In a recent article in U.S. News & World Report, Heather Whitson, MD, MHS, associate professor of medicine (Geriatrics), commented on the shortage of physicians specializing in geriatric medicine.

Economics is one factor contributing to the shortage: A career in geriatrics can be financially unattractive for doctors carrying large medical school debt. Geriatricians treat patients who are covered by Medicare and Medicaid, which traditionally have lower reimbursement rates than private health insurance companies.

“Geriatrics is the only sub-specialty where physicians can expect to ultimately earn less even though they did extra years of training,” Whitson says. “We need a restructuring of the reimbursement system so there isn't a financial disincentive to go down this career path.”

Medical schools and residency programs also need to include geriatrics in the curriculum, in the same way that all students are exposed to pediatrics even if they don’t plan to become pediatricians. “It's beginning to happen,” Whitson says.

“We are not prepared as a nation. We are facing a crisis. Our current health care system is ill equipped to provide the optimal care experience for patients with multiple chronic conditions or with functional limitations and disabilities.”

– Heather Whitson, MD, MHS

Continued on page 5
My very first interaction with Duke occurred during my first year of medical school. Desperate to embark on geriatrics research in 1985, I wrote to someone asking for a copy of the OARS instrument (Older Americans Resources and Services Program famously developed at Duke to measure the impact of services on the functional status of older adults.). Yes, someone sent me a copy in the mail, this was way before e-mail and scanners or faxing were popular. When I finally arrived at Duke for fellowship training in geriatrics I was afforded the privilege of working with Gerda Fillenbaum, PhD, one of the authors of the OARS instrument. Together we embarked on exploring data collected by the Consortium to Establish a Registry for Alzheimer’s Disease. I was particularly interested in the weight changes that many clinicians witnessed in caring for these patients, in particular the tendency to lose weight. As a junior faculty member I continued to explore care for patients with dementia collaborating with Edward Levin, PhD, to understand the potential for nicotine to improve the symptoms of this disease while avoiding potential adverse effects such as weight loss.

However, my passion for academic geriatrics could not be quenched by research alone, I am very much at home at the bedside or in the clinic with older adults, and I enjoy sharing this passion with learners. Dr. Robert Sullivan became one of my early clinical mentors, helping me to appreciate the value of caring for patients in the skilled nursing facility. As medical director at The Methodist Retirement Community that was located on Erwin Road, and later at the Croasdaile Village Retirement Community, I sharpened my skills and learned from patients, families and members of the interprofessional team. A Geriatric Academic Career Award allowed me to develop long-term care focused education for our geriatrics fellows, post-doctoral fellows, pharmacy residents, physical therapy residents, geropsychiatry fellows, palliative care fellows, and advanced nursing students. Although we were doing a laudable job teaching them about clinical care in this setting, The Advanced Course in Long-Term Care that resulted ensures a more nuanced curriculum regarding this care setting, in relationship to the larger health system, so our learners are poised to become leaders and change advocates.

Funding from the Reynolds Foundation has allowed me to extend myself into the arena of faculty development. Working with faculty from other institutions to develop their own curriculum in post-acute and long-term care has been a prized endeavor accomplished through the weeklong mini-fellowships...
EDITORIAL*  
Health Risks of E-Cigarettes for Elders

The health risks of tobacco use, whether smoked or smokeless, are well known and well established. Tobacco causes lung cancer as well as many other forms of cancer and cardiovascular diseases. Recent studies indicate that tobacco also increases the risk of Alzheimer’s disease and other forms of dementia. These risks increase with age which makes it especially dangerous for elders.

Electronic cigarettes are being marketed as safer than regular cigarettes, because they do not contain the tars and other toxic chemicals that are in the smoke of cigarettes. E-cigarettes were developed to provide smokers with a smoke-free source of nicotine through heated vapors which look like smoke.

However, we now know that e-cigarettes also deliver a cocktail of other toxic chemicals, including carcinogens, into the lungs. New studies show that using e-cigarettes may even promote antibiotic-resistant bacterial infections, such as by Staphylococcus aureus.

There are two main dangers with e-cigarettes. One is the nicotine which gives the users the kick they desire. Nicotine of course is a poison and has the effect of constricting blood vessels. The second danger is in the nanoparticles which have been linked to asthma, stroke, heart disease, and diabetes, all of which tend to increase with age. The solvents used to dissolve the nicotine and flavoring are known as lung irritants, which when vaporized can transform into more toxic carbonyls, such as formaldehyde and acetaldehyde. If users of the high-temperature e-cigarettes maximize the power of their devices, formaldehyde can reach the same levels as in regular cigarette smoke.

Considering all these dangers, nicotine addicts, especially older ones, would probably be safer getting their “fix” from Nicorette chewing gum or nicotine patches than from e-cigarettes.

* The opinions in this editorial are those of the editor and do not necessarily reflect policy of the Center on Aging.

White Named as ADMA Vice President

AMDA (The Society for Post-Acute and Long-Term Care Medicine) has announced that Heidi K. White, MD, MHS, MEd, CMD, will be its Vice President for 2015-16. The acronym “AMDA” comes from its former name, the American Medical Directors Association.

Dr. White is an Associate Professor of Medicine in the Division of Geriatrics and a Senior Fellow in the Center for the Study of Aging and Human Development. She has nearly 20 years of experience serving as a Medical Director in Durham, NC at Croasdaile Village Retirement Community. Dr. White has served as Secretary/Treasurer, Vice-President, President and Past-President of the North Carolina Medical Director Association (2004-2009) and remains active in the chapter. She has served on the AMDA Education, Program, and Membership Committees, and chaired the Program Committee for AMDA’s Annual Conference. In 2014 Dr. White was acknowledged for her work in AMDA with the James Pattee Award for Excellence in Education. (See also accompanying article on Featured Researcher.)
Erdman Palmore, PhD, Professor Emeritus of Medical Sociology, was inducted into the GRITS Hall of Fame at the 36th annual meeting of the Southern Gerontological Society in Williamsburg on April 16, 2015. GRITS also honored Frank Whittington, PhD, Professor of Gerontology at George Mason University in Fairfax, Va., and Victor Marshall, PhD, Director of the University of North Carolina Institute on Aging. Whittington received his PhD in Sociology from Duke University with Palmore as his mentor.

Palmore received his BA from Duke University and PhD from Columbia University. His research and writing deal with ageism, longitudinal studies, and international gerontology. He was the 5th president of the Southern Gerontological Society.

GRITS is the acronym for Gerontologists Rooted In The South. It has three goals:

- To recognize individuals who have made important contributions to gerontology through research, teaching, administration, advocacy or applied practice.
- To maintain and stimulate interest in the history of SGS, perpetuate the legacy of past and present members, their achievements in the field of gerontology, and their contributions to enhancing the lives of elders in the SGS region.
- To honor past and present members who serve as role models for future generation interested in the advancement of knowledge and practice in the field of aging.

**FREQUENTLY ASKED QUESTIONS**

*Does Lung Vital Capacity Decline?*

Even though you have not had tuberculosis, some aspects of lung capacity do tend to decline, but the good news is, some do not decline. While vital lung capacity (as measured by the volume of air that can be expelled in one breath) tends to decline, residual volume tends to increase, so that total lung capacity tends to remain about the same, even in old age. Also cardio-vascular exercise, especially breathing exercises, can counteract the loss of vital lung capacity.

*Adapted from Palmore, Older Can Be Bolder (Amazon, 2011).*
FEATURED RESEARCHER: Heidi White, MD, continued

that have been offered over the past 10 years. My concern for care environments that meet the needs of many of the oldest and frailest among us has led me to volunteer my time with AMDA The Society for Post-Acute and Long-Term Care Medicine. I enjoy co-directing the Futures Program that brings approximately 60 geriatrics fellows to the annual meeting to learn more about a career in medical direction. I will serve as the president of this professional organization for 2017-2018.

In the wake of health care reform, my expertise in caring for older adults with cognitive and physical disabilities, especially in post-acute and long-term care, has opened doors of opportunity. Duke Connected Care, the newly formed physician-led Duke Accountable Care Organization is very interested in programs and systematic changes that will improve both the quality and cost of care for older adults with complex care needs. I have been pleased to serve on the operating committee, and to help establish a geriatrics advisory group. Working with Dr. Tom Owens, our Duke Health System Chief Medical Officer and his associate Laura Huffman, we have established quarterly conferences that bring together an interprofessional group of Duke leaders from our hospitals and home health care agencies, with area skilled nursing facility (SNF) leaders to gain knowledge of best practices and discuss issues of mutual concern. Concurrently, I was asked to lead a Health Optimization Program for Elders (HOPE), to improve care transitions from Duke Hospital to area SNFs. The outcomes of this pilot program have gained attention and funding for hospital-wide expansion. Also the Duke Institute for Healthcare Innovation has funded a portion of this project, that will develop interactive on-line education for Duke and SNF staff to continue to improve transitions and care for vulnerable seniors in need of post-hospital rehabilitation.

I am especially blessed to have the opportunity to share my passion for providing and improving care with many Duke undergraduate students, primarily women, many of whom have been referred to me over the years by Deborah Gold, PhD, who provides the first spark for gerontology to so many Duke undergraduate students in the classes she teaches. These interactions with undergraduates, and a dense network of professional connections at Duke in part provided by my spouse and fellow Duke faculty member, Leonard White, PhD, a neuroscientist, has led to a growing collaboration with two younger Duke researchers, Cassandra Germain, PhD, and Tobias Overath, PhD, also both neuroscientists. Together over the next year, we will lead a Bass Connections funded program involving three undergraduate students and two medical students to explore the scientific basis of personalized music, a currently popular intervention to improve the behavior and quality of life for older adults suffering from Alzheimer’s disease and other forms of dementia.

Duke is truly a rich environment of experimentation and change that has fueled my career as an academic geriatrician over the past 20 years. I hope to continue to make a difference, not just for my own patients but for all the elders in our health care system, while providing opportunity and experiences for the professional development of the passionate geriatricians and gerontologists who will eventually take my place.
Harvey Jay Cohen, MD, was among the ten “Top Doctors” who were asked by the AARP how they would recommend our health system be improved. He responded as follows:

**Create a unified system of care.**

My grand vision would be to have a system where all levels are linked. Transitions within health care are very problematic. That’s where mistakes happen and errors creep in, because things aren’t transmitted accurately. It’s the most vulnerable point—especially for older people. So if someone were moving from an outpatient setting to the emergency room or from the hospital to assisted living, there would be a seamless ability to do that across financial boundaries. If we had one system where all those costs and expenses were seen as part of the whole and any part of the system that saved money would save money for everybody, that would remove those barriers. Then complement that with a shared electronic record, so that when we have to move patients from one place to another, their information follows them seamlessly. The people admitting that patient back to the nursing home or back to the doctor would have the information right there that says; This is what we know, and this is what needs to be done.”

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**Blazer Receives IOM Medal**

Dan Blazer, MD, PhD, Professor of Psychiatry and Senior Fellow of our Center for the Study of Aging, has been awarded the Walsh McDermott Medal, which is given to an Institute of Medicine (IOM) member for distinguished service over an extended period. Blazer has served on three IOM boards, two of which he chaired. He currently chairs the Board on the Health of Select Populations and a new ad hoc committee on the public health dimensions of cognitive aging. He has been a member of 16 study committees, six of which he chaired, and four advisory committees.

Blazer has been at Duke since 1973, has served as Dean of Medicine, and has published several books and numerous articles.
The Duke Family Support Program (DFSP) is celebrating 35 years of connecting people who have some form of dementia and their caregivers with the many resources available in North Carolina and beyond. The DFSP was founded in the Center for the Study of Aging in 1980 with help from the Duke Hospital Auxiliary, NC Foundations, and families committed to helping other families caring for members with Alzheimer’s and related diseases. The DFSP tagline is “A Bridge to Understanding Your Options”.

The Caregiver newsletter of the DFSP has been connecting families ever since with stories and poems, tips and resources, book reviews and online help. It is co-sponsored by the Joseph and Kathleen Bryan Alzheimer’s Disease Research Center and the Duke Center for the Study of Aging with funding from the NC DHHS Division of Aging and Adult Services.

Lisa Gwyther, MSW, LCSW, was the founder and remains the Director. She is assisted by Bobbi Matcher, MSW, MHA.

For more information, contact DukeFamilySupport@duke.edu or 919-660-7510.
COMING EVENTS


September 24: Annual Education in Palliative and End-of-Life Care (EPEC) training conference. Oakbrook, IL. Contact: info@epec.net or 312-503-3732.

September 25: 60th Anniversary Celebration of the Duke Center for the Study of Aging and Human Development. Contact: jamazina.smith@duke.edu.

