The Department of Internal Medicine: Hub of the Academic Health Center Response to the Aging Imperative

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In the 21st century, geriatrics will increasingly dominate U.S. health care as the median age of the population progressively increases. Academic departments of geriatrics have been created in nations that have already experienced this shift. As an alternative strategy that builds on traditional strengths of academic medicine in the United States, departments of internal medicine should lead a multidisciplinary, pan-institutional response to the aging imperative. Recognition of gerontology and geriatric medicine as central to the missions of internal medicine in clinical care, education, and research must be increased. In the process, academic departments of internal medicine will develop a high level of geriatric expertise and will launch many programs that address this challenge. Successful development of geriatric programs will serve as a catalyst to strengthen the integration among and between generalists and subspecialists. This will entail developing optimal sites and systems of geriatric care—at different levels of care and over time—that can enhance the geriatric education of medical students, residents, fellows, and practicing physicians. The study of aging and geriatric health care will also become an integral part of departmental research, in its subspecialty divisions as well as its divisions of general internal medicine and geriatrics. This strategy is urgently recommended as both a challenge and an opportunity for all departments of internal medicine.


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Much has been written about the progressive aging of the U.S. population, the “demographic imperative” that will make geriatrics—the health and social care of elderly persons—a central focus of almost every health profession in the 21st century. In nations that have already experienced this phenomenon, academic departments of geriatrics have been created. In the United States, it would be natural for geriatrics to follow the lead of other concentrations driven by demographics or scientific progress, such as pediatrics, psychiatry, and neurology, and become a separate specialty with its own academic department. To date, only three academic health centers in the United States have departments of geriatrics, but two of these departments have been established in the past 3 years.

Let me, however, recommend as a preferred alternative the establishment of a pan-institutional program or center on aging that is firmly anchored in the department of internal medicine. My support for this strategy is based on my experience initiating similar programs at three academic health centers (1–3). Although this alternative is more complex and perhaps more difficult to develop, its successful application provides an efficient, effective path to excellence in geriatrics, one that reinforces and capitalizes on the strengths and natural domains of internal medicine as an integrating academic and clinical specialty. It should provide the most enduring benefit to elderly Americans, who will be cared for by well-trained, sensitive, sensible physicians.

Arguments in Support of This Strategy

Internal medicine is concerned with all of the nonsurgical elements of adult medical care, both primary and subspecialty. It emphasizes integration of those elements into ongoing, comprehensive care that focuses on the patient as a whole human being with unique, changing health care needs. As the patient clientele served by internists progressively ages, the patients’ medical needs will become more chronic, more complex, and more progressive and will have greater social and psychological effects. Who better to lead a multidisciplinary medical management team than the internist, who is schooled in the medical care of the sickest, most challenging patients? Internists will be well equipped to care for elderly persons if they acquire additional skills through enhanced geriatric training and learn to provide a continuum of care across different levels and sites (for example, ambulatory care, home care, and long-term care).

Moreover, during the ascendancy of U.S. scientific medicine in the second half of the 20th century, internal medicine historically attracted the greatest proportion of medical graduates to both general medicine and the medical subspecialties. (For example, in 2000, more than twice as many first-year residents matched in internal medicine than in the next leading specialty, family practice.) Therefore, successful application of this alternative strategy will reach the largest group of future physicians and will teach them to deliver optimal geriatric care. In addition, among...
academic clinical departments, internal medicine has most often assembled the largest faculty; made the greatest overall contribution to the education of students during the 4 years of medical school; developed the largest residency training program; hosted the largest number of subspecialty fellowships and fellows; and received the largest share of extramural research support from the National Institutes of Health, industry, and foundations. Therefore, if geriatrics is integrated into all elements of internal medicine, its development according to the highest academic standards in education, research, and clinical care is assured. Conversely, separating geriatrics from this large and powerful clinical department would risk isolating it from the mainstream.

**Action Steps for Internal Medicine**

To capitalize on this opportunity and to address this challenge in our own academic departments, we as internists must take a series of critical steps. First, we must clearly and enthusiastically commit ourselves to making gerontology and geriatric medicine a centerpiece of our expertise and professional activity. This focus will intensify as the age of our patients increases and will require us to place more emphasis on the care of aging and elderly persons than has ever been done before in U.S. medicine.

Second, in accepting this challenge, we as internists must ourselves become expert in the delivery of high-quality geriatric care. We must master those additional domains of knowledge, practice, attitudes, and behaviors that define geriatrics as the health and social care of elderly persons, especially those older than 75 years of age. Our enhanced expertise must encompass health promotion and disease prevention; the primary, ongoing care of older but still independent patients with several chronic diseases; and the care of frail, dependent, functionally disabled patients, including those confined to their homes, congregate living communities, or long-term care facilities. As our practices begin to include more patients of older and older age, we must concurrently shift our emphasis from diagnosis and management of specific diseases to optimization and preservation of functional status in each individual patient.

Third, those of us who serve as faculty in academic health centers must commit to training all medical students in the fundamentals of gerontology and geriatric medicine. All residents in internal medicine, especially, must be trained to achieve a high level of excellence in geriatric care. It is assumed that most nonsurgical care of elderly patients will continue to be delivered by generalist physicians, internists, and family physicians, only a fraction of whom will have acquired additional geriatric expertise through fellowship training. If we do not prepare all internists to provide superior geriatric care, we will ensure that such fellowship-prepared geriatricians will rapidly be overwhelmed by the demands on their services. This conclusion reflects the sobering reality of present fellowship programs in geriatrics, which continue to attract fewer than 1% of U.S. graduates from internal medicine and family practice residencies. This percentage has not increased even though eligibility for the Certificate of Added Qualifications (CAQ) in geriatrics now requires only 1 additional year of training. Even more foreboding for the future of geriatrics has been the small proportion of geriatric fellows who choose to undergo additional years of advanced training in education and research to become fully competitive academic faculty.

To attract the most competitive fellows and to optimize their training, fellowship programs in geriatrics should be developed in the richest local academic environment. At some institutions, this may be a department of family medicine. At others, it may be possible to develop a department of geriatrics with the requisite clinical and scientific resources. Indeed, just as in a department of internal medicine, the opportunity to develop such departments around a cohesive theme of clinical education and research in gerontology and geriatrics should not be dismissed lightly. However, in most academic centers, these programs can be most efficiently developed in a department of internal medicine. Physicians can build on existing concentrations of expertise and resources, and the contributions of general internists, fellowship-trained geriatricians, medical subspecialists, physician-scientists, and PhD investigators can be used to prepare both future faculty and practicing geriatricians.

Fourth, to succeed in our educational missions, we must capitalize on every available opportunity to transmit our geriatric expertise and enthusiasm to all learners under our charge. We must expand our traditional focus on inpatient medicine to include transitional (subacute) care, rehabilitation (in collaboration with physiatrists), psychiatry (in collaboration with psychiatrists), neurology (in collaboration with neurologists), ambulatory care, home care (including house calls), and long-term care in skilled nursing and congregate living facilities. In other words, we
must extend our clinical teaching services to the entire continuum of geriatric health care.

This will be a special challenge to postgraduate geriatric training. Although in an ideal world practicing internists and family physicians might return to academic health centers to train for the CAQ in geriatrics, logistic and economic barriers make this impossible for all but a few mid-career physicians. We must ensure that we infuse continuing medical education with many opportunities for geriatric enrichment, from traditional didactic presentations (good), to case-based, small group discussions (better), to mini-fellowships in the geriatric divisions of our academic health centers (best). It should be apparent that to provide excellent, contemporary care in the fast-evolving field of geriatrics, effective lifelong learning for all physicians who care for elderly persons will be essential. Departments of internal medicine will be squarely at the center of an educational and training program to meet this challenge, which will involve a broad array of faculty and collaboration with such key professional organizations as the American College of Physicians–American Society of Internal Medicine, which has a tradition of excellence in postgraduate medical education.

Fifth, to demonstrate optimal geriatric care to our learners, we must actively develop an efficient, effective continuum of excellent geriatric health care in our local environment. This will act as a learning laboratory but will also ensure that the health care enterprises we serve as clinical leaders remain vital and competitive in the medical marketplace.

Sixth, because the department of internal medicine serves as the hub of its many subspecialty divisions, it can provide a crucial link to the enormous pool of talent and energy in those subspecialties, each of which will have a critical and growing role to play in meeting the needs of the aging population. Each subspecialty therefore faces the same opportunity and challenge in geriatric health care that internal medicine faces as a whole (2).

Seventh, fellows and junior faculty in the department of internal medicine—those in the medical subspecialties, general internal medicine, and geriatrics—must become integrally involved in the research, teaching, and clinical missions of each discipline. This will ensure the continued central position of the department of internal medicine as the academic health center adapts to meet the imperatives of an aging population.

Eighth, broad application of this strategy will “gerontologize” departments of internal medicine. In the process, the academic identity and recognition of these departments will become increasingly linked to their gerontologic research, be it basic, patient-oriented, or population-based. Grant proposals for such research in each medical subspecialty, in divisions of general internal medicine, and in divisions of geriatrics could be directed to the National Institute on Aging, with its explicit research and training mandates, as well as the Agency for Healthcare Research and Quality and foundations that have focused their resources on gerontology and geriatrics.

Ninth, for internal medicine to exert appropriate institutional leadership of a comprehensive aging initiative, it must collaborate widely in teaching, research, and practice, perhaps at the hub of a pan-institutional center on aging. After all, geriatrics is perhaps the first “supraspecialty” (4), demanding cooperation across traditional domains of internal medicine as well as those outside the department (Figure). Such cooperation will especially involve disciplines that focus on the greatest needs of elderly patients, such as family medicine, psychiatry, neurology, and rehabilitation. Collaborations with the surgical subspecialties, gynecology, anesthesiology, and the public health and social sciences (epidemiology, biostatistics, clinical trials, and medical sociology) will also be required. Cooperation will extend well beyond the medical profession to include nursing, pharmacy, dentistry, social work, and other disciplines.

No narrow-minded, territorial attitude or practice can succeed here, and only the most broadly conceived agenda is appropriate. I emphasize that a central goal should be to avoid any “we–they” scenarios. For example, in institutions that establish departments of geriatrics, a cordial and collaborative relationship with the department of internal medicine is a necessity. There is simply too much to be done by too many providers to exclude any health care profession from contributing its full effort and expertise. Too much is at stake. By the same token, developing a center on aging without major contribution from the department of internal medicine would risk isolating such a center from the mainstream of institutional power, influence, and resources. In addition, it would be a missed opportunity to develop an appropriate response to the aging imperative.

Tenth and finally, we must not allow ourselves to be intimidated by the logistic, organizational, and financial obstacles to be overcome. Instead, we must approach this challenge as an opportunity, as we would any other new...
venture in medicine or business. The care of elderly persons will progressively dominate the health care agenda of the 21st century, and we must develop a clear strategic plan to demonstrate that internal medicine will be a central force in managing it.

Who Will Lead Geriatrics in the New Millennium?

Which approach will prevail in the 21st century? Will departments of geriatrics become the model for the United States? Will other existing departments step into leadership positions? Or will departments of internal medicine sustain their central academic and clinical position and serve as the hub of the medical response to this current health care challenge? My position of advocacy on this issue remains clear: Internal medicine must embrace this challenge and seize this opportunity.

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