as possible in order to bring care of elderly persons to the attention of students, residents, faculty, and deans. The initial Geriatric Medicine Academic Awards provided support for faculty members to develop these programs. These awards helped establish a number of vibrant and successful geriatric programs.

The National Institute on Aging has had many partners in the development of American geriatrics. The American Geriatrics Society and The Gerontological Society of America gave academic and clinical homes to those interested in the care of elderly people. Foundations such as the Hartford Foundation and the Donald W. Reynolds Foundation gave needed philanthropic support, especially to junior faculty and to clinician educators. Societies such as The Alzheimer’s Disease and Related Disorders Association brought public attention to a number of conditions that often affect elderly people. Finally, The American Boards of Internal Medicine and Family Practice provided academic credibility to geriatrics by introducing the “Added Qualifications in Geriatric Medicine” certification.

It is, however, the demographic imperative of the growth of the elderly population that has finally captured the attention and interest of the academic leaders and policy makers of American medicine. Geriatrics now has a “seat at the table” in most American medical centers. The further growth and development of geriatrics, and its placement in American academic medicine in the next few decades, will depend on the ability of geriatricians to advance the science and teaching of geriatric medicine.

The future of this field is now firmly in the hands of the present and developing leaders of American geriatrics. These individuals, and their students, must move the scientific base of geriatric medicine forward, develop models of care that are centered on the goals and needs of older individuals, and ensure that every physician caring for adults in the country is knowledgeable and skilled in the most effective and appropriate methods of caring for older Americans.

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Geriatrics in the United Kingdom: What Happened Next

John Grimley Evans


Ignatz Nascher invented the word, Marjory Warren created the specialty; directly and indirectly, her work inspired the development of geriatrics in many countries of the world. She set out principles of care for chronically disabled older people and recognized the importance of bringing geriatrics expertise into the training, practice, and thinking of both doctors and nurses. To achieve this, it would be essential, she averred, to develop geriatrics units in acute hospitals (1).

In the United Kingdom, geriatrics was established as a recognized specialty as soon as the National Health Service (NHS) was introduced in 1948. Geriatricians were immediately confronted with problems in medical politics. The NHS had merged the previous dual system of charity and workhouse hospitals into a single service with geriatrics departments based in the latter. Before the NHS, hospital consultants had given their services to the charity hospitals for free while earning their living in private practice. It continued to be assumed that NHS salaries would never be more than token honoraria. While members of the medical establishment were happy for other people to look after the workhouses, they were less enthusiastic about increasing the number of consultants competing for private practice. Geriatricians were therefore established as an underclass without access to acute hospital beds and with limited rights to private practice.

It rapidly became clear that Marjory Warren had been right. The key to a successful geriatrics service lay in the acute hospital where most of the mistakes that led to unnecessary disability among older patients were being made. The reasons why geriatrics needed to be based in acute hospitals rather than primary care were also clear (2). Geriatricians set about trying to influence the care of older people in acute general hospitals in a variety of ways, depending on local resources and support from colleagues. By the late 1970s, three basic patterns of geriatrics services had become established in England and Wales. The traditional model was restricted to a geriatrics unit that offered long-stay rehabilitation and day hospital facilities accepting referrals from acute hospitals or general practitioners. The age-defined model was established where geriatricians had, by one means or another, acquired sufficient beds in an acute hospital to provide full medical services for people above a defined age. The integrated model, aimed at “geriatricizing” the whole hospital service by placing Physicians with Special Responsibility for the Elderly (PSREs) on the staff of the acute hospitals, sharing in the acute emergency medical rotas but also providing the rehabilitation and long-stay services on the same or other sites. The PSREs shared the same junior medical and nursing staff with other physician colleagues, thereby contributing indirectly as well as directly to the care of older patients and to the training of professionals of the future.

For 20 years, debate continued over the relative merits of these three models. The traditional model was dependent on other doctors knowing when and about what to consult the geriatrics service; although continuing in Scotland, where hospital beds were plentiful, it became less prevalent in England and Wales where resources were more limited. The age-defined model indirectly fostered ageism in some centers by creating two parallel medical services—for young and for old patients—but with poorer facilities for...
the old. The integrated model depends on sharing of resources and a degree of collegiality that is not always attainable among doctors and nurses. However, at a time when recruitment of British medical graduates to geriatrics was essential to the development of the specialty, it seemed to be effective in attracting young doctors (3).

The NHS has always been seriously underfunded, and for years was only able to survive because its minimal bureaucracy allowed it to be outstandingly efficient at translating money into care. Politically, the NHS is vulnerable because of its funding from central taxation; lack of hypothecated funding means that government can divert money that might go toward health to other interests. In the 1990s, government policy led to the closure of NHS long-stay geriatrics beds in order to shift the costs of long-stay care from the NHS budget—free at the point of delivery—to the private and the means-tested social services sector (where costs fall partly to local rather than central taxation). Many rehabilitation units have also been closed to save revenue. Although the government has now started to inject more money into the service, too much of it is being soaked up in elaborate new management and information structures. While health professionals continue to see themselves as primarily responsible to the public, government-imposed “targets” leave the new breed of managers in no doubt that their jobs depend on loyalty to their political masters.

Government intentions for the future care of older people have been decreed in a National Service Framework, which some critics see as aimed primarily at reducing NHS expenditure on older people rather than enhancing their well-being (4). Geriatricians are still being actively recruited, but it is not clear what their future role will be. Academic departments of geriatric medicine, more successful in teaching than in research in the United Kingdom, are withering in an age of molecular medicine. But perhaps the specialty as originally conceived has served its purpose. In 1973, one newly appointed professor of geriatric medicine commented that, if at end of his career medicine had become sufficiently geriatricized for there to be no need to appoint a successor, he would rejoice rather than grieve. However, ageism is so deeply entrenched in British society that if geriatrics were to disappear, it would surely have to be reinvented.

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REFERENCES


Geriatrics: Specialty, Subspecialty, or Supraspecialty?

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As concisely summarized by Professor Morley (1), as a field, geriatrics has a relatively brief but checkered history characterized by great scope and a dizzying array of relationships with other fields. In the early 21st century, however, we are still struggling with an ambiguous identity that even we in geriatric medicine cannot clearly define: Are we a specialty in our own right, a subspecialty (of internal medicine or perhaps psychiatry), or a “supraspecialty,” embracing all of the breadth and complexity germane to optimal health and social care of elderly people and necessitating our multidisciplinary, team-oriented modus operandi?

My dedication to the last of these three has dominated my life both professionally and personally for the past quarter century. I transitioned to this field from a solid base in endocrinology and metabolism, the subspecialty of origin of many future geriatric leaders from my generation. In doing so, with alacrity and no more than a handshake, I accepted a charge by Bob Petersdorf, chairman of the Department of Medicine, Ed Bierman, my mentor and head of the Division of Endocrinology and Metabolism, the training ground of a substantial cohort of those future leaders (Jeff Halter, Andy Goldberg, and Bob Schwartz), and Carl Eis dorfer, chairman of Psychiatry (and reinforced by Paul Beeson) to build a Division of Gerontology and Geriatric Medicine in the Department of Medicine at the University of Washington.

The philosophy of geriatrics, broadly defined as a “supraspecialty,” served as a major underpinning of our geriatric program development at three academic health centers: the University of Washington, Johns Hopkins University, and Wake Forest University. However, to succeed in these environments, a corollary principle also guided our efforts at each institution: to develop the aging program on the highest plane of academic currency and respect in order to compete for the resources necessary to build a distinguished, enduring program of excellence, principally by attracting and retaining the best talent. At each institution, this dictated an initial focus on research—the traditional coin of the realm at those institutions—and especially the development of fully research-trained and academically committed fellows and junior faculty as the lifeline of long-term success. It also translated into efforts to recruit the most talented scientists and clinicians from the myriad relevant disciplines to the aging enterprise at each center, an attractive opportunity for them to expand their horizons in a field with enormous growth potential.

This also translated into investing our energies and fate in the mainstream of power and influence at each institution,