European Geriatric Medicine 3 (2012) 228–232

Available online at SciVerse ScienceDirect www.sciencedirect.com

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Hot topics in geriatric medicine

The history of geriatric medicine. The present: Problems and opportunities

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ARTICLE INFO

Article history:
Received 12 January 2012
Accepted 16 January 2012
Available online 28 February 2012

Keywords:
Geriatric medicine principles
Geriatric medicine challenges
Geriatric medicine problems and opportunities
History
Ageism

ABSTRACT

Geriatric medicine has contributed to the advance of medicine by bringing into several basic principles, most of them consolidated nowadays as standard care. Some of these principles have been "exported" to other specialities. Among these principles are: fighting against immobility, multidisciplinary teams, orthogeriatric care, day hospitals, progressive patient care, home care, memory clinics and stroke units, the importance of environment, the value of quality of life, the fight against ageism, the description of geriatrics' syndromes, and the introduction of Comprehensive Geriatric Assessment as a working tool. At present we must find valid answers to questions like: who are we today? Who are our target patients? Or where is geriatric medicine nowadays? Among the main challenges of geriatric medicine are: to reach a universal presence of geriatric medicine in the public health care system of every country, to incorporate teaching of geriatric medicine to every School of Medicine, to contribute to establish good public health educational programmes for older people, to reach comprehensive, inclusive and successful coordination of medical and social services for older individuals, and to fight against all forms of ageism. We must, also, to take into account as priorities clinical research and prevention. Finally, it is necessary to avoid some risks. The main of them are the temptation of the so-called "antiaging" ideas, or to fall in rivalry or competence with other specialities.

The first issue raised when considering the present of geriatric medicine is what does the word "present" means. Discussing the past may be an easier task, as past is well defined. Past is part of history, and the most significant events can be recalled and exposed. The future is unknown, so it is open to speculation or desires. On the other hand, interpreting or reading the present is complex. Each individual lives the present according to his/her own circumstances, and many interpretations are possible. However, the present comes from the past and shapes the future. In this brief paper, I will try to summarize my personal point of view about the present of geriatric medicine, as I understand it. The result may be read as a sort of personal statement position open to discussion among those interested in this field.

Let me start with a short but necessary reference to some recent demographic facts. In Europe, between the years 1900 and 2000, we have watched a 2 to 2.5-fold increase in life expectancy at birth (from 35–45 to 75–85 years), and this means 35 to 50 added years of life. Similar changes can be observed using different age cut-off points. Presently, population over 65 years old is eight times higher than only one century ago; population over 100 years old is 20 higher. Furthermore, for the first time in humankind, there are more elders (65 years or older) than children (below 15 years old) in Europe!

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1878-7649/$ – see front matter © 2012 Published by Elsevier Masson SAS.
doi:10.1016/j.eurger.2012.01.002

As Christensen et al. emphasize, most babies born nowadays in developed countries will celebrate their 100th birthday, and research suggests that people will live longer without suffering from severe disability [1].

1. Our present (a legacy of the past)

After Marjorie Warren established, 70 years ago, the first corner-stones of geriatric medicine [2–4], our discipline has contributed to the advance of medicine by bringing into several basic principles, most of them consolidated nowadays as standard care. The most important principles were proposed by British geriatricians along the central years of the last century [4–16]. Some of these principles have been "exported" to other specialities (Table 1), but unfortunately, in many cases their geriatric roots have been forgotten – even by geriatricians – and specialists working in other medical fields consider these principles as born in their own speciality. I believe that we, as geriatricians, must vindicate the paternity of these principles, even if only to be proud of how they have grown to conform basic knowledge.

For long centuries, bed rest was a mandatory recommendation in medicine in the care of acute medical or surgical events, especially in older patients. The first time that this principle was challenged was in the 1940s of the 20th century, after Lionel Cosin ruled that "bed is bad". Since then, the advantages of early mobilization in recovery and prognoses have been applied to conditions as orthopaedic

Table 1
Basic clinical principles born in geriatric medicine and exported to other specialities.

Fighting against immobility: "*bed is bad*"	L Cosin (1947)
Multidisciplinary team. Orthogeriatic care	L Cosin (1947–1948)
Day hospitals	L Cosin (1950)
Progressive patient care and home care	N Exton-Smith (1951–1953)
Memory clinics	N Exton-Smith (1953)
Stroke units	B Isaacs (1972)

surgery, acute myocardial infarction, acute infectious diseases, and many other medical or surgical conditions.

Other basic geriatric principles or ways to organize care are now accepted by physicians working as specialists in many fields of medicine. Among them, the value of a multidisciplinary team offering multidisciplinary care, the importance of day hospitals or home-care programs as optimal care settings for some conditions, and the need for progressive patient care policies. But perhaps the most significant of those improper appropriations of geriatric principles came from Neurology and neurologists, who usually consider memory clinics or stroke units as born in their discipline [17,18]. It has to be remembered that all of these points are geriatric principles introduced in mainstream medicine by the British pioneers of geriatrics more than half a century ago, and they remain unquestionable nowadays.

Beside those "exported" principles, other aspects have to be considered in order to understand our legacy and to establish what may be the "core business" of our discipline (Table 2). Although any geriatrician feels familiar with them, some were new and challenging medical concepts when described. For instance, falls had never been considered as a medical problem until they were included in the list of geriatric syndromes. The same happens with immobility. It was not until the end of the 1980s that the most important internal medicine textbooks (Harrison's, Cecil's...) included chapters to cover these topics. Sensible concepts like "putting the right patient in the right bed" or "giving life to the years" come also from the geriatric arena. In fact, the first of these two ideas was adopted by the British Medical Association as early as 1947.

I want to underline that a great part of these principles came from the United Kingdom, and were described by their first geriatric leaders. There are two remarkable exceptions. The question of ageism, discrimination and related problems, was first brought out by the American geriatrician Robert Butler in 1969 [19], and since then it has been a *battle field* in day to day geriatric care. The relevance of Comprehensive Geriatric Assessment as a basic working tool in geriatrics was mostly established by Lawrence Rubenstein along the 1980s, gathering different contributions of many researchers in geriatrics [20,21].

Following Barton and Mulley [22], the most important innovations in geriatric medicine, today consolidated, can be divided into themes and services. Among themes:

Table 2
Other "classic" geriatric principles nowadays consolidated.

The concept of geriatric medicine and the importance of environment	M Warren (1935–1948)
Considering the clinical consequences of the aging process	T Howell (1945)
The value of quality of life: "give life to years"	Lord Amulree (1951)
The role of unreported needs (the "iceberg" theory)	J Sheldon (1952)
The fight against ageism, stereotypes and prejudices	R Butler (1969)
The "Giants of geriatrics" (Geriatrics' syndromes)	B Isaacs (1970s)
"Comprehensive Geriatric Assessment" as a working tool	L Rubenstein (1980s)

- the awareness of atypical and non-specific presentation of acute illness;
- a holistic individual approach to older people with co-morbidity and complex disability;
- interdisciplinary team work and comprehensive geriatric assessment;
- the importance of rehabilitation of function;
- the recognition of caregivers' stress and needs, and the relevance of respite care;
- the need to teach geriatric medicine to medical undergraduates.

Besides these innovations, there is a list of new models of care introduced by geriatric medicine, including day hospitals, home-care programmes, and speciality clinics (falls, Parkinson, stroke, memory clinics, incontinence...).

At present, it seems unquestionable that there is solid and multiple evidence supporting geriatric principles and models of care. This evidence has, in many cases, been introduced successfully into other medical disciplines.

2. Problems and opportunities in 2011

2.1. Who are we today?

The main problem of geriatric medicine nowadays is perhaps that, over the whole evidence, we as geriatricians still feel the need to answer every day the question "what are geriatricians good for?", frequently posed by colleagues, administrators and decision makers. Although this is a peculiar problem for a long-standing and solid specialty, having to answer and discuss this question may give us challenges and opportunities. The same happens with statements like "I have more than enough internists, I don't need geriatricians". This is an opinion frequent heard from executive managers of hospitals. This peculiar point of view brings some other questions: is the geriatrician's duty to be the internists of older patients? Or, in other words, what is the added value of geriatric medicine compared to other medical specialities caring for older patients? It may happen that we have not yet satisfactorily proved our strengths. Doing this may be problematic and sometimes difficult, but it is certainly an opportunity.

Another controversial topic is the question about internal medicine and geriatrics working together: is it possible? Is it good for patients and for health care organization? In my opinion, the right answer to both questions is yes. Both specialties can work together, and in some aspects this may be even desirable. The key elements for a successful cooperation between internists and geriatricians are:

- both of them should want to work together;
- internists and geriatricians must accept that they are complementary and not antagonist;
- roles must be clear;
- criteria to clearly define geriatric and frail older patients are needed.

The main contributions of geriatric medicine in cooperative settings with other specialities are, in my view:

- a good knowledge of the aging process and its consequences, and the use of this knowledge to improve understanding and treatment of older patients;
- the use of a specific instrument or technique: Comprehensive Geriatric Assessment;
- a longstanding tradition of multi/interdisciplinary team work;
- specific expertise in the diagnosis and management of geriatric syndromes;