The progressive aging of the U.S. population presents an unprecedented demographic challenge to our health care system. To address this imperative, gerontology (the study of aging) and geriatrics (the health and social care of the elderly) must become embedded into medical education at all levels, especially the postgraduate training of all residents and fellows (except perhaps pediatricians). Furthermore, since the needs of elderly patients are typically chronic, progressive, and complex and the care of these patients is quintessentially multidisciplinary, communication and collaboration among specialists must be a cardinal feature of effective geriatric care. In this picture of the world of geriatric care, general internal medicine and family practice will share the leading role in primary care, skillfully orchestrating contributions from all of the medical subspecialties, neurology, psychiatry, physiology, and surgery (including its subspecialties and related disciplines, such as anesthesiology and emergency medicine). This editorial focuses on partnerships between general internal medicine and geriatrics.

Where do geriatricians fit in this world? Here geriatrics functions as a “supraspecialty” (1), practiced by a relatively small cadre of certified geriatricians and their multidisciplinary teams concentrated principally in academic health centers. They maximally leverage their professional efforts as researchers and clinician-educators who provide exemplary, coordinated, longitudinal care to some of the oldest, most frail and vulnerable patients across a continuum of sites and levels. Geriatricians must assume such focused roles because so few U.S. medical graduates—currently less than 1% (2)—pursue geriatric fellowship training after residency in internal medicine or family practice. Even if all certified geriatricians were to remain full-time academic faculty—at least half to date have not—their efforts would not meet the geriatric education needs of all medical students and residents. Nor would clinical education confined to geriatric venues be appropriate: Education should occur wherever care is delivered, which will be widely dispersed throughout the academic health center and into the community. Thus, the great preponderance of geriatric care and geriatric education will be delivered by nongeriatricians, with geriatricians broadly facilitating such disseminated education while focusing their direct clinical teaching on geriatric ambulatory care clinics and long-term care venues. As a result, much geriatric instruction must always come from generalist physicians: chief residents, fellows, and attending physicians in clinics and on hospital units, as well as academic staff in areas such as epidemiology, biostatistics, and health services research.

These considerations make a compelling case for general internal medicine to incorporate geriatrics into the training of internal medicine residents. The field must embrace this challenge. However, neither logic nor urgency necessarily dictates reality, and at many academic centers the 2 parent academic units coexist in a relationship that is independent at best and sometimes frankly indifferent or even frosty. This perplexing conundrum generated the study, sponsored by the Society of General Internal Medicine and co-led by Seth Landefeld and Christopher Callahan, that is the subject of the supplement in this issue. Supported by the John A. Hartford Foundation, this initiative was conceived during a Hartford Foundation-sponsored Geriatric Education Retreat in General Internal Medicine; held in 1999, the retreat was cochaired by Landefeld and Eric Larson as 1 in a series of similar 5-day conclaves (3). The challenge to general internal medicine that arose from this retreat was clear: View the care of the elderly, gerontology, and geriatrics as an opportunity; ignore this challenge at your peril. The views of the attendees were eloquently articulated by Larson in his Annals article “General Internal Medicine at the Crossroads of Prosperity and Despair” (4) and subsequently reinforced by Harold Sox, another attendee (5).

The papers in this supplement (6–9) speak to the logic and necessity of academic general internists and geriatricians forging a synergistic partnership to assure excellence in geriatric training of medical students and internal medicine residents. The authors focus on the barriers that have inhibited such a partnership: workload, money, and attitude:

1. Inadequate numbers of trained, enthusiastic, and charismatic faculty: too many busy, overextended, otherwise preoccupied faculty from general internal medicine and geriatrics who have little contact with each another and little overlap in their perceived agendas.

2. Inadequate resources: mostly too little money to protect the time of faculty and fellows from competing clinical or administrative demands.

3. Inadequate respect paid to geriatrics by the academic general internal medicine community: Too often, we hear a familiar proclamation by general internal medicine faculty: “But I already do that,” a code phrase suggesting that they have little to learn from geriatricians, whom they perhaps regard as being of lesser caliber.

On the more positive side, the authors offer suggestions to overcome these barriers. These must ultimately include far more robust and equitable funding, most importantly from Medicare, which must reverse its longtime, seemingly perverse underfunding of the care of the oldest and frailest Americans, especially by generalists. Division heads and internal medicine department chairs (and, by extension, deans and hospital directors) must support op-
opportunities for general internal medicine faculty to acquire special expertise in geriatric education in primary care settings. General internists and geriatricians who wish to see the partnership of their disciplines flourish must convince these powerful leaders by meeting their expectations for productivity in research and research funding.

Finally—and most promising and natural—the path to long-term success would start with a joint commitment by general internal medicine and geriatrics leaders to generate a new cohort of faculty who work at the interface between the two disciplines. These future leaders must have full clinical and academic credentials and skills in both disciplines. The path would lead through internal medicine residency and continue with a year of geriatrics fellowship training and at least 2 years of research fellowship training in either division. Most fellows would acquire skills in the public health (“macro”) sciences and earn a Masters degree (Masters in Public Health or its equivalent). We can expect these well-prepared academic generalists to compete successfully for extramural career development awards and thrive in divisions of general internal medicine or geriatrics as educators, researchers, and exemplary clinicians throughout long, satisfying, and productive careers.

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