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Outpatient Geriatrics Referrals: A Balancing Act

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I recently asked a group of internal medicine residents the difference between internal medicine and geriatrics, and the overwhelming answer was that there was none. Good, I thought. I can write a different article.

But, of course, I am a geriatrician. I think there are enormous differences between what I see and what a general internist regularly handles. Just as I shudder when (rarely) faced with a woman with menometorrhagia, I imagine that the generalist dreads an appointment with an agitated, aggressive, and paranoid 85-year-old man with Parkinson's disease and two exhausted offspring.

However, if you have been treating that 85-year-old patient with Parkinson's for the last 15 years, you may not notice right away when the geriatrics referral can help. Funny, you referred directly to the neurologist when he developed a tremor, but why make a geriatrics referral?

So, should you refer? If so, when? And why are you reluctant?

Let's look at the last question first—reluctance to refer. Many practitioners do not refer because they feel that patients already see too many physicians. Why add to the mix? The second reason is more subtle—geriatricians are often primary care providers and not perceived as referral specialists. If the generalist refers, he/she may be giving up the care of the patient.

First, why add to the mix? Geriatricians are trained to simplify. They may look at the patient's medication regimen, both prescription and nonprescription; modify the regimen if adverse interactions are present; eliminate duplication; and make sure all participating health care professionals are aware of each other's activities with regard to the patient. It may be, for example, that our patient with Parkinson's developed a tremor after starting an SSRI, being seen by the neurologist, receiving the diagnosis of Parkinson's, and starting carbidopa/levodopa, perhaps without direct involvement of the internist. The outside observer—the geriatrics professional—may be able to see the time pattern of symptoms, change the antidepressant, and eliminate the need for the carbidopa/levodopa.

Second, although most geriatricians do have a panel of primary care patients, they also work as referral specialists, and if you the internist want to continue to manage your patient, you simply need to make it clear that you consider the referral a request for expert advice, not transfer of care. The patient and family should also be aware that you want to continue to be involved so that they know to whom to return.

What about when to refer? I often hear, jokingly, that an internist decides to refer an older patient when the visit takes longer than 15 minutes. In truth, however, complexity is a major factor in deciding to refer. An internist's schedule is not designed to deal with five chronic medical conditions, plus memory loss, plus a recent fall. A geriatrician's practice is often set up to screen for functional issues, perform a cognitive evaluation, do a medication reconciliation check, and refer for further gait evaluation—all in the first visit. In short, referral to a geriatrician should be considered when:

- *Functional issues that may hinder evaluation and treatment of other medical conditions*. Geriatricians are well versed in helping patients decide when to pursue further testing and treatment and when to consider quality of life and functional capacity when making diagnostic and treatment decisions.
- *Cognitive decline is apparent, either with or without functional impairment*. Geriatricians can help with diagnosis, treatment decisions, and behavior modification.
- *Depression has made a major impact on function*. Many older patients have significant depression, and the medications often used without side effects in younger adults affect older adults adversely. The geriatrician can help with a geropsychiatric referral when appropriate, modify the treatment regimen, adjust medications, and assure that the depression is having as little impact on other medical conditions as possible.
- *Gait and balance issues are prominent*. Geriatricians often work in interdisciplinary teams and have ready access to well-trained therapists. A medication evaluation is also part of gait and balance assessment to look for potential contributors to falls.
- *There is significant polypharmacy*. A pharmacist may be part of the interdisciplinary team often found in the geriatrics office and can assist with discussions of drug interactions, over-the-counter appropriateness, and treatment of the side effects of one medication with another. (Is it appropriate to eliminate both drugs?)

continued on page 2

SIGN OF THE TIMES: PART I

continued from page 1

- *Frailty or failure to thrive is a concern*. Geriatrics professionals can help a patient and caregivers manage difficult evaluation and treatment decisions and work to achieve the highest level of function possible.

In short, referral to a geriatrics specialist can help the internist in assessing the overall picture. Geriatricians are skilled in working closely with other specialists to assure that older patients get the most comprehensive care possible. General internists may serve their older more frail patients best if they refer early, establish a working relationship with the geriatrics group, and maintain the team-based approach to patient care.

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