

## Correspondence:

### RE: HUMAN RESOURCES, TRAINING AND GERIATRICS

#### TO THE EDITOR:

After reading Dr. Hogan's editorial on the manpower crisis in Geriatrics,<sup>1</sup> we thought we would throw in our two cents worth. Please recognize that, as Internal Medicine-trained Geriatricians, our comments are limited to that training stream. To address Dr. Hogan's interest in obtaining input from residents, we met with senior medical residents to ask the question "Why didn't you choose Geriatrics?" We tried to meet with five, but only two showed up, despite being bribed with dinner at a swanky restaurant — an indication of interest, perhaps. Each of these Residents had done a month of Geriatrics as a first-year resident, working on the consult service, attending daily teaching sessions, and home visits/clinics as time allowed.

Both Residents had a positive image of Geriatrics. They believed that our attendance on the Clinical Teaching Unit helped raise our specialty's profile, as the difference between our approach and the typical Internist's approach was readily apparent. Both finished their Geriatrics rotation somewhat turned-off of the specialty. Much of the consult service's work involves assessing orthopedic cases for appropriateness of transfer to our restorative care unit. The Residents did not enjoy this work. They believed they might have left the rotation with more curiosity about Geriatrics if they had been systematically exposed to the breadth of what we do and the things that set us apart from General Internal Medicine. They were interested in seeing the Day Hospital, Home Visits, Satellite Clinics, the Memory Clinic, the Geriatric Assessment Unit and Restorative Care. It seems we need to restructure our first-year rotation.

We offer an elective for senior residents, but they rarely select this option.

Of great concern, one of the Residents who did not attend our meeting had entered Internal Medicine training planning to become a Geriatrician, but then had a change of heart. This resident hoped to locate in a specific medium-sized community with a referral hospital, but no geriatric services. The local health board indicated that there was no need for a geriatrician, but other subspecialties would be welcome. Thus, the resident changed

to accommodate this bizarre point of view.

As Dr. Hogan wrote, "It is important . . . that all of us individually strive to improve the attractiveness of geriatrics for good trainees".<sup>1</sup> We both see Geriatrics to be, obviously, the best career choice available to anyone in medicine. To the list of the breadth of what geriatricians do should be added 'infecting trainees with our enthusiasm'. To this end, making clear how we differ from the traditional internal medicine approach appears to be a high priority, as does advocating for our approach in those dark corners of the country where the light of comprehensive care of frail older adults who are ill does not now shine.

**Chris MacKnight, MD, MSc, FRCPC**  
Assistant Professor

**Kenneth Rockwood, MD, FRCPC, Professor**  
Division of Geriatric Medicine  
Dalhousie University  
Camp Hill Veterans' Memorial Bldg  
Halifax, NS

#### REFERENCE

1. Hogan DB. Human Resources, training and geriatrics. *Geriatr today: J Can Geriatr Soc* 2000; 4:7-10.

#### TO THE EDITOR:

Thank you for the copy of the *Journal of the Canadian Geriatrics Society*. I also appreciate having the article on the need to encourage physicians to train in this specialty by Dr. David Hogan brought to my attention.<sup>1</sup>

At the national level, Health Canada supports the Federal/Provincial/Territorial Advisory Committee on Health Human Resources (ACHHR) and the National Coordinating Committee on Postgraduate Medical Training (NCCPMT) in their work on advising governments on the health human resource needs of the health care system across Canada. The latter committee is comprised of representatives from governments and the national medical organizations. Collaboration between the federal, provincial and territorial governments and the medical community is key to the success of an enhanced capacity to ensure the adequate supply and distrib-

ution of appropriately trained physicians to meet the needs of Canadians now and in the future, and certainly, the aging of the population needs to be taken into consideration.

I will ensure that the ACHHR and the NCCPMT are made aware of the concerns expressed in this article.

**Allan Rock**

Minister of Health/Ministre de la Santé  
Ottawa

**REFERENCE**

1. Hogan DB. Human Resources, training and geriatrics. Geriatr today: J Can Geriatr Soc 2000; 4:7-10.

**REPLY:**

The letter from Drs. MacKnight and Rockwood conveys worrisome information. The two residents who succumbed to the invitation to dinner both finished their rotations less disposed to a career in geriatric medicine; a third who had started post-graduate training planning to enter the discipline had been diverted elsewhere by a lack of career opportunities. This suggests that even if trainees are interested in the field and/or have a clinical training experience, this may not be enough. Another area of concern about the future is data from the Canadian Resident Matching Service (CaRMS) post-match

survey. For the English-speaking schools, the response rate is over 70%. One of the questions asked these graduating medical students is what career in medicine have they selected. Research has shown that most physicians select their specialty before the end of medical school. In 1996, 5 respondents said they planned to become a specialist in geriatric medicine (if they took the required 3 years of internal medicine training without interruption, they would have entered sub-specialty training in July of 1999). In 1997, 7 planned to become a specialist in geriatric medicine. However, in 1998 and 1999 (the last year available) only 2 per year had made that choice. For July of 2001 (which is when the 1998 class would be expected to start training), only 3 English-speaking residents will be entering residency training in geriatric medicine. However, there is good news; in 1999, 23 students entering family medicine training stated that they intend to do training in care of the elderly. The letter from the Right Honourable Allan Rock, Minister of Health offers hope that our concerns are being heard at the highest levels.

**David B. Hogan, MD, FACP, FRCP**

President, Canadian Geriatrics Society;  
The Brenda Stafford Chair in Geriatric  
Medicine, University of Calgary

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