Proceedings and Recommendations of the 2007 Banff Conference on the Future of Geriatrics in Canada

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ABSTRACT

An invitational meeting on the future of geriatrics in Canada was held in Banff, Alberta, on the 19th of April 2007. The purpose of the meeting was to examine the challenges facing the field and explore potential strategies for overcoming them. Participants agreed on eight recommendations for moving geriatrics forward in our country: (1) a national coalition should be established for raising the profile of aging and improving its image; (2) the Canadian Geriatrics Society (CGS) should strike a working group to develop a document identifying what distinguishes geriatricians from other physicians; (3) geriatricians need to join those committees and organizations both within and outside government where funding decisions are made; (4) CGS should determine by appropriate methods what best practices in Canada are for specialized geriatric services and the management of common clinical challenges encountered in older patients such as delirium and falls; (5) CGS should determine by appropriate methods which health outcomes are relevant to the care of older patients and sensitive to the impact of specialized geriatric services; (6) while continuing to allow entry for those with an internal medicine background into subspecialty training in geriatric medicine, the addition of other entry routes into geriatric medicine training programs should be explored; (7) a meeting of the Royal College of Physicians and Surgeons of Canada Specialty Committee in Geriatric Medicine and the College of Family Physicians of Canada Care of Elderly Committee should be held to explore areas of common interest in the education of physicians with additional training in geriatrics; and (8) CGS should review its current expenditures on education and examine their effectiveness. Based on this review, CGS should develop and implement a long-term educational strategy that would include mechanisms to evaluate its effectiveness in promoting recruitment into geriatrics.

Key words: geriatrics, geriatric medicine, health manpower, health services for the aged

On April 19, 2007, 39 administrators, family physicians (many with care-of-the-elderly training), geriatric psychiatrists and postgraduate trainees and specialists in geriatric medicine (see the Acknowledgements for a listing of their names) met to discuss the future of geriatrics in Canada. The meeting was precipitated by three concerns:

1. Recruitment into care-of-the-elderly and geriatric medicine training programs has been poor over the past decade (it is harder to get information on geriatric psychiatry because this is not a recognized subspecialty of psychiatry in Canada):
   • In 2006–2007, there were 10 care-of-the-elderly trainees (compared with 90 in emergency medicine) (Table 1A).
   • In the 2007 internal medicine R4 match, four trainees (including one at McGill) chose a training program in geriatric medicine. In addition, there were three new francophone residents in Quebec (one at Laval and two at Université de Montréal) starting training in July 2007.
   • In 2006–2007, there were a national total of 19 trainees enrolled in the 2-year geriatric medicine training program (Table 1B).
   • The number of trainees in geriatric medicine peaked in 1997 at 39; while geriatric medicine has experienced approximately a 50% drop since then, the total number of postgraduate trainees has gone up about 70% (i.e., the number of ministry-funded positions increased from 6,490 in 1997 to 11,195 in 2005).
The National Advisory Council on Aging (NACA) in its 2003 Interim Report Card and its 2006 Report Card commented on the low number of geriatricians. (Note: On March 5, 2007, the creation of a National Seniors Council that will advise the government on seniors’ issues of national importance was announced.)

2. There is a current need for our services that cannot be fully meet; this need/service gap will worsen as the Canadian population ages and increasing numbers of practising geriatricians retire if recruitment into the field remains poor. We cannot do everything we might want to do. Difficult decisions will have to be made as to what can and cannot be done.

3. The health care system is evolving with the creation of different models of health care delivery and advances in technology. Specialty medicine is at a crossroads—it has to align itself with the 21st century. Do we have the right form and function for the future?

The preceding concerns about geriatrics are not new and have been discussed previously. To date, though, there is the sense that effective action has so far eluded us.

The attendees were a group of individuals committed to the care of older Canadians. The conference was an oasis of time allowing them the opportunity to discuss a complex and ultimately unknowable issue—the future of Canadian geriatrics. They took this time to reflect on what individually and collectively could be done to influence the forces framing this future so that it will be better for Canada, for older Canadians, and for those caring for them. The focus of the meeting was on internists, family physicians, and psychiatrists with additional training in the care of older patients.

**Background**

The meeting was funded by the Brenda Strafford Foundation.

**Table 1B. Data Derived from Canadian Post-M.D. Education Registry—Annual Census of Post-M.D. Trainees**

| Medical Subspecialties: Number of Trainees Enrolled in Subspecialty Training Programs |
|---|---|---|---|
| Year | Geriatric Medicine | Cardiology | Rheumatology | Rank* |
| 1988–1989 | 19 | 122 | 43 | 10 |
| 1989–1990 | 29 | 114 | 33 | 7 |
| 1992–1993 | 26 | 135 | 35 | 10 |
| 1993–1994 | 27 | 134 | 32 | 10 |
| 1994–1995 | 23 | 130 | 32 | 10 |
| 1995–1996 | 24 | 143 | 33 | 10 |
| 1996–1997 | 29 | 155 | 27 | 9 |
| 1998–1999 | 28 | 161 | 43 | 9 |
| 1999–2000 | 29 | 194 | 39 | 10 |
| 2000–2001 | 25 | 207 | 29 | 10 |
| 2001–2002 | 23 | 234 | 24 | 11 |
| 2002–2003 | 24 | 231 | 35 | 11 |
| 2003–2004 | 15 | 254 | 34 | 11 |
| 2004–2005 | 15 | 266 | 39 | 11 |
| 2005–2006 | 15 | 273 | 41 | 11 |
| 2006–2007 | 19 | 306 | 40 | 11 |

*Rank (most = 1, least = 13) of geriatric medicine in the total number of trainees out of the following internal medicine subspecialties (listed alphabetically): cardiology, clinical immunology/allergy, clinical pharmacology, critical care, endocrinology/metabolism, gastroenterology, geriatric medicine, hematology, infectious diseases, medical oncology, nephrology, respiratory medicine, and rheumatology.
Chair in Geriatric Medicine at the University of Calgary. Invited attendees had aportion of their expenses covered, but no honoraria were provided. To promote attendance, the meeting took place the day before the start of the 2007 Annual Scientific Meeting of the Canadian Geriatrics Society (CGS) and at the same location. The number invited was limited by the desire to ensure an interactive meeting with ample opportunity for open discussion, the size of the meeting room, and the realities of our available budget. There were many other potential participants of equal worth who could have been invited. Attendees included trainees, practising physicians, members of the Council of the CGS, and those who held leadership roles within either training programs or services targeted to older Canadians. The organizer of the meeting (D.H.) consulted with colleagues on who should be invited and approached those identified. An attempt was made to ensure representation from all regions of the country and the three options for additional training in the care of older Canadians. A list of those who accepted the invitation and/or attended the meeting can be found at the end of the article.

Prior to the meeting, those who agreed to attend were asked to complete a questionnaire (see Appendix 1 for a copy of the questionnaire). Respondents were asked if they saw geriatric practice as primary medical care (i.e., first-contact care for older persons with any undiagnosed sign, symptom, or health concern; comprehensive care for the older person that is not organ or problem specific; longitudinal or continuous care for the older patient; and, that responsible for coordinating other health services as they relate to the older patient’s care) for all seniors or a subgroup of older Canadians. If a subgroup, respondents were challenged to describe them. Alternatively, did they feel geriatricians should function as consultants (i.e., an individual to whom one refers for expert advice or services)? Respondents were asked if geriatrics should be a widely available field of clinical practice or whether it should be predominantly an academic specialty. They were requested to comment on the current organization for additional postgraduate training in the care of older individuals with three separate options. The questionnaire was developed by the organizer of the meeting (D.H.). Because of time constraints, it was not pilot tested. Twenty-eight of the 35 sent the questionnaire (80%) completed it. The responses received were collated, summarized, and presented to the attendees at the start of the meeting.

The format used for the meeting was a series of short presentations to provoke debate followed by time for open discussion. Overviews of the current status of care of the elderly (Chris Frank), geriatric medicine (D.H.), and geriatric psychiatry (David Conn) were provided. This led into a general discussion about what should be (and can be, in light of limited physician resources) the principal roles and responsibilities of Canadian geriatricians. (In this article, the term geriatrician is used in an inclusive manner and includes all physicians with additional training in the care of older patients.) Ken Rockwood presented his personal view on the preceding topic. Laura Diachun then reviewed what medical students and residents find attractive about geriatrics. This led into a discussion about how to improve recruitment into the field. Though of critical importance, because of time constraints the group did not have a detailed discussion about the general education of family physicians, specialists, subspecialists, and other health care workers in the principles of good geriatric practice.

Attendees were then divided into working groups and asked to develop a series of specific, high-priority recommendations that would help the field in attaining its desired future. They were told that they should be clear on what should be done, who should do it, and by when. The working groups dealt with (1) how to enhance the image of the field, (2) how to improve rewards for practitioners, (3) how to improve service delivery, and (4) what should be done with postgraduate education. These recommendations were then presented to the entire group for discussion, clarification, and ratification.

Results of the Questionnaire

Twenty-one of respondents (75%) agreed with the definition of geriatrics found at Wikipedia, that is, “Geriatrics is the branch of medicine that focuses on health promotion and the prevention and treatment of disease and disability in later life.” The most common concern raised about this definition was that current practitioners are not engaged in health promotion. The most common suggested addition was emphasizing the management of frailty. A variety of responses were given to the second question about the principal roles and responsibilities of Canadian geriatricians. Clinical roles (n = 35) were noted most often followed by those dealing with education (21), research (12), administration/policy development (7), and advocacy for seniors and their care (7). Please see Table 2 for a list of potential roles and those most favoured by respondents. The overwhelming majority (26/28; 93%) did not see geriatricians being responsible for the primary medical care of all seniors. While 16 (57%) did not believe that geriatricians should provide primary medical care to even a subgroup of seniors, 12 (43%) did. The subgroups identified were those with complex issues, cognitive impairment, disability, and/or frailty. Eighteen (64%) felt geriatricians should restrict their clinical activities to consultation. Most (76%) felt that geriatrics should be both an academic and a widely available clinical field, but concern was expressed about the feasibility of this desire in light of the small number of practitioners. Twenty-five (89%) saw a distinction between those trained in care of the elderly and geriatric medicine with 19 (68%) feeling we should continue having these two training options.

Summary of Presentations

Approximately 130 family physicians have taken either a 6- (55%) or 12-month (45%) residency in care of the elderly...
Table 2. Potential Roles for Physicians with Additional Training in the Care of Older Patients*

A. Advocacy for older persons and their care

B. Clinical service
   i. Health promotion/disease prevention
   ii. Primary medical care of all older patients
   iii. Primary medical care and/or consulting services for the following:
       1. Older patients with complex health needs (e.g., older patients with multiple chronic medical conditions, those requiring interdisciplinary/multidisciplinary care and/or frail seniors)
       2. Older patients with disabilities: (a) geriatric rehabilitation (e.g., orthogeriatric services) and (b) older patients requiring continuing care services (i.e., assessing care needs, care coordination, and/or medical care of older patients in supportive housing such as assisted living or long-term care)
       3. Older patients with an acute illness (i.e., working on acute care of the elderly units, providing emergency health services, and/or delivery of other acute care services)
       4. Select problems/conditions that have particular relevance to older people (e.g., delirium, dementia, falls, impaired mobility, incontinence)
       5. End-of-life care

C. Development of health policy and medical administration
   i. Policy and system development
   ii. Program leadership/administration (e.g., program development, program evaluation, and/or medical administration such as working as a medical director of a continuing care facility/agency)
   iii. Guideline development

D. Academic activities
   i. Education
      1. Medical (both general medical education and postgraduate education of physicians acquiring additional training in the care of older patients)
      2. Other health care providers
      3. Older individuals and their caregivers
      4. General public
   ii. Research relevant to aging
      1. Biomedical
      2. Clinical
      3. Health system and service
      4. Population and public health
      5. Knowledge translation

*Bolded areas are those that received the most support from respondents to the questionnaire.
Geriatric medicine is the branch of specialty practice concerned with the prevention, diagnosis, treatment, and remedial and social aspects of illness in older people. Currently, entry into geriatric medicine training programs is limited to those with prior training in internal medicine and other specialties, but the Council of the RCPSC decided to limit the field to those with internal medicine training. The Canadian Medical Association Committee on the Health Care of the Elderly in 1987 recommended that geriatric medicine become a primary specialty and that the two national colleges should work out a mechanism to recognize CFPC training as part of the requirements for RCPSC certification in geriatric medicine. Nothing came of this. At the time of the creation of the subspecialty, it was anticipated that geriatric medicine would be an academic field with only two to four physicians per academic health centre. The specialty evolved beyond this constrained role and became a field concerned with the care of frail seniors. The 2004 National Physician Survey provides detailed information on their current practice. In 2007, there are a total of 211 specialists in geriatric medicine.

Geriatric psychiatry has a long history in our country. Like care of the elderly and geriatric medicine, the field has limited physician resources. The 200 members of the Canadian Academy of Geriatric Psychiatry (CAGP) represent less than 5% of the 4,131 psychiatrists in Canada. A survey of academic centres found that over the past 3 years, a total of 22 fellows have been trained in geriatric psychiatry. There are international standards for the organization of mental health services in the care of older persons that can be used as a benchmark. Among geriatric psychiatrists, the relationship between geriatric medicine and geriatric psychiatry is perceived as a positive one. A useful set of recommendations from Australia and New Zealand for these relationships is available. CGS has been a partner in the CAGP-initiated national coalition on seniors’ mental health (i.e., Canadian Coalition for Seniors’ Mental Health or CCSMH). Key issues for the field over the coming years would include improving recruitment, obtaining subspecialty recognition from the RCPSC (96% of our questionnaire respondents were in favour of this), and obtaining adequate funding for service development. All three are conditional on effective advocacy and collaboration at all levels. Building on the success of the CCSMH, David Conn raised the possibility of a new coalition for seniors’ health.

The number of trainees in care-of-the-elderly and geriatric medicine programs has dropped both in absolute and relative terms over the past 10 years (see Tables 1A and 1B). To deal with this decline, we need to understand what factors have led to it. The underlying reasons are complex but would include the decline in the number of undergraduate medical students during the 1990s, increasing medical school debt, the perception that all fields of medical practice are facing deficiencies, and the sense that there is nothing unique about the medical care of older persons.

In 1992, the Federal/Provincial/Territorial Conference of Deputy Ministers of Health decided to partially implement the recommendations of the Barer-Stoddart Report. This led to a cut in first-year medical school admissions. Enrolment went from 1,894 in 1980–1981 to a low of 1,577 in 1997–1998. It took 5–10 years for these cuts to begin having an impact on the physician workforce as this was when the first graduates from the reduced-sized schools completed their postgraduate training. Declines in the total number of Canadian trainees exiting specialty programs began in 2002. If spread equally across all postgraduate training options, this should have had a minor impact; but the dropping number of residents led to more competition for them. Less attractive fields were at risk for disproportionate losses.

Financial considerations have become more important in...
the specialty choices of students. During the latter part of the 1990s, tuition more than doubled at Ontario medical schools (e.g., at the University of Toronto tuition went from $4,844 in 1997–1998 to $14,000 in 2000–2001). A survey comparing medical students who entered in 1997 (fourth-year students) with those who began their studies in 1998, 1999, and 2000 (first-year students) found that the expected debt of students at graduation climbed from $57,000 to $80,000 (the proportion who expected a debt load of $100,000 or more doubled). First-year compared with fourth-year students were more likely to cite financial considerations as having a major influence on specialty choice. Approximately a quarter (25.4%) of first-year students felt that financial considerations would be a major influence on their choice of a specialty, compared with 13.3% of fourth-year students. Lower levels of reimbursement have been a long-standing barrier to the growth of geriatrics.

Over a short period of time, we have gone from a perceived glut of physicians to what is felt to be an alarming shortage. In 1982, the Federal/Provincial Committee on Manpower estimated that there would be an overall surplus of 6,000 physicians by the year 2000. As recently as 1997, it was predicted that trainees in radiation oncology would be in unemployment lines. Less than 10 years later, it was being said that the “growing shortage of physicians in Canada is a matter of public record,” extending across the whole profession—from pediatrics to anesthesiology, urology, and dermatology. When the market for physician jobs was felt to be tight, students and residents did consider to a greater extent the anticipated need for specialties and subspecialties when making career choices. This changed when we moved from a perceived surplus to widespread shortages. Canadian Resident Matching Service surveys of graduating classes during the 1990s showed significant drops in the proportion of graduating students who said they wanted more information on job opportunities (from 54% in 1996 to 34% in 1999) and physician resource planning (from 32% in 1996 to 14% in 1999).

The postgraduate training system became more akin to a free market as limitations on the number of training positions for popular specialties and subspecialties relaxed. For example, in 1997–1998, there were 148 trainees in cardiology. By 2006–2007, the number of trainees had more than doubled to 306.

Partly in response to irresponsible alarmist declarations of prior years, it has been argued that the aging of the Canadian population will pose “no threat of shortage to the Canadian physician supply in general.” In fact, it was later claimed that “as a result of population change alone [author’s emphasis], overall requirements are likely to increase by less in the future than in the past.” Little attention was paid to aging in the final reports of the Senate Committee on Health Care (chaired by Michael Kirby) and the Romanow Commission on the Future of Health Care in Canada. While these articles and reports did not specifically address the resource requirement for physicians with additional training in geriatrics, they did feed into a sense among a wide range of stakeholders that there was not a need for physicians to take a different approach to the care of the growing number of older Canadians. At least with regard to geriatric medicine, Canadian program directors in internal medicine have felt that there is nothing unique about the field and that rotations on clinical teaching units would provide trainees “ample time to become fully familiar with illnesses presenting in the elderly.” There is a sense that because “the majority of hospital patients are old” trainees will “absorb what they need to know by osmosis.” Other internal medicine subspecialties do not encounter this: while “all patients have hearts … that doesn’t make all doctors cardiologists.”

Rotations in geriatric medicine are still not a mandatory requirement for Canadian internal medicine training programs.

To counteract these factors, we should support the growth of medical school enrolment, look at ways to deal with the financial concerns of medical students and residents, explain in a responsible manner why the aging of Canadian society must lead to changes in the health care system, make a compelling case why our physician resource issues are particularly pressing, support a controlled postgraduate training market with the allocation of training positions based on societal need, and do a better job of explaining to educators and others what we do that is unique and important.

Four occupational groups that provide a large part of the consultation service offered to older persons are general internists, care-of-the-elderly physicians, geriatric psychiatrists, and specialists in geriatric medicine. They present a range of talents. General internists are highly visible to medical students and residents. They work very hard and are comfortable with a broad range of illness, multi-morbidity/comorbidity, and the acutely ill. They frequently function as medical leaders. Core skills of care-of-the-elderly physicians include their ability to work well in teams, comfort with the social aspects of illness, confidence in their dealings with their family physician peers, and ability to skillfully deal with a number of the common clinical challenges encountered in older patients. Geriatric psychiatrists are knowledgeable about dementia and the range of psychiatric conditions encountered in older patients. They are adept at working within the health care system and have experience in working outside acute care hospitals. As a group, they are skilled in influencing public policy and playing an advocacy role. Specialists in geriatric medicine combine a number of the previously listed attributes—visibility to students/residents, skills in the management of a range of relevant conditions, the ability to deal with acutely ill patients, an understanding of cognitive impairment, experience in working with multidisciplinary/interdisciplinary teams, comfort working within and outside acute care hospitals, and a willingness to both lead and advocate for their field of practice. To deal with the challenges facing us, we need to understand how best to meld these skills together and/or work constructively
together. As a group, we must know where we want to go and put our house in order. We will have to advocate for what we believe in tirelessly, shamelessly, relentlessly, strategically, and with competence and confidence. Spontaneous creation of the required elements for our desired future will not occur, but spontaneous combustion of our hopes might.

The Geriatric Recruitment Issues Study (GRIST) did inform us on how “converts” and potential recruits view the field of geriatric medicine. Those in the field like the type of patients seen and the opportunities for an academic practice and a family life. They often identified exposure to a positive role model as an early motivation. They enjoy intellectual challenge, complexity, team care, the focus on the whole person, and the sense that they are making a difference. Medical students and residents found the perceived lifestyle and the image of the subspecialty as attractive. An obvious message in the effort to improve recruitment is to emphasize the favourable lifestyle aspects of the field and promote its status. Practitioners need to be positive role models for students and residents. They will have to work on improving remuneration and job security, while reaching out to students and trainees. Unfortunately, entering medical students have a limited interest in geriatrics, and this appears to drop over their time in school. Increasing early, ongoing, and meaningful exposure to positive learning experiences in geriatrics would be a way to hopefully awaken interest and counteract its decline. An example of this is contained in correspondence from a geriatrician: “You don’t miss what you don’t know. The only reason I went into geriatrics is that at U of T I had a mandatory rotation. I went in thinking it would be utterly useless and boring (pee and vitamins, to paraphrase South Park), met Gary Naglie and Barry Goldlist, and the rest is history. No amount of preaching or Goldlist, and the rest is history. No amount of preaching or information sessions will replace getting your ‘hands dirty’ and seeing how you can transform someone others refer to as a ‘train wreck’ into an active member of the retirement community” (personal communication).

Working Groups
Attendees were divided into working groups and charged with the responsibility of coming up with one or more practical recommendations to deal with the challenges facing geriatrics in recruitment and in the allocation of our limited resources (Tables 3 and 4). These recommendations were to be directed to a specific person or organization; if not, much like a tree falling in the woods with no one around to hear it, it would be doubtful that they would be heard and have any meaningful impact.

Image of the Field
Ageism is prejudice based on age. Older Canadians have long encountered this form of bigotry, and a recent study sadly found that they encountered it more frequently than older Americans. Ageism can be encountered among medical students, residents, and practising physicians. The medical school experience can have a negative impact on attitudes toward caring for older patients.

Other physicians can be quite negative about geriatrics and geriatricians. In correspondence, a retired geriatrician commented on the “apathy (if not hostility) within the general medical community” that he encountered during his career (personal communication). Physicians outside the field incorrectly perceive it as a depressing field of practice. The 2004 National Physician Survey found that geriatricians were the second most satisfied group of doctors, while an American study found that physicians in geriatrics were more than twice as likely as family physicians to be very satisfied with their careers. When the RCPSC recognized geriatric medicine as a subspecialty, the Specialty Committee in Internal Medicine twice (1978 and 1979) passed motions deplored this decision. At the time, geriatrics was felt to be most advanced in the United Kingdom, but members of the Specialty Committee described British geriatricians as “curators of parking lots,” with geriatrics called “the refuge for failed internists.” It was claimed that “the elderly [in the United Kingdom] receive very indifferent care.” They declared that the field possessed no specific knowledge base and that advances in the study of aging came from clinicians and scientists in other fields. It was felt that “geriatric practice can be very depressing, and that physicians are more likely to perform well with a broad spectrum of patients.” Medical students and postgraduate trainees with an interest in geriatrics still experience active discouragement from peers and faculty. Even without such overt action, negative stereotyping of older persons and the field of geriatrics

Table 3. Key Challenges Facing Canadian Geriatrics in Improving Recruitment

| 1. Ageism and the low prestige in which the field is held by other physicians |
| 2. Poor remuneration/financial disincentives |
| 3. Difficulty in defining the field and the complexity of the training options |
| 4. Insufficient availability of funded staff positions and challenges in obtaining the required infrastructure and/or system support (e.g., interdisciplinary team) required for graduates of geriatric training programs to do what they have been trained to do |
| 5. Failure to mobilize public support (i.e., the general public has told there is a crisis in every medical field and have not been convinced that there is something pressing and unique about our crisis) |
1. Combat "ageism"
   A. Speak out against it
   B. Make partnerships with other professional and lay organizations to promote a positive message
   C. Develop and obtain funding for a media campaign
   D. Identify, recruit, and support champions/celebrities to promote the positive message

2. Market the field more effectively and raise its profile
   A. Are we using the right term? There is a negative response to terms like geriatrics and frailty
   B. Clarify the role of a geriatrician ("brand recognition")
   C. Make the case that geriatricians are "value added"
   D. Document the gap between need and current physician resources better
      i. Develop a detailed physician human resource plan
      ii. Lobby to have the allocation of postgraduate positions linked to societal need
   E. Increase research funding—as a secondary outcome, it would raise the profile of geriatrics in the academic community

3. Improve remuneration and other rewards
   A. Loan forgiveness for residents who go into geriatrics
   B. Better pay for geriatricians
   C. Financial support for advanced fellowships to train geriatricians to become leaders in research, education, and administration
   D. Career development awards
   E. Enhanced nonfinancial rewards (e.g., professional recognition; acknowledging equally all aspects of the work—time spent on teaching, research and/or leadership-administration would be considered equivalent to that spent on clinical activities; balanced lifestyle; work flexibility; spousal employment opportunities; educational opportunities for family members; cultural/recreation/religious activities; community orientation and involvement; funding for locums/sabbaticals; assistance with practice establishment costs; vacation/educational leave)

4. Medical education
   A. "Gerontologize" the profession—all physicians with a few exceptions (e.g., pediatricians) must attain the required attitudes, knowledge, and skills to deal with older patients in a caring and competent manner
   B. Actively recruit medical students/residents into geriatrics
      i. CGS should strike a resident recruitment work group
      ii. Promote positive personal and professional aspects of the field
      iii. Provide mentoring opportunities
      iv. Make geriatric exposure mandatory
      v. Develop local journal clubs and interests groups
      vi. Subsidize attendance of students and trainees at national meetings
   C. Flexible training
      i. Open up a variety of entry routes into subspecialty training
      ii. Facilitate changes in careers during postgraduate training
      iii. Facilitate the recruitment of international medical graduates
      iv. Facilitate the retraining of mid-career physicians
      v. Look at innovative approaches to postgraduate training: (a) dual fellowships and (b) "focus" or "interest" training programs
   D. Secure additional sources of funding for postgraduate positions
   E. Develop more continuing medical education/continuing professional development opportunities in geriatrics

5. Medical practice
   A. Enhance effectiveness/efficiency
      i. Explore different models of care (e.g., shared care)
      ii. Promote interdisciplinary collaborative practice
      iii. Ensure the required infrastructure and support are provided
   B. "Inoculate" protocols, guidelines, and quality improvement initiatives with geriatric principles

Table 4. Strategies Proposed to Address the Shortfall in Physician Resources
creates barriers to recruitment and having all physicians embrace the principles of good geriatric care.

Seniors themselves have reservations about the terms used to describe what we do. For example, a cross-sectional survey of 107 seniors (60+ years of age) living independently in a high-density apartment complex and 20 inpatients on a geriatric rehabilitation unit (GRU) found that seniors and senior citizens were the terms they preferred (mean score 4.81 and 4.51, respectively, on a six-point Likert scale from 1 [totally unacceptable] to 6 [prefer it]) while the least liked was geriatrics (mean score 1.86).38

The working group agreed that a positive message about aging is necessary. Terms such as vitality, aging better, and independence should be used while words like frailty, geriatrics, and dementia should be avoided. A broadly based coalition with communication, financial, and other expertise is needed to carry this positive message forward. The establishment of a foundation could help in ensuring ongoing funding for its activities. Funding sources could include insurance and financial companies, which have an obvious interest in the well-being of seniors, and there was discussion about the potential role of the pharmaceutical industry. The CCSMH could act as an organizational model. Older persons have to be involved in a meaningful way. Colin Powell reported on how the Council of Reference in Halifax (a group of vocal, committed, and influential seniors) successfully advocated for health care improvements in local institutions. Identifying high-profile and respected individuals willing to be spokespersons was seen as important.

**Recommendation 1:** A national coalition should be established for raising the profile of aging and improving its image. CGS, CAGP, and Canada’s Association for the Fifty-Plus should be approached to provide leadership and support to the initiative. It was felt that 1 year would be required to organize and plan the coalition. With the help of a professional marketing firm, a national communication strategy to improve the image of aging and the care of older persons would be developed. Implementation would require 3–5 years.

**Rewards for Practitioners**

Poor remuneration is seen as a major barrier to increasing recruitment. In correspondence leading up to this meeting, this was the most common issue raised, for example, “the financial disincentives”; “there are five reasons recruitment is poor—$, $, $, $, and $”; “Lack of money…Had (yet) another student come up to me to express interest in geriatrics yet [had] concerns over debt load—if it’s a recurring theme no one seems to want to admit to” (personal communications). As has been pointed out, “Residents follow the money.”28

A better job in defining the field of practice and what it has to offer is needed to justify greater financial rewards. Geriatrics, though, is not a precisely defined field. It is not organ based, has no striking distinguishing feature or technique (e.g., like surgery), and there is no agreement on the age above which you become “geriatric.” What is a geriatrician worth? At the present time, there isn’t a good answer to that question. Current incomes vary considerably depending on factors such as how physicians are paid (e.g., fee for service, alternate payment plans) and what else the physician might be doing, such as family medicine, general internal medicine, and general psychiatry. Those spending more time in better-paying areas of practice may have higher personal incomes but at the cost of doing less geriatrics. To achieve higher levels of remuneration, decision makers within government and medical organizations will have to be convinced that this is appropriate. The value of what we do is not currently recognized by them. What would make someone want to pay more for a geriatrician? A convincing response to this question will have to be crafted with a business case developed around the answer.

Different ways might be used to increase income. For example, mandatory evaluations by geriatric specialists at certain critical times (e.g., when older persons are being assessed for LTC) to identify and forestall problems could be put into place. There would have to be evidence that this is cost effective, and even then this may not be practical or saleable to others. Establishing a fee code that would reward those with additional training in geriatrics is no simple task and would require a sustained lobbying effort. Payment mechanisms other than fee for service may well have to be used.

There are other rewards that might help with recruitment. These could include the following:

- Student loan forgiveness
- Reimbursement of office and overhead expenses
- Infrastructure support (e.g., interdisciplinary team)
- Lifestyle (e.g., option for part-time employment and/or job sharing, hours of work, vacation time, opportunities for various types of leave)
- Compensation of aspects of work independent of the base salary (e.g., additional pay for on-call coverage, though a critical mass of participants would be needed to make this work)

**Recommendation 2:** CGS should strike a working group to develop a document identifying what distinguishes geriatricians from other physicians. This is to both describe what we do and the value we add to the health care system. This could then be used across the country to advocate for greater rewards for geriatric practitioners. Examples of similar documents would be the “Fact Sheet: The American Geriatrics Society (AGS)”39 and the Regional Geriatric Programs of Ontario “Fact Sheet: The Role and Value of Specialized Geriatric Services.”40 This should be done by the end of 2007.

**Recommendation 3:** Geriatricians need to join those committees and organizations, both within and outside government, where funding decisions are made. This is to ensure that the reward system is equitable to geriatricians. There may be a need to look outside of traditional funding systems (e.g.,
fee for service). While this recommendation is primarily directed at individuals working at regional and provincial levels, CGS could be an enabler by developing mechanisms to support those with an interest by linking them with potential mentors and colleagues, disseminating background material (e.g., salary ranges across the country), running professional development programs in medical administration, and otherwise supporting common strategies in this effort. The intent is to improve the financial position of all three training options, both clinicians and academics, and those in rural and urban practices.

Service Delivery
The group began by reviewing available models for geriatric services with the limited physician resources available. It is essential that the models of geriatric care utilized are effective and efficient. It is not currently well known which models of geriatric care are available in Canada, let alone which ones are the most effective and efficient. During discussions, it became apparent that what we are able to do is largely dependent on the control we have over our own pattern of practice and the availability of resources. Do we have the license to develop and the resources required to create geriatric rehabilitation units (GRUs), acute care of the elderly (ACE) units, geriatric day hospitals, ambulatory clinics, and outreach services? A major resource limitation is the availability of the interdisciplinary team members necessary to implement each of these service models.

Even within a particular type of service, implementation can vary significantly leading to quite different models of care. An example of this would be the way ACE units are structured in Vancouver compared with London, Ontario. In Vancouver, geriatricians are consultants to primary care physicians and internists who are the attending physicians for admitted patients. This ACE unit is linked to transition beds, allowing the transfer of patients requiring longer stays from the ACE unit. This ensures a continuous patient flow. In London, the geriatricians are the attending physicians and there is not the link to transition beds. These are clearly two quite different ACE models, and the outcomes seen might vary. The work demands on the geriatricians as well as the educational experience of learners would differ. There is great interest in determining how to optimally provide integrated, comprehensive, and LTC to seniors with complex needs. The newer models of community-based care have rarely been formally evaluated and have not become widely disseminated. The Edmonton CHOICE program is one such model. Programs with a similar mandate have been implemented elsewhere (e.g., C3 in Calgary and SIPA in Montreal), but it is not clear exactly how they may differ and whether they achieve similar outcomes. Key determinants of the effectiveness of comprehensive geriatric assessment (CGA) are control in implementing recommendations and providing extended follow-up. There is wide variability in how CGA services deal with these two issues. How does this influence their impact?

A very real challenge in Canada is balancing the growing need for specialized geriatric services with the limited resources available. How do we use consultant time most effectively to obtain the best outcomes for our patient populations? The group discussed working with nurse practitioners and other cross-trained interdisciplinary team members to extend the reach of geriatricians. The group deliberated about where to focus physician resources in regions with very constrained physician numbers such as Saskatchewan and Manitoba. Should inpatient units that are very resource intensive be closed and the focus placed on specialized geriatric services in the community to prevent acute care admission and/or permit an earlier hospital discharge?

How should we measure outcomes? The principles of senior-friendly hospitals are being implemented in Ottawa, and delirium-prevention protocols can be found in a number of Canadian and American hospitals. How do we measure the efficacy and efficiency of these approaches? Examining health determinants such as income levels, availability of transportation, and the presence of supportive housing/assisted living programs were discussed as ways to facilitate the comparison of the overall health of seniors in the different provinces. Within hospitals, indicators of good clinical practice could include delirium and fall rates. Over time, older inpatients seemed to be becoming more frail.

**Recommendation 4:** CGS should determine by appropriate methods which best practices in Canada are for (1) specialized geriatric services (e.g., CGA, GRUs, ACE units, integrated and comprehensive ambulatory care for older persons with complex needs); and (2) the management of common clinical challenges encountered in older patients such as delirium and falls.

**Recommendation 5:** CGS should determine by appropriate methods which health outcomes are relevant to the care of older patients and sensitive to the impact of specialized geriatric services. The Council of the CGS will have to decide how to move these recommendations forward. To accomplish these tasks, CGS will have to either hire an evaluator(s) on a contractual basis or hold a special funding competition with a national call for applications. We should do more than just list the types and locations of geriatric programs. We may opt to perform systematic reviews to develop evidence-based recommendations. The findings obtained should be presented at the 2009 CGS Annual Scientific Meeting in Toronto and possibly at the 2009 International Association of Gerontology meeting in Paris. As a starting point, CGS could begin with the collation of models of geriatric services described in the Regional Geriatric Programs of Ontario Handbook on Specialized Geriatric Services.

Postgraduate Education
A number of recommendations to further education in geriatrics have already been made and are included in Appendix 2.
There is a current shortage of physicians with additional training in geriatric medicine, and the number of trainees entering the field over the past decade has been inadequate to deal with the shortfall. The working group discussed the possibility of increasing routes of entry into specialty training in an attempt to attract more physicians into geriatrics. While the quality of the relationship between internal medicine and geriatric medicine may vary from centre to centre, it was felt that it remains generally beneficial for geriatric medicine to remain a subspecialty of internal medicine rather than becoming a primary specialty. While geriatric medicine and care-of-the-elderly are both well-established postgraduate training options, there is a degree of overlap between them. No formal communication to identify common interests between those responsible for these two training programs has occurred at a national level. Over the years, CGS has funded a variety of educational activities. The absolute and relative effectiveness of these investments are currently uncertain.

Recommendation 6: While continuing to allow entry for those with an internal medicine background into subspecialty training in geriatric medicine, the addition of other entry routes into geriatric medicine training programs should be explored. This recommendation will be communicated to the RCPSC Specialty Committee in Geriatric Medicine for information and, through them, dissemination to relevant parties within RCPSC. This will take place by the end of 2007.

Recommendation 7: A meeting of the RCPSC Specialty Committee in Geriatric Medicine and the CFPC Care of Elderly Committee should be held to explore areas of common interest in the education of physicians with additional training in geriatrics. Common core competencies as well as unique aspects of these training programs could be identified. This recommendation will be communicated to the two committees. The meeting should occur before or during the 2008 Annual Scientific Meeting of CGS.

Recommendation 8: CGS should review its current expenditures on education (e.g., Summer Institute, sponsorship of trainee members to attend the AGM) and examine their effectiveness. Based on this review, CGS should develop and implement a long-term educational strategy that would include mechanisms to evaluate its effectiveness in promoting recruitment into geriatrics. This might involve the hiring of an external consultant or holding a special funding competition.

Acknowledgements

Those who accepted the invitation and/or attended the meeting must be thanked for their contributions. They are (listed alphabetically) Nahid Azad, Andrew Baker, Jenny Basran, Marilyn Bater, Howard Bergman, Michael Borrie, Darren Burback, Jo-Anne Clarke, Adrienne Cohen, Scott Comeau, David Conn, William B. Dalziel, Laura Diachun, John Feightner, Chris Frank, Janet Gordon, David Hogan, Fatima Maryam Hussain, Angela Juby, John Kirk, Janet Kushner Kow, Chantal Kroon, Deviani Maher, Fred Mather, Mike McByryde, Peter McCracken, Janet McElhaney, José Morais, Chris Patterson, Colin Powell, Kiran Rabheru, Omar Rahaman, Ken Rockwood, Philip St. John, James Silvius, Chandrasekaran Sivakumar, Jean Triscott, Cornelia (Kristel) van Ineveld, and Roger Wong. Errors in relaying their thoughts are the sole responsibility of the author.

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2007 Banff Conference

Appendix 1: Questionnaire on the Future of Geriatrics

1. “Geriatrics is the branch of medicine that focuses on health promotion and the prevention and treatment of disease and disability in later life.”
   Do you agree with this definition of geriatrics?  
   Yes  
   No  
   If you responded “No”, what definition would you propose?  
   ______________________________________________________  
   ______________________________________________________

2. What should be the principal role(s) and responsibility(ies) of Canadian geriatricians (list up to three)?
   a.  
   b.  
   c.  

3. Do you see geriatric clinical practice as the primary medical care of seniors?  
   Yes  
   No  

4. Do you see geriatric clinical practice as the primary medical care of a subgroup of seniors?  
   Yes  
   No  
   If “Yes,” please describe/define the subgroup:  
   ______________________________________________________

5. Should geriatricians restrict their clinical activities to working as consultants?  
   Yes  
   No  

6. Should geriatrics be predominantly an academic field (i.e., teaching and research) or a widely available clinical one?
   Predominantly academic field?  
   Widely available clinical field?  

7. Do you see a clear distinction between CFPC care-of-the-elderly physicians and RCPSC geriatric medicine physicians?  
   Yes  
   No  
   If you responded “Yes,” please explain the distinction you see:  
   ______________________________________________________
   ______________________________________________________

8. Do you believe we should continue to have these two postgraduate training options (care of the elderly, geriatric medicine) or would you be in favour of a unified postgraduate training option with entry open to both trainees in family medicine and trainees in a specialty?
   Continue to have two training options?  
   Unified training option with more open entry?  

9. Are you in favour of recognizing geriatric psychiatry as a subspecialty of psychiatry?  
   Yes  
   No  

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Hogan
Appendix 2. Recent Recommendations for Education in Geriatrics

A. GENERAL EDUCATION OF PHYSICIANS IN THE CARE OF OLDER INDIVIDUALS

1. The educational needs of medical students in the care of older patients should be clearly defined. Although not to be used as a rigid template, the definition of core content for undergraduate medical students would be of use to both educators and students. Suggestions for a core undergraduate curriculum were made in 1977 and 1987 but require updating. In 1993, the Canadian Society of Geriatric Medicine (CSGM) recommended the development of national curricular objectives for each educational level, including the undergraduate.

2. Greater emphasis should be placed on gerontology and geriatric content within medical school curricula at all faculties of medicines in Canada. This recommendation was made in the Statement of Policy on Aging of the CMA (1965), the “Final Report of the Special Committee of the Senate on Aging” (1966), the Report of a Working Party Convened by the Health Standards and Consultants Directorate—Health Programs Branch (1977), and the General Counsel of the CMA (1986). The Association of Faculties of Medicine of Canada (AFMC) should be approached about setting standards for geriatric content and addressing the needs of older Canadians as part of their initiative in social accountability.

3. Canadian Faculties of Medicine should be surveyed to assess the gerontology and geriatric content in the undergraduate medical curricula and a mechanism to allow this to be periodically updated should be established. The gerontology and geriatric content was most recently examined for the 2004–2005 academic year (Can J Geriatrics 2006;9[Suppl 1]:S6–S11). Over 20 years ago, in 1993, CSGM recommended that a process to allow ongoing tracking of geriatric education be developed. Although the undergraduate geriatric content in medicine and pharmacy has been intermittently determined, no mechanism to ensure that it is done in an ongoing fashion has been put in place. This information should be made available to both medical education administrators and educators in each faculty.

4. Every faculty should ensure that identified educational needs are being addressed by well-designed programs that are continuously evaluated. A similar recommendation was made in 1993 by CSGM. Educational programs will have to be tailored to each faculty of medicine. Both “stand-alone” courses and integration of material within other educational offerings will be required to cover the recommended material. The American experience suggests that “lip service” frequently occurs with efforts to incorporate geriatric content within established educational offerings. A variety of curricular innovations in undergraduate geriatric education supported by the John A. Hartford Foundation were recently supported. A similar effort in Canada to improve teaching about the care of older people would pay large downstream dividends.

5. There should be more explicit coverage of geriatric topics by the objectives of the Medical Council of Canada (MCC) QE Parts I and II. Geriatric content on the MCC QE Parts I and II should be promoted. The current objectives for these examinations raise concerns about the adequacy of geriatric content on the examination. Examinations influence what students’ value, study, and learn. A similar recommendation was made in 1966 by the CMA Committee on Aging and in 1993 by CSGM.

6. There is a need to more thoroughly integrate geriatrics within specialty postgraduate medical education. CFPC has developed explicit educational expectations in geriatrics. Time is overdue in Canada for a similar effort to enhance training in the care of older patients by specialists and subspecialists. In 1987, a recommendation of the CMA Committee on the Health Care of the Elderly was that “All RCPSC-accredited Post Graduate Training Programs, except Pediatrics, should incorporate a period of training dedicated to geriatrics.”

7. Educational objectives in geriatrics for postgraduate trainees in specialties and subspecialties that deal with older patients should be defined by the relevant RCPSC specialty committees. They should be developed by multidisciplinary groups that must include specialists or subspecialists from the discipline in question. These identified objectives should be reflected in the training content requirements for the specialty or subspecialty.

8. Residency program committees should ensure that the objectives in the care of older patients are being dealt with by educationally sound experiences that are evaluated.

9. RCPSC examinations for specialties and subspecialties should include appropriate geriatric content. In the early 1980s, a review of the RCPSC examinations in internal medicine found that only 3.2% of the questions pertained to geriatrics. The current status of geriatric content in this examination and any other RCPSC examination is unknown.

10. CME/Continuing professional development in geriatrics must be encouraged. In 1987, the CMA Committee on the Health Care of the Elderly recommended that “Provincial Governments give high priority to funding appropriate continuing educational programs in geriatric medicine” and that “The Association of Canadian Medical Colleges [now the AFMC], individual Faculties of Medicine and other educational bodies continued to develop extensive continuing education programs related to geriatric medicine.” Academic CME units, the Canadian Academy of Geriatric Psychiatry (CAGP), and the Canadian Geriatrics Society (CGS) should be encouraged to develop attractive, evidence-based programs in geriatrics that use active learning methods. One option to ensure that practising physicians receive additional training in the care of older patients would be to seek a mandatory number of credits in...
Appendix 2 continued. Recent Recommendations for Education in Geriatrics

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geriatrics as a condition of licensure, membership, or privilege renewal. Although CME in general may become mandated for Canadian physicians, it is not likely that this will become an effective tool to enforce learning in geriatrics. It must be recognized that licensure, membership, and privileging all occur at different levels in the practice environment, with some being voluntary, some involuntary, and all managed by different organizations.

11. **Factors such as practice structure and remuneration must not function as a disincentive to the delivery of good care to older Canadians.** Not addressing these issues would undermine educational efforts to improve the care of older Canadians.

12. **CAGP and CGS should develop and/or maintain education committees and/or interest groups within their organizations.** These groups would allow members of the organizations to share information, advocate for improvements, and plan group initiatives.

13. **In light of the limited human resources, careful consideration is required in determining how to allocate, organize, and deploy these resources within faculties to have the maximum impact on education.** The report of the CMA Committee on the Health Care of the Elderly (1987) recommended “that medical schools develop administrative and educational models that formally incorporate the multidisciplinary nature of geriatric medicine.” The currently favoured model of divisions within Departments of Family Medicine, General Medicine, and/or Psychiatry does not easily allow for this. John C. Beck, writing about American geriatrics, noted that “the further and more intensive development of academic centres of geriatrics is linked to the decision to confer upon the field departmental or departmental equivalent (e.g., a clearly defined centre) status.”

14. **An immediate training priority is to build up the professoriate.** To deal with teaching and other requirements, a short-term priority must be increasing the number of academic physicians working in the field of aging.

**B. EDUCATION OF SPECIALISTS IN THE CARE OF OLDER INDIVIDUALS**

1. **CAGP and CAGP should take the lead in developing a detailed plan for physician human resources in geriatrics.** In 1987, the CMA Committee on the Health Care of the Elderly recommended that the National Committee of Physician Manpower should identify geriatrician supply as a priority and should bring together appropriate groups and individuals to plan for Canada’s future need for geriatricians. In 1993, CAGP made a similar suggestion. In its “Blueprint for Discovery” the association recommended that a “more scientifically based Canadian geriatric resource” plan be established. The physician human resource needs should be expressed in full-time equivalents (FTEs), and the influence of the functional specialty of individual physicians, work organization and conditions, recruitment and retention, and new models of care will need careful study. This will require clarification of the scope of practice for each of the three training options in geriatrics. Even before the development of a detailed physician human resource plan, we feel that we should do the following:

   a. **Establish targets for recruiting trainees into the care of the elderly, geriatric medicine and geriatric psychiatry.** A multifaceted recruitment strategy will have to be developed. Although the exact number required will be based on the physician human resource plan, we are confident in saying that there is a need for more physicians with additional training in the care of older patients. CAGP and CGS can provide national leadership, but local initiatives will have to be undertaken. We will have to “think globally, act locally.” We must come together to develop common positions, strategies, resources, and approaches, but we will have to work hard to improve things in our own backyards. Nationally accepted ideas will have to be modified for local circumstances and translated into action. If the sociodemographics, personality, and attitudinal factors that predispose medical students to choose geriatrics could be accurately identified, it might be possible to use these data to lobby for changes in medical school admission policies to increase the pool of students likely to choose the field. Exposure to students and residents is of vital importance. During undergraduate and postgraduate medical education, learners with an active or potential interest in geriatrics should be identified. This interest should be maintained and fostered during their medical education. This would include looking at incentives/disincentives that arise from the undergraduate education system, interpersonal factors, the role of experiences and achievements, and the postgraduate education system. Some physicians have stated that summer student projects and attendance at summer institutes played a pivotal role in choosing geriatrics. Other subspecialties of internal medicine have developed national programs for internal medicine trainees where each Canadian faculty with a training program invites two internal medicine trainees to a yearly 1-week program held at the same time as the national meeting of the subspecialty. As a small step in this area, CGS now waives registration fees for trainees at its annual general meeting, but we will have to do more. Although post-training barriers to recruitment, such as the level of remuneration and/or job opportunities, will have to be identified and modified if possible, a positive case for additional training in the care of older patients will have to be made.

   b. **Support having the allocation of postgraduate positions to the subspecialties of medicines based on provincial, regional, and national physician workforce needs.** In internal medicine, the current allocation of subspecialty physicians does not reflect physician workforce needs. We feel this situation must change.
Appendix 2 continued. Recent Recommendations for Education in Geriatrics

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<th>C. RECOMMENDATIONS FOR IMPROVING RECRUITMENT TO CANADIAN TRAINING PROGRAMS IN GERIATRIC MEDICINE</th>
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<tr>
<td>1. In formulating an effective geriatric medicine recruitment initiative, consider feedback from both the “converted” (geriatric medicine trainees and geriatricians) and the “not-yet converted” (residents and medical students).</td>
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<td>2. Implement and integrate local, provincial, and national mentorship programs to best use the influence of effective role modelling.</td>
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<td>3. Implement local, provincial, and national advocacy campaigns to increase undergraduate exposure to geriatric medicine and the care of older people.</td>
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<td>4. Implement student incentive programs similar to rural or northern medicine recruitment initiatives to increase attractiveness of geriatric medicine as a career choice.</td>
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<td>5. Consider decreasing the duration of geriatric medicine training to increase the appeal of the specialty to Canadian medical students and residents and increasing training opportunities in geriatric medicine to international medical graduates.</td>
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<td>6. Initiate recruitment campaigning by national medical organizations (Canadian Medical Association, Royal College of Physicians and Surgeons of Canada) at all educational levels, which simultaneously highlights the need for geriatricians and available training positions.</td>
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- Consider nontraditional ways of increasing physician resources, such as offering reentry positions and alternative certification. In 1993, it was suggested that we do what we can to facilitate the “refocusing of interested clinicians in other specialties to the field of aging.” In many provinces, the terms of reentry physicians make it financially, professionally, and personally difficult for physicians to leave their practices for further training.

- Examine the current organization of the various options for additional training in the care of older patients. For example, should we be looking at a common training program for care of the elderly and geriatric medicine? The CMA Committee on the Health Care of the Elderly recommended that geriatric medicine become a primary specialty for certification by RCPSC and that the two national colleges establish a mutually acceptable formula to recognize training accredited by CFPC as part of the requirements for Royal College certification in geriatric medicine. It must be recognized that there are potential advantages and disadvantages to changing the status quo. We feel that it may mean the reestablishment of geriatrics as a more powerful, attractive field of practice that can recruit from a larger pool of trainees.

- CAGP and CGS should develop and/or maintain educational committees and/or interest groups within their organizations. These groups would allow members of the organizations to share information, advocate for improvements, and plan group initiatives. An example of a topic for sharing information would be the exploration of why Quebec has done relatively better than the rest of the country in attracting trainees in geriatric medicine. Is it because of the mandatory 1-month rotation for third-year medical students in acute care settings? The more controlled postgraduate training environment? Exposure to role models? Something else? CGS is in the process of doing this.

- RCPSC should be lobbied to grant recognition to geriatric psychiatry as a subspecialty of psychiatry. RCPSC is currently considering a submission from the Canadian Psychiatric Association requesting recognition of geriatric psychiatry.

- Care-of-the-elderly, geriatric medicine, and geriatric psychiatry graduates should be surveyed to find out what they are doing and to receive feedback on their educational experiences. A particular challenge in doing this is identifying care-of-the-elderly trainees. Currently identifying physicians who have taken accredited training is difficult, even through the individual training programs. Without knowing where care-of-the-elderly trainees practice and what they do, it is difficult to make accurate human resource plans. The CFPC should keep an updated list of names and addresses of physicians with care-of-the-elderly training that can be used to obtain outcome data on the graduates of this program.

- Support from senior groups, other health care professionals, and the general public should be sought in trying to bring our case to the attention of medical education decision makers. It is the impression of many that the general public has gone further than the medical profession in overcoming ageism, though there is some evidence that older Canadians experience ageism more often than older Americans. When those outside of medicine are told of small members of physicians entering training in geriatrics in the face of the aging of Canadian society they are universally surprised. Since older Canadians are the consumers of the care we provide and the general public has to foot the bill, their input should be solicited and listened to. The experience of palliative care in Canada may be instructive. Senator Sharon Carstairs became a strong, visible advocate for improving end-of-life care in our country. This has been associated with a significant increase in public awareness, policy changes (e.g., improved access to compassionate leave for caregivers), enhanced clinical services, and initiatives to improve palliative care education for undergraduate students and postgraduate trainees.

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