

Training & Practice Update

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Graduate Medical Education: Preparing All Physicians to Care for the Aged

ACGME Residency Review Committees' Requirements for Geriatric Medicine Curriculum

Although the practice of adult medicine by all specialties has always involved the care of older patients, demographic trends and an expanding geriatric medicine knowledge base require that every physician develop skills specific to the care of the older adult. The percentage of ambulatory care visits for patients over the age of 65 to non-primary care specialists increased from 1980 to 2000, going from 39.7% to 55% of all visits.

This increase was accompanied by a decrease in the percentage of visits by older patients to general and family practice physicians (from 37.5% to 20.2% of all visits). Internal medicine physicians experienced a slight increase in visits from those over 65 (from 22.7% to 24.5% of all visits).¹

Table 1 lists ambulatory visits by older adults to selected specialties, shown as a percent of all visits to each.

**Table 1. Ambulatory Visits by Patients 65 Years and Older
(As a Percent of All Visits to Each Specialty)**

Practice	1999	2000 ²	2001
Ophthalmology	55.8	51.5	48.5
Cardiovascular diseases	53.9	59.7	58.4
Urology	46.2	53.1	47.9
General internal medicine	38.9	39.0	42.7
General surgery	32.9	30.1	35.8
Neurology	26.6	28.5	28.6
Dermatology	25.8	26.3	28.1
Otolaryngology	24.8	22.3	22.5
Orthopedic surgery	22.5	20.4	25.0
General /family practice	20.7	20.4	25.9
Psychiatry	10.2	6.6	9.9
Ob/Gyn	6.6	4.7	7.1

Source: National Ambulatory Medical Care Survey

The 1993 Institute of Medicine (IOM) report, *Strengthening Training in Geriatrics for Physicians* specifically recommended substantially expanding geriatric medicine training in primary care residencies and also increasing geriatric medicine education in non-primary care specialties.³ This edition of the *Training and*

Practice Update presents current data regarding the involvement of the Accreditation Council for Graduate Medical Education (ACGME) in encouraging residency and fellowship programs to address the IOM's geriatric medicine training recommendations.

Accreditation Council for Graduate Medical Education (ACGME)

Formal geriatric medicine training for virtually all physicians ends with their primary care or specialty residency training. In 2002, 9,558 physicians graduated from allopathic family practice and general internal medicine residency programs, but only 292 subsequently entered geriatric medicine fellowships. Likewise, 997 physicians completed allopathic psychiatry residencies, but only 73 enrolled in geriatric psychiatry fellowships. In that same year, 14,161 physicians graduated from other residency and fellowship programs (these figures do not include pediatrics).⁴ Therefore, the integration of specific geriatrics content into the curriculum of all primary care and other specialty training programs is essential to achieve a well-trained physician workforce to care for older adults.

The ACGME is responsible for the accreditation of post-MD training programs within the United States. Accreditation is accomplished through a peer review process and is based upon established standards and guidelines. Individual Residency Review Committees (RRCs) of the

ACGME are responsible for establishing training requirements for each specialty.⁵ These requirements are used by the ACGME when it accredits the more than 6,700 non-pediatric residency and fellowship programs in over 100 specialties.

In 2002, the Association of Directors of Geriatric Academic Programs (ADGAP) project team at the University of Cincinnati Institute for Health Policy and Health Services Research (IHPHSR) reviewed all non-pediatric RRC program requirements to identify specific curriculum requirements related to the elderly, aged or older adult. At that time, only 24 programs had specific geriatric requirements. In December 2003, we updated this review by re-evaluating the 39 programs with new guidelines. Three more programs now require specific geriatric content: Vascular Neurology, Adult Reconstructive Surgery, and Urology.

Table 2 lists the 27 programs with requirements for geriatric training. (See Table 3 on page 6 for the actual geriatric requirements.)

Commentary on geriatric medicine training in selected specialties

Internal Medicine

The RRC for internal medicine (IM) has required geriatrics training since 1989. The most recent revision of these requirements became effective in July 2003. While both the new and previous IM requirements mandated that residents have formal instruction and regular, supervised clinical experience in geriatric medicine, the new requirements further stated that “curriculum and clinical experience should be directed by an ABMS-certified geriatrician”. The new requirements also require a subspecialty education coordinator in geriatric medicine who must be certified in the specialty by the ABIM or possess qualifications judged by the RRC to be acceptable. (Subspecialty education coordinators are also required for the other IM specialties.) While the previous RRC requirements listed specific topics

that should be taught to the residents, i.e., end of life care, elder abuse, the new requirements omit these specifics.⁵ For the past several years, the requirements in geriatric medicine have been one of the top 10 areas cited by the ACGME for lack of compliance, i.e., ‘Residents do not have formal instruction and regular, supervised clinical experience in geriatric medicine’.^{6,7}

(Continued on page 4)

Table 2. Allopathic Residency and Fellowship Programs with Specific Requirements for Geriatric Medicine Curriculum

Residency Review Committees	Programs	Effective Date*
Anesthesiology	Anesthesiology	January 1, 2001
Anesthesiology	Pain Management	July 1999
Emergency Medicine	Emergency Medicine	January 2001
Family Practice	Family Practice	July 1, 2001
Internal Medicine	Cardiovascular Disease	July 1999
Internal Medicine	Critical Care Medicine	July 1999
Internal Medicine	Endocrinology, Diabetes, and Metabolism	July 1999
Internal Medicine	General Internal Medicine	July 2003
Internal Medicine	Hematology	July 2001
Internal Medicine	Hematology and Oncology	July 2001
Internal Medicine	Infectious Disease	July 1999
Internal Medicine	Nephrology	July 2001
Internal Medicine	Oncology	July 1999
Internal Medicine	Pulmonary Disease and Critical Care Medicine	July 1999
Internal Medicine	Rheumatology	July 1999
Neurology	Pain Management	June 2000
Neurology	Vascular Neurology	February 12, 2002
Obstetrics and Gynecology	Obstetrics and Gynecology	July 2003
Orthopaedic Surgery	Adult Reconstructive Surgery	January 2003
Physical Medicine and Rehabilitation	Physical Medicine and Rehabilitation	July 2003
Physical Medicine and Rehabilitation	Pain Management	July 2001
Psychiatry	Addiction Psychiatry	July 2003
Psychiatry	Forensic Psychiatry	July 2003
Psychiatry	Pain Management	June 2000
Psychiatry	Psychiatry	January 2001
Surgery	Critical Care	July 2001
Urology	Urology	July 2003

Internal medicine subspecialties were not included in this list if their individual program requirements did not specifically mention requirements related to the elderly. However, all Internal Medicine subspecialties must meet not only their own subspecialty requirements but also the overall program requirements for residency education in the subspecialties of internal medicine. (See Table 3, page 8)

*The effective date is the date of the current RRC program requirements and not necessarily the date when geriatric requirements were first added.

Source: IHPHSR ADGAP Database Project, January 2004

Commentary on geriatric training (cont'd from page 2)

Family Practice

A requirement for geriatrics training has been part of the family practice program requirements since the beginning of the specialty in 1969. In 1997, continuity experience in the nursing home was changed from a “must” to a “should” recommendation, and the requirements for geriatric education to occur throughout the curriculum was removed. However, by 2001, the requirements again stated there “must” be experience with the older adult patient in a long-term care facility.⁵

Psychiatry

General psychiatrists without advanced training in geriatric mental health will continue to provide the majority of psychiatric care to older adults. New RRC requirements for residency training in psychiatry that included a required month of supervised clinical management of geriatric patients went into effect on July 1, 2001. This clinical experience can be fulfilled as an inpatient or outpatient experience.⁵

Emergency Medicine

Approximately 20% of all emergency department (ED) encounters are by the elderly, and the highest rate of ED use when analyzed by age group is by those 75 years and older.⁸ In 2000, adults 75 years and over made 65 ED visits/100 adults 75 years and over as compared to the group under the age of 18, which made 38 ED visits/100 persons.⁹ Eight percent of adults 75 years and over and 7.1% of those 65-74 made 2 or more ED visits in 2001.¹⁰ Nonetheless, Emergency Medicine RRC requirements state that “16% of the resident emergency department encounters, or 4 months of full-time equivalent experience, must be dedicated to the care of infants and children.” The only requirement related to care of the elderly includes instruction on the presentation, detection and management of domestic violence including elder abuse, physical and sexual as well as neglect.⁵

Obstetrics/Gynecology

Since 1996, the RRC for Obstetrics and Gynecology has required a structured experience

in geriatric medicine that is the equivalent of at least a 1-month block rotation. In 1999, the Council on Resident Education in Obstetrics and Gynecology (CREOG) published educational objectives for training residents in basic geriatric care.¹¹ In 2001, to assess how Ob/Gyn program directors were establishing this geriatric rotation, Vitale and colleagues surveyed the 226 program directors. Fifty one percent (N=116 out of 226) responded to their survey.¹²

The findings included:

- The majority of residents worked in an ambulatory setting, yet two-thirds also had their residents spend time in an acute inpatient setting. Only 15 programs required their residents to have home care exposure, and 46 programs had some nursing home exposure.
- Program directors did not agree on which year during the residency the geriatric experience should be provided or whether the rotation should consist of a 1-month block or be spread out over the 4 years.
- Fifty-five programs did not utilize a formal geriatric curriculum.
- Program directors were equally divided on whether their Ob/Gyn residents should have more, less, or the same amount of training in geriatrics

Other Specialties

Even though 49% of ophthalmology; 36% of general surgery; and approximately 25% of all neurology, dermatology, and otolaryngology patients seen in physician’s offices in 2001 are over 65 years of age, the RRC requirements for these programs do not contain specific requirements for geriatric medicine training.

Ophthalmology does require that “each resident have major technical and patient care responsibilities in order to provide an adequate base for a comprehensive ophthalmic practice that includes pediatric ophthalmology.”

Dermatology requires that training should also be provided in pediatrics, and there are separate

(Continued on the next page)

Commentary on geriatric training (cont'd from page 4)

programs in child neurology, pediatric surgery, and pediatric otolaryngology.

Urology, with 48% of ambulatory visits from patients over the age of 65, added specific, although limited, geriatric medicine training requirements in July 2003.

Discussion

Since the 1993 Institute of Medicine report, it has been recognized that all physician training should include general geriatric medicine principles and specialty-specific topics related to aging. Of the over 100 non-pediatric specialties, only 27 specialties now have such requirements. In other words, 75% of the graduate medical education specialties training non-pediatric physicians do not have specific geriatrics curriculum requirements. Yet once these physicians establish their clinical practices, many adults over the age of 65 will become their patients. For some of these specialists, the older patient will make up 50% or more of their practice.

The enactment of a RRC geriatric medicine training requirement does not ensure that quality geriatrics training is occurring. For example, general internal medicine has had these requirements since 1989, and yet one of the top 10 citations from recent RRC accreditation visits is that GIM residents do not have formal instruction and regular, supervised clinical experience in geriatric medicine.

Developing exciting, challenging rotations with well-trained faculty is also critical; residents will dismiss nominal experiences. Leadership committed to the importance of geriatric training is a requisite to enhance the value that residents place on geriatric medicine rotations. Without department chairs and program directors commitment to geriatric medicine faculty and curriculum development, as well as commitment to enhanced appreciation of geriatrics among the various subspecialties in each department, externally imposed requirements for geriatric medicine training will have limited success.¹³

In summary, progress in curriculum and faculty development in geriatric medicine is well

Neurology does not have specific RRC requirements for geriatric medicine training, although the training programs in vascular neurology and neurology pain management require geriatrics training.

underway. Three more disciplines enacted geriatric medicine curriculum requirements in 2003. Geriatrics curriculum is being developed for several disciplines, such as ophthalmology, even though these programs do not yet have RRC requirements for geriatrics. Other programs are in place that target geriatric medicine faculty and curriculum development. These programs include:

- Donald W. Reynolds Foundation Comprehensive Programs to Strengthen Physicians' Training in Geriatrics
- American Academy of Family Physician's Residency Assistance Program/Hartford Geriatrics Initiative and Curriculum Retreats for Family Practice Residency Program Directors
- Association of Specialty Professors/Hartford Integrating Geriatrics into the Subspecialties of Internal Medicine
- American Geriatrics Society/Hartford Increasing Geriatrics Expertise in Surgical and Medical Specialties
- Association of Subspecialty Professors/Atlantic Philanthropies T. Franklin Williams Scholars program
- American Geriatric Society/Hartford/Atlantic Philanthropies Jahnigen Career Development Scholars program
- Society of General Internal Medicine/Hartford Increasing Education and Research Capacity in General Internal Medicine to Improve Care of Older Americans

A future edition of the *Training & Practice Update* will focus on these ongoing projects to increase geriatrics training in residency programs.

Table 3. Residency Review Committees' (RRC) Requirements for Geriatric Medicine Curriculum in Selected Allopathic Specialties¹

RRC Specialty Effective Date	ACGME Requirements
Anesthesiology Anesthesiology January 1, 2001	Educational Program – Clinical Components: Appropriate didactic instruction and sufficient clinical experience in managing problems of the geriatric population.
Anesthesiology Pain Management July 1999	Educational Program – Didactic Components: Management of pain in the elderly.
Emergency Medicine Emergency Medicine January 1, 2001	Educational Program – Curriculum – Family Violence: There must be instruction on the presentation, detection and management of domestic violence including ... elder abuse (physical and sexual) as well as neglect. Such instruction should promote the understanding of its effects on both victims and perpetrators.
Family Practice Family Practice July 1, 2001	Educational Program – Focused Experiences – Human Behavior and Mental Health: Family violence including ... elder abuse (physical and sexual), as well as neglect, and its effect on both victims and perpetrators. Educational Program – Focused Experiences – Care of the Older Patient: Educational experience must be provided in the common and complex clinical problems of the older patient and must include the preventive aspects of health care, functional assessment, the physiological and psychological changes of senescence, the sociocultural parameters of the patient and his or her greater community, the nutritional and pathological (acute and chronic) entities of aging, and the effective utilization of all members of the health care team. There must be experience with the older adult patient in the hospital, the FPC, a long-term care facility, and the home.
Internal Medicine Cardiovascular Disease July 1999	Specific Program Content – Formal Instruction: Management of geriatric patients with cardiovascular disease.
Internal Medicine Critical Care Medicine July 1999	Key Clinical Faculty – There must be key clinical faculty members in geriatric medicine ... who are available to participate in the education of residents in critical care medicine.

Table 3. Residency Review Committees' (RRC) Requirements for Geriatric Medicine Curriculum in Selected Allopathic Specialties' (cont'd)

RRC Specialty Effective Date	ACGME Requirements
Internal Medicine Endocrinology, Diabetes, and Metabolism July 1999	Specific Program Content – Clinical Experience – Residents must have formal instruction, clinical experience, or opportunities to acquire expertise in the evaluation and management of the following disorders: Endocrine aspects of aging, with particular emphasis on the care of geriatric patients with endocrine disease and diabetes and the endocrine changes associated with aging.
Internal Medicine General Internal Medicine July 2003	Introduction – Definition and Scope of Specialty: Internal medicine is the discipline encompassing the study and practice of health promotion, disease prevention, diagnosis, care, and treatment of men and women from adolescence to old age, during health and all stages of illness. Facilities and Resources – Patient Population: There must be patients of both sexes, with a broad age range, including geriatric patients. Subspecialty education coordinators – In conjunction with division chiefs, the program director must identify a qualified individual (subspecialty education coordinator) in each of the subspecialties of internal medicine ... geriatric medicine. The subspecialty education coordinator must be certified in the specialty by the American Board of Internal Medicine or possess qualifications judged by the RRC to be acceptable. Subspecialty Experience -- Residents must have formal instruction and regular, supervised clinical experience in geriatric medicine. The curriculum and clinical experience should be directed by an ABMS-certified geriatrician. These experiences may occur at one or more specifically designated geriatric inpatient units, geriatric consultation services, long-term care facilities, geriatric ambulatory clinics, and/or in home-care settings.
Internal Medicine Hematology July 2001	Specific Program Content – Care and management of geriatric patients with hematologic disorders.
Internal Medicine Hematology and Oncology July 2001	Specific Program Content – The residents must have formal instruction, clinical experience, or opportunities to acquire knowledge in the following: Care and management of the geriatric patient with malignancy and hematologic disorders.
Internal Medicine Infectious Disease July 1999	Specific Program Content – Residents must have clinical experience or formal instruction in the prevention, evaluation, and management of the following disorders: Infections in geriatric patients.

Table 3. Residency Review Committees' (RRC) Requirements for Geriatric Medicine Curriculum in Selected Allopathic Specialties¹ (cont'd)

RRC Specialty Effective Date	ACGME Requirements
Internal Medicine Nephrology July 2001	<p>Specific Program Content – Residents must have formal instruction, clinical experience, and opportunities to acquire expertise in the prevention, evaluation, and management of the following disorders: Geriatric aspects of nephrology, including disorders of the aging kidney and urinary tract.</p> <p>Specific Program Content – Formal Instruction – Specific content areas that must be included in the formal program (lectures, conferences, seminars, and journal clubs) include the following: Geriatric medicine, including: 1. physiology and pathology of the aging kidney and 2. drug dosing and renal toxicity in elderly patients.</p>
Internal Medicine Oncology July 1999	<p>Specific Program Content: The residents must have formal instruction, clinical experience, and opportunities to acquire knowledge in the following: Care and management of the geriatric patient with malignancy.</p>
Internal Medicine Pulmonary Disease and Critical Care Medicine July 1999	<p>Key Clinical Faculty – There must be key clinical faculty members in geriatric medicine ... who participate in the education of residents.</p>
Internal Medicine Rheumatology July 1999	<p>Specific Program Content – Formal Instruction – In the study of rheumatic diseases, musculoskeletal disorders, metabolic diseases of bone, osteoporosis, and acute and chronic musculoskeletal pain, the following specific content areas as a minimum, must be included in the formal program (lectures, conferences, and seminary): geriatric and aging influences.</p>
Internal Medicine (Requirements for all subspecialties) July 1999	<p>Facilities and Resources – A sufficient number of new and follow-up patients, including the geriatric age groups, and patients of both sexes must be available to ensure adequate inpatient and ambulatory experience for each subspecialty resident.</p> <p>Specific Program Content – Patient Care Experience: Such experience should include sufficient opportunities in the management of the complex physical, social, and psychological problems prevalent in elderly patients.</p>
Neurology Pain Management June, 2000	<p>Educational Program – Didactic Components – The pain management curriculum must include the following topics in lectures and reading: Management of pain in the elderly.</p>

Table 3. Residency Review Committees' (RRC) Requirements for Geriatric Medicine Curriculum in Selected Allopathic Specialties¹ (cont'd)

RRC Specialty Effective Date	ACGME Requirements
Neurology Vascular Neurology February 12, 2002	Duration and Scope of training – Care of patients in different settings, including nursing homes, medical rehabilitation centers, and outpatient clinics.
Obstetrics and Gynecology Obstetrics and Gynecology July 2003	Educational Program – General – Organization and Structure: In addition to rotations in obstetrics-gynecology, general medical management experience may also be obtained during rotations in geriatric medicine. Residents must have an experience in menopausal healthcare and geriatric medicine that is the equivalent of at least one month of a block rotation. Educational Program – Specific Educational Experiences – Primary and Preventive Care: Ambulatory primary care problems of the geriatric patient.
Orthopaedic Surgery Adult Reconstructive Surgery January 2003	Institutional Resources and Organization – There should be broad support from other clinical specialties, including gerontology.
Physical Medicine and Rehabilitation Physical Medicine and Rehabilitation July 2003	Facilities and Resources: Equipment must be suitable for all age groups, with special attention to modified equipment for the ... geriatric patient. Educational Program – Clinical Components – The clinical curriculum must be written and implemented for the comprehensive development of measurable competencies for each resident in the following areas: geriatric rehabilitation. Educational Program – Clinical Components – The resident must have opportunities for progressive responsibility in diagnosing, assessing, and managing the conditions commonly encountered by the physiatrist in the rehabilitative management of patients of all ages of at least the following: diseases, impairments, and functional limitations seen in the geriatric population.
Physical Medicine and Rehabilitation Pain Management July 1, 2001	Educational Program – Didactic Components – The pain management curriculum must include the following topics in lectures and reading: management of pain in the elderly.

Table 3. Residency Review Committees' (RRC) Requirements for Geriatric Medicine Curriculum in Selected Allopathic Specialties¹ (cont'd)

RRC Specialty Effective Date	ACGME Requirements
Psychiatry Addiction July 2003	<p>Educational Goals and Objectives: Clinical experience must include the opportunity to evaluate and follow a variety of patients of both sexes, including adolescents, adults, and geriatric age groups spanning a broad range of diagnoses, as enumerated in Program Requirements.</p> <p>Other Program Personnel: The resident should work in settings that include representatives from clinical disciplines such as ... geriatrics ... as appropriate for the care of the patient.</p> <p>Clinical Experiences: The number and variety of new and follow-up patients spanning the life cycle from adolescence to old age must be sufficient to ensure an adequate outpatient and inpatient experience.</p>
Psychiatry Forensic July 2003	<p>Introduction – Educational Goals and Objectives: Clinical experience must include experiences in the following: forensic evaluation of a variety of subjects of both genders, including ... geriatric ages groups, who represent a broad range of mental disorders and circumstances, in both civil and criminal contexts.</p> <p>Educational Program – Components of the Educational Program: A sufficient number and variety of patients, ranging from adolescence to old age and of diverse backgrounds, should be provided to ensure an adequate experience.</p>
Psychiatry Pain Management June 2000	<p>Educational Program – Didactic Components – The pain management curriculum must include the following topics in lectures and reading: management of pain in the elderly.</p>
Psychiatry Psychiatry January, 2001	<p>Educational Program – Curriculum – Clinical Experience – Geriatric Psychiatry: One-month FTE supervised clinical management of geriatric patients with a variety of psychiatric disorders, including familiarity with long-term care in a variety of settings. This may be fulfilled as part of the inpatient or outpatient requirement.</p>
Surgery Critical Care July 2001	<p>Introduction – Objectives – This advanced body of knowledge and level of skill must include the mastery of the use of advanced technology and instrumentation to monitor the physiologic status of ... adults of ... advanced years.</p>
Urology Urology July 2003	<p>Faculty qualifications -- To provide the greatest depth of knowledge in a variety of subjects, the faculty should possess special knowledge in all of the urological domains: geriatric urology.</p> <p>Didactic Component – Urologic core knowledge must include: geriatric urology.</p>

¹Internal medicine subspecialties were not included if their individual program requirements did not specifically mention requirements related to the elderly. However, all Internal Medicine subspecialties must meet not only their own subspecialty requirements, but also the overall program requirements for residency education in the subspecialties of internal medicine. (See Table 3, page 8)

Source: IHPHSR ADGAP Database Project, January 2004

References

- ¹Centers for Disease Control and Prevention, National Center for Health Statistics, National Ambulatory Medical Care Survey. Health United States, 2003. Special Excerpt: Trend Tables on 65 and Older Population. November 2003.
- ²Neill GO, and Barry PP. Training Physicians in Geriatric Care: Responding to Critical Needs. Public Policy and Aging Report. 2003;13:17-21.
- ³Institute of Medicine, Committee on Strengthening the Geriatric Content of Medical Training. Strengthening Training in Geriatrics for Physicians. Washington, DC: National Academy Press, 1993.
- ⁴AMA and AAMC data from the National Survey of GME programs. Journal of the American Medical Association. 2003;290:1234-1248.
- ⁵Accreditation Council for Graduate Medical Education. Residency Review Committees Common Program Requirements. Available at www.acgme.org. Accessed December 2003.
- ⁶Accreditation Council for Graduate Medical Education. Common Citation in Internal Medicine. Available at http://www.acgme.org/RRC/Int_Cit.asp. Accessed November 13, 2003.
- ⁷Association of Professors of Medicine. Geriatrics in Internal Medicine Clerkships and Residencies: Current Status and Opportunities. The American Journal of Medicine. December 15, 2001;111:738-741.
- ⁸Meldon SW, Milon LC, Palmer RM, Drew BL, Connor JT, Lewicki LJ, Bass DM Emerman CL. A Brief Risk-Stratification Tool to Predict Repeat Emergency Department Visits and Hospitalization in Older Patients Discharged from the Emergency Department. Academic Emergency Medicine. 2003;10:224-232.
- ⁹Centers for Disease Control and Prevention, National Center for Health Statistics, National Ambulatory Medical Care Survey and National Hospital Ambulatory Medical Care Survey. Health United States, 2003. Special Excerpt: Trend Tables on 65 and Older Population. November 2003.
- ¹⁰Centers for Disease Control and Prevention, National Center for Health Statistics, National Health Interview Survey. Health United States, 2003. Special Excerpt: Trend Tables on 65 and Older Population. November 2003.
- ¹¹Council on Resident Education in Obstetrics and Gynecology. Basic Geriatric Care Objectives for Residency Training in Obstetrics and Gynecology. Washington, DC: ACOG, 1999.
- ¹²Vitale C, Petriella M, Grifone T, and Steel K. Letter to the Editor. Implementing a Program in the Surgical Specialties – What is Out There and How to Begin. Journal of the American Geriatrics Society. 2001;46:237-238.
- ¹³Sox, HC. Association of Professor of Medicine. Supply, Demand, and the Workforce of Internal Medicine. The American Journal of Medicine. 2001;110:745-748.

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*Marsha Goodwin, 58, Director of Geriatrics at the Veterans Health Administration (VHA) died on December 18, 2003, of cancer. She was an enthusiastic advocate for improving the quality of geriatric medicine training for all health professionals. Her knowledge of the comprehensive VHA geriatrics training programs will be greatly missed by the ADGAP study team.

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