ELDERS *in* DISTRESS

By Nicole Peradotto

GERIATRIC PSYCHIATRY FELLOWSHIP ADDRESSES CRITICAL NEEDS

In little more than two decades, the U.S. Census Bureau estimates, 72 million people will be able to call themselves senior citizens.

That translates to one in five Americans, a demographic that's bound to have a profound impact on the health-care system. As the Baby Boom generation of 1946–1964 redefines the face of aging, they will magnify critical issues related to illness and long-term care needs for every sector of the health industry.

To help fill the ranks of a medical subspecialty projected to be in great demand among elderly Americans—and one that's already experiencing serious shortfalls—the School of Medicine and Biomedical Sciences recently introduced a funded fellowship in geriatric psychiatry.

"The need is omnipresent," explains fellowship director Marion Zucker Goldstein, MD, professor of psychiatry. "There are an enormous number of patients. Desperate families and patients come looking for us; however, the workforce is grossly inadequate to meet the demands of our aging population."

Experts predict that many Baby Boomers will spend some of their senior years in long-term care settings, such as assisted living facilities and nursing homes, which were originally intended to treat chronic physical incapacities and, in many cases, are lacking in medical mental-health services.

According to the American Geriatrics Society, in fact, the proportion of elderly with mental illness who receive adequate treatment is markedly lower than in younger groups despite substantial rates of morbidity. This under-provision of services persists even though treatment of mental illness in older people has been shown to be as effective as treatment in younger people.

Those are several reasons why the specialized expertise of geriatric psychiatrists is critical, Goldstein says.

PHOTO BY DOUGLAS LEVERE

Goldstein

"One major problem is that older patients and families do not get the benefit of preventive medical psychosocial interventions, so they come to us in a state of crisis. We need to move away from this emergency room model, where patients who get referred to a geriatric psychiatrist are first seen in the emergency room.

"The condition shouldn't get to the stage where an emergency room is needed," she adds. "The family and the patient need to have proper and sufficient support to obtain diagnostic assessment and treatment earlier, and under more desirable conditions."

As an example of the status quo, Goldstein recalls the case of a widow in her 80s whose verbal tirades so unnerved her children that they brought her to the Erie County Medical Center's Comprehensive Psychiatric Emergency Program (CPEP). When Goldstein met her after her initial emergency care, the woman was so dispirited about her visual impairment, disabling arthritis and resulting isolation that she'd taken to unleashing her frustration on her loved ones.

"Here was this sweet mom who was having these outbursts and hanging up on her children," Goldstein recalls. "They're wondering, 'Why is Mom getting so angry?'"

It's common for geriatric psychiatrists to consult with family members, so Goldstein discussed the woman's plight with her children. Recognizing that the books-on-tape their mother listened to were no substitute for interaction with another individual, they resolved to find ways for her to avoid long periods of solitude.

On Goldstein's recommendation, the woman continued to take her prescribed anti-anxiety medication while discontinuing the antidepressant. She ate and slept well and was not suicidal. Goldstein met with her and her family regularly and, over time, the woman's outbursts subsided.

"The causes for depression and anxiety are very different late in life than they are early in life," Goldstein notes. "Many of them are secondary to the aging process, like the loss of independence, a decline in health, widowhood, fear of dying, having to give up a residence or driving and diminished sensory perceptions.

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Rich Clinical Milieu

The responsibilities of the geriatric psychiatrist are many. Trained to detect the earliest signs of Alzheimer's disease and differentiate them from those of other dementias, they also spot warning signs of substance abuse or suicidal tendencies. One of their primary jobs is to manage the complex medication mix of their patients—who, in addition to psychotropic medications, are typically taking prescription drugs for one or more physical conditions—and to stay alert to pharmaceutical interactions that can cause mood changes, confusion and symptoms of dementia. They also help relatives understand and cope with their loved ones' illness, particularly if those relatives double as caretakers.

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As it happens, psychiatry for the elderly is still a rather young field. It was only in 1991 that the American Board of Psychiatry and Neurology offered the first subspecialty examination in geriatric psychiatry. Since then, the field has faced a major shortage of new practitioners and researchers. According to the American Association for Geriatric Psychiatry (AAGP), there are 1,500 such specialists nationwide—just one for every 10,000 Americans 75 years of age or older.

That deficit, Goldstein notes, is felt acutely in Western New York, where the number of senior citizens is higher than the statewide average.

"With the dearth of practitioners out there it behooves Buffalo to cultivate its own. There are great opportunities here. This is something we have to develop locally to get a pipeline going," she says.

The yearlong UB fellowship, which begins after completion of a four-year residency, consists of rotations at Erie County Medical Center, the Kaleida Health System, Buffalo Veterans Affairs Medical Center, the Buffalo Psychiatric Center, skilled nursing home facilities and Hospice Buffalo. It includes intensive exposure to geriatric medicine and neurology and includes telepsychiatry.

During the course of the program, fellows have the opportunity to interact with a variety of specialists within and outside the medical profession. During the Hospice rotation, for example, they make home visits alongside a team composed of a family practitioner, pharmacists, nurses, social workers and a chaplain.

Kuldip Rai Jassal, MD, the program's first fellow (2006–2007), describes the fellowship as intellectually and emotionally stimulating training that helped him appreciate the complexity of caring for elderly patients.

"I wanted to improve my understanding of this exciting and challenging subspecialty since, looking at the epidemiology, physicians will be assessing and treating more elderly without having had adequate training in their general residency," he says. "I wanted to

be an active proponent of the interests of the elderly, whether it comes to source funding or providing education to the public in an effort to dispel the stigma attached to aging."

Now an attending psychiatrist with Restigouche Health Authority in Campbellton, New Brunswick, Canada, Jassal recalls that, prior to the geriatric psychiatry fellowship, he received only limited instruction in the field of elder care. "To acquire the knowledge, skills and attitudes to become a geriatric psychiatrist," he says, "the fellowship was an opportunity of a lifetime."

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Goldstein stresses that the program has much to offer physicians interested in the interaction of mental and physical illness.

"With so many of our patients having a chronic physical illness coexisting with mental illness, the fellow participates in a rich clinical milieu," she says. "It's very rewarding in terms of being a part of teams and creating collegiality."

As a representative of the American Psychiatric Association, Goldstein helped formulate the requirements for the geriatric psychiatry fellowship when she served on the Accreditation Council for the Graduate Medical Education's residency review committee in psychiatry.

Since 1994, the year the fellowship was approved, 60 geriatric psychiatry fellowships have been accredited, including UB's, which has funded lines for two fellows. Nationally, however, only about half of the 132 available positions are filled.

One reason more physicians don't pursue these fellowships, Goldstein speculates, is that they are first required to complete a four-year general psychiatry residency, whereas other fellowship programs, such as child psychiatry, can be started after the third year of residency.

"There's so much competition for residents," says Goldstein, who explains that there are now five psychiatric subspecialties that offer fellowship training. "But we're continually making efforts to increase the workforce for the elderly."

Reluctance to specialize in geriatric psychiatry also may stem from concerns about Medicare reimbursement. On a positive note, the Centers for Medicare and Medicaid Services (CMS) will implement a separate specialty code for the field this spring, thereby allowing Medicare's billing for services provided by geriatric psychiatrists to be favorably distinguished from the billing of non-geriatric psychiatrists.

"There is continued advocacy by the AAGP to improve reimbursements for medical mental health care for the elderly," she says, adding many salaried hospital positions exist for geriatric psychiatrists. "We have come a long way."

Changing Patient Profile

Goldstein is passionate about the fellowship not only because so many Western New Yorkers would benefit from a larger cadre of geriatric psychiatrists, but also because living in Buffalo can sometimes pose inordinate burdens on the elderly.

For one, the region's winters can be harsh on older residents, in some cases reducing their mobility and forcing them to live as shut-ins for several months of the year, a circumstance that can contribute to anxiety and depression.

Another factor is the region's high rate of poverty among seniors, which compromises their health and access to care, as well as their ability to retreat from inclement weather. "It's not like you can be a snowbird and move to Florida when you're poor," Goldstein points out. For those who become widowed and whose children move away, the picture becomes bleaker still.

On the upside, Buffalo's strong faith communities offer plenty of opportunities for the elderly to interact and socialize. "Whenever I hear that one of my patients belongs to a church or a synagogue, it's a relief," says Goldstein. "But we're not all 'group people' who like to participate in religious organizations or go to senior citizen centers. We're not all geared toward that, especially men. This is a major issue for men who haven't gotten remarried after widowhood and whose friends have died," she adds, noting the high rate of suicide in this group.

As the Baby Boomers advance to their senior years, the profile of the elderly will change dramatically, Goldstein surmises. Not only are the Boomers more affluent, better educated and more technologically savvy than the preceding generation, they're less averse to receiving mental health care and more outspoken about the need for better health care overall.

"The Baby Boom generation will have quite different attitudes than the generation before them," she says. "I can't tell you how many families come in and say that they had to convince their parent that nothing bad would happen if they saw a psychiatrist. That will change with the Baby Boomers. They will be more comfortable with psychiatry. They're going to make sure that there's more, and better, medical help. They're going to look out for themselves, and the whole scene is going to change. That generation is going to make more sophisticated demands on their health-care facilities."

For its part, the fellowship is one way to respond to the challenge.

"Care for the elderly ought to be a priority," Goldstein says. "It's an issue that ought not to be pushed aside for other priorities, particularly in this era when there is so much chronic illness in late life—physical and mental—and so much research indicating how much of it can be relieved with access to appropriate care." BP

To learn more about the geriatric psychiatry fellowship in the School of Medicine and Biomedical Sciences, contact Marion Zucker Goldstein, MD, fellowship director, at (716) 898-4256; or mzg@buffalo.edu.

Buffalo's Pioneer in Neurological Diseases

THE DR. WALTER A. OLSZEWSKI COLLECTION DONATED TO UB

By Judith Adams-Volpe

The late Walter Olszewski, MD '54, a longtime professor at UB, was a pioneering neuropathologist who was renowned for creating and classifying a comprehensive collection of neural images of his patients and for case reports and clinical insights that resulted in more accurate diagnoses and improved treatments.

In 2008, his wife, Virginia, donated his papers and an extensive collection of clinical slides to the University Archives at UB. The Dr. Walter A. Olszewski Collection: Neuropathology Reports and Images, 1949-1990, documents the clinical study of neurological conditions during a time when the only way to study such conditions was by the direct examination of brain and nerve tissue via dissection following surgery or death.

The case files include autopsy protocols, clinical summaries, dissection reports and over 35,000 slide images. Also included are candid photographs of medical school students and faculty, as well as slides from neurological surgeries and slides organized by various diagnoses, including autopsy files grouped by diagnosis, such as Alzheimer's (1968) and sickle cell (1976). In addition to the slides and papers, a number of medical instruments were also donated, which have been placed in the Robert L. Brown History of Medicine Collection at the UB Health Sciences Library.

"The Olszewski Collection contains meticulously documented physical and neurological findings from Dr. Olszewski's personal examination of his patients," explains Edward Fine, MD, associate professor of neurology and former colleague of Olszewski.

Fine extols the Olszewski Collection as "a treasure of learning and the hands-on work of a compassionate and clinically superb neurologist and a meticulous neuropathologist."

Born in Rome, New York, Olszewski served in the Army Air Force during World War II as an aircraft navigator. Following his military service, he earned a bachelor's degree from Colgate University and a medical degree from UB, after which he joined the clinical faculty of UB in 1963.

From 1961 to 1983, Olszewski held appointments at Buffalo General Hospital, including head of neurology and director of neuropathology, where he built his extensive slide collection documenting neurological conditions. He served as chief of the Neurology Service at the Buffalo Veterans Hospital from 1984 to 1986, and in 1989 he was named director of the Transcranial Doppler Laboratory, a position he held until his death in 1995.

John R. Wright, MD, former dean of the UB School of Medicine and Biomedical Sciences and professor of pathology, recalls that Olszewski was one of his first teachers in Buffalo in 1963. "Walter took the neuropathology laboratory in a new direction, correlating anatomic abnormalities with the clinical signs and symptoms of patients," explains Wright. Such a correlation, he adds, serves to "advance medical knowledge while being applicable to living patients.

"There is now great interest in determining if, or how, what is seen on MRI scans correlates with the clinical presentation of living patients," Wright continues. "Unfortunately, with the alarming decline in autopsies, such correlations will be significantly handicapped. Therefore, Walter's extensive collection and body of work represents a unique and irreplaceable resource in this important field."

On a personal note, Wright recalls that Olszewski made himself highly available to the pathology residents on the autopsy service at Buffalo General Hospital.

Virginia Olszewski, who donated the collection to UB following a suggestion by Fine, also generously helped to underwrite the housing and processing of the sizable Olszewski Collection. Initially she was concerned about the privacy of patient records and sought the advice of several professionals, including Linda Lohr, curator of the Robert L. Brown History of Medicine Collection at the UB Health Sciences Library.

Virginia explains that Olszewski served as the photographer for the medical school yearbook while earning his medical degree at UB, which accounts for the many informal photographs of students and educational settings that are included in the Olszewski Collection. She further notes that her husband regularly used his large collection of neuropathology slides during his grand rounds presentations, relying on actual cases to illustrate symptoms and medical conditions. His style was so compelling, she says, that students, technicians and even secretaries would be transfixed.

Virginia, who notes that the collection "was such a big part of Walter's life," is delighted that its value is recognized by the University Archives and that such care is being taken for its organization, conservation and accessibility for future generations of physicians and technicians in Buffalo and beyond. BP

The Olszewski Collection is open for research; however, in order to maintain patient privacy, folders in the "Case Files" series are provided to researchers with the patients' personal information redacted. To view or consult the collection, contact the University Archives at (716) 645-2916 or email lib-archives@buffalo.edu.

Judith Adams-Volpe is director of communications for the UB Libraries.