

Q & A with Dr. Richard Besdine

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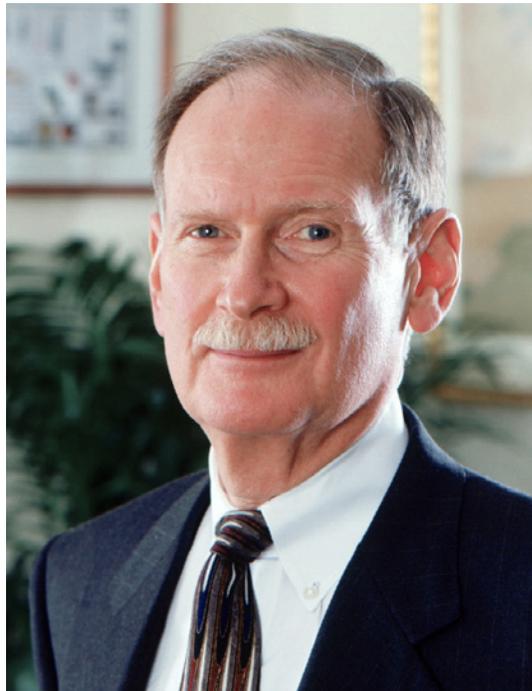
PROVIDENCE – Richard Besdine, MD, director of the Center for Gerontology and Healthcare Research at Brown University, recently sat down for a candid conversation about geriatrics and his personal path into the field, which took root in the Scottish city of Glasgow in 1972.

1. Who has influenced you the most in your life, both professionally and personally?

My Scottish mentor, Sir Ferguson Anderson, known to all as Fergie, was my first professional mentor. I began my career as a basic scientist and in ID (infectious disease). I became less and less fulfilled as a scientist and did some soul searching. I realized my greatest satisfaction was in figuring out the toughest and most complicated patients – most were older – and improving their lives. Howard Hiatt [later dean of public health at Harvard], my Chair of Medicine, told me about Fergie.

I went to the University of Glasgow in 1972 and did a geriatrics fellowship with Fergie, who was Europe's first professor of geriatrics. He inspired me and I came home determined to build one of the nation's first academic geriatrics programs in the United States, which I did with Jack Rowe at Harvard Medical School.

My second mentor was Bruce Vladeck at what was then known as HCFA (Health Care Financing Administration, today's Centers for Medicare and Medicaid Services). I was on a one-year sabbatical (1995) from UConn. [At the time, Dr.



Dr. Richard Besdine

Besdine was chief of the division of geriatrics at the University of Connecticut.]

Bruce was a brilliant visionary and introduced me to the world of health care policy. He eventually offered me the position of director of HSQB (Health Standards and Quality Bureau) and first chief medical officer at HCFA. It was the bulliest pulpit for geriatrics and the most exciting job I've ever had.

And my treasured wife Fox has been a powerful influence in my life. I first met Fox in 1978. I was a young and arrogant Harvard faculty member. I was great at finding flaws in humans. She taught me to look for the good in people. Here at the Center, people do good

work and care for and about each other. It's important to publicly recognize their accomplishments. That's paying it forward.

2. What distinguishes a geriatrician from an internist or primary care physician?

What makes the field of geriatrics different? Pure aging in the body happens no matter how healthy a person is. Diseases common in the 60s, 70s, 80s, and 90s almost always also occur in middle age. But when major diseases are superimposed in the older population, they present differently. Increasingly, subspecialists

are recognizing this. The management of complex and chronic diseases in older people is the bread and butter of geriatricians.

A good solid educational program can prepare future doctors in treating these patients. We've put this into the core curriculum at Brown's medical school.

3. In your experience, who are the predominant referral sources for geriatricians?

We get referrals from well-read family members and patients. Surgeons are a large source of our referrals, both general and orthopedic, neurosurgeons, neurologists and other subspecialists.

4. Should all elderly patients have a geriatrician as their PCP?

No. We usually see 5 to 10 percent of the very elderly, with multiple health problems on a variety of medications. We see a patient in referral, do a comprehensive assessment, and return them to their internist or PCP, if they have one.

5. To what extent do you involve hospice care and particularly our local Home & Hospice Care (HHCRI) in your attempts to lessen the costs of health care while simultaneously improving the emotional well-being of your patients?

We facilitated the affiliation of HHCRI with Alpert Medical School, based upon its huge capacity and activities as a teaching center for hospice and palliative care for Brown medical students, residents and faculty. We now have a fellowship in palliative care. I'm a zealot for palliative care.

The primary goal is not saving money. It is delivering the care that patients and their families want once they are informed of all their choices. Geriatricians often begin the conversations on palliative care and advanced directives with patients and families. We need to have patients and families begin to have these

conversations earlier, while the patient is capable and able to communicate his/her choice. An advanced care directive is not a single sheet of paper. It's a conversation. Things change over time.

6. Do you have a favorite quote on aging?

I have several. One is from George Burns at 95: "If I had known I was going to live this long, I would have taken better care of myself." ❖