Journal of the American Geriatrics Society

Journal of the
American Geriatrics Society

SPECIAL ARTICLE

In Search of Geriatrician Identity

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Received: 4 December 2025 | **Revised:** 4 February 2026 | **Accepted:** 9 February 2026

Keywords: aging | geriatric medicine | geriatrician | identity | profession

ABSTRACT

Geriatricians have struggled to describe a complex and sometimes ambiguous professional identity. Unlike other medical specialties anchored in discrete organ systems, diagnostic and interventional technologies, or clearly defined clinical settings, geriatric medicine encompasses the care of a heterogeneous population of older adults with widely varying clinical needs, priorities, and trajectories relevant to function, multimorbidity, and complexity. This Special Article examines four distinct but overlapping perspectives on geriatrician identity—the complexivist, the healthful longevitist, the syndromist, and the contextualist. The complexivist perspective emphasizes expertise in managing multimorbidity, frailty, and the interplay of medical, functional, cognitive, and social challenges. The healthful longevitist reframes the discipline around extending healthspan, promoting resilience, and supporting healthy aging. The syndromist reflects a trend toward syndrome-specific specialization, such as "brain health," in some respects, paralleling subspecialty evolution in other fields. The contextualist highlights geriatricians who center their work within specific care settings or models of care, including home-based primary care, skilled nursing facilities, PACE programs, ACE units, co-management models of care with other specialties, and Age-Friendly Health Systems. While each perspective offers valuable insights, none alone fully captures the breadth of geriatric medicine or resolves long-standing tensions around recognition, prestige, and the profession's future. Debates over identity should not be viewed as divisive, but rather as essential to strengthening the profession. Continued examination of geriatrician identity is critical to ensuring that the specialty remains relevant, valued, and morally ambitious in the face of an aging population, major advances in geroscience and technology, and an evolving healthcare system.

In an article published over a decade ago entitled "The Unknown Profession," a group of geriatricians wrote, "Our name has not been heard. The beneficiaries of our services—older adults and their caregivers, and even some of our colleagues—are unaware of who we are and what we do." [1] This quotation captures a paradox that persists to this day; while there may be high societal need for the profession of geriatric medicine, that reality is coupled with low professional recognition. This mismatch has undermined our profession's visibility, relevance, and influence.

In contrast, clinicians in many other specialties do not face the same challenge of anonymity. For them, their identity follows "logically" from the biology and pathophysiology of a specific organ or system, from specialty-specific diagnostic tests and therapeutic interventions, from a defined clinical setting as in the case of critical care and hospital medicine, or in providing care to a patient population considered by others as less ambiguous and heterogeneous, as with pediatrics and obstetrics.

In considering geriatrician identity, Tinetti and colleagues once cautioned, "Our well-intentioned efforts to be inclusive and comprehensive lead to the creation of long, complex descriptions of what [geriatricians] do that further compromise understanding, while eroding interest in, and support of, our field" [2].

The following composite description, drawn from numerous such efforts [3–8], illustrates the phenomenon Tinetti and colleagues warned about: Geriatric medicine involves caring

Summary

- Key Points
  - Geriatricians lack a widely accepted and universally understood professional identity
  - Four perspectives—the complexivist, healthful longevitist, syndromist, and contextualist—capture different, but complementary ways of describing the professional identity of the geriatrician.
  - Ongoing examination of geriatrician identity is essential for strengthening the specialty's visibility, relevance, and impact in an aging society and a rapidly changing healthcare environment
- Why Does This Paper Matter?
  - This Special Article argues that unresolved identity is not a weakness, but a defining challenge that will shape the future of the profession of geriatric medicine.
  - By describing four diverse, but complementary, perspectives, it frames identity as central to maintaining the specialty's continued clinical and societal relevance.

for older people with complex, often atypical, clinical presentations characterized by multiple, simultaneous, interacting problems including frailty, functional and cognitive decline, multimorbidity, and polypharmacy. The practice of geriatric medicine prioritizes interdisciplinary care, the involvement of care partners, and an older patient's values and preferences in clinical decision-making. Geriatric medicine also draws upon specialized expertise in the physiology of aging—how age-related changes in organ systems, homeostasis, and resilience shape clinical presentation, response to stressors, and treatment choices.

Like many professional identities, that for geriatricians is a dynamic construct that can and will change over time [9]. This article offers a framework for considering geriatrician identity by presenting four different perspectives: the complexivist; the healthful longevitist; the syndromist; and the contextualist (see Table 1). These perspectives should not be considered mutually exclusive, as for many geriatricians, their identities are defined by more than one. Each perspective is prefaced by an exemplar quote from leading figures in geriatric medicine.

1 | The Complexivist: Embracing Multicomplexity

> First and foremost, big "G" Geriatricians will be complexivists … who provide direct care to older adults with the most-severe illnesses, multimorbidity, and frailty.
>
> (Simpson et al. [10])

The conception of geriatricians as complexivists follows from the construct of "care complexity." According to this paradigm, complexivists address the care needs of older patients with multiple chronic conditions, physical frailty, disability, and cognitive, psychiatric, social, and financial challenges, who are more likely to be high utilizers of health care resources [11].

The medical conditions and issues that affect our patients and their caregivers are complex and ever changing. Providing care for this population can be exceedingly challenging in our fragmented US healthcare system. Still, complex care is what we have been trained to do, how we practice, and what geriatricians teach to our trainees, across the full spectrum of care settings. Our training as geriatricians is holistic and person-centered, and unequivocally embraces the care of older adults with multiple chronic conditions, psychosocial challenges, and functional and cognitive limitations. This orientation is seldom adequately conveyed and experienced in internal medicine and family medicine residency training [12]. It therefore seems logical to define geriatricians as complexivists, positioning this expertise as our "unique [professional] niche" [13].

While the training and perspective of the internist and family physician about the care of the complex older patient may differ substantially from that of the geriatrician, for those who are not part of the geriatric medicine community, these important differences are not always fully appreciated. For that reason, geriatricians today are not alone in laying claim to the complexivist brand. For example, the American College of Physicians characterizes all internal medicine physicians as being "experts in *complexity*, who thrive in uncertainty, and who help patients with multiple, complex chronic conditions." In a recent episode of the *New England Journal of Medicine's Not Otherwise Specified* podcast, a general internist described his work as follows: "You're astounded by the range of *complexity*, where you shift your mind from a social driver of health bisected by three complex conditions with interacting medications, and new symptom issues, a new diagnostic quandary, a family conflict, some preventive needs … and you're trying to manage their care and have them not land in a hospital" [14].

A pediatrician and a geriatrician, Jay and Sarah Berry, have described the universal features of "complex care" as when cutting-edge technologies and treatments are not always consistent with goals of care or are not always beneficial to the patient, where the evidence-base guiding management is not always strong, and where providing care can require an enormous amount of time and effort involving communication and coordination among multiple health care professionals and caregivers [15]. In fact, "complex care" has emerged as a specialized field within pediatrics to address the complex care needs of children who have serious chronic conditions, substantial functional limitations, and increased health and service needs, leading to increased health care costs [16]. Perhaps geriatricians can learn something from our colleagues in pediatrics.

Descriptions of complex care and multicomplexity, emanating from internal medicine and primary care, are being conflated with how many geriatricians have described their unique roles and their special approach to the care of older adults. While some advocate for the use of the complexivist designation to help distinguish the specialty of geriatric medicine, the reality is that we are no longer alone in claiming ownership of the complexivist brand.

TABLE 1 | Perspectives on geriatrician identity.

Geriatrician identity	Definition	Key characteristics
Complexivist	A geriatrician who specializes in caring for older adults with multicomplexity—multiple interacting chronic conditions, functional and cognitive impairment, frailty, and social vulnerability.	• Expertise in managing multimorbidity, frailty, disability, cognitive and psychiatric issues, and social/financial challenges. • Skilled at coordinating care across fragmented systems. • Addresses high utilization and complex decision-making needs. • Overlaps with internal medicine and primary care claims of "complexity," complicating exclusive brand identity.
Healthful longevitist	A geriatrician who focuses on extending healthspan by promoting healthy aging, resilience, preventive care, and well-being—not only managing decline.	• Emphasizes healthy aging, independence, purpose, and function. • Integrates geriatrics with preventive medicine and whole-person care. • Aligns with translational geroscience. • Risk of conflation with commercialized, non-evidence-based "anti-aging" medicine.
Syndromist	A geriatrician who develops subspecialty-level expertise in a particular geriatric syndrome, such as dementia, delirium, frailty, falls, incontinence, or syncope.	• Applies geriatric principles to syndrome-specific care. • Example: "memory care specialist." • Mirrors subspecialization in other fields. • Potential for turf conflicts with other specialties.
Contextualist	A geriatrician whose professional identity is defined by mastery of a particular clinical environment or model of care.	• Practices in settings linked to geriatrics: home-based care, SNFs, long-term care, PACE, ACE units, Age-Friendly Systems. • Provides interdisciplinary, comprehensive care tailored to a clinical context. • Geriatrician involvement in these models is often optional rather than deemed essential. • Clinical setting alone does not reliably define or distinguish geriatricians.

2 | The Healthful Longevitist: Extending Health and Well-Being Into Later Life

> The field [of geriatric medicine] should be positioned to address not only disease, debility, frailty, and death, but also patients' hopes to remain healthy and high functioning for as long as possible.
>
> (Aronson [17])

Multicomplexity and frailty characterize only a minority of older adults. Some have argued that the complexivist identity narrows the realm of the geriatrician solely to the inevitable declines associated with aging, limited to caring for the "oldest, sickest, and frailest old patients" [17]. Might it be better for geriatricians to promote an identity for themselves that is more "optimistic," one that deemphasizes the health challenges associated with aging, while promoting how advances in medicine and science are allowing us to live longer, healthier lives? Rather than complexivists, should geriatricians characterize themselves as "healthful longevitists," an identity that places the focus of the specialty on fostering healthful aging? [18]. The care provided by the healthful longevitist could primarily center on promoting lifestyles, behaviors, services, supports, and infrastructure focused on improving health, productivity, and quality of life as people age [19].

Some may date the "healthful longevitist" concept back to 1980 when Fries proposed his novel "compression-of-morbidity" hypothesis, postulating that morbidity and disability could be postponed and compressed into fewer years at the end of life leading to an increased healthspan [20]. Under this paradigm, a healthful longevitist might be defined as a clinician who integrates the principles of geriatrics, preventive medicine, and whole-person care to extend healthspan—years lived with independence, purpose, and less disease and disability. A focus on healthful longevity also aligns nicely with the burgeoning field of translational geroscience, a scientific discipline focused on increasing the number of years free (or freer) from disease and disability [21].

Yet, there are downsides to this identity for geriatricians. First, the role of a healthful longevitist best begins in the life course of a patient long before a geriatrician would traditionally be involved. Second, branding oneself as a healthful longevitist risks being conflated with the commercialized, non-evidence-based field of antiaging medicine, where the lines between science, marketing, and profiteering are often blurred.

Is the healthful longevitist identity a net positive or a net negative for the profession of geriatric medicine? If geriatricians narrow their focus solely to maximizing healthspan, then their patient panels may skew younger and limit or exclude access of older adults with multiple chronic conditions, frailty, reduced functional status, advanced dementia, and complex psychosocial needs. If many geriatricians embrace the healthful longevitist identity exclusively, that will just further reduce the very small number of geriatricians available to provide care to older adults with the most complex care needs—those patients who are most in need of the expertise of a geriatrician.

3 | The Syndromist: Syndrome-Specific Care Employing Geriatric Principles

> All of a sudden, dementia treatment is becoming very exciting. Biomarker-based therapeutics are changing everything.
>
> (Jason Karlawish [22])

Some geriatricians have migrated toward syndrome-specific identities. For the purpose of this article, I refer to them as "syndromists." They are geriatricians who apply geriatric principles to a syndrome or condition, such as dementia, delirium, syncope, incontinence, frailty, or falls, and explicitly align their identity with that condition.

As an example of the geriatrician syndromist, the "memory care" or "brain health" specialist is becoming a popular role. As described by Chin and colleagues, geriatricians have the opportunity to be involved in every step of the appropriate use of monoclonal anti-amyloid antibodies for the treatment of Alzheimer's disease. Geriatricians, in contrast to many neurologists, "have the expertise to tailor these drugs to the right individuals, the training to focus on the whole patient and family care, and the skills to manage the complexity that comes with prescribing these drugs and providing comprehensive memory care … In the care of persons living with diseases such as Alzheimer's disease, geriatricians have always been needed, and mononclonal anti-amyloid antibody therapy just added another reason" [23].

In many ways, the notion of the geriatrician as syndromist parallels an approach to subspecialization that has taken place in other specialties like cardiology and oncology. Perhaps this evolution can be considered a sign of the maturation of the specialty of geriatric medicine and provide opportunities for a beneficial convergence of disciplines? [24]. Alternatively, this strategy could lead to "turf conflicts" with other specialties (e.g., with neurology in the case of "memory care"). In addition, the choice to pursue a narrower clinical focus could weaken connections and identification with the broader profession of geriatric medicine.

4 | The Contextualist Geriatrician—Mastery of a Specific Care Environment or Model of Care

> Home-based care provides interdisciplinary, comprehensive care for homebound older adults with multiple chronic conditions, functional impairments, and often challenging socioeconomic circumstances.
>
> (Leff [25])

One of the arguments for creating the hospitalist specialty, the prototypical contextually-defined specialist, was that hospitalists could deliver higher quality and higher value care of inpatients than healthcare providers not based in this setting. Similar arguments can be made for geriatricians whose practice is limited to a specific clinical setting or model of care.

There are numerous clinical contexts that have been historically associated with the profession of geriatric medicine. These include home-based medical care, skilled nursing facilities, long-term care, the Program of All-Inclusive Care for the Elderly (PACE) model, Acute Care for Elders (ACE) units, Geriatrics–Orthopedics/Trauma co-management models, and the Age-Friendly Health Systems initiative.

Geriatricians have played leading roles in developing and/or advancing these models of care for older adults, but paradoxically, none of these clinical contexts is recognized as synonymous with geriatric medicine. In many instances, the majority of clinicians working in these contexts are not geriatricians. For example, while geriatricians are more likely than internists or family physicians to specialize in the care of skilled nursing facility and nursing home residents, they provide only a very small fraction of the overall care of this population [26].

In addition, while many of the aforementioned clinical contexts and models of care are held up as exemplars of high-quality geriatric care, their actual adoption remains modest. For example, across all US hospitals, the number of ACE units is likely fewer than 50 [27], and there are under 200 PACE programs nationwide.

Unfortunately, even in clinical contexts in which the involvement of geriatricians should be considered essential, it is not assured. Some have rationalized that there are not enough (and will never be enough) geriatricians to serve in these roles. For example, the uptake of the Age-Friendly Health Systems initiative has been remarkable, having been implemented in thousands of clinical sites across the United States. While this initiative draws directly from the principles of geriatric medicine, there is neither a requirement nor an expectation that a geriatrician be involved in the establishment or operation of an Age-Friendly site. Another example is the Centers for Medicare & Medicaid Services "Guiding an Improved Dementia Experience" (GUIDE) initiative, which requires that the healthcare team include a clinician with "dementia proficiency." However, no specific training in geriatric medicine is required, and this proficiency standard is satisfied simply if the clinician can establish that a quarter of their patient panel at some time in the past 5 years was comprised of adults aged 65 years or older.

In summary, even in clinical contexts in which the involvement of geriatricians should be considered indispensable, it is not assured. Clinical context cannot be considered a clear differentiator around which to frame the identity of the geriatrician.

5 | Conclusion

Describing the multifaceted professional identity of a geriatrician remains a complicated undertaking. Geriatricians often inhabit multiple identities concurrently or may transition between various identities over the course of a career. Simple approaches to communicating many of the key principles of geriatric medicine, like the 4Ms/5Ms framework [2], do not adequately capture the special qualities, training, skills, and evolving expertise of the geriatrician. The framework proposed in this article provides a different approach to describing and communicating what geriatricians do, and for overcoming the "unknown profession" challenge [1].

This article does not directly address the broader structural and cultural forces threatening geriatric medicine, including an entrenched hierarchy of medical specialties, persistent compensation inequities, the reality that many healthcare organizations remain intrinsically age-unfriendly, minimalist approaches to geriatric education across most medical schools and residency training programs, and pervasive societal ageism [12, 28]. While greater clarity around professional identity is necessary, that alone will not address disappointing fellowship match results, low prestige and influence, and inequitable compensation. These challenges require sustained, broad-based efforts to counter structural inequities and ageist assumptions throughout the medical establishment and society. However, this article highlights a separate but related problem: identity-value dissonance within the profession. The way geriatricians define their own professional identity—and the way that identity is understood by others—has important implications for professional respect, self-regard, and the stature and influence of geriatric medicine as a specialty.

The perspectives on geriatrician identity described in this paper have a number of important limitations. Geriatricians are much more than any of these identities, which fail to fully capture the special knowledge, skills, and expertise of geriatricians in leading interdisciplinary teams, organizational change, quality improvement efforts, and value-based care initiatives. They also do not consider important professional roles and identities for geriatricians as medical educators, clinician researchers, healthcare organization leaders, and policy experts. Furthermore, they do not capture the unfolding transformative impact that artificial intelligence and digital medicine are having on the entire field of medicine and the delivery of healthcare, which will inevitably affect the roles, responsibilities, and professional identities of geriatricians in ways that cannot yet be fully imagined.

Some may remain unconvinced that a continued examination of geriatrician identity is essential to strengthening our specialty's visibility, relevance, impact, and value. As Ettinger and Hazzard have written, "debating about our identity as geriatricians only reinforces the perception that geriatric medicine is not a legitimate discipline" [29]. I respectfully disagree. In other realms of medicine and science, it is widely acknowledged that "the only way to find a reasonable answer, or even a compromise, lies in continuous engagement with evolving debate" [30]. Such debate will bolster advocacy efforts for the profession of geriatric medicine, inform messaging by our professional societies, and guide workforce planning. More specifically, these perspectives on geriatrician identity can stimulate new thinking about fellowship curricula, how we model careers in geriatric medicine for our trainees, and how we promote the diverse professional opportunities and career trajectories available to geriatricians.

Addressing the professional identity question will only strengthen our discipline. Avoiding discussion of this topic risks fostering malaise and resignation within our specialty, rather than promoting geriatric medicine as the vibrant, morally ambitious profession that we all know it is, one in which we devote our working lives "to one of the truly great challenges of our time" [31]. Clarifying our professional identity is essential to remaining relevant and valued in the midst of a dramatically aging population and a rapidly evolving healthcare environment. It is central to maintaining our legitimacy—and for that reason alone, this debate should not end.

Author Contributions

Dr. Gurwitz prepared the manuscript.

Acknowledgments

Dr. Gurwitz would like to express thanks to Ariela Orkaby, MD, MPH for her review and suggestions relating to an earlier version of this paper.

Funding

The author has nothing to report.

Conflicts of Interest

Dr. Gurwitz serves as a consultant to United Healthcare.

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