



THE BIRTH OF A NEW SPECIALTY: GERIATRICS

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ABSTRACT

Though the need to care for frail older adults has always been an important responsibility of nearly all cultures, interest in and recognition of the special needs of older adults is relatively new in Western medicine. Geriatric medicine has its origins in England during the 1950's. With significant financial support from Congress during the 1970s, the specialty of geriatrics slowly grew into a more formalized academic program. In 1988, geriatric board certification was initiated, and it has continued yearly since then. With the population of older adults growing rapidly, increasing demand will require health care providers to develop the special knowledge and skills needed to care for our older adults.

INTRODUCTION

Within the American culture today aging or old age is considered a curse and something one wants to avoid at all cost. Television reinforces the message that youthfulness and physical beauty are synonymous with health and happiness, while aging is filled with urge incontinence, arthritis, and erectile dysfunction. Americans have grown used to the fact that older adults need to “fend for themselves,” and eventually will need to go to “the old people’s home.” Our society has very little time for frail older adults unless financial assets can be extracted from those who have been fortunate enough to accumulate sufficient assets to grow old with choices.

Historically, there was often a different perspective on aging, but it should be recalled that the average life expectancy at the beginning of the 20th century was only 47 years. Mark Twain once stated, “Aging is a thing of mind over matter. If you don’t mind it, it don’t matter.” The poet Robert Browning is well remembered for the verse, “Grow old along with me. The best is yet to be, the last of life for which the first was made.” The writer of Psalms 92:14 promised, “They shall bear fruit, even in old age; they shall be ever fresh and fragrant.”

ORIGINS OF GERIATRICS

The specialty of geriatrics is relatively new in the history of American medicine, and it continues to evolve. For those who find history boring, a quote from Cicero is

pertinent: “To be ignorant of what occurred before you were born, is to remain always a child.”

Ignatz Leo Nascher is given credit for the creation of the word “geriatrics” in 1909. Dr. Nascher was born in Europe in 1863 and graduated as a pharmacist in 1882. In 1885 he immigrated to the USA where he received his medical degree from New York University. He is the author of many articles on geriatrics and edited a book entitled *Geriatrics: The Diseases of Old Age and Their Treatment*. While Nascher demonstrated interest in improving the care of older adults, his contemporaries did not always share his perspective. The famous Canadian physician, William Osler, spent most of his career teaching at Johns Hopkins Medical School, but in spite of his brilliance as a physician and educator he devalued older adults. Osler’s final lecture near the end of his career indicated that he saw very little worth in adults over 40 years old. Men over 40 years were relatively useless, and men over 60 years were considered absolutely useless; indeed, for the latter chloroform was not a bad idea.¹ Thankfully, the medical profession has come a long way since his day.

Modern geriatrics is frequently attributed to Marjory Warren (1897-1960) at the hospital in West Middlesex, England.² She introduced the concept of rehabilitation for hospitalized older adults and encouraged increased mobility during her patients’ hospital stays. It was in England also that the first adult daycare hospital was established at Oxford in the 1950s. Dr. Lionel Cosin, an English orthopedic surgeon, recognized the importance of early mobility in post-operative patients. His motto, “bed is bad,” played a major role in the development of the hospital daycare program.^{3,4}

DEVELOPMENT OF GERIATRICS IN THE USA

Meanwhile, interest in geriatrics was also growing in the United States. With the Great Depression there was a rapid increase in the number of impoverished older adults. The percentage of older adults who were very poor rose from 30% at the beginning of the depression to 60% by 1940. Dr. Edmond Vincent Cowdry (1888-1975), who was very active in aging research, was a strong advocate for the special needs of the elderly. He edited a book entitled *The Problems*

of *Ageing: Biological and Medical Aspects*, and wrote two other books: *The Case of the Geriatric Patient*, and *Aging Better*.

In England in 1939, the Josiah Macy Jr. Foundation gave financial support to the newly developed Club for Research in Aging. With the support of the Macy and other foundations, the Gerontological Society of America was established in the United States in 1945.⁵ This organization began publishing its own journal, which continues to be recognized as one of the most significant and influential journals in the United States. The original journal, called "The Journal of Gerontology," later broke into two distinctively different journals in 1995. One was oriented to the biological and medical sciences and the other with the psychological and social sciences. In 1961, a third and distinctively different journal, "The Gerontologist," launched publication, so now there are three major journals that have their origins with the formation of the Gerontological Society of America in the early 1940s.

Also in the early 1940's, as interest in geriatrics grew among physician educators and researchers, the American Geriatric Society was organized and held its first annual meeting in 1943. The Journal of the American Geriatrics Society was first published in 1953. Yet, in spite of these early efforts and the interest of physicians, it was not until 1966 that Dr. Les Libow, who is still very active in geriatrics, started the first geriatric fellowship at City Hospital Center (a Mount Sinai School of Medicine affiliate) in New York.^{6,7}

The growing physician interest in geriatrics was followed only slowly by specific legislation. On May 31, 1974 the Research on Aging Act established the National Institute on Aging (NIA). Another influential step occurred in 1976 when Congress authorized the first Geriatric Research, Education, and Clinical Center (GRECC), thus providing much needed funding for the development of geriatric faculty by supporting the establishment of geriatric fellowships in medicine and psychiatry.⁸ Also, during this time the VA system introduced the concepts of interdisciplinary teams and palliative care.

But in spite of the development of geriatric organizations and fellowship between 1940 and 1970, it wasn't until 1977 that the first Professorship in Geriatrics in the United States was established at Cornell University. The first Department of Geriatrics at a major teaching center, Mount Sinai Medical School (Dr. Libow's institution) was started In 1982.

A yearly certifying examination in geriatrics was initiated in 1988. At that time, there were 62 fellowship programs in

internal medicine and 16 in family practice. The initial geriatric fellowship programs had a two year requirement, but in 1995 this was reduced to one year. While there are a few institutions that offer a second and third year of additional geriatric training, most of the fellows in geriatrics prefer the one year fellowship. Among geriatric academicians there continues to be some discussion about changing the requirement back to 2 years. From 1988 to 1993, anyone with Board certification in Internal Medicine or Family Medicine could be "grandfathered" to take the certifying examination in geriatrics without additional geriatric training. Many physicians without formal geriatric training found the certifying exam very demanding. At the present time, the only persons who qualify to take the exam or re-exam are those who have successfully completed a minimum of a one year fellowship in geriatrics or those who successfully passed the certifying exam during the "grandfathering-in" period which ended in 1993. Recertification is required every 10 years. Since 2007 physicians with Board certification in Internal Medicine are no longer required to take recertification board exams in general internal medicine if certified in geriatrics. However, a family physician certified in geriatrics must maintain family medicine recertification.

While there is a growing demand for trained and certified geriatricians in the USA, there is limited interest among US medical school graduates. At the most recent reporting period for graduate medical education in December of 2006, there were 104 internal medicine geriatric fellowships in the USA with 243 fellows. The family medicine geriatric fellowship track had 35 programs with 44 fellows.⁹ In the internal medicine track, 66% of the fellows were international students and 59% were females.

GERIATRICS AT LANCASTER GENERAL HOSPITAL

Under the visionary leadership of Dr. Nikitas J. Zervanos, Director of the Lancaster General Hospital Family Medicine Residency Program, efforts were made to initiate a geriatric fellowship program in the early 1990's. Due to lack of support by the physician community the geriatric fellowship was not finally established until 2001 under the direction of Dr. Zervanos and Dr. Scott Paist. The considerable time and energy that Dr. Paist gave to the initial application to the Accreditation Council for Graduate Medical Education (ACGME) resulted in a three year fellowship accreditation. Dr. Ken Brubaker continued the growth of the fellowship as director from 2003 to 2006. Since February 2006, Dr. Matt Beelen, a graduate of the LG family practice residency, the LG

faculty development fellowship, and the LG geriatric fellowship, has stepped into the director position and ably guided the training of new geriatricians. At the program's last accreditation visit in 2007, the ACGME awarded the maximal time period of 5 years.

While the geriatric fellowship received initial approval for three positions, the program's goal was to accept two fellows each year. During the academic year of 2007 2 FTE fellows and 1 part-time fellow were accepted into the program. Fortunately, a number of recent Lancaster General Family Practice graduates have chosen to train in the geriatric fellowship, and subsequently to join the faculty in geriatrics. During the short fellowship history the program has also been very fortunate to have attracted two experienced and successful local physicians, Drs. Dale Hursh and Leon Kraybill, who both took the required additional geriatric fellowship training and subsequently joined our geriatric faculty. Both have contributed significantly to assuring that the growth of geriatric education has been reflected in similar growth and success of clinical geriatric services in the Lancaster community.

The Lancaster geriatric fellowship has enjoyed considerable success, and has trained 15 fellows thus far. Thirteen have passed the examination for the Certificate of Additional Qualification (CAQ) in geriatrics on their first attempt. The remaining two are recent graduates who will take the examination this Fall. These results are especially significant when one reviews the summary of pass rates for all first-time exam takers for initial certifi-

cation. The American Board of Family Practice website indicates that in 2007 only 69% of the first-time takers passed the geriatrics CAQ. According to the American Board of Internal Medicine website, which combines results for both internal medicine and family medicine, the lowest pass rate for first time takers was in 2005 at 78%, while the highest pass rate was 88% in 2003.

FUTURE OF GERIATRICS AT LANCASTER GENERAL HOSPITAL

During the past year Lancaster General has developed a White Paper through the Geriatric Division. This visionary guide describes LGH's goals for geriatric care in the Lancaster area, proposes a service line for geriatric care, and delineates strategies for meeting these ideals. With the needs of the frail older adult population growing exponentially, the demand for additional care for the frail elderly is expected to multiply. The Lancaster community is blessed with a number of well trained and passionate geriatricians and CRNPs. With the support of Lancaster General, the nursing and medical staff will be able to continue to improve the care of the elderly, raise the bar of expectations for quality of geriatric care, and serve as a model for community geriatric care to other similar health care institutions throughout the USA.

Our passion for the care of older adults in the Lancaster community is captured in a quote by Hubert Humphrey: "The way we treat our children in the dawn of their lives and the way we treat the elderly in the twilight of their lives is a measure of the quality of a community and a nation."

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