperly discharge chronic patients to post-acute care settings. In this catastrofic and apparently "dead end" scenario, preliminary attempts to redirect previously inevitable hospital admissions to more suitable allocations are beginning to take place. For example, Di Bari and colleagues [11] recently developed and validated a prognostic stratification instrument able to support in the Emergency Department triage the choice of the destination ward (i.e., internal medicine versus geriatric). Although these should be considered as preliminary steps with obvious limitations [12,13], these proposals of novel approaches to the issue suggest that efforts are moving in the right direction.

Last but not least, it is important to keep in mind that an increased flexibility of the health care system towards geriatric patients will never be obtained without major cultural and academical modifications. Older age (which still is a pure anagraphical speculation) should not be anymore seen as an impairment or a problem, but hopefully as a resource for the entire society. This change will require the vision of elders under a new perspective, leaving the youth-centered characterization of the society. Moreover, schools of medicine should perhaps start considering aging and age-related conditions as crucial components of the students' education (possibly since the very beginning of the medical curriculum), rather than relegating them at the end of the studies as a marginal appendix. After all, not everyone is at risk of getting sick of a specific disease, but everyone of us is (right now) experiencing the aging process (and maybe even its consequences).

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