COMMENTARIES ON “A BRIEF HISTORY OF GERIATRICS” 1165

17. International Classification of Functioning, Disability and Health. www.who.int/classification/

The First Geriatric Residency–Fellowship in the United States

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At the time of the 1964 to 1970 period of the creation of the first Board-approved residency–fellowship training program in geriatrics within the United States (1–5), there was almost no use of the term “geriatrics” within U.S. medicine or academia. There appeared to be a fear that the academic establishment would be offended, or worse, that the designation as “geriatrician” would be seen as a denigration of the individual so referred to.

Thus, the approval in 1968 by the American Board of Internal Medicine (ABIM), of a year of geriatrics as equivalent to any other subspecialty year or any general medical year, and credited toward the 3 years necessary to become eligible for the Board exam, was a surprise to many and a focus of celebration for those trying to develop an identified field of clinical and academic geriatrics (2).

During the early years of the fellowship and residency training in geriatrics, the majority of trainees experienced 2 years of geriatric medical training usually as PGY4 and PGY5, occasionally as PGY3 and 4, and even more rarely as a single year of PGY3 or PGY4.

Large numbers of internal medicine residents received 4 to 8 weeks of geriatric training as part of their general internal medicine curriculum and without any goal of becoming geriatricians (2,6).

The method I utilized (2) to obtain approval of the ABIM derived directly from their written guidelines for all fields of internal medicine. The key steps involved the following: 1) developing an approved inpatient and outpatient program of clinical care, teaching, and research focused entirely on elderly people and on aging. This program was in operation from 1964 onward and was in place at the time of the Board approval; 2) obtaining the written support, approval, and commitment to the geriatric program from a) the Chairman of Medicine of the Mount Sinai School of Medicine (the late Solomon Berson, MD, the creator, with Rosalyn Yallow, PhD, of the “Radio-immune Assay,” the Nobel Prize-winning insight into the world of micromolecular measurements), and b) the Director of the Department of Medicine (the late Stanley G. Seckler, MD), at the 1000-bed “Mt. Sinai City Hospital Center at Elmhurst,” the major public teaching hospital for the medical school. Both of these leaders were ahead of their time in being willing to go against the resistance of colleagues, especially within the field of internal medicine.

In 1976, I started a second geriatric fellowship and residency program linked to another academic nursing home (many years later termed “the teaching nursing home”) at the Jewish Institute for Geriatric Care—Long Island Jewish Medical Center of New York (now the Parker Geriatric Institute), a major component of the State University of New York School of Medicine at Stony Brook. Here, too, the Chairman of Medicine at Long Island Jewish (Edward Meilman, MD) utilized his foresight to apply the appropriate support requested by the ABIM (2,3,6) for approval of the training program.

There was turmoil and distress within internal medicine over the recently established field of family medicine, which was considered a threat to the funding and growth of internal medicine and seen as an error in tactics by many in medicine. Thus, the sudden development of the residency–fellowship in geriatrics and the accompanying likely further development of an entire field of geriatrics as a specialty was another understandable worry to those leading internal medicine.

At an ABIM retreat in 1968, at which T. Franklin Williams, John Beck, and I were sharing with the Board our experience and views about geriatrics, one of the leaders of the Board stated publicly: “we should rename the Board as the American Board of Internal Medicine and Geriatrics” with a goal of incorporating rather than dividing.

The establishment of America’s first full department of geriatrics in 1982 at the Mount Sinai School of Medicine (4,5,7,8) allowed for further growth of the medical school aspect of geriatrics, since between 1968 and 1982 there were already 10 to 15 newly established fellowships in geriatrics throughout the U.S., with about 50 trainees per year.

The opportunity to develop a medical school curriculum for an obligatory clinical clerkship of 4 weeks in geriatrics...
for every medical student in their senior year was unusual and stimulating.

Though granted the 4 weeks by the Dean, T. Chalmers, we (Robert N. Butler and myself) still met great resistance from the curriculum committee, whose chairman was actively resistant to the presence of geriatrics and its taking from the pie the time and money from various training programs.

Of special note was our choice of having each student spend 2 of the 4 weeks at the Jewish Home and Hospital, the teaching nursing home partner for the new department of geriatrics. During the initial years, more than 100 students per year experienced this geriatric medicine curriculum. The students surveyed rated this experience very highly in a study initiated by the President of the Medical Center. In all, more than 2300 students have had obligatory training in geriatrics at the medical school, with the majority experiencing a significant portion of this training at the nursing home (2,5,7,8).

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REFERENCES
8. Libow LS. A teaching nursing home: ten years of partnership between the Jewish Home and Hospital for Aged and the Mount Sinai School of Medicine. Mt. Sinai J Med. 1993;60:553–554.

The History of Geriatrics:
A Model for Equity

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Many ideas came to my mind when I read the interesting historical review written by Professor Morley (1). In these lines, I will comment only on two of them. The first one, conceptually, will underline the role that geriatrics has played for one century in the quest for a better society. My second thoughts will try to add some data to that shown in Morley’s review.

Nascher introduced the word “geriatrics” at the beginning of the last century in the context of important emerging social movements: trade unions movements, retired worker rights, pre-Russian revolution, and so forth. All of them were movements that, both in Europe and in America, fought for the achievement of a less discriminative society. Elderly people were then—and sadly they are still nowadays—a good example of discrimination. The cry of Nascher, perhaps unconscious, tried to avoid or to minimize this bigotry in the medical framework, looking for a better clinical response in elderly patients through a specific model of care that took into account the “age” parameter. Three decades later, Marjory Warren started building a scientific basis for this model.

From this standpoint, we might accept the idea that the history of the development of our specialty along a century has been the history of a struggle for equity. This is true not only in the essential question—what geriatrics means—but also in the ways chosen to get desirable results. Geriatrics was born and grew up to overcome inequities. It was born to favor poor people, the “excluded” ones. Then and now, older people represent, better than any other social group, the victimized class, the forgotten ones. No matter the point of view, the aging process is a story of losses. Physical, mental, and social losses increasingly limiting the protective possibilities of an individual, both on biological grounds and—perhaps this is more important in such a competitive society—on social grounds. Since the beginning, the history of geriatrics and geriatricians has been the chronicle of a fight against losses.

This continuing quest can also be found in our working methods. We geriatricians have pioneered the search for political solutions to health problems two or three decades before epidemiologists did. Our working methods introduced expressions such as “comprehensive assessment” or “continuous care.” We started working closely together with professionals coming from other health or social fields: nurses, therapists, social workers, psychologists, and so forth from the very first moment. We introduced in our daily activities the concepts of “multidisciplinary” and “interdisciplinary” work, and we put them into practice every day. We incorporated Professor Butler’s term and idea of “ageism,” and we were active militants against this kind of discrimination. Several working systems accepted and well-established today in other medical specialties were fostered by geriatricians: “day hospital” and “home care” programs are excellent examples. And finally, as a rule, we have always been and we are still to this day active players in any sort of social or health oriented movements or programs focused on elderly people.

I think that these minimal reflections might help toward a better and complementary understanding of our history. At the same time, we face a permanent challenge with many obstacles to confront. We have a large amount of work to do. Our professional activities go beyond clinical grounds and place us in a position where aspects such as health education of society, prevention, research, and ethical issues will have a prominent role into the next century.

I would like to add some complementary data related to Spain to those presented by Dr. Morley. Manuel Beltrán Báguena was full professor of medicine in the School of