

LEADERSHIP PROFILE/IN CONVERSATION

AN INTERVIEW WITH DR. PETER BOLING—THE 2019 DISTINGUISHED PROFESSOR OF GERIATRICS

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Dr. Boling (peter.boling@vcuhealth.org) is professor of medicine and is the Division of Geriatrics chair at Virginia Commonwealth University. In his career, he has focused on improving health and quality of life in individuals with multiple chronic conditions, specifically on home-based health care. He is also dedicated to medical education and uses his platform to bring the needs of this population into focus. Dr. Harris (pfharris@mednet.ucla.edu) is an associate professor and director of the Medical Home Visit Program at UCLA. She incorporates Dr. Boling's (and some others') principles into her practice every day.

At the 2019 meeting, Dr. Peter Boling gave the annual Distinguished Professor in Geriatrics (DPG) address. We were treated to the story of his career as a home visit physician and of the development of home-based medical care over his career. The following is a post-DPG interview by Dr. Harris via email, with Dr. Boling.

—*What were your favorite aspects of this year's meeting?*
In my career, I have concentrated my efforts in Geriatrics and home care medicine. SGIM is notable for the intellectual rigor and openness that its leaders have always espoused. As for my favorites, I list three things. a) the poster walk-around, that was a successful activity with good group participation and exchange of ideas; b) the opportunity to synthesize some ideas that I have been considering for a long time in preparing for my formal presentation and c) re-connecting with some people at SGIM that I have not seen for several years.

—*What are your thoughts regarding the role of the geriatrician at SGIM? Where should geriatricians focus their energy at SGIM?*

Academic geriatrics has increasingly large common ground with a few other groups of academic physicians, particularly palliative care, as well as groups that have organized around site-specific delivery models such as home care medicine and nursing home medicine. The aging of our population, and the dearth of professionals trained formally in geriatrics makes these issues more and more salient to General Internal Medicine. SGIM is rich in people who are skilled at measuring treatment safety and effectiveness, an area of Geriatric care that will need continued investment. In our rush to “do something” when older patients present for care, we seem easily to lose track of what treatments are really most effective, and reflexively slip into applying (often mis-applying)

regimens developed and tested in younger, healthier populations. Older adults with co-morbidity and frailty will soon be driving half of the health care expenditures in the US; we need to be better informed about what works best and what works less well.

—*In what ways do you think SGIM and geriatrics interactions can be strengthened?*

I think the current model with the visiting professor is a good idea and should continue, as should inclusion of geriatrics-specific scientific presentations at SGIM wherever possible. Another approach could be to separate the annual meetings a little more in terms of participant interests, I know this is difficult; the planning process has been the subject of much discussion and the problem is not an easy one to solve.

—*Will you elaborate on how you chanced into home visits? How can the generalist use that model of care? Or, can the generalist use that model of care?*

Happenstance, and in myself, a desire to be a change agent. When I was in training at the Medical College of Virginia (MCV) now Virginia Commonwealth University (VCU), a visionary physician offered me a job to start a home care medicine program; at the time he was primarily thinking of education as the focus. By making home visits to 75 individuals, I soon realized that there was a significant unmet societal health care need. If we believe in patient-centered care as a first principle, the mainstream model, based on “bricks and mortar,” in which we require patients to come to us at our convenience, on our terms and on our schedules, is not something we should espouse for patients who are immobile and burdened by co-morbidity and frailty. Most of their care is clearly better planned and delivered at home. With

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smart application of technology, with care system and payment re-design, we can give patients and families the care that they need and want. This is care that is overall the most cost-effective. Hospitals, emergency departments, ambulatory treatment centers and physician offices should become adjunct resources that we use selectively, not the places where these individuals typically receive that care. General internists have been historically focused on patient-centered care; think about that and think about these patients for a minute.

—What are some of the important areas in aging research that you think SGIM members can and should continue to pursue in the future, especially more junior investigators looking for their niche?
In Geriatrics, a key area will be effectiveness (and cost-effectiveness) research, aimed at populations with co-morbidity and limited prognosis. As a society, we still collectively approach these vulnerable elders with care plans that are poorly designed, if we look at the correct application of probability-based statistical and

economic principles like those of Thomas Bayes and Vilfredo Pareto.

—Do you have any final words of wisdom for junior generalists and geriatricians?

Find a problem that is meaningful to you and focus on it, using your skills and training; be persistent; learn from history; find experienced colleagues who can support and guide your work. Do not settle for “just OK.” Change health care for the better.

SGIM