Personal History of the Growth of Geriatrics in America

by

Robert N. Butler, M.D.

Long before my arrival in New York in 1982 to establish our nation’s first Department of Geriatrics (which I named Geriatrics and Adult Development) I began to talk and write about the geriatric imperative. I emphasized five points:

The demographic imperative – the rapidly growing numbers and proportions of older persons with particular emphasis on the Baby Boomers who would soon reach “Golden Pond,” at which time, 20% of all Americans would be older persons (defined conventionally as 65 and above).

The epidemiological imperative – with aging (following the underlying idea manifested in the Gompertz Curve) there would be increasing incidence and prevalence of cancer, coronary heart disease, stroke, Alzheimer disease, diabetes and other disorders of old age.

The cost imperative – rising costs associated with population aging and, in particular, with technological advances would require efforts to provide affordable, cost-effective, high quality care of older people.

The research imperative – in order to properly diagnose, care, treat and rehabilitate older persons – and optimally to prevent disorders - would require better understanding of the basic biology of aging as well as its associated clinical disorders.

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2 Dictated over the Winter 12/00 – 3/01. Prepared at the request of Dr. Mark Beers, Editor, Merck Manuals.
The imperative based on attitude – as a result of ageism or prejudice toward age as well as the tendency to avoid the subject altogether, it is essential that medicine address, and eliminate, ageist language, imagery and attitudes, such as therapeutic nihilism and references to older persons as crots, gorks, gomers, vegetables, sops.

I can’t say that those imperatives were in my mind in 1951 when I began to think about aging but they sum up nicely why our country and the world should be thinking about the subject. The revolution in longevity is upon us, a gain in the industrialized world of roughly 30 years since 1900 and in the United States, for example, of 40 years since the beginning of our nation in 1776. It is likely that the growth of healthy older populations will intensify, consequent to gene-based and regenerative medicine. However, inasmuch as in the foreseeable future, there will always be those who are adversely affected in old age, the future of geriatrics seems absolutely assured.

My view of geriatrics has always been based on the analogy of the United Nations and individual sovereign nations. We need an overarching field in order to be assured that every medical student and each and every intern and resident, whether entering primary care or specialty medicine, has proper training in geriatrics regarding the knowledge, skills required and attitudes that are essential. If geriatrics as an academic entity is buried within internal medicine, psychiatry or neurology, its power to command integration or mainstreaming is decidedly weakened. History bears this out. Further, for the field to grow its leaders must be able to sit on the council of the Dean as well as have direct claims upon curriculum time, physical space and the fund-raising arm of the institution.

This is not to say there should not be geriatric medicine, geriatric psychiatry, geriatric neurology, etc., but only that geriatrics is larger and more comprehensive than any one of
these. This view is based upon the fact that older people themselves are not simply bodies or medical problems or psychiatric problems. Nor are they simply people affected by a particular disease or diseases. Rudolph Virchow, the German pathologist who helped articulate the central role of cellular life in disease, considered disease to be “life under different circumstances.” Put simply, older people have emotional, psychological, economic, cultural and societal as well as diverse medical needs.

How did I come to all this during the period 1951-1955?

There is a personal answer and a professional answer. The personal answer is the influence of my grandparents with whom I grew up and whom I saw struggle to survive during the worldwide economic depression which began in 1929. My grandfather was always cheerful and effective in managing our farm. Upon his death in 1934, however, we lost our farm because we could not meet the mortgage payments. My grandmother became a seamstress at a WPA sewing room and then a secretary at a glass factory as we both struggled together to survive devastating poverty and brief homelessness. I worked regularly from the age of ten.

Little wonder, then, upon my arrival at Columbia University’s College of Physicians and Surgeons how troubled I was to hear revered professors refer to older people (and middle-aged women) as “crock.” This term also referred to in their medical charts with a multiplicity of complaints, most of which I came to realize brought about a sense of impotence in doctors. Physicians did not know what to do to help them. Nonetheless, this word and other words to follow were used: Gork (God only really knows), Gomer (get out of my emergency room), Spos (special piece of s----) and vegetable. These terms are more than disturbing, they are quite horrifying. They form a cruel lexicon of epithets (also described in The House of God, the novel written by a medical resident who trained at Beth Israel Hospital in Boston). During my medical
school days I did hear about Harry Simms, a scientist who was doing aging studies but he was considered “strange.”

When I entered my internship I was determined to be an internist, in fact, a hematologist, but was struck by the greater number of older patients in the wards than I had been introduced to during medical school. Indeed, at P & S – Presbyterian Hospital, it was my experience that older patients, particularly if they were problematic, e.g., with strokes and dementias were quickly gotten rid of and sent to Bellevue Hospital. We were introduced to the concept of Occam’s Razor at P&S: we should find one diagnosis to account for all symptoms and signs – clearly not relevant to the complex, multiple interactive psychosocial and physical pathologies, acute and chronic, that characterize significant numbers of older patients. But Occam’s Razor was law in medical schools. Older people were not yet “seen” and there I was, a young intern, confronted with a different demography.

One night during my internship the charge nurse called me because a 72-year old man was agitated. She wanted me to prescribe a “yellow jacket”; that is, a Seconal, to calm him down, but when he took it he became all the more agitated, and it became a “good reason” to send him to Bellevue Hospital which we did. (This was 1953, before the advent of tranquilizers.)

But I also sought out the medical literature and found reports that in older people, particularly in the presence of brain damage, hypnotics and sedatives frequently agitated patients further rather than have a calming effect – the so-called paradoxical reaction. Puzzling and interesting, I thought.

3 After William Occam, the medieval philosopher.
That, along with my demographic shock of recognition, was catalytic.

I soon decided that we knew too little about “what makes people tick” (human behavior) - let alone aging - and I applied to the Langley Porter Neuropsychiatric Institute at the University of California San Francisco for a residency. The Chair and Vice Chair of the Department of Psychiatry, Karl Bowman and Alexander Simon, respectively, were interested in older people. I had not known this when I applied, and it was encouraging to see others with such an interest. It made the subject respectable.

At Langley Porter I participated in some of the very early work on chlorpromazine (thorazine) and reserpine for schizophrenia, accomplished with Simon, Lester Margolis, a neurologist, and Ames Fischer, a fellow resident. This early work on the therapeutic effects of these medications was published in a book by the American Association for the Advancement Science.

This work undoubtedly contributed to my being referred to Seymour Kety who was then the Scientific Director of both the National Institute of Neurological Diseases, Blindness and Stroke (NINDBS) and the National Institute of Mental Health (NIMH) at NIH in 1955. He was recruiting potential researchers. I enjoyed what was perhaps the best interview ever in my life. During a 2-hour walk up and down the hills of San Francisco, Kety asked me myriad questions about my thinking on a variety of subjects including whether LSD - psychosis was an appropriate model for schizophrenia. At the end of our walk he asked if I would be interested in coming to NIMH as a research associate to which I replied, “yes,” in a nanosecond.

Kety was an extraordinary scientist and leader, a visionary who should be better recognized as one of the key American founders of neuroscience and certainly of biological psychiatry. He and Schmidt developed the nitrous oxide technique (based on the Fick Principle)
for measuring cerebral blood flow, oxygen consumption and glucose utilization. This measured the whole brain. Some years later, his younger colleague Louis Sokoloff created the basis for positron emission tomography, making it possible to make precise measures of blood flow and oxygen and sugar consumption in specific areas of the brain. Our CBF findings in the 1950s and early 1960s on healthy, community-resident older persons were essentially confirmed by the more precise methods used later. The brain is one of the chief pacemakers of life and of aging.

I arrived at NIMH at an opportune time, at a point when Kety, Sokoloff, James Birren, Seymour Perlin, Marian Yarrow and Samuel Greenhouse were in the beginning process of conceptualizing a major comprehensive longitudinal study of healthy human aging. I joined as a research associate and ended as a principal investigator. Out of this work came two volumes, Human Aging I & II published in 1963 and 1971 respectively, describing the results of eleven years of study.

In my opinion, this study along with the longitudinal studies at Duke University, constitute the beginning of modern gerontology and the redefinition of old age. Until that time the majority of studies were cross-sectional and usually conducted on chronic disease hospital and nursing home populations, who were compared to college or graduate students. The studies were not carried out over time. The Duke and the NIMH studies, in effect, demonstrated that modifications were possible even in very old age, and that much that had been attributed to aging was in fact a consequence of disease and disability, social adversity and even personality. For example, hypochondriasis is not limited to the old. Young and old alike may manifest this behavior. Of special importance, we found that “senility” was not an inevitable result of aging but due to several forms of dementias. We found that cerebral blood
flow and oxygen consumption did not change with age in individuals who were neither
demented nor had evidence of cerebrovascular disease.

In the course of this work, as a young commissioned U.S. Public Health Service Officer, I spent some time in Montgomery County helping to create an occupational therapy assistant program within nursing homes. Montgomery was one of the wealthiest counties in the country, and the locus of Bethesda, which is the site of the National Institutes of Health (NIH). I was shocked by what I saw. I concluded that a nursing home was a place that had no nurses and surely did not deserve such a comforting word as home. I wrote a paper describing my experiences and point of view (published in 1961). My interest in basic human aging, its biology and cerebral physiology, was now supplemented by a new interest in the social-economic, even political and cultural conditions which shroud old age.

In 1957 Dr. Kety informed me that if I wanted to advance in the Public Health Service I would have to be boarded in a specialty. There was none in geriatrics. I had only one year of neuropsychiatry when I came to NIH. He gave me a year of credit at NIMH, based on a standing agreement between the American Board of Neurology and Psychiatry and NIMH. He urged that I do a year’s residency in a local mental hospital in order to add a year to meet the required three years in psychiatry. This was an unusual pattern for becoming a psychiatrist. I spent my year at the then famous Chestnut Lodge; my time was divided between setting up what perhaps was the first experimental program on the psychotherapeutic care of older persons with dementia and depression in the U.S. while seeing a required four patients with schizophrenia in intensive treatment. I returned to NIMH in 1958 and remained through 1962.

At that time I turned aside offers to return to the University of California at San Francisco, the University of Chicago and Yale University. I set up an unusual arrangement as a
consultant to the National Institute of Mental Health for the Human Aging studies, teaching at both George Washington and Howard University Medical Schools and conducting a private practice to help support myself and build a family. During this period I was virtually the only psychiatrist in the Washington area who would make house calls and visit nursing homes to see older patients. I conducted and published a study at that time which showed that only 2% of psychiatrists were willing to see older patients, and those who did very quickly referred them to nursing homes or mental hospitals. I continued to write about various topics of aging – introducing the life review, ageism, etc. and completing a book Why Survive: Being Old in America in 1975. This book provided a portrait of old age in America coupled with recommendations for change such as the development of geriatrics and the establishment of a National Institute on Aging.

During this time I received a surprise telephone call from Dr. Lamont-Havers, deputy director of the National Institutes of Health, and Chair of the Search Committee to find the first and founding director of the new National Institute on Aging. Following a variety of interviews I was delighted to be offered the responsibility by Dr. Donald Fredrickson, Director of NIH, in 1975.

The legislative authority of the Research on Aging Act that created the National Institute on Aging was remarkably broad, covering biomedicine and the social and behavioral sciences including economics. I identified some fourteen priorities to reflect this multidisciplinary base, appropriate and realistic to deal with the advance of aging populations.

Nonetheless, I concluded from the study of the growth of the other NIH institutes that success in Congressional funding of the Institutes depended on what I call “the health politics of anguish,” based on the strength of advocacy groups, and the pain and suffering of American
families. While the National Cancer Institute had the American Cancer Society and the National Heart Institute had the American Heart Association, I had little organizational support to whom I could turn. While sympathetic, the American Association of Retired Persons (AARP) and the National Council of Senior Citizens were preoccupied with such issues as Social Security and Medicare. Therefore, I sought out Dr. Irving Wright, cardiologist, to help establish the American Federation for Aging Research and later worked with Senator Alan Cranston and Daniel Perry to form the Alliance for Aging Research. I also worked with Don Tower, Director of the Neurology Institute, Jerry Stone a Chicago businessman and others to establish the Alzheimer’s Disease (and Related Disorders) Association. I also helped establish the American Association for Geriatric Psychiatry. We needed this kind of advocacy and it helped build the Institute.

In 1977 or 1978, when Dr. Jack Weinberg was President of the American Psychiatric Association, I gave one of the Presidential lectures at a plenary session and called for an American Association for Geriatric Psychiatry (AAGP). It was pre-arranged that Dr. Sandy Finkel would follow-up. He did so and did a fine job in creating the organization. Interestingly, psychiatry, among medical specialties, has been a leader in advancing geriatrics in the United States.

Another big effort I made at NIA was to build the field of geriatrics. In the winter of 1977 I called upon medical schools to send representatives to an NIA meeting. About thirty sent representatives and among those were early pioneers in the field including Dr. Leslie Libow who had worked for me at NIMH in the Human Aging Studies in 1961 – 1963. He had built a geriatrics residency program at Elmhurst City Hospital in New York City that had grown out of Mount Sinai Hospital (Mount Sinai did not have a medical school at the time).
Ms. (now Dr.) Patricia Lanoie-Blanchette, a medical student at the University of Hawaii, had created a very impressive geriatrics curriculum. I invited her to attend and to present her ideas. She is now the key academic geriatrician at the University of Hawaii Medical School. This meeting with medical schools proved catalytic.

Another influence on my life was Dr. Alvin Goldfarb, a psychiatrist who worked out of the Jewish Home and Hospital for Aged (JHHA) and Mount Sinai. I was also aware of an internist, Dr. Frederick Zeman, also at JHHA, who wrote a scholarly series of articles on the history of geriatrics. (Ignatz Nascher, who had been an attending physician at Mount Sinai, had written a book on geriatrics and given the field its name in 1909. It is noteworthy that Mount Sinai also contributed to the development of pediatrics. It should be understood, however, that there was no relation between Nascher’s contribution and the fact that Mount Sinai was willing to establish a department some 73 years later. Indeed, I brought this history to the attention of Tom Chalmers and Jack Rowe, presidents of Mount Sinai.)

It was possible in 1955 to read essentially all the literature in the field of aging including its ancient history. My first meeting of the Gerontological Society was held that year in a dim, deteriorating Hotel Emerson in Baltimore. I recollect that about 54 people attended the meeting – and that may have included spouses. The Gerontological Society and the American Geriatrics Society were born in the late 1940s, barely a decade before.

In 1976 I found that only 4% of research grants under the Aging Program that I inherited from the National Institute of Child Health and Human Development concerned medicine and aging. In 1979 I published “Geriatrics and Internal Medicine” in the Annals of Internal Medicine (91:903-908) as part of my “campaign” to advance geriatrics. I also traveled to Philadelphia to the Board of Medical Examiners to seek agreement (successfully) that
questions regarding aging be routinely included in the examinations. Under the Research on Aging Act of 1974 that created the National Institute on Aging I could finance research training in aging but not training of doctors to provide clinical services.

In 1979 I was invited to the Medical University of South Carolina to meet with Albert Sabin concerning an endowed chair of geriatrics. At that time, there were no candidates for the position. My proposal that MUSC offer a rotating professorship to the great geriatricians of the U.K. was not adopted. As of 2001, the chair goes unfilled.

I asked Robert Berkow, Editor of The Merck Manual to integrate geriatrics into The Merck Manual and create a special section. I worked closely with Bill Abrams to effect changes in the Food and Drug Administration to build guidelines for clinical studies in older persons.

In 1979 I talked to David Hamburg, the President of the Institute of Medicine (IOM). I told him I would like NIA to contract a task force under the IOM with the charge “how to best integrate the teaching of geriatrics within American medical schools” and not to decide whether there should be geriatrics in American medical schools. He agreed but reminded me that by IOM rules I could have no influence over the selection of the Committee. He selected wisely. One of the great figures in medicine, Dr. Paul Beeson, accepted the chairmanship. He objectively and thoughtfully chaired the panel and produced a creative and provocative report Aging and Medical Education published in 1978 by the Institute of Medicine and supported by the NIA. Of course, we were invited to testify and we worked with the Committee. Just as I had hoped, this report described the basic model, the integration of material related to aging during the first preclinical years and a rotation in the third year of medical school among other recommendations. Later I built upon this model when I established the Mount Sinai department.
During this period I spoke often before various associations (e.g., American College of Physicians and the American Association of Chairs of Medicine), testified at Congressional hearings to advance geriatrics and wrote many articles on the subject. (Much “lobbying” was off the record.) Congressional members Claude Pepper, Edward Roybal, John Paul Hammerschmidt, Joe Early and others were very supportive. Senators Tom Eagle ton, John Glenn and Alan Cranston were also supporters.

At the National Institute on Aging, we were also creating the major research plans which would help shape priorities for decades to come. The first, required by Congress, was entitled by me “Our Future Selves,” the second “Toward an Independent Old Age.”

Dr. James Shannon was the remarkable leader of the National Institutes of Health during its major flowering following World War II, especially in the 1950s. These were the halcyon years which brought Nobel Prizes to NIH; to Marshal Nierenberg, for example, who broke the genetic code. Other extraordinarily creative NIH-trained physicians became the chairs of departments of medicine and other specialties throughout the country. As has been said, NIH was “the Weimer Republic of biomedical science.” Shannon brought to my attention the Pulmonary Academic Award which had been created by Claude Lenfant who later became the Director of the National Heart, Lung and Blood Institute. We used this concept of external support to create the Geriatric Medicine Academic Award and later the Geriatric Dentistry Academic Award. This was a mechanism to produce leaders within the field of geriatrics and many of the winners of those awards did, indeed, become leaders. Examples of our grantees were Jack Rowe, Bill Hazzard, Bill Applegate, Patricia Barry, Leo Cooney, Robert Kane, Knight Steel and Fred Sherman (see appendix). All became leaders in the field, more than justifying the program. We also published a brief look into the history of the development of geriatric
medicine and identified the early pioneers. I commissioned Professor Rosemary Stevens to write a brief history that compared the development of pediatrics with the possible development of geriatrics, and to make predictions regarding its future. She argued, that, just as pediatrics grew out of the “clean milk movement,” i.e., pasteurization, that geriatrics might grow out of a “clean up the nursing home movement.”

Historically, there had been resistance within organized medicine to pediatrics, based on the notion that children were simply “miniature adults;” internal medicine feared fragmentation and the loss of vested financial interests. Similar concerns have restricted the growth of geriatrics. Indeed, establishment of the National Institute on Aging itself had been opposed by NIH and the Department of Health, Education and Welfare. The NIA came into existence as a result of citizen advocacy and a Congressional effort mobilized in part by the Gerontological Society of America and the American Association of Retired Persons. It was accomplished largely by Florence Mahoney who, with Mary Lasker, had helped build the modern NIH. Florence Mahoney is a citizen activist and brilliant figure, 102 years of age in 2001, and intellectually thriving. Her contributions to NIH included the growth of the mental health, child health and arthritis as well as aging institutes. Mahoney has not been appropriately recognized.

During my tenure as the Director of the National Institute on Aging, I did everything I could to encourage the development of geriatrics and gerontology in relation to all NIH institutes. Initially, no NIH director invited me to visit or came to see me. I walked across the campus to see each Institute director and invited each to speak at NIA council meetings in order to build bridges. Before I left in 1982 we had programs with every Institute – for example, osteoporosis with Arthritis and Metabolic Diseases and with Dentistry (because of
periodontal disease) and with Neurology and Mental Health out of which the Alzheimer's disease initiative grew. The NIA became the lead agency in Alzheimer's disease research.

While the AARP helped some with both geriatrics and Alzheimer's disease in general their concerns were elsewhere and the nation's need for a biomedical research agenda in aging and geriatrics has not been prominent in AARP thinking.

In 1981, I was invited by Dr. Thomas Chalmers, President and Dean of the Mount Sinai School of Medicine, to advise him how to proceed in developing an institute in gerontology. After reviewing their thinking and their relationship to Hunter College and the City University of New York, I suggested Mount Sinai do something dramatic and establish our country's first department of geriatrics. But to do so Mount Sinai would have to provide an inpatient unit, outpatient services, a teaching nursing home⁴ and home care, indeed the entire continuum with a multiplicity of services needed by older people as they change through time. There would have to be required integration of knowledge about aging within the first two years and a required medical student rotation, as well as research laboratories. This built upon the concepts I had favored and which were part of the Beeson IOM report.

Chalmers asked me to take an endowed chair at Mount Sinai and build a department.

I had no interest in leaving the National Institute on Aging. Hans Popper, the famous liver expert, along with Mount Sinai Trustees: Helene Kaplan; Robert Ruben, later Secretary of Treasury; Bill Golden, science advisor to the Truman White House; and Lewis Thomas, physician and author, were among those that encouraged, indeed, pressed me to come. I was very ambivalent. Finally Popper said, "why don't you write the most comprehensive statement

⁴ A concept I had implemented through a "teaching nursing home" NIA Award and proposed in an article in JAMA, 245:1435-37, 1981.
of the program you would wish. If Mount Sinai agrees to it, then you should agree to come.” I accepted his challenge. I received excellent advice in writing up the program from Leslie Libow and Mal Schechter who were to join me in the new department. To my shock Mount Sinai agreed to it all and hence began the Department.

The idea was not altogether popular but it was to have profound effects. Dr. Richard Gorlin, a good man, a distinguished cardiologist and Chair of Medicine, felt that geriatrics should be part of Internal Medicine. Other department chairs were alarmed at the prospect of losing beds and other valuable space to this new geriatrics unit. Were it not for the Board of Trustees and the President, the Department would not have fared. We also received the equivalent of $4 million endowment to help get the Department started. I had to raise the rest myself and by 1995, according to Dr. Jack Rowe, we were the second best endowed Department within Mount Sinai at that time and had about $20 million of endowment equivalent. This included indirect support from the Jewish Home and Hospital of the Aged (JHHA) in the form of funding of faculty, and provision of resources for training in the long-term institution, which had also been one of my requirements. I secured four endowed chairs, including one in neurobiology, one in molecular biology and one in long-term care. My fund-raising efforts resulted in further endowments that did not enter into the department coffers until after I left.

Upon arrival at Mount Sinai I received two applications for faculty jobs that proved critical from Drs. Christine Cassel and Diane Meier, both at the Portland (Oregon) V.A. Hospital. They not only helped make the Department a success, but Diane went on to create a fine

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5 At the same time period, Mount Sinai was raising funds for its new hospital. Therefore, I was precluded from approaching the traditional Mount Sinai donors and I had to turn elsewhere.

6 From the Willard T.C. Johnson Mathers and The Greenwald Foundations, respectively.
program on end of life, palliative care and Chris succeeded to the department chair in 1995. Among other outstanding contributors to the department were Drs. Barbara Paris and Howard Fillit. Prior to my arrival Dr. Fred Sherman, NIA grantee, had significantly influenced the Department of Medicine’s activities and teachings in geriatrics. He directed the Division of Geriatrics.

The Department was successful and included a teaching nursing home at JHHA (with its endowed Anna A. Greenwald professorship in geriatrics and long-term care) an inpatient unit in the new I.M. Pei hospital endowed by Michael Eisner, outpatient services endowed by Lee and Phyllis Coffey and a “healthy elderly” program developed with the 92nd Street Y with the help of Janet Fisher, the wife of Avery Fisher. Evaluations by students of the four-week rotation were soon on par with other clinical rotations despite criticisms.

The Department was erroneously perceived as a threat to internal medicine and I was invited by Drs. William Kelly and Samuel Thier to advise the American Board of Internal Medicine (ABIM) concerning how to recognize geriatrics. One measure (and result) of the impact of the department were the decisions by the American Board of Internal Medicine (ABIM), the American Academy of Family Practice and the American Board of Psychiatry and Neurology to establish certificates of “added competence in geriatrics” – a kind of subspecialty.

It is hoped that by 2025 when the Baby Boomers attain their maximum size as older persons – 20% - 1 in 5 Americans - that academic geriatrics will be firmly established to assure that no one graduates from medical school and residency training – regardless of specialty - without full knowledge of the special needs of other persons and how to best deal with them.

The Brookdale Foundation under the leadership of its president, Stephen Schwartz, has been especially loyal to the department and to the development of geriatrics in the United
States. The Brookdale Foundation supported my endowed chair, and the Brookdale Center of Molecular Biology at Mount Sinai and the National Fellowship Program of which I am Chairman. The latter program has been richly rewarding and has sponsored many of the individuals who have helped build the field of geriatrics and gerontology in 35 American medical institutions. The Foundation view has been to build upon existent strength in developing the field. Fifty percent of the selection of a Brookdale Fellow is based on the leadership qualities of the individual, 25% upon the commitment of the institution and its mentoring and 25% upon the proposed research project.

The Hartford Foundation has also been key to building geriatrics, for example, in its efforts to integrate geriatrics within subspecialties. Together with The Commonwealth Fund (particularly with Margaret Mahoney and later Karen Davis as its President), an anonymous group of funders and the Alliance for Aging Research helped support the Beeson Program of advanced fellowships in geriatrics. Since 1992, the largest funding for geriatrics has come from the Donald W. Reynolds Foundation. Donald W. Reynolds was a media magnate who made his fortune, principally in the three states of Arkansas, Oklahoma and Nevada. Soon after his death the Board of Directors of the philanthropic foundation he had established learned there was a shortage of geriatricians in the United States and called upon me as consultant. I urged them to develop departments of geriatrics which they subsequently established in Arkansas and Oklahoma. A three-person advisory committee was created of which I am a member, along with Harvey Cohen of Duke University and David Rueben of UCLA School of Medicine. We were concerned that the monies provided to the medical schools in Arkansas and Oklahoma be carefully monitored, with pre-determined milestones to ensure promises made to the fledging departments were kept by the administration of the institutions. We had no concern about the
commitments of their respective chairs Drs. David Lipschitz and Marie Bernard but rather wished to protect them, and we urged the selection of a program officer to monitor the programs. Richard Sharpe, formerly of the Hartford Foundation, was selected by the Reynolds Foundation.

The advisory group strongly felt that there should be a national program and the result was a $60 million program that was developed with Sharpe. Its aim is to strengthen geriatrics in American medical schools, coupled with debt relief to attract academic geriatricians. As of the year 2000 some $40 million has been provided to the Departments in Arkansas and Oklahoma and some $80 million committed to the national program. Notably, the two departments secured additional money from other sources as well. By 2000, for example, Arkansas had about $60 million! Thus, the Reynolds Foundation initiative constitutes the largest funding ever made available to the development of geriatrics by any private source - and it has stimulated additional funding.

But there are also public monies available under Medicare’s Graduate Medical Education (GME), the Health Resources and Services Administration (HRSA)’s Geriatric Career Academic Award (GACA) and the Veteran’s Administration. Medicare funds have not focused on the development of geriatrics, which is ironic, given the fact that Medicare’s purpose is to serve older people (and disabled people and, of course, old people become disabled and disabled people become old). GME provides funding for geriatrics fellowships but not faculty development. In 1989, because of COBRA - a Congressional Budget Act - I fought (as did others) to rescue geriatrics from the three-year cap on training which would have ended geriatrics, since geriatric fellowships follow three years of training in internal medicine or family practice. Congress has sought to reduce specialization in a country where 70% of doctors are
specialists and only 30% primary care doctors. I argued that geriatrics must constitute an exception. Senators David Durenburger and John Heinz agreed and effected the necessary change. Thus, Medicare supported two years of geriatrics fellowships until it was argued that more people would go into geriatrics if only a one-year fellowship was required. Unfortunately, this reduced the strength of academic geriatrics. To become an academic geriatrician requires three or four years of development in order to be competitive at NIH or elsewhere to develop a program. Medicare GME funds should again support two years of geriatrics fellowships and faculty development.

GACA provides only $50,000 per year but does so for five years. This modest program should be expanded.

When the National Institute on Aging came into existence the Veterans Administration was energized to do more in the field of aging and we soon had the further evolution of the V.A. Geriatric Research Education Clinical Centers (GRECCs) and the Veterans Administration Geriatrics Fellowship Program. In fact, the VA has made important contributions to the development of geriatrics. It was, therefore, dismaying that as a result of Hazzard’s views, however well-intended, VA support for geriatrics fellowships was reduced from two years to one year.\(^7\) It comes at a time of growing interest of young physicians in the field, influenced doubtless, by the pressures of demography and other economic issues within medicine.

Nonetheless, geriatrics remains at risk since there are still very few star academic geriatricians who can compete with the heroic images of great surgeons, interventionist cardiologists and aggressive oncologists. Geriatrics also suffers because of its restricted

\(^7\) The correct diagnosis is always important in medicine. The causes of the failure to attract doctors into geriatrics is not the two years \textit{per se} but far larger issues such as income, status and medical school debts.
payments despite the fact that more time, understandably, is required for the evaluation and treatment of older persons with their multiple complex, interacting psychosocial and medical problems, both acute and chronic. “Classic geriatric patients” are usually 75 and above. Geriatrics is much more demanding intellectually than the medicine of the young and requires a wider knowledge of life, as well as of medicine per se. Geriatricians don’t get rich practicing geriatrics. Jobs within geriatrics, of course, are affected by the lack of programs and departments within American medical schools and the unattractiveness to many of nursing homes and managed care facilities. Nonetheless, the latter, has advanced the field of geriatrics to a degree.

I believe there is a silent unrecognized but strong undercurrent of interest in geriatrics by the American public. America is growing older. When parents get older, both they and their adult middle-aged children must come to grips with deficiencies in care.

In my own case, professors of medicine, not charitable toward geriatrics during the daytime, call - somewhat sheepishly - at night, to ask for my help regarding their mothers.

The IOM addressed again the issues of geriatrics in its 1987 report “American Geriatrics for the Year 2000.” I participated in its direction. In July 1992, I participated in hearings conducted in the U.S. House Select Committee on Aging, “Geriatrics and the Senior Boom.” I tried to broker a Claude Pepper Chair in Geriatrics for Jack Rowe at Harvard but couldn’t secure Dean Dan Tosteson’s interest. Pepper had graduated from Harvard Law School and I believed his friends would have financed the Chair.

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8 Social-economic, cultural and psychosocial issues.
Given the longevity challenge, the biggest obstacles are avoidance and ageism. Individual and national responsibility are great. The civil society and business as well as government must all pitch in to address this challenge.

At this stage I argue that we must have both departments of geriatrics and Graduate Medical Education or Health Resources and Services Administration (HRSA) support for geriatric faculty development. We must continue to turn to the private sector for foundation and individual philanthropy to create programs, professorships and buildings or space to provide the appropriate infrastructure. But only the government has the funds to build academic geriatrics.

Were it not for the National Heart Institute and its support of cardiology, it is hard to believe we would have enjoyed the dramatic 60% reduction in deaths from heart disease and stroke since 1950. NIH trained 16,000 cardiologists during the first 22 years of its existence. Gerontology and geriatrics have not had the same break. Yes, there is research training money from the National Institute on Aging, and there is now the limited fellowship money under the government, but we must have a true national initiative, a private/public partnership to establish geriatrics.

Bruce Vladeck, administrator of the Health Care Financing Administration (1992-1998), wrote of the importance of geriatrics training.

My view of geriatrics is interventionist, not passive; much can be done and much is accomplished in good hands. There is a serious mismatch between Medicare benefits and the actual needs of older persons. That some $6 billion in Graduate Medical Education is used to train residents is fine but it is ironic that Graduate Medical Education money has not been used to build a cadre of geriatrics faculty in medical schools.
Building academic geriatrics constitutes my present 2000-2001 campaign at the International Longevity Center catalyzed by a policy report we prepared that was funded by the W.R. Reynolds Foundation which we completed at the International Longevity Center. See attached materials - first, a brief statement of principal goals timed for a one-floor elevator ride during which I would have a chance to convince a senator, second, a longer version for his legislative assistant and third, the full Reynolds policy report.

There is no reason why any of us should be turned over to some new doctor at some arbitrary age, such as 65. Rather we should be certain our urologists, neurologists, gynecologists, internists, family practitioners, etc. have the basic intellectual and emotional wherewithal - and first-rate training - to do the job. Among the dangers of not developing academic geriatricians is the fact that, currently, whether trained or not, doctors are free to call themselves geriatricians. We could soon have another expensive specialty, this time of practicing geriatricians, collectively heading to Washington to win larger reimbursements, when, in fact, what is really needed is good training in medical schools and resident training programs.

The other danger in failing to develop geriatrics is unnecessary rising health costs, due to inefficiencies. Finally, and perhaps most importantly, quality of life would suffer.

Data from the year 2000: Only 2% of foundation funds\(^9\) go to the entire field of aging, much of that accounted for by two foundations - the Hartford and the Reynolds Foundations. Physicians themselves, including geriatricians, have failed to energetically speak up for the field and encourage endowments from families and patients who they have served well, which has traditionally been an appropriate and usual approach to funding in American medicine.

\(^9\) According to Corinne Reider, President, the John A. Hartford Foundation.
Personal History of Geriatrics: Additions

While serving on the Physician Payment Review Commission, a creation of the Congressional Office of Technology Assessment (which no longer exists), I proposed codes for geriatric assessment and team payment and argued that the Resource-based Relative Value scale (RB-RVS) developed by Dr. William Hsaio intended to properly pay for so-called cognitive evaluation and management did not reflect the reality of older patients. I argued that the time needed by physicians due to the increased complexity, severity and multiplicity of conditions of many older patients were not being properly paid for and there was inadequate representation of older complex patients in Hsaio’s patient vignettes. I arranged for leading geriatricians Drs. Leslie Libow and Diane Meier to present before the Physician Payment Review Commission to no avail.

* * *

When I spoke at the Royal Society of Medicine in London I argued that the term “care coordination” should be used rather than case management which term I regard as patronizing and infantalizing. People require “care coordination” but don’t want to be regarded as “cases” to be “managed.”

* * *

At Mount Sinai at the Department of Geriatrics, in 1983 I created special emphasis clinics, devoted to mobility and falls, incontinence and dementia. We created New York City’s first osteoporosis clinic. The Hartford Foundation supported the mobility and falls clinic.
Personal History – Geriatrics Editions

Corporate Contributions

Other corporate contributions to geriatrics include the Traveler’s Insurance Company which established the Travelers Center and Professorship in Geriatrics at the University of Connecticut. SmithKline and Beachem also endowed a Center of Excellence in Geriatrics at the University of Pennsylvania.

The pharmaceutical industries have been especially supportive of the development of geriatrics. In particular, Dr. William Abrams of Merck played a critical role in creating guidelines appropriate to clinical trials in older persons. Moreover, Abrams along with Dr. Robert Berkow created The Merck Manual of Geriatrics, of which Dr. Mark Beers is now editor. Merck designated representatives to join the boards of both the American Federation for Aging Research and the Alliance for Aging Research. Other pharmaceutical companies such as Johnson & Johnson, SmithKline and Beachem and Pfizer did also. Merck also supported the Merck/AFAR Geriatric Pharmacology Fellowship and established the Merck Institute of Aging and Health. Pfizer provided fellowships in medical science which included geriatrics. Allied-Signel provided major awards to support the basic science of aging.

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It is hoped that by 2025 when the Baby Boomers attain their maximum number as older persons – 20% - one in five Americans – geriatrics will become permanently established to assure that no one graduates from medical school or residency training – regardless of specialty – without full knowledge of the special needs of older persons and how to best meet them.
APPENDIX – Recipients of the Geriatric Medicine Academic Award, 1979-1984

1979

Bosmann, Bruce H.
Calkins, Evan
Hickler, Roger B.
Irvine, Patrick W.
Kane, Robert L.
Lindsay, Richard W.
Rowe, John W.
Steel, R. Knight
Tisdale, William A.
U’Ren, Richard C.
Winograd, Carol H.

1980

Crapo, Lawrence M.
Hamilton, William J.
Hazzard, William R.
Moore, James T.
Sherman, Fredrick T.
Smith, Ian

1981

Applegate, William B.
Barry, Patricia P.
Cooney, Leo M.
Marcus, Robert A.
Tobis, Jerome S.

1982

Caranasos, George J.
Gambert, Steven R.
Leventhal, Elaine A.
Logerfo, James
Scott, Veronica J.
1983

Beck, Paul
Duthie, Edmund H.
Lichtenstein, Howard
Mitchell, Margaret
Pawlson, Gregory L.
Stead, Nancy W.
Weiler, Philip G.

1984

Blanchette, Patricia A.
Cropper, Rosalind A.
Fretwell, Marsha D.
Harvey, John C.
Robinson, Bruce E.
Sorensen, Leif B.