

Caring for Older Americans: The Future of Geriatric Medicine

American Geriatrics Society Core Writing Group of the Task Force on the Future of Geriatric Medicine

In response to the needs and demands of an aging population, geriatric medicine has grown rapidly during the past 3 decades. The discipline has defined its core values as well as the knowledge base and clinical skills needed to improve the health, functioning, and well-being of older persons and to provide appropriate palliative care. Geriatric medicine has developed new models of care, advanced the treatment of common geriatric conditions, and advocated for the health and health care of older persons. Nevertheless, at the beginning of the 21st century, the health care of older persons is at a crossroads. Despite the substantial progress that geriatric medicine has made, much more remains to be done to meet the healthcare needs of our aging population. The clinical, educational, and research approaches of the 20th century are unable to keep pace and require major revisions. Maintaining the status quo will mean falling further and further behind. The healthcare delivery and financing systems need fundamental redesign to improve quality and eliminate waste.

The American Geriatrics Society (AGS) Task Force on the Future of Geriatric Medicine has identified five goals aimed at optimizing the health of older persons:

- To ensure that every older person receives high-quality, patient-centered health care
- To expand the geriatrics knowledge base
- To increase the number of healthcare professionals who employ the principles of geriatric medicine in caring for older persons
- To recruit physicians and other healthcare professionals into careers in geriatric medicine
- To unite professional and lay groups in the effort to influence public policy to continually improve the health and health care of seniors

Geriatric medicine cannot accomplish these goals alone. Accordingly, the Task Force has articulated a set of recommendations primarily aimed at the government, organizations, agencies, foundations, and other partners whose collabora-

tion will be essential in accomplishing these goals. The vision described in this document and the accompanying recommendations are only the broad outline of an agenda for the future. Geriatric medicine, through its professional organizations and its partners, will need to mobilize resources to identify and implement the specific steps that will make the vision a reality. Doing so will require broad participation, consensus building, creativity, and perseverance.

The consequences of inaction will be profound. The combination of a burgeoning number of older persons and an inadequately prepared, poorly organized physician workforce is a recipe for expensive, fragmented health care that does not meet the needs of our older population. By virtue of their unique skills and advocacy for the health of older persons, geriatricians can be key leaders of change to achieve the goals of geriatric medicine and optimize the health of our aging population. Nevertheless, the goals of geriatric medicine will be accomplished only if geriatricians and their partners work in a system that is designed to provide high-quality, efficient care and recognizes the value of geriatrics. *J Am Geriatr Soc* 53:S245–S256, 2005.

Americans are living longer. Improved control of infectious diseases and other advances in medicine and public health have resulted in an increase in life expectancy at birth from 47.3 years in 1900 to 77.2 years in 2001.¹ This longevity must be considered in the context of the surge in the U.S. birth rate during the 2 decades following the Second World War. In 2000, these 75 million baby boomers accounted for nearly 30% of the U.S. population.² By 2030, when the last of the baby boomers reaches the age of 65, the U.S. population aged 65 and older will exceed 70 million—approximately twice the number in 2000.³ Despite some evidence that the prevalence of disability among older persons may be declining,⁴ the vast majority of these older persons will have at least one chronic disease, and substantial numbers will have impairments in abilities to perform basic and more advanced activities of daily living.⁵

The health needs and demands of an aging population have spurred the growth of the discipline of geriatric medicine. Geriatrics, including geriatric medicine and geriatric psychiatry, is the physician discipline that focuses exclusively on health care for older persons. Its mission is to improve the health, functioning, and well-being of older

This statement on the future of geriatric medicine was developed and written under the auspices of the American Geriatrics Society (AGS) Task Force on the Future of Geriatric Medicine and approved by the AGS Board of Directors in March, 2005.

Address correspondence to Marianna Racz, American Geriatrics Society, 350 Fifth Avenue, Suite 801, New York, NY, 10118.
E-mail: mracz@americangeriatrics.org

DOI: 10.1111/j.1532-5415.2005.53350.x

persons and, when this is not possible or is not the patient's preference, to provide palliative care that is consistent with the patient's wishes. Recognizing the interdependency of medical, social, and mental health issues in the overall health and health care of their patients, geriatricians take care of older people, not just their diseases. A key component of this care is the management of chronic conditions, often multiple and usually incurable, in a variety of settings, including home, nursing homes, and community-based long-term-care sites.

Geriatricians are especially skilled at balancing the benefits and burdens of therapy and providing care for frail older persons and those at the end of life. They have mastered the management of syndromes such as immobility, incontinence, and dementia as well as the common diseases such as osteoarthritis, hypertension, and heart failure that affect older persons. Moreover, geriatricians coordinate care with other professions and across healthcare and community-based settings to ensure that their patients' needs are met. In addition to their clinical roles, geriatricians lead research efforts aimed at improving the health of older persons and providing optimal care for this population, and they teach physicians and other health professionals how to provide the best care for older persons. They also fill leadership and advisory roles for healthcare delivery systems (e.g., as medical directors of nursing homes, medical groups, and health plans). Geriatricians are sought for their expertise and insight into the healthcare needs of older persons, particularly those who are frail and those who must use high levels of healthcare resources. In all their professional roles, geriatricians are advocates for their patients and for older persons in general.

Many geriatricians provide a full range of services, although some have focused on specific segments. Moreover, geriatricians vary with respect to the extent that they provide primary versus consultative care. Yet, by virtue of their training, skills, values, and advocacy for older persons, geriatricians have established a core identity and culture. The values, attributes, and competencies that characterize this identity and culture are listed in Table 1. Many of these are shared by physicians in other disciplines, but this particular constellation of values, attributes, and competencies focused on older persons is unique to geriatrics.

During the past 3 decades, geriatric medicine has experienced dramatic growth and has established itself as a major force in American medicine. Notable accomplishments in this growth of geriatrics include the:

- establishment of the National Institute on Aging (NIA), whose mission is to improve the health and well-being of older Americans through research;
- creation of a body of scientific knowledge (basic science, clinical, social and behavioral) to guide the clinical care of older persons and establish a foundation for future research;
- identification of new clinical interventions for geriatric syndromes and for many diseases common in older adults;
- infusion of geriatric medicine into the general and post-graduate education of physicians;
- development of specific fellowship programs aimed at training a cadre of physicians with expertise in geriatric medicine; and

- implementation of certification processes for geriatricians in internal medicine, family medicine, and psychiatry.

Building on these accomplishments, the field has developed innovative approaches to the care of older persons, particularly those who are frail or have multiple diseases. These models, which usually involve interdisciplinary team care, have been applied successfully in hospital,^{6–8} outpatient,^{9,10} home,^{11,12} and nursing-home^{13,14} settings. They have also led to improved diagnosis and treatment of common geriatric conditions such as falls,¹⁵ urinary incontinence,¹⁶ delirium,⁷ and osteoarthritis.¹⁷ Research in geriatrics has provided new insights into the heterogeneity of aging, ranging from frailty¹⁸ to successful aging, in which good health and functional ability persist well into older age.¹⁹ Geriatrics has also infused its research findings, approaches, and values into other areas of health care (e.g., ethics,²⁰ hospice and palliative care,²¹ and chronic disease management^{22,23}) and other areas of the medical profession (e.g., subspecialties of internal medicine and surgical and related medical specialties^{24–26}).

Despite numerous advances and increasing prominence, geriatric medicine is facing challenges. Perhaps most important, the discipline has failed to secure adequate reimbursement for many of the core elements of good geriatric care (e.g., assessment and care coordination, community-based prevention programs, and long-term-care services). Financial support for education and research, and payment for clinical care have been insufficient to foster the needed growth of the discipline. Although geriatricians have the highest professional satisfaction rates among physicians,²⁷ recruitment into the field has been modest. For example, fewer than 300 physicians entered geriatric medicine fellowships in 2003.²⁸ As a result, there are currently fewer than 7,000 certified geriatricians²⁹ (approximately 1 per 5,000 Americans aged 65 and older), far short of the estimated current need for 14,000 geriatricians.³⁰ Moreover, the discrepancy between available and needed geriatricians is expected to worsen, to 36,000 by 2030.³⁰ These current and future shortages of geriatricians demand a reexamination of the roles of geriatricians and better leveraging of the scarce resources of a small geriatrician workforce.

In this document, the American Geriatrics Society (AGS) Task Force on the Future of Geriatric Medicine describes the goals of geriatric medicine, identifies the obstacles to achieving these goals, and outlines strategies for overcoming obstacles. We also craft a vision of future roles of geriatricians. Finally, we provide a set of recommendations primarily aimed at the government, organizations, agencies, foundations, and other partners whose assistance will be essential to achieve the goals of geriatric medicine.

This vision and these recommendations are only the broad outline of an agenda for the future. The discipline, through its professional organizations and its partners, will need to mobilize resources to identify and implement the specific steps that will accomplish the goals of geriatric medicine. This will require broad participation, creativity, perseverance, and consensus building.

The document focuses on geriatric medicine (and uses the terms “geriatrics” and “geriatric medicine” interchangeably); in this document, both terms refer to internists and family physicians who are certified as having added qual-

Table 1. Geriatrics Core Values—Attributes and Competencies

Core Values	Core Attributes and Competencies
Excellence in clinical care	<ul style="list-style-type: none"> ● Patient-centered care that respects patient and family preferences and balances the burden of therapies with potential benefits ● Comprehensive care that addresses mental health and social issues as well as medical conditions ● Provision of coordinated care across all settings, including office, hospital, nursing home, acute rehabilitation unit, home, community-based long-term-care sites, and hospice ● Coordinated care that includes communication among providers ● Interdisciplinary team care with shared responsibility for patient care processes and outcomes ● Commitment to quality and its continuous improvement ● Focus on function and quality of life as outcomes ● Expertise in the diagnosis and care of chronic diseases and geriatric conditions ● Communication and interpersonal skills that serve both patients and families ● Prevention (primary, secondary, and tertiary) and rehabilitation as strategies to preserve, maintain, and restore function and prevent disability and dependency ● Palliative care for the relief of physical and psychological suffering, regular communication about care goals as disease progresses, and continuity of comprehensive palliative services for both patient and family caregivers across healthcare settings ● End-of-life and hospice care when patients are terminally ill and intensive comprehensive palliative care becomes the primary focus of health care ● Emphasis on patient safety and avoiding iatrogenesis ● Cultural competency and respect
Professionalism	<ul style="list-style-type: none"> ● Highest ethical standards ● Excellent peer relations ● Acquisition and maintenance of board certification ● Lifelong learning and continuous professional growth ● Respect for roles of all members of the healthcare team ● Teaching lay and professional audiences
Expansion of knowledge related to health and aging	<ul style="list-style-type: none"> ● Research on the basic science of aging and age-related diseases and geriatric conditions, clinical research, clinical and population-based research, social and behavioral research, and health services research, including quality-of-care research
Education of a health professions workforce to care for older persons	<ul style="list-style-type: none"> ● Teaching in traditional and nontraditional settings, both at academic institutions and in the community ● Teaching primary care physicians, medical subspecialists, surgical and related medical specialists, and other health professionals
Advocacy for older patients	<ul style="list-style-type: none"> ● Balancing autonomy and safety for individual patients ● Working within healthcare systems to ensure that needs of older persons are comprehensively met ● Working within educational settings to promote curriculum reform to foster the goals of geriatric medicine ● Collaborating with other medical professional societies and the societies of other healthcare disciplines to promote high-quality care of older persons ● Working with lobbyists, governments, and consumer groups to implement policy changes that promote the goals of geriatric medicine
Leadership	<ul style="list-style-type: none"> ● Vision and flexibility to anticipate and respond to changing healthcare and political environments ● Ability to mobilize resources to meet current and future goals ● Willingness to share leadership roles with other specialties and disciplines in the care of older persons ● Rising to leadership positions in all relevant environments (e.g., academia, healthcare systems, government)

ifications in geriatrics. Many of the issues also apply to geriatric psychiatry and other specialties and professions (e.g., nursing, social work, pharmacy, dentistry) that have focused on the health care of older persons and whose practitioners are important members of the interdisciplinary team. These other disciplines have other unique issues, however, that cannot be considered here because of space considerations.

THE GOALS OF GERIATRIC MEDICINE

To meet its mission of improving the health, functioning, and well-being of older persons, geriatric medicine must achieve the following goals.

- To ensure that every older person receives high-quality, patient-centered health care
- To expand the geriatrics knowledge base
- To increase the number of healthcare professionals who employ the principles of geriatric medicine in caring for older persons
- To recruit physicians and other healthcare professionals into careers in geriatric medicine
- To unite professional and lay groups in the effort to influence public policy to continually improve the health and health care of seniors

ACHIEVING THE GOALS OF GERIATRIC MEDICINE

To achieve the goals of geriatric medicine, the nation will need a healthcare delivery system that is organized and financed to provide high-quality care by a workforce of physicians and other healthcare professionals trained in the care of older persons. It also requires strong educational components to train these professionals, most of whom will not become geriatricians, in the appropriate care of older persons. Older patients (and when appropriate, their families) should be well informed about their health conditions and be active participants in making healthcare decisions and in implementing treatment plans. Finally, meeting the goals of geriatric medicine requires a strong and evolving research base to guide clinical care, provide insights into prevention and natural history, and develop interventions that will prevent disease or reduce its burden. The following sections present the specific goals of geriatric medicine, describing for each goal its requisites, the existing obstacles to its achievement, and strategies needed to overcome the obstacles.

GOAL: TO ENSURE THAT EVERY OLDER PERSON RECEIVES HIGH-QUALITY, PATIENT-CENTERED HEALTH CARE

Requisites

Planning for healthcare delivery for the older age group should be aimed at the entire population of older persons but must address the unique needs of individual patients. Thus, healthcare delivery must consider the full range of needs for the heterogeneous older population. Diversity in health and functional status, culture and ethnicity, and socioeconomic status must be recognized. Physicians must be taught to appreciate differences among older persons in

their health beliefs and practices and to accommodate these differences with respect and without prejudice. In addition, the healthcare needs of rural older persons must be met with the same comprehensiveness and quality provided for those living in urban and suburban areas. Similarly, other special populations, such as the homebound and those with low health literacy, must be accommodated.

Healthcare providers and organizations must recognize the need to maintain the health and function of the healthiest older persons with preventive and lifestyle interventions. The needs of the most robust older adults for episodic health care must be met promptly, conveniently, and effectively. Those with chronic diseases should be enrolled in programs to manage their illnesses and coordinate their care across providers and with community resources. Many older persons with acute or chronic illnesses will require rehabilitation and tertiary prevention to preserve, maintain, and restore function and to prevent disability and dependency. For older persons who have multiple illnesses and are frail, symptom management and preservation of function are as important as disease management. Healthcare providers and organizations must take proactive roles to ensure that frail patients' needs are met, prognosis and preferences are discussed, and high-quality care is provided, with attention to psychological, social, and spiritual needs and the relief of pain and other symptoms. End-of-life care and hospice services should be available to all older persons as they approach the final phases of their lives.

Health care for older persons should embrace the six aims identified by the Institute of Medicine in its 2001 report *Crossing the Quality Chasm: A New Health System for the 21st Century*—care that is safe, effective, patient-centered, timely, efficient, and equitable.³¹ There are some important aspects of these six aims that have special meaning when they are applied to the care of older persons. For example, with regard to safety, pharmacotherapy for older persons is particularly risky because of age-related changes in distribution, metabolism, and elimination of drugs as well as potential interactions among the multiple drugs that many older persons are taking. Additional aims for the care of older persons that meet the goals of geriatric medicine include

- continuity and seamlessness across all sites and providers;
- appropriateness of care within the context of the goals of the individual patient and the values of society.

Healthcare financing must support comprehensive care and align reimbursement to reward healthcare systems and providers who deliver efficient (economical) and effective (high-quality) care for older patients with multiple chronic conditions, functional limitations, or disability. It also should include support of services that are provided outside the healthcare system (e.g., community-based exercise programs, in-home assistants) that provide substantial health benefits to patients and family members, who are often invaluable as caregivers.

Obstacles

Almost all older Americans have Medicare entitlement, which would seemingly ensure their access to care. Yet

substantial obstacles remain, wherever physicians choose not to participate in Medicare and wherever higher copayments (e.g., for mental health services) pose barriers to receiving needed care. Moreover, the healthcare benefits for older persons are not uniform. Medicare beneficiaries enrolled in health plans may receive essential services (e.g., case management) that are not covered benefits for beneficiaries enrolled in fee-for-service Medicare. Community-based alternatives to long-term care (e.g., Program for All-inclusive Care of the Elderly) are essentially out of reach financially for older persons who are not dually insured by Medicare and Medicaid. Medicaid eligibility criteria and benefits, which are so crucial for the poor, vary from state to state. Finally, the dearth of culturally competent providers and systems for many ethnic minorities has limited their access to care that meets the goals of geriatric medicine.

The current predominant structure of financing of health care of older persons, fee-for-service Medicare, also presents major obstacles to providing high-quality care for older persons. The basis for this system was developed in the mid-20th century and relies on payment for units of service provided rather than on the quality of care provided or patient outcomes. It is particularly suited to reimburse individual procedures (e.g., surgeries, diagnostic tests) but leaves large gaps in coverage for services that many older persons need (e.g., case and disease management). Frail older persons and those with chronic diseases or disabilities require care that is provided in many venues and often outside the context of the face-to-face physician visit. Moreover, fee-for-service Medicare encourages the utilization of expensive services (e.g., treating acute illness in hospitals rather than in nursing homes). As noted by other primary care disciplines,^{32,33} the current system of healthcare financing is flawed and needs to be revamped if primary care is to remain a viable component of medicine.

The effort to provide high-quality, continuous health care to older persons has been impeded by barriers to the communication of health information across providers. The lack of access to previously collected clinical information, including conversations with patients about their preferences, has led to redundancy, waste, and inappropriate care. Information technology and the electronic health record hold great promise for improving patient care, yet this promise largely remains unfulfilled. Although efforts to develop electronic health records are underway, only a minority of healthcare providers currently have access to systems that truly facilitate care, and most of these do not span across settings of care (e.g., between hospital and nursing home). Electronic documentation of the content of the patient visit remains behind that of most American commerce (e.g., automobile servicing, purchasing goods). Moreover, the cost of developing comprehensive information technology is large, and there is no revenue stream to support the investment in software development and hardware that is required before these systems can be operational.

Improvement in healthcare delivery to older persons requires innovation and investment in the development and testing of new models of care. To date, this innovation and evaluation have been neglected by the major federal agencies (Centers for Medicare and Medicaid Services [CMS] and the Agency for Healthcare Research and Quality [AHRQ]). For the former, such efforts largely fall

outside its mission, and for the latter, the limited funds available have precluded meaningful efforts to develop new approaches to healthcare delivery.

Although the costs of innovations may be accommodated by elimination of waste, increased efficiency, and improved outcomes, it is possible that better health care will cost more. Thus, it becomes a societal decision as to how much care can be supported and how purchasers and users will share the burden of these costs. Consumers in the United States, both older and younger, have a sense of entitlement to services that has been fueled by an explosion of direct-to-consumer advertising. With advances in technology, the difference between what is possible and what is appropriate has become an increasingly common issue in clinical care.

Strategies for Overcoming Obstacles

Financial disincentives to providing geriatric care must be rectified. Justification for these changes should be based on the quality and value added by the use of a geriatrics approach in providing care. This quality of care should be measured by specific indicators and by evidence of the physician's role in decision-making processes and in coordinating the team approach.

Electronic health records need to be developed and implemented that provide a common core structure that can be used across healthcare systems as well as across all settings within individual systems. The travel industry, among others, provides examples of how this can occur. Electronic health records, however, will need to have adequate safeguards to maintain patient privacy. Moreover, electronic health records need to be "smart," incorporating decision-support systems that lead geriatricians and other physicians through appropriate care processes and decision making. Similarly, electronic health records could vastly reduce the problem of drug-prescribing errors in treating older persons by identifying potential drug interactions and suggesting more appropriate medications or dose adjustments on the basis of the patient's age, other medications, and comorbid conditions.

Innovation in healthcare delivery, particularly for those who have multiple chronic diseases, will require the collaboration of several key federal agencies as well as private support. Foundations might provide small funds to conduct pilot studies of the feasibility of novel clinical programs. CMS (the primary payer for health care of older persons) could actively partner with AHRQ (whose mission is to advance excellence in health care) to fund further development and evaluation of the more promising new models of care. The Department of Veterans Affairs (VA) healthcare system, which has been a leader in developing and evaluating new models of geriatric care, should continue these efforts, and the applicability of these innovations to private-sector health care should be examined.

GOAL: TO EXPAND THE GERIATRICS KNOWLEDGE BASE

Requisites

To achieve the mission of geriatric medicine, the standard of care for older persons must continually improve as the

knowledge base and therapeutic options expand. To this end, medicine and science must continue to develop improved approaches to the delivery of health care, as well as new technologies and pharmaceutical agents. A coherent, relevant geriatrics research agenda needs to be developed and continually refined, and the products of geriatrics research must be systematically evaluated for their clinical benefits and advantages over existing treatments. This agenda should include research focused on the needs of frail older persons and those with multiple illnesses. Research on prevention of frailty, disability, geriatric syndromes, models of care, and decision making about high-technology procedures and devices are examples of important topics for future research. Older persons, particularly those who have multiple morbidities and those from ethnic minorities, need to be included in clinical trials of new therapies. For those innovations that offer clear benefits, systematic efforts must be mounted to facilitate dissemination, adoption, and adaptation.

Obstacles

Currently, too few geriatricians are trained in research (e.g., in 2003 a total of only 62 fellows in the second year and beyond were in training).²⁸ Moreover, most formally trained geriatricians do not focus on research. For example, only 11% of geriatricians trained in fellowships from 1990 to 1998 report spending more than half of their time on research.³⁴

In addition, the funding for research on aging through the NIA and AHRQ has been inadequate to substantially expand the knowledge base to meet the health needs of the growing older population. Many high-quality proposals for aging research cannot be awarded because of insufficient funding. The funding issue is exacerbated by the general stagnation of the NIH budget following a period of dramatic growth. For instance, the NIA received \$1.025 billion for fiscal year 2004, compared with an estimated \$1.056 billion budgeted for 2005. This 3% increase only approximates the general inflation rate and will not permit the expansion of health research needed for the impending surge in the older population. Budget projections for the NIA are even more concerning, with anticipated appropriations that increase at less than the rate of inflation and will result in reduced support for aging research. Hence, sustained federal salary support for geriatrics research is tentative, even for successful researchers. Furthermore, the NIA's research training support program (the K series) has gaps for research faculty support, especially at the earliest and most advanced levels of experience.

Strategies for Overcoming Obstacles

To advance the scientific basis for the care of older persons, the global medical research budgets for the NIH, including the NIA, and AHRQ need to be increased. It is critical to invest in research on aging now, in anticipation of the healthcare needs of the older population that will begin to burgeon within the next decade. Advocacy groups and professional organizations can facilitate increased funding of aging research through heightened public awareness, including among members of Congress, about the pressing need for new knowledge about the health and health care of the rapidly expanding older population.

In addition, all NIH institutes need to pay increasing attention to the health problems that affect older persons. Mechanisms need to be developed to provide support for geriatrics research faculty at all levels of experience. Foundations should be encouraged to continue to fund programs that support subspecialists and surgical and related medical specialists who conduct aging research.

The NIA, other branches of the NIH, the VA, AHRQ, private foundations, professional organizations, and industry should focus on setting an agenda and providing funding for geriatrics and aging research to improve the health of older persons. This agenda must include funding for research on new models of healthcare delivery for an aging population, including community participatory research. Most important, priorities should be set and areas of focus for each partner should be identified, to ensure that the entire agenda can be covered and duplication is minimized.

GOAL: TO INCREASE THE NUMBER OF HEALTHCARE PROFESSIONALS WHO EMPLOY THE PRINCIPLES OF GERIATRIC MEDICINE IN CARING FOR OLDER PERSONS

Requisites

In the future, as now, physicians and other healthcare professionals who are not geriatricians will provide the majority of health care for older people.³⁵ Although some professionals will seek continuing education in geriatrics, most will have had no formal training or will have received geriatrics training only within the context of core training in their medical or other health professional school, residency, or subspecialty training. This nongeriatrician workforce should have the requisite attitudes, knowledge, skills, and resources and sufficient reimbursement that they welcome older patients into their practices and enjoy caring for them. Hence, geriatrics competency must be imparted during core training to create a prepared workforce, and geriatrics should be an area of focus in continuing professional development for primary care providers.

Obstacles

Interest in primary care disciplines, especially general internal medicine and family medicine, has been steadily declining. In large part, this has been due to lifestyle issues and a payment system that discourages continuous physician-patient relationships and the commitment to non-face-to-face time between visits that is required to manage chronic illness successfully. As a result, the adequacy of the workforce of physicians to provide primary care for older persons is threatened.

In addition, the ability of academic geriatricians to train healthcare professionals is in jeopardy. A paucity of academic geriatricians remains, and most educators in geriatric medicine are dependent upon clinical income, as academic institutions have generally been unable to provide adequate support for teaching geriatrics. The costs of graduate medical education have been supported in large part by CMS, and these funds have been administered through hospitals. As a result, in some programs, little or none of the medical education funds directly support geriatrics education. Geriatrics academic programs may therefore be

caught in a bind of being asked to provide an ever-increasing amount of teaching but not being compensated for time spent teaching.

Strategies to Overcome Obstacles

Core training in medical school and postgraduate training must include substantial geriatrics training to ensure competency in caring for older persons. Beginning in medical school, trainees also should have ample experience with healthier older persons in community settings, which can improve attitudes toward geriatric patients.^{36,37} During residency training, internists and family physicians should receive training in the comprehensive care of older persons with multiple and complex illnesses.

To meet these large teaching demands, geriatricians will need to partner with other teachers. Most often, geriatricians will lead other faculty, including general internists, family physicians, surgeons, and related specialists, to develop, implement, and teach the geriatrics curriculum to medical students and residents. At some institutions where local expertise and interest among nongeriatrician faculty is great enough, these physicians, rather than geriatricians, will lead geriatrics curriculums in their disciplines. In these instances, geriatricians will be invaluable as collaborators who have additional expertise to contribute. Funding for medical education should be included in the budget of the healthcare system and should remunerate the time spent teaching geriatrics.

At the level of the practicing physician, geriatric medicine should collaborate with general internal medicine and family medicine to ensure that primary care specialties remain viable and increasingly attractive as career choices. Within these specialties, physicians must be given incentives to provide high-quality geriatric care.

GOAL: TO RECRUIT PHYSICIANS AND OTHER HEALTH PROFESSIONALS INTO CAREERS IN GERIATRIC MEDICINE

Requisites

The ability of geriatric medicine to meet its mission is critically dependent upon having a sufficient workforce of geriatricians. As noted below in the section "Future Roles of Geriatricians," geriatricians will be needed as leaders in clinical, educational, research, and administrative roles to accomplish these goals. Accordingly, recruitment efforts must focus on expanding the numbers of geriatricians, not merely replacing those who have left the field.

Obstacles

Recruitment into the field remains a major challenge to the growth of geriatrics and to achieving the goals of geriatric medicine. Currently, many physicians-in-training are reluctant to go into geriatrics because of concerns that the lifestyle will be too onerous, the pay will be too low, the systems needed to support physicians to "do the right thing" will be lacking, and the funds available to support research and educational efforts will be inadequate.

Strategies for Overcoming Obstacles

Although meeting the projected needs for clinical geriatricians may not be a realistic goal, the high demand for geriatricians' services in academic and other healthcare settings justifies a substantial effort to increase the number of physicians entering geriatrics. If more young doctors are to be attracted to the discipline, trainees must envision a bright future as geriatricians. They must have role models who enjoy their work and feel satisfied with their lifestyle and remuneration. Whether they plan to focus on clinical care, research, education, or administration, trainees must feel confident that their skills and the services they can provide will be valued for the next 40 years. Geriatricians and their professional organizations must make concerted efforts to recruit professionals-in-training into geriatrics by promoting the positive aspects of this personally and professionally rewarding field.

Given the current low recruitment rates, measures to "jump-start" recruitment into the field are justified and are urgently needed. These measures should include loan repayment; ample support for advanced fellowships (beyond the 1 year required for certification) to train geriatricians to be leaders in research, administration, and education; and plentiful career development awards. Certifying bodies and the Accreditation Council for Graduate Medical Education should explore pathways that increase the attractiveness of geriatrics fellowship training.

GOAL: TO UNITE PROFESSIONAL AND LAY GROUPS TO INFLUENCE PUBLIC POLICY TO CONTINUALLY IMPROVE THE HEALTH AND HEALTH CARE OF SENIORS

Requisites

Major advances in the treatment of acquired immune deficiency syndrome, cancer, and heart disease have been achieved through increased recognition of their importance by the general public and through partnerships between professional and lay organizations. These partnerships have influenced policy, funding for research, and the provision of health care to those afflicted. Geriatric medicine needs the same prominence and influence to achieve its mission and goals.

Obstacles

Despite the "graying" of America, the culture is predominantly youth oriented. In fact, much of the cultural and economic emphasis is on antiaging products aimed at preserving the appearance of youth and offering the hope of immortality. The mass media have propagated images that lead to expectations of a nation of superhero older persons. This distorted vision is a distraction from the more common reality of aging with chronic diseases, often multiple, that are the focus of much of geriatric medicine.

In addition, the contribution of the geriatrician who orchestrates the health care of frail older persons has received less attention than the care of specific diseases that affect older persons. Although patients and families who have received geriatric care have been extremely grateful and have gained a clear understanding of the worth of this approach, it has been difficult to communicate the added

value of geriatric care to others. Moreover, efforts to meet the clinical, research, and educational goals of geriatric medicine have been impeded by the lack of coordination across professional groups who are working toward similar goals.

Strategies for Overcoming Obstacles

The goals of geriatric medicine will best be met through partnerships among professional societies (e.g., the AGS, the Gerontological Society of America, the American College of Physicians, the American Academy of Family Physicians, the Society of General Internal Medicine, the American Medical Directors Association, the American Academy of Hospice and Palliative Medicine, the Society of Hospital Medicine, the American Academy of Home Care Physicians, and societies representing geriatric surgeons, medical subspecialists, pharmacists, nurses, and social workers) and lay organizations (e.g., the AGS Foundation for Health in Aging, AARP, the Alliance for Aging Research, and the Alzheimer's Association). In these relationships, the goals, responsibilities, and expected outcomes need to be established at the outset, monitored, and revised as necessary. In many cases, geriatricians and their professional groups will take the lead. In other instances, geriatricians will serve as partners while other organizations lead.

These partnerships will be critical in influencing policy to achieve the goals of geriatrics. For example, if an organized public demand for geriatric services can be mounted, the potential for meaningful policy changes will be vastly enhanced. Public demand can be conveyed through media, grass-roots organizations, lobbyists, and consumer groups.

FUTURE ROLES OF GERIATRICIANS

As the older population expands, the skills of the relatively small number of geriatricians will need to be augmented by those of other physicians and healthcare professionals. Geriatricians will continue to be leaders in designing and implementing efficient yet effective systems of care for older persons. Such systems will rely on information technology, quality-improvement methods, and interdisciplinary healthcare teams. Geriatricians will maintain key roles in the clinical care of older persons, including providing primary care for some older persons and leading teams for frail older patients and those with complex medical conditions.

As systems of care continue to evolve, there will be mounting pressure to provide more efficient care. Other members of the healthcare team will increasingly assist geriatricians with data collection and recording. The geriatrician's responsibilities will shift toward obtaining additional necessary information, discussing goals of care with the patient, and synthesizing information from diverse sources to formulate, negotiate, and initiate treatment plans. With the assistance of the team, geriatricians will monitor the older patient's response to treatment and make adjustments on the basis of response and the evolving clinical situation. In all clinical care, the geriatrician will be the patient's advocate in providing care that is consistent with her or his wishes and goals for treatment. Nevertheless, an important function of geriatricians will be to communicate how these goals may or may not be consistent with the medical realities confronting the patient.

Geriatricians will also maintain essential academic (educational, research, and clinical) and private industry (research and administrative) roles. As in clinical care, they will also frequently assume leadership but will increasingly partner with other physicians and health professionals to achieve shared goals. Geriatricians will lead research programs to answer the important clinical questions about the health and health care of older persons. They will develop and test new models of care that promote improved quality, coordination, and efficiency. Geriatrician researchers will continue to lead research on geriatric syndromes and the linkage between clinical aspects of aging and the underlying science. They will also be vital collaborators on aging research conducted by disciplines other than geriatrics.

By virtue of their broad grasp of health problems of older persons and settings of care where these are managed, geriatricians are also uniquely qualified for administrative leadership in many healthcare systems. For example, geriatricians will serve as medical directors and in other leadership positions for hospitals, nursing homes, home-care agencies, senior programs for health plans and medical groups, quality-improvement organizations, governmental agencies, industry, and foundations. Geriatricians will increasingly be consulted as the experts on the health and health care of older persons on questions of policy by federal, state, and local governments; advocacy groups for older persons; and the media. In these roles, they will be able to influence policies to ensure that care for older persons is of the highest quality and is consistent with the goals of geriatrics.

RECOMMENDATIONS

Goal: To Ensure That Every Older Person Receives High-Quality, Patient-Centered Health Care

1. Given the current and projected shortage of geriatricians, the Institute of Medicine or a similar body should examine and provide recommendations on how the physician and nonphysician workforces can optimally provide health care for the anticipated growth in the older population.
2. Congress should commission a study to examine the current reimbursement structure for evaluation and management services, particularly as it applies to primary care providers and how it serves patients with multiple chronic and complex conditions. Alternative methods of reimbursing providers for the care of older persons must be developed. These reforms should include reimbursement parity for the treatment of mental illnesses.
3. The Centers for Medicare and Medicaid Services (CMS), together with the Agency for Healthcare Research and Quality (AHRQ), should lead efforts to measure and reward quality of care for older persons of all ethnicities and cultures, including those with multiple conditions; work with the medical profession to set clear and explicit performance expectations for providers and health systems; fund the development of new models of care to improve quality; and facilitate dissemination of these models into clinical practice.
4. Efforts to define elements of a standard electronic health record should include the involvement of professionals

with geriatrics expertise. This technology should be capable of transmitting clinical information across care transitions and of facilitating the measurement and improvement of quality in each care setting.

Goal: To Expand the Geriatrics Knowledge Base

5. Research on models of care for the diverse population of older persons receiving care in various settings needs to be supported by a stable fraction of the healthcare budget. An important focus of this research needs to be on rational use of high-technology procedures and devices.
6. The National Institute on Aging (NIA) should develop additional funding mechanisms to increase the number of geriatrician researchers, including a mechanism for making research-training support available for qualified geriatricians who want to pursue research careers and who are not based at institutions that have NIA training grants.
7. NIA should develop mechanisms to provide ongoing research support for physicians in geriatric medicine that spans all periods of their research careers.
8. NIA, other branches of the National Institutes of Health (NIH), the Department of Veterans Affairs, AHRQ, professional organizations, private foundations, and industry should establish a comprehensive agenda for research to improve the health and health care of older persons and identify areas of focus for each partner to ensure that the entire agenda can be covered and duplication can be minimized.

Goal: To Increase the Number of Healthcare Professionals Who Employ the Principles of Geriatric Medicine in Caring for Older Persons

9. Congress should reexamine the current costs of medical education with the intent of providing a mechanism for compensating faculty for time spent teaching geriatrics.
10. The Health Resources and Services Administration should develop mechanisms to provide ongoing support for physicians leading educational programs in geriatric medicine that spans all periods of their teaching careers, including mid-career and senior-level Geriatric Academic Career Awards.

Goal: To Recruit Physicians and Other Healthcare Professionals into Careers in Geriatric Medicine

11. Federal and state governments should implement incentives (e.g., loan forgiveness) to help recruit physicians into geriatrics.
12. The American Board of Internal Medicine and the American Board of Family Medicine (and equivalent osteopathic certifying organizations), in conjunction with the major professional societies, should reexamine pathways to geriatrics board certification and consider mechanisms to recognize leadership in geriatrics research, education, and administration.
13. Geriatrics fellowship training should be strengthened to ensure that geriatricians are able to fulfill leadership

roles in implementing the goals of geriatric medicine. This should include formal training in educational methodologies, research, and administrative skills (e.g., quality improvement, organizational change).

Goal: To Unite Professional and Lay Groups to Influence Public Policy to Continually Improve the Health and Health Care of Seniors

14. Professional and consumer organizations should build partnerships, alliances, and other relationships that will support the goals of geriatric medicine.
15. Through their professional societies, geriatricians should collaborate with the media to engage in social marketing to portray a realistic picture of aging, create a public voice for policy change, and recognize the roles that geriatricians can fill in providing health care.

CONCLUSIONS

The health care of older persons is at a crossroads. Although geriatric medicine has made substantial progress in improving the health of older persons, much more remains to be done to meet the healthcare needs of our aging population. Maintaining the status quo will mean falling further and further behind. The clinical, educational, organizational, and research approaches of the 20th century are unable to keep pace and require major revisions. The healthcare delivery and financing systems need fundamental redesign to improve quality and eliminate waste. With the impending crisis in the solvency of the Medicare trust fund, which is anticipated to be exhausted by 2019³⁸ (well before the peak in numbers of older persons), it is critical that efforts to revamp healthcare delivery and financing begin now. The consequences of inaction will be profound. The combination of a burgeoning number of older persons and an ill-prepared, poorly organized physician workforce is a recipe for expensive, fragmented health care that does not meet the needs of our older population.

By virtue of their unique skills and advocacy for the health of older persons, geriatricians will be key leaders of change to achieve the goals of geriatric medicine and improve the health of this population. Nevertheless, the goals of geriatric medicine will be accomplished only if geriatricians, in all their roles, are able to productively partner with other physicians, healthcare professionals, consumer-based organizations, and consumer groups. Moreover, geriatricians and their partners must work in a system that is designed to provide high-quality, efficient care and that recognizes the value of geriatrics. The agenda for the future of geriatrics is broad, the need is dire, and the obstacles are immense. Yet, if our society is to meet the healthcare needs of older persons, we must face these challenges and succeed. Our nation's older people deserve nothing less.

DEVELOPMENT PROCESS AND METHODS

In November 2003, the Board of Directors of the AGS determined that there was a need for geriatric medicine to define its future as a first step in ensuring that the growing population of older adults in America enjoys high-quality, affordable health care. The AGS Board identified distin-

guished leaders who represented key stakeholders in ensuring high-quality care for older adults. Task Force members include representatives from geriatric medicine, palliative care, nursing, general internal medicine, and family medicine, as well as individuals with expertise in healthcare policy and finance, ethics, nursing home care, health systems, and the use of technology in health care. Early on, it became apparent that the Task Force would be unable to address the future roles of the many healthcare professionals in a single document. Accordingly, the Board limited the scope of the charge to the Task Force to geriatric medicine, with the intent that future efforts of the AGS would focus on other healthcare professions. Although this document addresses geriatric medicine, the AGS Board strongly supports the independence and capability of other geriatric healthcare providers in meeting the mission of improved geriatric care.

In advance of its June 2004 meeting, the members of the Task Force reviewed the literature related to the care of older adults to identify the contributions that geriatric medicine has made through innovations in research, clinical practice, and education. In addition, the members reviewed the literature to identify the ways in which other disciplines had defined their future roles in the care of older adults. It is important to note that the literature cited in this paper includes only those articles that were available to the Core Writing Group of the Task Force on the Future of Geriatric Medicine as of March 2005.

Following the June meeting, a Core Writing Group was created and charged with developing a first draft of "Caring for Older Americans: The Future of Geriatric Medicine." This early draft was reviewed by members of the Task Force, AGS Board and Committee members, State Affiliate leaders, and the members of the Board of the Association of Directors of Geriatric Academic Programs. Once the initial draft was revised, it was again circulated to the key internal stakeholder groups for review, as well as to stakeholder organizations with expertise and interest in this topic, senior leaders in medicine, and the membership of the Association of Directors of Geriatric Academic Programs.

THE AMERICAN GERIATRICS SOCIETY (AGS) TASK FORCE ON THE FUTURE OF GERIATRIC MEDICINE: MEMBERS AND AFFILIATIONS

Core Writing Group of the Task Force on the Future of Geriatric Medicine

The members of the Task Force who served as the Core Writing Group: Richard Besdine, MD, FACP, AGSF (Co-Chair of the Core Writing Group), Brown Medical School, Providence, RI; Chad Boulton, MD, MPH, MBA, The Johns Hopkins University, Baltimore, MD; Sharon Brangan, MD, AGSF, SUNY Upstate Medical University, Syracuse, NY; Eric A. Coleman, MD, MPH, AGSF, University of Colorado Health Sciences Center, Aurora, CO; Linda P. Fried, MD, MPH (Chair of the Task Force), The Johns Hopkins Medical Institutions, Baltimore, MD; Meghan Gerety, MD, AGSF, University of Texas Health Sciences Center, San Antonio, TX; Jerry C. Johnson, MD, University of Pennsylvania, Philadelphia, PA; Paul R. Katz, MD, University of Rochester Medical School, Rochester, NY; Jane F. Potter, MD, AGSF (Co-Chair of the Core Writing Group),

University of Nebraska Medical Center, Omaha, NE; David B. Reuben, MD, AGSF, David Geffen School of Medicine at UCLA, Los Angeles, CA; Philip D. Sloane, MD, MPH, AGSF, University of North Carolina at Chapel Hill, Chapel Hill, NC; Stephanie Studenski, MD, MPH, AGSF, University of Pittsburgh, Pittsburgh, PA; Gregg Warshaw, MD, University of Cincinnati, Cincinnati, OH.

Other Task Force Members

The others who served as members of the Task Force: Patricia P. Barry, MD, MPH, Merck Institute of Aging & Health, Washington, DC; Caroline Blaum, MD, University of Michigan Medical School, Ann Arbor, MI; Libbie Bragg, PhD, RN, University of Cincinnati, Cincinnati, OH; Richard Della Penna, MD, The Permanente Federation, San Diego, CA; Samuel C. Durso, MD, AGSF, The Johns Hopkins University, Baltimore, MD; Rebecca D. Elon, MD, MPH, North Arundel Senior Care, Millersville, MD; James E. Fanale, MD, Mercy Medical Center, Springfield, MA; Luigi Ferrucci, MD, PhD, National Institute on Aging, Baltimore, MD; Terry Fulmer, RN, PhD, FAAN, New York University, New York, NY; Jennifer Kapo, MD, University of Pennsylvania, Philadelphia, PA; Rosanne M. Leipzig, MD, PhD, Mount Sinai School of Medicine, New York, NY; Diane E. Meier, MD, Mount Sinai School of Medicine, New York, NY; R. Sean Morrison, MD, Mount Sinai School of Medicine, New York, NY; Joseph G. Ouslander, MD, Emory University, Atlanta, GA; Carlos Weiss, MD, The Johns Hopkins Medical Institutions, Baltimore, MD.

ACKNOWLEDGMENTS

Frank Schneider, PhD, Human Services Management Institute, Inc., New York, NY, provided facilitation of the Task Force meeting. Barbara B. Reitt, PhD, ELS(D), Reitt Editing Services, Northampton, MA, provided editorial services. Susan Radcliff, Independent Researcher, Denver, CO, provided research services.

Members of the AGS Board of Directors and the following AGS Committees and groups provided review of this report: AGS Clinical Practice, Education, Ethics, Ethnogeriatrics, Health Care Systems, Professional Education, Executive, Public Education, and Research Committees, and the AGS Council of State Affiliates, as well as the members of the Association of Directors of Geriatric Academic Programs (a supporting foundation of the AGS).

Review by External Organizations

The following organizations provided peer review of a draft of this report: Agency for Healthcare Research and Quality, Alliance for Academic Internal Medicine, Alliance for Aging Research, American Academy of Family Physicians, American Academy of Home Care Physicians, American Academy of Hospice and Palliative Medicine, American Association of Geriatric Psychiatrists, Association of American Medical Colleges, American Board of Family Practice, American Board of Internal Medicine, American College of Physicians, American Federation for Aging Research, American Medical Association, American Medical Directors Association, Association of Program Directors of Internal Medicine, Association of Subspecialty Professors,

Bureau of Health Professions of the Health Resources and Services Administration, Centers for Medicare and Medicaid Services, Gerontological Society of America, Society for General Internal Medicine, Society of Hospital Medicine, Department of Veterans Affairs.

Individual Reviewers

The following individuals provided a peer review of a draft of this report: William B. Applegate, MD, MPH; B. Lynn Beattie, MD; John Beck, MD; Daniel G. Blazer, MD, PhD; Walter M. Bortz II, MD; Troyen Brennan, MD; Kenneth Brummel-Smith, MD; Harvey Jay Cohen, MD; Leo M. Cooney Jr., MD; George W. Drach, MD; Lee Goldman, MD, MPH; Jeffrey B. Halter, MD; Richard J. Ham, MD; William Hazzard, MD; Kevin High, MD, MSc; Ralph Horwitz, MD; Eric Larson, MD, MPH; Richard W. Lindsay, MD; Edward H. O'Neil, MPA, PhD; L. Gregory Pawlson, MD, MPH; David H. Solomon, MD; R. Knight Steel, MD; Mary E. Tinetti, MD; Edward H. Wagner, MD, MPH; Frank Williams, MD.

Disclosures

The disclosure statements that follow are from individuals who are all members of the Core Writing Group.

Financial Disclosure: Drs. Besdine, Boulton, Coleman, Fried, Gerety, Potter, Reuben, Sloane, and Warshaw indicate no financial relationships with commercial entities. Dr. Brangman serves as a paid consultant to Pfizer, Eisai, and Forest Laboratories and is a member of the Speakers Bureau for Pfizer, Eisai, Janssen, and Forest Laboratories. Dr. Johnson is a member of the Speakers Bureau for Novartis, Janssen, and Pfizer. Dr. Katz serves as a paid consultant to Endo Pharmaceuticals and Abbott Laboratories. Dr. Reuben's spouse serves as a paid consultant to Wyeth. Dr. Studenski serves as a paid consultant to Wyeth, Ortho Biotech, and Merck for disability and physical function and receives grants from Eli Lilly & Company for measurement of frailty and physical function. The John A. Hartford Foundation, Inc. and The Robert Wood Johnson Foundation provided support for the development of this report.

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