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Editorial

From geriatric medicine to aging medicine

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Aging poses global challenges, especially concerning physical and mental wellbeing and long-term care. And the challenges relating to disease management or disability/dementia care are never restricted to people older than 65 - most disease or functional decline begins during middle age. Therefore, the WHO World Report on Aging and Health[1] recommends a life-course approach to promoting healthy aging, within a conceptual framework based on intrinsic capacity and functional ability rather than simplistic age-based approaches. With the ultimate goal of maximizing functional capacity in later life, the report suggests different strategies according to a person's current functional status.

The development of each chronic condition culminating in multimorbidity usually begins in earlier life, either independently or synergistically;[2] even in healthy people, functional declines in both physical and cognitive domains are evident before age 60. Adverse effects of uncontrolled chronic conditions may result in earlier onset of functional declines and poorer quality of life in older age. Hence, preventing disability or dementia is certainly a life-long endeavor for every individual and healthcare professional.[3]

Traditionally, the purview of Geriatric Medicine is looking after older adults with multiple complex diseases as well as frailty, disability and dementia. Marjory Warren pioneered the discipline by comprehensive geriatric assessment that substantially re-abled frail older people to regain their independent living.[4] We now know that earlier and more appropriate intervention can completely change the destiny of frail older patients. For example, inappropriate dietary restriction in patients with chronic conditions may cause malnutrition and later-life sarcopenia and frailty. Moreover, the management of chronic conditions did not usually follow a life course approach. Suboptimal control of diabetes in middle age may increase the risk of dementia in later life, but silent hypoglycemia secondary to tight glycemic control in older patients with diabetes increases their risk of dementia, too.[5]

Geriatricians' core competence is managing multiple comorbid conditions, disability, and dementia, and devising care plans to maximize functional capacity for every frail older patient;[6,7] managing mood conditions and other mental health issues is also important.[8] This expertise should be dedicated to healthy aging, not just geriatric care. Geriatricians may have very different roles in different healthcare settings. Most work in hospitals, with the main mission to treat frail older patients with acute conditions, while patients with multiple complex care needs are mostly referred to outpatient services. The responsibility of promoting healthy aging lies with primary care physicians, regardless of how old their patients are; therefore, it is a priority to inculcate a life-course approach to healthy aging among primary care physicians. The United Kingdom model of community geriatricians, who play active roles in education and clinical care, may be a good solution to bridging

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the gap between hospital geriatricians and primary care physicians. Elsewhere, especially in Asia, geriatricians may work in hospitals for inpatient care, and some effectively become primary care physicians. Several models, such as frailty clinics, that also have active participation of geriatricians, have been implemented to promote the principles of healthy aging in communities. Therefore, the roles of modern geriatricians should be expanded from caring for patients with complex needs to include advocating of healthy aging - from Geriatric Medicine to Aging Medicine!

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