



24 July 2006

Dear Dr. Smith,

I am writing to you today to explain how I approach care of the geriatric patients and work with the primary care physician. I have seen your patient, Betty Jones and family. During my twelve years in primary care practice, I have seen too many instances in which I was faced with frail elderly patients presenting exceedingly complex psychosocial problems—and time limitations that forced me to try to address them in an incredibly limited time slot. I have found these patients challenging and even frustrating simply because the current system, which focuses procedures over evaluation and management, and doesn't support the type of care that they need. I aim to focus on the geriatric syndromes and support the primary care physician.

Let me offer an example of one such case: Mr. Y, a distinguished looking man diagnosed with Alzheimer's came to my office. His family reported that his behavior was erratic: at times, he was extremely docile, while he became nearly uncontrollable at others. At this particular visit, his wife reported that he was experiencing chest pain, but he adamantly refused to lie down for an EKG, even hitting us as we tried to put on the EKG leads. At the time, my focus was on diagnosing the medical condition that was causing the chest pain. Retrospect, though, makes me wish that I had had the time or a colleague that would have allowed me to address the deeper underlying issues of continuing care for an elderly Alzheimer's patient. Presented with this situation today, in my new capacity as consultative eldercare physician, I would provide advice for addressing difficult behavior, support the family in the challenges of his care, assist in clarifying his goals of care, and exploring potential treatment options.

Mr. Y is exactly the kind of patient that would benefit most from the type of partnership that I am proposing between primary care physician and eldercare consultant. In my consultative role, the primary care physician would remain in their traditional capacity and would maintain all authority over the case. In turn, I would act in a consultative role with the primary care doctor in evaluating and advising frail elderly patients and their families.

In my capacity, I would suggest paths of potentially useful treatment options to the primary care doctor. This "chain of command" would ensure a closely aligned treatment plan, and avoid conflict, contradiction and confusion for the patient. I would provide the primary care physician with up-to-date information on geriatric syndromes/diseases and medication issues. As an internist who has returned for a geriatric fellowship, I have learned new approaches to the ambulatory care challenges of frail and demented patients that frustrated me in my ten years of practice. As a geriatrician, I assess patients from a global standpoint as well as through a lens of addressing disease issues (for example, constipation can be a major contributor to agitation amongst the frail elderly).

In addition, I am able to prescribe medications for common problems of the elderly, such as agitation. Finally, I would be available by cell phone to the primary care physician for consultation on various matters.

Sincerely,

Elizabeth Landsverk, MD