

Geriatrics Training in General Internal Medicine Fellowship Programs: Current Practice, Barriers, and Strategies for Improvement

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To ensure its growth and prosperity, general internal medicine will need to embrace care of the elderly, research on aging, and geriatrics education as components of its core mission. Experts agree that general internal medicine fellows could benefit from increased opportunities in research on aging and geriatrics education; however, important barriers will hamper efforts to integrate geriatrics training into general internal medicine fellowship programs.

This article reviews the barriers to integration and proposes solutions for overcoming those barriers. As a result of interviews and meetings with a broad representation of general internists, geriatricians, funding agencies, and policymakers, we propose 2

interventions: 1) the development of institutional program grants to foster collaboration between general internal medicine and geriatrics faculty in the training of general internal medicine fellows and 2) the creation of a 3-year fellowship program combining general internal medicine and geriatrics.

This article discusses the importance of evaluating these and other programs intended to increase the geriatrics experience of general internal medicine fellows, and it describes the potential implications of these changes for a broad array of stakeholder institutions.

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Leaders in general internal medicine, as in other medical subspecialties, have recognized the need for general internists to develop greater competency in geriatric medicine (1–8). Preparing general internists to care for elderly patients, to conduct research related to aging, and to teach geriatric topics requires different types of exposures and experiences in geriatrics, depending on the general internist's stage of training.

More than 100 internists each year complete general internal medicine fellowship training in more than 60 programs in the United States (9–12). Emphasizing fellows' preparation for careers as clinician–educators or clinician–investigators, general internal medicine fellowship programs offer no advanced certification to their graduates, yet they draw competitive pools of talented internists who wish to develop the knowledge, attitudes, and skills to become leaders in academic general internal medicine. General internal medicine fellowships offer a valuable opportunity to extend geriatrics education and training to academic general internists, but little is known about how these fellowships have incorporated geriatrics into their formal and informal curricula. We therefore sought to define the current practice of geriatrics training in general internal medicine fellowships, identify barriers to increasing and enhancing geriatrics training for general internal medicine fellows, and explore possible strategies for incorporating geriatrics training into general internal medicine fellowship programs.

METHODS

We performed a broad-based study of geriatrics training in general internal medicine fellowship programs by reviewing published literature and reports of grant programs, convening 3 expert panels of national leaders in geriatrics and general internal medicine, and conducting in-depth interviews with key informants.

Systematic Literature Review

We searched the MEDLINE (1966 to December 2002) and HealthSTAR (1975 to December 2002) databases using combinations of the terms *aging*, *fellowships*, *geriatrics*, *gerontology*, *graduate medical education*, and *internal medicine*, both as key words and mapped to relevant Medical Subject Headings (MeSH) terms when possible. Our search included only English-language articles. We scanned the reference lists of identified articles for additional citations of interest and searched Current Contents and Science Citation Index for other relevant references. We reviewed the full text of all articles potentially related to geriatrics training in general internal medicine fellowships and prepared an annotated bibliography (available from the authors upon request). A panel of nationally recognized experts in geriatrics and general internal medicine fellowship training reviewed the annotated bibliography and confirmed its completeness. We also examined the full text of articles related to geriatrics training in internal medicine fellowship programs in subspecialties other than general internal medicine. We excluded articles related to geriatrics training for internal medicine residents and for faculty development.

Review of Grant Reports

We contacted representatives of the John A. Hartford Foundation, Inc.; the American Geriatrics Society Foundation for Health in Aging; the Donald W. Reynolds Foundation; and the Novartis Foundation for Gerontology, seeking information on any past or current programs or initiatives intended to increase or improve geriatrics training in general internal medicine fellowship programs. We also searched the U.S. government's Computer Retrieval of Information on Scientific Projects (CRISP) database (<http://crisp.cit.nih.gov>), using the search terms *geriatrics* and *fellowship(s)*, to identify any federally funded grants.

Expert Panels

On 19 March 2001, an expert panel of 8 national leaders in geriatrics and general internal medicine convened in Boston, Massachusetts, for a day-long series of discussions of topics on the integration of geriatrics into general internal medicine fellowship programs. The invited panel members reviewed and discussed relevant literature, recommended and prioritized topics for subsequent in-depth interviews, and identified potential interviewees.

At a national conference titled "Training General Internists in Geriatrics: Planning for Sustained Improvement" (held on 9 to 10 July 2001 in Baltimore, Maryland), representatives of stakeholder organizations as well as leaders in academic general internal medicine and geriatrics reviewed the initial results of this study and recommended further data collection and integration.

At a second national conference (held on 22 to 23 October 2001 in Baltimore, Maryland), attendees discussed the barriers to integrating geriatrics into general internal medicine fellowships and debated various proposed interventions. First by straw poll and then by consensus, participants identified the 2 highest-priority and most promising program initiatives. A subgroup of the conference attendees expanded and refined the 2 identified proposals.

In-Depth Interviews with Key Informants

We identified approximately 20 key informants on the topic of geriatrics training in general internal medicine fellowships. These were persons in the United States who had published articles in this area; had served in leadership positions in general internal medicine, geriatrics, or both; or had unique or representative careers that integrated geriatrics and general internal medicine. They were a diverse array of geriatricians and general internists from across the United States and included junior and senior faculty from small and large academic and community institutions, current and former general internal medicine fellows, directors of geriatrics and general internal medicine fellowship programs, geriatrics and general internal medicine division chiefs, and chairs of departments of medicine.

We conducted semi-structured interviews, either by telephone or in person, with each interviewee, using a discussion guide that comprised both open- and closed-ended questions. We pretested the discussion questions by soliciting feedback from 3 former presidents of the Society of General Internal Medicine (SGIM), each of whom had previously served as director of a general internal medicine fellowship program or chief of a general internal medicine division, or both. We recontacted most of the interviewees on more than 1 occasion to clarify information that they had provided or to obtain their reactions to information we had collected and synthesized from other interviews.

RESULTS

Overall, we found no evidence, published or otherwise, of formal curricula, programs, or mechanisms for providing general internal medicine fellows with clinical training, research opportunities, or research mentorship in geriatrics. However, some general internal medicine fellowship programs do have informal relationships with geriatrics fellowship programs and divisions of geriatrics, and these relationships foster fruitful collaboration among general internal medicine fellows and geriatrics faculty members. Where such informal relationships do not exist, some general internal medicine fellows have forged their own collaborations with geriatrics faculty. We describe current practices in several domains of geriatrics training for general internal medicine fellows and the barriers to achieving integration. We then present 3 case examples to illustrate pathways that former general internal medicine fellows have taken into careers that straddle general internal medicine and geriatrics. Finally, we describe 2 proposals, which emerged from the interviews and expert panels, for integrating geriatrics into general internal medicine fellowship programs.

Formal Curriculum

Formal curricula in geriatrics do not exist in any general internal medicine fellowship programs in the United States. The SGIM has published guidelines for the content and curriculum of general internal medicine fellowship programs (9), but historically each fellowship program has determined its own curriculum and its own set of expectations for fellows. The curriculum of a program depends on the program's emphasis (for example, it may focus on developing clinician-educators rather than clinician-investigators), but it varies even more widely according to the preferences and career objectives of the individual fellows (11-14).

In 1989, Orlander and Callahan (12) surveyed 348 current and recently graduated fellows from 39 programs to determine 1) the curricular content of the programs and 2) areas where respondents thought the curriculum should be enhanced. The respondents' top 10 areas of educational need during fellowship training were as follows: research methods, ambulatory medicine, critical review of the literature, epidemiology, biostatistics, teaching skills, medical consultation, grant writing, preventive medicine, and design of educational curriculum. Geriatrics ranked 15th, ahead of office procedures, medical ethics, and administration, which were at the bottom of the list. The respondents believed that although geriatrics was of low priority, it received inadequate emphasis in their programs.

Informal Curriculum

In contrast with formal curricula, informal curricula are the unscripted, predominantly ad hoc, and highly interpersonal forms of teaching and learning that take place among faculty and learners (15). The relationships and interactions between and among general internists and ger-

iatricians constitute an important informal curriculum in general internal medicine fellowship training. In most institutions, the relationship between faculty members in geriatrics and general internal medicine is one of peaceful coexistence at best; at worst, faculty in the 2 divisions struggle with each other for leverage within departments of medicine. During our discussions with key informants, it became apparent that academic institutions with a connection between the divisions of general medicine and geriatrics have a cadre of general internal medicine fellows actively engaged in research on aging. The connection is usually at the level of individual faculty members and is rarely a formal one. The opportunity for fruitful exchange is the result not of a formal curriculum but rather of professional relationships between productive and visible faculty members. Only a few academic institutions manifest this kind of collaboration of general internal medicine and geriatrics faculty.

At the University of California, Los Angeles, for example, 1 faculty member has appointments in both the division of geriatrics and the division of general internal medicine and serves as a role model and mentor. The 2 divisions have a semi-formal relationship; for example, the fellows of each division attend conferences and take research-methods courses together. At the University of Washington, fellows in all 3 of the programs housed in the division of general internal medicine have easy access to, and are encouraged to identify mentors in, divisions, departments, and schools outside the division of general internal medicine. This unfettered structure enables general internal medicine fellows to forge successful partnerships with faculty in geriatrics. The University of Iowa has no separate division of geriatrics; 4 certified geriatricians are members of the division of general internal medicine, and they do not differ from other general internal medicine faculty members in their interactions with and mentoring of fellows. Furthermore, general internal medicine fellows and faculty doing research on aging at the University of Iowa frequently collaborate with members of the department of family medicine, another academic home of geriatricians at that institution.

In comparison, at institutions such as Stanford University, Harvard University, Boston University, Johns Hopkins University, and the University of California, San Francisco, connections between geriatrics and general internal medicine occur exclusively at the level of individual faculty members and are harder to develop; an individual fellow's interest in research on aging and opportunities to pursue that interest depend largely on chance intersections. General internal medicine fellows interested in certain areas of research on aging may not know that faculty in the geriatrics division are doing research in similar areas, and interdivisional communication may require substantial effort and commitment by fellows and faculty members. Formalizing, or at least strengthening, existing connections, and forging them where they do not already exist,

would be 1 of the most powerful and effective ways to enhance the geriatrics training of general internal medicine fellows. Regular interactions among the faculty of the 2 divisions and their fellows—within the context of fellowship training—would allow fellows exposure to potential mentors, new research methods, and new research questions.

Barriers

Several barriers impede the development of connections between geriatrics and general internal medicine: lack of knowledge of colleagues and their work; lack of perceived benefit; lack of support or interest at the level of the division chiefs and department chairs; the persistent belief among many general internists that geriatrics is principally a clinical field rather than a distinct intellectual, scholarly discipline; and the perception of some persons involved in the training of general internal medicine fellows that geriatrics fellows are not of the same intellectual caliber as general internal medicine fellows. In addition, 1 informant noted, "The shortening of geriatric training in many fellowships to 1 year has created a wider cultural gap between general internal medicine and geriatrics, with most general internal medicine fellows primarily interested in an academic pathway and most geriatric fellows interested in a non-academic clinical pathway." These cultural issues are probably multifactorial in origin and may be the most important barriers to collaboration between geriatrics and general internal medicine.

Research Activities

The hallmark of most research-intensive general internal medicine fellowship programs is that fellows undertake one or more fellowship projects. Fellows usually conceive the projects; propose them in formal written documents; and then carry out the work, including data collection, analysis, presentation, and eventual publication. Fellows and graduates from each of the research-intensive programs that we sampled had undertaken research projects in areas typically considered the purview of geriatrics. For example, fellows have studied functional disability in the elderly (16), breast cancer screening in the elderly (17), and ethical considerations in end-of-life care (18). Other fellows have investigated Parkinson disease (19) and the influence of physician race, age, and sex on physician attitudes toward advance care directives (20).

We found wide variation in the degree to which geriatrics faculty members were involved in advising or mentoring the general internal medicine fellows doing this aging-related work. In some cases, fellows had selected as their mentors faculty members who hold appointments in both general internal medicine and geriatrics. In other cases, the fellows had no input at all from geriatrics faculty. Several geriatricians pointed out that health services or clinical epidemiologic research done in elderly populations does not in itself constitute geriatrics research. Many geriatricians thought, and some general internists agreed, that

geriatrics faculty members have a different view of the kinds of questions that need to be answered to improve the care of the elderly. As 1 geriatrician noted, geriatrician–researchers view the world through a geriatrics lens, focusing principally on outcomes such as functional status and quality of life and paying attention to the physical and emotional implications of diagnostic and therapeutic interventions. To succeed in research on aging, this geriatrician added, general internal medicine fellows need a “geriatrics perspective” that can be attained by 1) collaborating with geriatrician–researchers and 2) having mentored clinical experiences in geriatrics. Two general internal medicine division chiefs and several general internal medicine fellowship graduates doing research in aging-related fields offered a different view, suggesting that learning rigorous methods of scientific investigation is paramount and would suffice to prepare general internal medicine fellows for successful careers in research on aging.

Teaching Activities

Even graduates of research-intensive general internal medicine fellowship programs spend a substantial proportion of their faculty time in teaching activities (11). In fact, in a recent national survey (14), 35% of general internal medicine fellows intended to pursue careers as clinician–educators. Because elderly patients make up a large and growing proportion of both inpatients and outpatients, general internal medicine faculty will continue to have opportunities to teach medical students and residents about geriatrics. Some general internal medicine fellowship graduates, like many general internal medicine faculty members in general, feel uncomfortable teaching on topics usually considered the domain of geriatrics, such as advance care directives, delirium, dementia, falls, functional assessment, and incontinence (Sullivan G. Personal communication). They report that they feel comfortable and competent caring for elderly patients with these clinical problems but that they lack confidence in teaching about them. Their trepidation may be due, in part, to the paucity of role models teaching on similar topics.

Teaching has gained increased visibility and prominence in the experiences of general internal medicine fellows. For example, some general internal medicine fellowship programs currently provide sessions on “teaching fellows to be teachers.” Despite this growth of teaching activities, however, we learned of no specific geriatrics teaching components in any of the curricula.

Programmatic Variation

Many key informants considered the possibility of changing the structure of general internal medicine fellowship programs to give fellows more opportunities to pursue careers in research on aging or geriatrics teaching. Currently, the modal structure of general internal medicine fellowship programs is a 2-year experience during which at least 80% of the fellow’s time is spent developing the skills needed to be an independent investigator, through formal

coursework and fellowship projects. Most fellows continue with a nominal amount of clinical work, usually a half-day session per week, which is sometimes spent in a continuity practice of primary care and sometimes spent in urgent visits. While these limited clinical experiences could theoretically be spent in geriatrics settings (such as nursing homes, assisted-living facilities, and geriatrics consult services), we found no precedent for such experiences among general internal medicine fellows.

The American Board of Internal Medicine Research Pathway (formerly called “short tracking”) is open to candidates interested in pursuing a clinician–investigator career in geriatrics. Through this program, persons complete 2 years of internal medicine residency, then at least 3 years of research training in a subspecialty field, and then 1 or 2 years of subspecialty clinical training, depending on the subspecialty. The Research Pathway option is offered in general internal medicine, but only a handful of persons have short tracked into general internal medicine fellowship programs, and to our knowledge none has chosen to complete the Research Pathway’s clinical requirements in a geriatrics setting.

Certification

General internal medicine fellowship programs lead to no advanced certification or licensure. In contrast, fellows who complete a 1-year clinical geriatrics fellowship program become eligible to sit for the American Board of Internal Medicine/American Board of Family Practice Examination for Certification of Added Qualification (CAQ) in geriatrics. Several discussants wondered whether obtaining the CAQ would be a necessary and sufficient incentive to draw general internal medicine fellows into the field of geriatrics. Having a CAQ would give credibility and evidence of clinical expertise to a fellowship-trained general internist wishing to pursue a career in research on aging or geriatrics education. The CAQ would also distinguish the general internist and would serve as a “pass key” to enter academic geriatrics, a young field with much potential for growth and leadership development. Currently, a general internal medicine fellow must complete a geriatrics fellowship to obtain a CAQ; several interviewees wondered whether the clinical requirements for the CAQ could be woven into the fabric of the general internal medicine fellowship program.

Possible Geriatrics Career Pathways for General Internal Medicine Fellowship Graduates

The following case examples describe 3 representative career pathways for general internal medicine fellows with interest in geriatrics.

An Internal Medicine Residency Program Director

During her general internal medicine fellowship, 1 fellow gravitated toward the mentorship of a geriatrician. With the geriatrician’s guidance, the fellow conducted a research project related to Parkinson disease. She found

that doing research on aging under the tutelage of a geriatrician enhanced her knowledge of geriatric conditions. Now the director of an internal medicine residency program and a clinician–educator, she points out that her experience studying a geriatric condition has helped to enrich the geriatrics curriculum of her residency program and her daily practice in general internal medicine.

A Health Services Researcher

Upon completing a traditional 2-year, research-intensive fellowship in general internal medicine, emphasizing access to health care for underserved populations, a fellowship graduate engineered a third fellowship year in the early 1990s that included patient care responsibilities in geriatrics clinical settings (for example, in an extended-care unit and an inpatient geriatrics consultation after service). A decade later, this nationally recognized health services researcher and leader of the SGIM notes reflectively that his geriatrics clinical experience had profound effects on the research questions he has been able to ask and the perspectives on aging that he has brought to answering those questions. However, he does not think that clinical experiences in geriatrics are essential for all fellows doing research in aging. Instead, recognizing the heterogeneity of general internal medicine fellows and fellowship programs, he recommends that general internal medicine fellows consider the costs and benefits of spending substantial fellowship time in clinical geriatrics.

A Geriatrics Division Chief

In a research-intensive general internal medicine fellowship program, this fellow became interested in various research and health policy issues related to geriatric populations. By seeking mentors in both clinical epidemiology and geriatrics, he developed methodologic and clinical expertise that has enabled him to become a highly productive researcher in the clinical epidemiology of an important area of aging. In addition, he has become a geriatrics division chief and director of research on aging at a prominent academic institution.

Proposals for Integrating Geriatrics into General Internal Medicine Fellowships

Two proposals emerged from the national summit conferences held to address the integration of geriatrics into general internal medicine fellowship programs. The first proposal, the creation of a funding mechanism for innovative programs, has already taken form as the SGIM Collaborative Centers Program. The second proposal recommends the establishment of combined geriatrics–general internal medicine fellowship programs.

The SGIM Collaborative Centers Program

Because attitudinal and cultural barriers are probably the most challenging to overcome, the first proposed inter-

vention aims to change culture at the institutional level. The SGIM Collaborative Centers Program strives for the targeted integration of geriatrics and general internal medicine in 10 academic institutions selected through a competitive process. A key criterion for judging applications for this program was the demonstration of intra-institutional commitment to collaboration between academic units of general internal medicine and geriatrics. Some of the 2-year awards will support faculty who participate in innovative, collaborative programs for training general internal medicine fellows. The character and degree of collaboration vary across the applicant institutions. Innovation will take different forms at each institution, depending on the current cultural climate at each one.

Combined Geriatrics–General Internal Medicine Fellowship Programs

In a combined geriatrics–general internal medicine fellowship, clinical geriatrics training would give fellows not only the experience of caring for older adults but also a “geriatrics perspective” in research and teaching. The general internal medicine fellowship program would provide the breadth and depth of methodologic expertise necessary to prepare fellows for productive careers as clinician–investigators and, less frequently, clinician–educators. Bringing together the complementary strengths of these programs, and their divisions, will create synergies and opportunities for fellows and may have spillover effects that will benefit faculty in the two disciplines, as well as the residents and students with whom they interact.

As with the SGIM Collaborative Centers Program, a combined geriatrics–general internal medicine fellowship program will help to mitigate cultural and attitudinal barriers to integration. More important, it will directly address the manpower and economic barriers we identified. Collaborative endeavors between geriatrics and other subspecialties of internal medicine do have precedents (6, 7), most notably the American Society of Clinical Oncologists’ “Geriatric Oncology Training Program Development Grant” to aid institutions in developing 3-year fellowship training programs in geriatric medicine and medical oncology (21).

To make an extended training program appealing to general internal medicine fellows, the third year of committed research time could be offered with a salary at or near that of a junior faculty member. Programs for student loan repayment or forgiveness may also be considered as a possible economic incentive for participation. Fellows would be committed to 3 years of training, with 80% of their time devoted to research on aging and 20% dedicated to clinical geriatrics, and they would have the option of accepting a faculty position in the third year as long as the 80%/20% arrangement is maintained. Under the American Board of Internal Medicine’s current requirements, fellows completing such a combined program would not have

accrued enough geriatrics clinical training to qualify for the geriatrics CAQ. The primary goal of these combined programs would not be to develop clinical geriatricians or clinician–educators. Instead, the programs would strive to produce academic general internists who do research in aging and have a perspective on that research that has been influenced by substantial experience in caring for elderly patients and by mentorship by geriatricians.

The 3-year geriatrics–general internal medicine fellowship program would produce physicians with state-of-the-art research skills and more clinical geriatrics expertise than fellows trained in traditional general internal medicine fellowship programs have. These geriatrics-oriented academic internists would be poised for leadership and investigative opportunities closely aligned with geriatrics, such as research or administration positions in long-term care facilities. A combined fellowship program would require the financial support of faculty mentors to facilitate mentoring and curriculum development. Institutions that already have strong fellowship training programs in both geriatrics and general internal medicine would be likely candidate sites for combined fellowship programs.

Evaluation

Evaluating how well these proposals succeed at integrating geriatrics into general internal medicine fellowship training presents many challenges familiar to educators and policymakers attempting to assess the effects of curricular reform (22, 23). Surveys of fellowship programs' curricular activities, done before and after these interventions, would provide a necessary but rudimentary measure of the success of integration. Measuring the tangible products of programs, such as numbers of fellows trained, publications, grant applications, and funded research awards, would provide some additional objective evidence of increased interest among and opportunities for general internal medicine fellows in research on aging and geriatrics education. However, these objective measures may not be sensitive enough to detect changes in the cultures of general internal medicine and geriatrics, which may be the more relevant targets of the interventions.

DISCUSSION

We found limited integration of geriatrics in the formal and informal curricula of general internal medicine fellowships. Various cultural, attitudinal, and programmatic barriers stand in the way of incorporating geriatrics into the training of general internal medicine fellows. The primary goal of the proposals we describe is to foster the integration of geriatrics and general internal medicine at individual academic institutions and nationally. This integration, often manifested by professional collaboration in a range of research and educational activities, already exists in a few institutions and in small pockets of the 2 professional societies, but it is not the norm. On the basis of our interviews and discussions, we envision the integration of

Table. Geriatrics in General Internal Medicine Fellowship Programs: Key Summary Points

General internal medicine fellowship programs provide advanced preparation, typically research training, for internists wishing to pursue academic careers.

Substantial barriers prevent the successful integration of geriatrics training into general internal medicine fellowship programs.

These barriers, including cultural differences between geriatrics and general internal medicine, as well as the existing structures of general internal medicine fellowship programs, can be overcome through collaborative efforts across specialties.

Innovative programs may foster such collaboration and may lead to the creation of combined geriatrics–general internal medicine fellowship programs.

general internal medicine and geriatrics as the creation of a bridge between the 2 disciplines, with an exchange of resources and expertise in both directions (Table).

Both collaborative and cooperative relationships should exist between individual investigators and educators with a knowledge and understanding of one another's work. These relationships should be solidified by visible and tangible partnerships between divisions and departments. The development of such bridges would probably require external funding from stakeholder organizations. Stakeholders in the areas of research on aging and geriatrics education are many, because elderly persons are the primary bearers of chronic illness and develop diseases in every organ system. Many U.S. government institutions have a vested interest in developing general internists with interest and competency in research on aging and geriatrics education; these include the Agency for Healthcare Research and Quality; the Department of Veterans Affairs; the Health Resources and Services Administration; and many branches of the National Institutes of Health, such as the National Institute on Aging, the National Heart, Lung and Blood Institute, and the National Cancer Institute. In addition, several private foundations (for example, The John A. Hartford Foundation, Inc., and The Donald W. Reynolds Foundation) can play a pivotal role in building bridges.

We have described the 2 most promising and highest-priority interventions identified through interviews and subsequent consensus development among representatives from key stakeholder organizations. Our interviews and discussions yielded other ideas for interventions, such as enhanced programmatic collaboration between the SGIM and the American Geriatrics Society and additional research into the careers of general internists who have successfully bridged the fields of general internal medicine and geriatrics. Clearly, overcoming the barriers to integration will require numerous interventions, both nationally and locally, over the course of many years.

Collaboration is imperative. As both Sox (2) and Lar-

son (3) have recently pointed out, general internal medicine must begin to embrace the care of the elderly as a central part of its domain if it wishes to assure itself a key role in the care of patients with chronic, progressive illness. Such patients are the fastest-growing segment of the population. As Larson states (3), "A focus on geriatric medicine could help general medicine continue to flourish. General internists are ideally suited to the integrated care of elderly patients with multiple problems, research opportunities are enormous in the geriatric population, and the teaching of geriatrics requires a high level of generalist skills." The effort to expand the able workforce and science base of care for the elderly must include both geriatrics and general internal medicine, for neither field has the resources to do it alone. Together, they can develop and promote a science and culture that can serve the needs of every elderly patient.

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