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HISTORY OF MEDICINE

Geriatric Medicine: History of a Young Specialty

Mary Ann Forciea, MD

The fascination of Medicine lies in its basic qualities—its wide social and humanitarian aspects, its progressive nature and its variety. Of all branches of Medicine, that of treatment of the chronic elderly sick has received, so far, less attention than others and consequently offers the widest scope for pioneer work and research.

—Marjory W. Warren, 1948 [1]

While devoted to the care of elderly patients, the specialty of geriatric medicine is itself young. The field was named, professional societies formed, and specialized training programs certified all during the twentieth century. Competencies required for geriatrics in medical education were developed early in the twenty-first century. Geriatric medicine joins the group of medical specialties that are defined by stages of human development (such as pediatrics, neonatology, and adolescent medicine), rather than by organ system (cardiology, neurology, and gastroenterology).

Although the formal organization of geriatric medicine happened recently, interest in aging and the realization that certain diseases cluster in older patients has existed since antiquity [2]. In Egyptian hieroglyphs, images for old age are associated with the kyphosis of osteoporosis [3]. Aristotle and Galen both examined the connection between metabolism (heat generation) and aging. Galen, in fact, proposed that changes associated with aging could be delayed by attention to diet and exercise [3]. Still, the numbers of people who achieved old age in ancient times was very small; the median length of life in ancient Egypt was less than 30 years.

During the late Middle Ages and early Renaissance, knowledge of physiology began to increase. Physical scientists like Francis Bacon developed an idea that aging was produced by unequal repair rates in different organs. Scientists began to look at aging and disease processes like the “hardening” of fibers and arteries in older persons [3]. The concept that aging might increase vulnerability to specific diseases began to be explored. By 1793, Benjamin Rush declared in the new United States that “few people die of old age” [4]. Investigation into the aging process led to the field of gerontology, the science of the study of aging.

Equally important to early philosophers and scientists when thinking about aging phenomenon was whether these processes could be reversed. Rejuvenation of organs or whole persons was widely desired, and a variety of techniques or substances was proposed. Bathing in special waters (the “Fountain of Life”) or in bodily fluids

(mother's milk, the blood of virgins) was believed to restore youthful vigor [2]. The ingestion of numerous compounds was encouraged (herbs, alcohol, animal testicles), and sexual encounters (especially with virgins) were all recommended. Even today, companies offer an array of products aimed at reversing aging: a recent Google search for "rejuvenation products" yielded more than 6 million entries. While science and medicine have improved the numbers of people living to older ages, and have contributed to increased function in late life, the restoration of youthful vigor in late life remains elusive.

In 1909, Ignatz Nascher proposed the term "geriatrics" for care of the elderly, explaining,

Geriatrics, from *geras*, old age, and *iatrikos*, relating to the physician, is a term I would suggest as an addition to our vocabulary, to cover the same field in old age that is covered by the term pediatrics in childhood, to emphasize the necessity of considering senility and its disease apart from maturity and to assign it a separate place in medicine [5].

Until Nascher's time, older adults were not treated differently or in different ways than other adult patients. But social forces came into play in the period during World War I and World War II that both necessitated and facilitated long-term care for the elderly: The number of elderly people began to increase due to improvements in economic conditions and medicine. Large numbers of young wounded soldiers required long periods of care, and they and their families were able to advocate for better facilities and standards. An increase in the professionalism of medicine, nursing, and social work produced health care professionals with training in clinical care and research into the specific problems of their patients.

Great Britain led in the development of clinical care for the elderly in the early twentieth century. During the period between the World Wars, Britain reorganized many of its "chronic" hospitals. Acute hospital units and home services were added, and some chronic hospitals focused on medical long-term care, rehabilitation, or psychiatric care. In 1935, Marjory Warren, a young physician, was given the responsibility of caring for patients at a "chronic sick" hospital. She assessed all the patients and organized the patients and wards into five categories: "chronic up-patients (ambulatory); chronic continent bed-bound patients; chronic incontinent bed-bound patients; senile, quietly restless (not noisy or annoying) patients; and senile dementia (noisy and/or annoying) patients" [6].

She published a series of articles advocating and describing techniques for the assessment of patients that would allow them to be placed in the right type of long-term care facilities [7, 8]. Decades later, Warren's call for "assessment" of older patients was echoed in the United States by T. Franklin Williams and colleagues [9]. Warren ultimately recommended specialized training for medical students in the care of the elderly chronically ill, as well as in locating long-term care hospitals near

teaching hospitals to facilitate training and research into methods of care. She stated when speaking of her older patients, “These worthy people, whose lives have been every whit as useful as we would like to believe our own, are ill housed with younger folk who are irritated by them, and in turn annoy them” [10].

The principles developed by Warren and her colleagues were championed by the British Geriatric Society, which was established in 1947, and incorporated into the National Health Service when it was established in 1948 [11]. Geriatricians in the new National Health Service led in the creation of networks of care for older patients.

In the United States, roughly similar societal pressures (increasing numbers of the elderly and increasing demand on long-term care accommodations for the chronically ill elderly) contributed to new paradigms of care. Public policy during the twentieth century began to accommodate the economics of older patients. The Social Security Act of 1935 introduced guaranteed federal income assistance for the elderly and disabled. In 1965 President Lyndon Johnson signed the legislation establishing Medicare, a health insurance program for the elderly, and Medicaid, a program of social support for the poor of all ages. By the mid-twentieth century, then, it had become economically feasible for older people to receive treatment in hospitals, primary care settings, and long-term care settings. As advances in medical science and surgery have allowed people to live longer with multiple chronic conditions, the percentage of older patients cared for by almost all specialties has risen.

Physicians interested in focusing their practices on the elderly came from a variety of care settings. Older patients living in long-term care facilities offered an early, obvious patient population for specialty care. Physicians practicing in home care also contributed to the development of geriatrics. Martin Cherkasky described the clinical and financial benefits of providing in-home care to older chronically ill patients in New York City in 1949 [12]. The Veterans’ Administration began to sponsor innovation in the care of the elderly through its Geriatric Research and Education Clinical Centers (GRECC) in 1976 [13]. Leslie Libow published an article on the “Teaching Nursing Home” in 1984 [14] and developed the first fellowship training experience in geriatric medicine in the United States. Our practice at the Philadelphia VA Medical Center published the first description of a geriatric model system originating in a primary care practice [15]. The Hartford foundation sponsored the early development of acute inpatient care units for older patients: acute care of elders (ACE) units, many of which persist today [16].

Training in geriatric medicine sprouted from all these clinical settings. The National Institute on Aging, founded in 1974, sponsored training at many levels. The American Board of Internal Medicine offered a certification of added qualification in geriatrics in 1988. Professional associations like the American Geriatrics Society (1942), the American Medical Directors Association (1978), and the American Academy of Home Care Physicians (1988), among others, have been strong

advocates for standards of training, for accreditation of facilities, and for legislation to improve the care of the elderly. These societies remain involved in establishing competency standards for practice for trainees at all levels.

Coming increases in the numbers of frail older patients will strain the small supply of geriatricians as well as the primary care physicians of the future. Innovation in reimbursement for team practice will help to support the coordinated efforts required to sustain our frail older patients in the twenty-first century. The development and future growth of geriatric medicine will also depend on the continued evolution of our interprofessional partners in psychiatry, nursing, social work, and rehabilitation.

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Mary Ann Forciea, MD, is a clinical professor of medicine in the Division of Geriatric Medicine and director of the medical student and internal medicine residency elective in geriatric medicine at the University of Pennsylvania Health System in Philadelphia. She received her MD degree from Duke University. Her clinical practice centers on primary care of the older patient in office and home

settings. She has served for five years on the clinical guidelines committee of the American College of Physicians and been the co-director of the Geriatric Education Center of Greater Philadelphia for more than 15 years.

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