The American population—and, indeed, the world’s population—is getting older. Worldwide, over the next 40 years, the number of people over 60 is expected to increase threefold to reach nearly 2 billion. One in every five people on the planet will be 60 years or older, and one in six will be least 65 years old.\(^1\) The situation is similar in the United States, where the number of people over 65 will double in the next 20–25 years. By 2030, well within the careers of today’s medical trainees, one out of every five Americans will be 65 or older, and the over-85 age group will be the fastest growing segment of the population.\(^2\)

**Family Medicine and Geriatrics**

Against this background, I find the lack of interest in geriatrics by family physicians to be somewhat perplexing. The American Board of Family Medicine reports that of the nearly 74,000 board-certified family physicians in the United States in 2007, a mere 2,087 (2.8%) held certificates of added qualification (CAQs) in geriatric medicine. Indeed, in 2007, there were more family physicians taking the examination for initial certification in sports medicine than took the exam for initial certification in geriatric medicine (207 for sports medicine versus 137 for geriatric medicine).\(^3\) Based on the demographic trends described in the previous paragraph—the “aging” of the population—I find it hard to believe that our country, or our specialty of family medicine, has a greater need for sports medicine physicians than for geriatricians!

Further, only just more than two thirds of those sitting for the geriatric CAQ exam passed it (Table 1). In comparison, nearly 90% pass the sports medicine CAQ. I’m not sure what to make of the low pass rate. Perhaps the geriatrics exam is more difficult than the sports medicine exam. But, it also raises the possibility that in addition to being small in number, our family medicine geriatrics fellowship programs also may not be providing adequate education and training to the fellows enrolled in them.

Health care planners and policy makers in the United States have long recognized the need for more geriatricians and more geriatric training for primary care physicians. This need was stated 15 years ago in a report by the Institute of Medicine (IOM),\(^4\) and reiterated in an IOM report released this year.\(^5\) Other medical organizations, including the American Academy of Family Physicians (AAFP), the American Medical Association, and others have also advocated emphasis on geriatric training. As a result, as of a few years ago, nearly all family medicine residency

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**Table 1**

| Geriatric Medicine Certificate of Added Qualification: 2007 Examination Data |
|-----------------------------|-----------------------------|
| **Number of family physicians taking examination** | 137 | 144 |
| **Pass rate for family physicians** | 69.3% | 88.9% |

Data from Web site of the American Board of Family Medicine

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See related articles on pages 707, 715, and 721.

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programs had established a required geriatrics curriculum. But, a required curriculum in geriatrics hasn’t translated into large numbers of family physicians focusing their practice on geriatrics.

**Why So Little Interest in Geriatrics?**

Why is there such a lack of interest in geriatrics among family physicians? Why do so few family physicians seek additional training or a CAQ in geriatrics?

One possibility is cited in the article by Helton and Pathman in this month’s issue of *Family Medicine*—current residents don’t understand the demographics of the future in which they will practice. Helton and Pathman surveyed residents in seven residency programs in North Carolina and found that although nearly all residents reported positive attitudes toward elderly patients, only about two thirds of them thought that older people would constitute a significant percentage of their practice. Given the demographics of aging in America, how can one of every three family medicine residents think that geriatrics won’t be a significant part of the future practice?

Unless they are planning to work outside of mainstream primary care, the one third of residents in the Helton and Pathman study who did not think older people would be a significant percentage of their practice population are simply wrong. This misperception about how important geriatrics will be is not likely limited to residents in North Carolina. Family medicine residents need more education about the demographics of medical practice in the coming decades.

Helton and Pathman also cite the possibility that financial compensation for geriatric care is low, and this may dissuade newly graduated family physicians from seeking to provide more geriatric care, though it doesn’t explain why one third of residents think they won’t see lots of older adults in their practices. The concern about low compensation for geriatric care is well known and a topic of current political debate in Congress and elsewhere, and specialty choice is clearly influenced by compensation. Although we can’t improve compensation by training residents, our national organizations (AAFP, Society of Teachers of Family Medicine, and others) can and should work in collaboration with other health care societies to influence legislators to make needed changes in Medicare’s system of payment for geriatric care to increase compensation for primary care clinicians who care for older adults. Lobbying for such change is an urgent need for the American health care system, and our professional organizations should make it a priority.

A third possibility, and one not cited in the North Carolina study, is that geriatrics, as we currently teach it in our family medicine residency training programs and medical student clerkships, is seen by trainees as either overwhelming or depressing—or maybe both. In a typical geriatrics rotation, residents and students spend time in nursing homes seeing debilitated elders. They spend time in geriatric assessment clinics seeing older people whose health is failing, in hospice programs where people are dying, and working with underfunded social service agencies to deal with elders who are having trouble getting along in the community and who may or will ultimately end up in nursing homes because they can’t get the support they need at home. These patients often have multiple medical problems that are difficult to treat in combination and from which they will not “get better” in the course of a month-long rotation or a 1-day experience. Such short-term rotations and experiences don’t provide residents or students with the opportunity to develop satisfying long-term relationships with patients or to see that what they can do for these patients makes a difference over time for patients or the patients’ families. It is likely that few of these experiences are inspiring or fun. Rather, they may serve as a “turn off” to providing geriatric care.

**A New Approach Is Needed**

This month’s issue of *Family Medicine* contains several other articles that bear on the issue of what needs to be done—besides increasing compensation—to entice our trainees to develop a focus in geriatrics by making it less overwhelming and more satisfying. These articles report on approaches to geriatric training that have or could be implemented in our residency and student training programs around the country.

Steinweg from East Carolina University describes a continuum of care model that could permit residents to see how a more “seamless” geriatric care system could work effectively to provide care for people through different phases of their aging process and chronic illnesses. Though the model still relies on block rotations that don’t provide residents with the satisfaction of longitudinal contact with older individuals, it has the potential for focusing their training on effective systems of care that can make a difference for patients and the transitions in those systems, rather than on trying to manage individual patients on one’s own. This approach makes sense because it can expose trainees to systems that work, thus making care of older adults more effective and therefore less overwhelming, less depressing, and more rewarding.

In their article, Goldman, Wiecha, Brown, and Levine from Boston University describe an intensive experience in which medical students first participate in workshops to learn about a variety of geriatric assessment instruments, then make a home visits to see how the instruments are applied, and
consequently use the instruments to assess patients they see in clinic. While this experience also provides no longitudinal exposure or long-term relationship with patients, it does expose students to these geriatric assessment instruments in settings that are more meaningful than in the classroom settings in which many students learn about them. More importantly, evaluation data showed that students did not just learn about the instruments and how to use them. They actually did use them, and they rated the experience highly. High ratings for geriatrics training experiences are the key to getting trainees excited about geriatrics.

Many other training models are possible—some that might even seem unconventional—and we need more of them. As just one example, in our department at the University of Arizona, part of the residency’s geriatrics rotation now includes sending residents to go hiking with senior hiking groups of the Southern Arizona Hiking Club. Residents are impressed that when hiking with people in their 70s and 80s who are climbing mountains on rugged trails, the 30-something-year-old residents often struggle to keep up. They learn that not all geriatrics is about debilitated old people, that many older adults are healthy and vigorously active, and that the emphasis of geriatric care could be refocused on keeping healthy individuals healthy. By providing residents with exposure to the healthy side of geriatrics, they get a view that is different from what they see in nursing homes and dementia units. It is a not-depressing view of older adults that most residents would not otherwise see. It might even inspire those with an interest in sports medicine to focus their career on something more practical—maintaining health and physical activity for older adults.

Conclusions

We need more innovation in our geriatrics education programs. We need experiences for residents and students that show they can make a difference, even with brief interventions, for elderly patients and their families. We also need longitudinal experiences in addition to month-long rotations, so that residents can develop relationships with patients and learn the satisfaction of seeing patients through difficult times. We need to teach them that they can make a difference for those patients, so the geriatric care they provide can be rewarding. We need to show them that not all older adults are chronically ill; most are healthy, and the focus of their care is truly on “health maintenance.”

Finally, we need to be sure that all our current trainees understand that wherever they eventually work, their practice will almost certainly include large numbers of older adults, so they might as well get good at caring for those older adults. The way to really get good at that care, of course, is to consider training in a high-quality geriatric fellowship program. But, even for those without interest in fellowship training, high-quality geriatrics training during residency—lots of it—will be the key to a successful and satisfying career in family medicine.

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