The number of people older than age 65 is expected to increase from 33 million (12% of the 1994 population) to more than 65 million (20% of the population) by 2030. Ensuring adequate medical care for this aging population means that additional training is needed in geriatrics for family practice and internal medicine residents, along with continuing medical education for current practitioners who care for elderly patients. In 1994, the Institute of Medicine projected the need for an additional 1,000 to 2,000 academic geriatricians, but the current production of geriatrics faculty is not enough even to replace those who will retire in the near future. Of the 16,268 students who entered US medical schools in 1985, only 125 entered geriatrics fellowships in 1992, and only 63 of these fellows pursued academic careers. The 1994 Institute of Medicine Committee on Strengthening the Geriatric Content of Medical Training, therefore, recommended “enhancing the attractiveness of geriatrics” by encouraging physicians to enter geriatrics training programs.

What factors influence the decision to enter geriatric medicine? While few studies have been conducted to determine why physicians choose a geriatrics career, there is extensive literature on primary care career choices. Most of these studies have relied on survey methods. Key influences in the choice of a primary care career have been cited as intellectual stimulation, desire to teach, being intrigued by problem solving, and presence of role models. Research on career choices in geriatrics has focused on attitudes. Reuben et al found that beginning medical students have already formed some negative opinions about the elderly, and other studies have found that medical students rank preference for a geriatrics career low. However, medical students exposed to care of the elderly have more favorable attitudes and are more prepared to consider a geriatrics career than those without such exposure, and knowledge about geriatrics is a factor associated with more-positive attitudes. It has

**Why Geriatrics? Academic Geriatricians’ Perceptions of the Positive, Attractive Aspects of Geriatrics**

David D. Cravens, MD, MSPH; James D. Campbell, PhD; David R. Mehr, MD, MS

**Background:** Recruitment of geriatrics trainees has been poor, and the current shortage of academic geriatricians is expected to worsen. Although barriers to entering geriatrics practice have been identified, a review of the literature found few studies about why people choose to enter geriatrics. **Methods:** We used qualitative methods to investigate the positive, attractive aspects of geriatrics. Long interviews with six academic geriatricians were taped and transcribed. Transcripts were entered into a textual database computer program and reviewed independently by two investigators. **Results:** Six themes emerged: 1) traditional learning experiences, 2) value on personal relationships, 3) a perception of distinctive differences, 4) a desire to feel needed personally and societally, 5) prefer democracy versus autocracy, and 6) desire intellectual challenges. Academic geriatrics, therefore, is particularly attractive to people who value enduring relationships, see challenges in complexity, practice social responsibility, prefer working within a multidisciplinary team, and derive satisfaction from making seemingly small but nonetheless important changes in peoples’ lives. **Conclusions:** If further studies validate these findings, they could promote geriatrics as a career, by, for example, identifying students and family practice and internal medicine residents who share these values, beliefs, and attitudes and encouraging them to consider this important field.

(Fam Med 2000;32(1):34-41.)

The number of people older than age 65 is expected to increase from 33 million (12% of the 1994 population) to more than 65 million (20% of the population) by 2030. Ensuring adequate medical care for this aging population means that additional training is needed in geriatrics for family practice and internal medicine residents, along with continuing medical education for current practitioners who care for elderly patients. In 1994, the Institute of Medicine projected the need for an additional 1,000 to 2,000 academic geriatricians, but the current production of geriatrics faculty is not enough even to replace those who will retire in the near future. Of the 16,268 students who entered US medical schools in 1985, only 125 entered geriatrics fellowships in 1992, and only 63 of these fellows pursued academic careers. The 1994 Institute of Medicine Committee on Strengthening the Geriatric Content of Medical Training, therefore, recommended “enhancing the attractiveness of geriatrics” by encourages physicians to enter geriatrics training programs.
been suggested that teaching about normal and abnormal aging may improve attitudes toward the elderly. John et al suggest that such teaching requires not only a series of lectures but also an inspired and dedicated faculty as role models. The possibility that geriatrics is more attractive to more-mature individuals has also been raised by some authors.

Beyond understanding the lack of interest in geriatrics, it is important to know what is attractive about academic geriatrics as a career. In the study reported here, we sought to identify how academic geriatricians explain their decision to enter geriatrics and what they see as the field’s positive aspects. The specific objective of our research was to elicit their perceptions of the positive, attractive aspects of geriatrics.

Methods

We used qualitative methods to explore reasons for entering academic geriatrics. Qualitative research is well suited to discovering why people act in particular ways and to investigating the relationship between beliefs and behavior. We used grounded theory to uncover themes and concepts involved in choosing a career in academic geriatrics.

Informants

The subjects (informants) for this study were six geriatricians at Missouri and Kansas universities in 1997. Informants were selected because of availability and willingness to be interviewed. None who were asked declined the interview. These individuals exhibited considerable variation in training and background (Table 1).

Table 1

<table>
<thead>
<tr>
<th>Informant</th>
<th>Age (Range)</th>
<th>Primary Education</th>
<th>Upbringing</th>
<th>College Education</th>
<th>Medical Education</th>
<th>Residency-# of Years</th>
<th>Residency Location</th>
<th>Fellowship/Location</th>
</tr>
</thead>
<tbody>
<tr>
<td>A—male</td>
<td>40–50</td>
<td>Calif</td>
<td>Urban</td>
<td>West</td>
<td>West</td>
<td>Family practice–3</td>
<td>Midwest</td>
<td>Internal medicine-geriatrics/Midwest</td>
</tr>
<tr>
<td>B—female</td>
<td>50–60</td>
<td>Minn</td>
<td>Rural</td>
<td>Midwest</td>
<td>East</td>
<td>Rotating internship–1</td>
<td>East</td>
<td>Internal medicine-geriatrics/Midwest</td>
</tr>
<tr>
<td>C—male</td>
<td>30–40</td>
<td>Iowa</td>
<td>Rural</td>
<td>Midwest</td>
<td>Midwest</td>
<td>Internal medicine/psychiatry–5</td>
<td>Midwest</td>
<td>Internal medicine-geriatrics/ East</td>
</tr>
<tr>
<td>D—male</td>
<td>40–50</td>
<td>Mo</td>
<td>Urban</td>
<td>East</td>
<td>Midwest</td>
<td>Family practice–3</td>
<td>Midwest</td>
<td>Family medicine-academic/ Midwest</td>
</tr>
<tr>
<td>E—male*</td>
<td>30–40</td>
<td>Tenn, Okla, Pa</td>
<td>Rural/urban</td>
<td>Midwest</td>
<td>South</td>
<td>Family practice–3</td>
<td>Midwest</td>
<td>Family medicine-geriatrics/ Midwest</td>
</tr>
<tr>
<td>F—female</td>
<td>40–50</td>
<td>NY</td>
<td>Urban</td>
<td>East, Midwest</td>
<td>Midwest</td>
<td>Internal medicine–3</td>
<td>East</td>
<td>Internal medicine-subspecialty and geriatrics/East</td>
</tr>
</tbody>
</table>

* Senior geriatrics fellow when interviewed, now faculty member in family practice residency program in East

Information on age and specific locations is generalized to protect the anonymity of informants.

Procedure

One investigator conducted long interviews with each informant. Interviews were conducted to the point of redundancy; that is, additional informants were interviewed until no new data was forthcoming. This technique generally provides greater depth and richness of information than other qualitative techniques. The interview’s two “grand tour” questions broached topics broadly: 1) “How did you come to choose geriatrics?” and 2) “What do you see as positive aspects of geriatrics?” Grand-tour questions are designed to direct informants to areas of interest and encourage a thorough and descriptive narrative. Using floating and planned prompts as necessary, the interviewer elicited information in several categories of life experience: developmental, educational, occupational, religion, role models, and professional.

Interviews were audiotaped, transcribed, and entered in Ethnograph 4.0, a textual database computer software program (Qualis Research Associates, Amherst, Mass, 1995). After independently reviewing each interview, two of the investigators achieved agreement for classifying responses by general themes. In the first stage of analysis, we looked for associations in statements to identify common themes and categories. As data analysis progressed, we further refined these initial observations and concentrated on developing thematic patterns and their interrelationships. Finally, the themes that emerged from each interview were examined to see how they could be brought together to form a thesis.

The data’s trustworthiness was ascertained by several means: 1) During the interview, probing questions...
were used to clarify meaning to assess congruency with the informant’s intended meaning. 2) The research team sought disconfirming evidence by looking for incongruencies in responses. 3) Two investigators independently reviewed the data and achieved agreement in the analysis. 4) Informants reviewed our findings for accuracy of interpretations.\textsuperscript{14}

Results

Six themes emerged from examination and analysis of the transcripts: 1) experiences that fostered learning about respect, right, and responsibility, 2) a value on personal relationships, 3) a perception of distinctive differences, 4) a desire to feel needed personally and societally, 5) democracy versus autocracy, and 6) intellectual challenges.

1. Traditional Learning Experiences

All six informants described traditional learning experiences that taught respect for older people. Some learned lessons early in life from family experiences, including parental role modeling that showed respecting elders as what was right, proper, and expected.

We would go to Texas on vacation when I was a young child. Mom would go and visit all the old relatives with me in tow. My mom was respecting older people. When you came there, you went to visit these folks. It was the right thing to do.

Some informants also had encounters with elderly teachers who were influential in their early education. One informant recalled receiving exceptional piano lessons at age 5 from an octogenarian teacher; another informant recalled benefitting from an insightful, elderly teacher’s high expectations.

Some informants described traditional learning experiences that shaped their sense of responsibility—beliefs and attitudes about the elderly and an awareness that older individuals in the community may need help.

My parents would say, ‘We’re going to go help so and so rake their yard or shovel their walk, because they can’t do it.’ And, although my father did snow removal in the winter, there were a lot of people for whom he did it gratis, because they were old, and they couldn’t afford to pay him. But, he didn’t want them to not have their walk or driveway shoveled.

This sense of respect and social responsibility was reinforced by other early life experiences, such as the Boy Scouts, where, as one informant stated, “We were expected to help little old ladies cross the street.” Admiration and respect developed from family, community, religious, and/or cultural influences.

Through work, some informants not only reinforced their sense of responsibility but also learned customary ways of tending to the needs of elders.

One summer, I worked as a waitress in a local restaurant. There were the older people who would take their meals there. So I got to know them. And, if they weren’t in for their morning coffee or in for dinner that night, then somebody would call to check on them. That’s what people do in a small town.

Some interviewees had jobs before medical school in which they cared for older people. Older people were viewed as valuable assets, rather than as something to be discarded. Informants enjoyed learning history from elders’ first-hand accounts.

When I was in college, I started work as an orderly in a county nursing home. It was very interesting to work with people who were older, and some of them were just really interesting to talk to. I enjoyed hearing the stories. They always had a lot of good stories and some wisdom. I like history, so I found this really interesting, talking to people who are first-hand witnesses to [historical] events or people. One woman had gone west in a covered wagon as a child and had recollections of that trip. Having talked to somebody who had lived through that period in our history was really fascinating. It was really just fun to sit and talk with those people . . . to hear their stories.

Although not all early experiences with elders were positive, most informants (all of whom, of course, chose careers in geriatrics) recalled positive, memorable encounters with older people when they were growing up. Some described good relationships with grandparents or positive views of grandparents.

2. Value on Personal Relationships

A second theme among informants was the great value they placed on personal relationships.

I’ve gotten to a point where I think people are seduced by the thrill in health care, which is the technical thrills and the excitement of the emergency room. And, when you’re young and you’re impressionable, it just all looks so exciting to do codes and stick big holes in people and use those fancy machines. But, the enduring values are to create these relationships: to be ‘with’ people.

Most informants discovered early on that they liked old people. Given a wide spectrum of patients, they found clinic visits with very old individuals to be most enjoyable. The informants recognized that long-term relationships with patients were important in their professional happiness and that the same relationships also were important to the patients.
It’s not true that I always knew I wanted to be a geriatrician or that I understood what that might mean for the kind of practice I had. What I knew was that it felt nice when I visited with the old people.

They wanted somebody they could trust, who would be a good advocate for them and be knowledgeable if they got in trouble.

Informants enjoyed peer relations for the commonality of spirit, ideals, and approach to patients, their problems, and potential solutions. Part of this feeling of kinship stemmed from a high regard for the humanity of patients, which all respondents echoed.

It’s a powerful feeling I have, that you might as well be a car mechanic if you’re just going to stick holes in people and not talk to them.

Geriatricians are a wonderful group of people to work with. You have to look hard—I think you have to look very hard—before you find a geriatrician who’s a jerk. They all really seem to be nice, down to earth, yet real intelligent people.

3. A Perception of Distinctive Differences

Informants saw their elderly patients as different from younger people in several ways that generally were rewarding: experience, personality, and the need for care more than cure. It appeared that the combination of such characteristics with informants’ personalities led to practice styles that emphasize preservation of function as well as quality in life and in death.

It’s like if you collect antiques and find a dusty old one that needs to be dusted, polished, and maybe have a couple of screws tightened. Then you end up with a real treasure. That’s kind of what you do with geriatrics.

Part of the value of being a doctor is providing services. Not from a moralistic ‘I’ll go to heaven’ sort of thing but because there is a certain respect that I have for older people because of the things that they have been through. Because of their experiences, it makes it seem more important to try to be helping them. In part, maybe because it is harder for them to help themselves but also because of what they’ve been through and what they represent as a being that has endured. They have had a lot of meaningful experiences.

Learning about the human condition and trying to help people deal with adversity and face the challenges of serious illness, doubt, disability, and death were described as more substantial experiences than treating younger patients with minor, transient maladies.

In describing the distinctive characteristics of older people, respondents almost appeared to be describing themselves.

As practicing physicians, it’s the people we take care of who influence us the most.

Geriatric patients are very appreciative and willing to listen.

As a group, geriatric patients are more appreciative of what you are doing for them. The pace is different. You spend more time listening to them. There’s lots of times with younger patients, they’re in and out.

Another factor evident in each interview was the importance of a range of healing measures in caring for older persons: caring for and supporting patients and maximizing and maintaining function in the face of chronic disease and disability. These physicians sought to help patients find harmony with their environments.

It’s not only diseases that you are taking care of and responding to, it’s people with diseases and how they’re functioning that are really much more important.

Sometimes doing really simple things can make a lot of difference for people.

They are looking to me to help them achieve as much quality as they can get in whatever time they have left, and I enjoy that. I know I’m not going to cure them of their chronic illnesses.

This attitude extends to end-of-life issues as well, with respondents recognizing not only the importance of quality in life but also quality in death, when healing was no longer possible.

I really enjoy keeping independent, very old people doing well; I love my patients who are getting close to 100 and are still in their own places. We celebrate that together. I also love doing my best to help people have good deaths.

In contrast, one informant described the difficulty of dealing with a young patient’s sudden and unexpected death relative to the more manageable emotional toll of an elder’s gradual decline to an expected death.

4. A Desire to Feel Needed Personally and Societally

Geriatricians find both personal and professional fulfillment. Some informants emphasized the importance of addressing personal desires to feel needed, appreciated, and cared for.
I have that sense of being needed, too. It sort of validates what you’re doing.

There’s this strong sense that they care a lot about me. I feel loved. I feel appreciated, in a way that I don’t get nearly as much from younger patients.

Part of my interest in geriatrics is because I’m an iconoclast. You know, it’s sort of bucking the trend to become interested in geriatrics.

Helping people through the process of dying and bereavement are times when people are appreciative of that type of care.

Some interviewees described filling areas of need for others, both patients and society.

I had gotten more older patients and enjoyed them, so that’s how I got into it. There was a need, because so many physicians were not taking Medicare. The university was one of the few places that would take Medicare patients, and I felt that Medicare patients were a neglected group.

One of your jobs is to protect your patients from the system and sort of rescue them from the subspecialty care, inattention to functional status, and inappropriate living situations. That was a thing that was interesting and motivating for me.

If I was going to be in geriatrics, it was important for there to be someone who would take good care of the vulnerable.

This sense of duty moves geriatricians to care for patients that others might see as undesirable. One informant described taking on new patients who were already demented, establishing personal commitment for their care, and directing her sense of mission toward their families or caregivers.

I don’t think that someone who is going to make a wonderful geriatrician either has to know about it or has to start out loving demented, incontinent, bed-ridden people. I’m being very honest; I did not. I am learning to—but it’s not a natural thing—with the sense that there’s a person who’s not there so much anymore, and I could be part of helping deal with that situation.

5. Prefer Democracy Versus Autocracy

In contrast to areas of medicine in which physicians serve by choice or necessity as autocratic “captains” of their ships, this study’s informants recognized early that they enjoyed a more democratic team approach.

I’m happy in a collaborative practice, with teams. I like being useful to the team and to the patients. I can’t imagine being the king doctor or whatever. I just sort of thrive in that kind of environment with patients.

Informants’ teams include patients, patients’ family or caregivers, social workers, nutritionists, nurses, therapists, and other health professionals.

It’s emphasizing continuous, coordinated care, emphasizing communication, looking at a broader picture, working with patients within the context of their illness and their environment across settings of care with other members, acknowledging that other health professionals have great, significant contributions to make in the care of a person.

There’s a shared sense of success or accomplishment that in some ways is more rewarding than individual accomplishment. I find working as a team to be one of the most enjoyable parts of doing geriatrics.

6. Desire Intellectual Challenges

Our informants seemed to have found their niche after coming into medical education or practice with values, beliefs, and attitudes that were compatible with academic geriatrics. They found research, teaching, and working through complex problems to be appealing. Role models, when present, affirmed that geriatrics could be enjoyable, and positive practice experiences affirmed expertise. Most informants, however, recollected a paucity of role models, though the influence of role models, when present, could be powerful.

This visiting professor had a dynamic and interesting approach to geriatrics, and he would emphasize old people as basically people who were very fragile and who had multiple things that could kind of tip them off their equilibrium. I found this an intellectually attractive point of view.

He had much more clinical experience in caring for older people than I did. He was certainly a positive influence. He appreciated the people. He had fun doing it. I think that is so important to being a successful practitioner. You have to have some fun along the way, otherwise it just becomes drudgery.

Many informants did not begin medical practice in geriatrics. Their interest developed during practice, and they made early- to mid-career changes into geriatrics. Sometimes, that interest was obvious to others before it was obvious to the individual.

When I joined the faculty in the beginning, the department chair had sort of mentioned to someone that I was
interested in geriatrics. I’m not sure exactly why he thought that, that I’d given him the impression of that per se. That sort of expectation probably had some impact.

He got a grant to develop a geriatric curriculum in an interdisciplinary sort of way. He asked me if I would participate. So I agreed to do this and having decided that I was going to be helping to develop a geriatric curriculum, I decided I better get some geriatric patients.

Positive practice experiences are a factor in the development of interest in geriatrics. The experience of successes in treating older people affirmed expertise. This increased interest and enthusiasm for geriatrics. Many factors were at play in this positive practice experience, including a sense of duty, an awareness of need, and a sense of fulfillment in addressing that need.

Two of my first three nursing home patients turned out to be people who had major neglected problems. I was able to have an impact. That kind of got me ‘revved up,’ that I was capable of making a difference in people’s lives. So, that really got me interested in geriatrics, and I started actively pursuing it and reading, learning, and actively seeking patients. I gradually became known in the community as somebody with geriatric expertise.

The intellectual challenge of caring for older people was identified as a factor in both developing and maintaining interest in geriatrics.

I really like complex physiology. I like hard clinical problems. I didn’t want to do the same thing every day. I wanted to do something where I always had to keep learning and keep figuring things out.

I’m really into the intellectual demands: the breadth of knowledge, the challenge of the decision making when you have to weigh not only evidence and knowledge but patient preferences and risks. Those are really, really challenging decisions. I enjoy struggling my way through those. It’s always a little painful, but it’s good for you. I’m proud of sort of steering my way through Scylla and Charybdis. (Editor’s note: through multiple hazards)

I think one of the things that came first in terms of the initial interest was the challenge of geriatrics from both the intellectual side and the system side. On the system side, I saw how difficult it is to care for people who have chronic illness, frailties, or complicated problems within a system that tends to be disease oriented, subspecialty oriented, and hospital oriented. All of those things that medicine does well are not particularly things that it does well in caring for older people. The intellectual side is still an important thing to me. Obviously the physiology and pharmacology are interesting. The complicated types of clinical problems are interesting. How you mesh the responding to the complicated clinical problems with the setting of care and the providers of that care and all of that is sort of a puzzle in which each patient is somewhat of a different one. That’s part of my interest in geriatrics from the beginning and continues to be.

The informants described a holistic approach that combines medical expertise with specific knowledge of patients as individuals—their identity, beliefs and wishes, environment, illness, disability, and strengths and weaknesses. Beyond the Hippocratic principle of accurate diagnosis through observation and knowledge, they follow the Osler maxim: “Care more particularly for the individual patient than for the special features of the disease.” The great value informants placed on relationships serves this purpose well. They intricately weave the best art of medicine with the best current science to create a tapestry of care for each patient.

Informants had a sense of awe and adventure at being part of a developing discipline with so many opportunities to conduct research and develop programs. They had a particular dedication and enthusiasm for discovering new knowledge of geriatrics and sharing it by teaching others.

Sometimes I feel that some areas, like cardiology, they’re 50 years ahead of us, and the incremental gains are very different. The cardiologists are deciding between 16 different ACE inhibitors. The geriatricians are trying to figure out ‘what are we going to do about these falling people!’ I like being in this fairly unexplored territory. I feel like we’re pioneers.

Some informants observed that teaching in geriatrics has been neglected or ignored, and they set goals of changing attitudes of students and others toward older people. They served with great satisfaction as role model and resource, revealing to others a field that could be of great pleasure to its practitioners.

There [are] a lot of opportunities to teach in this area because there aren’t a lot people with a good perspective on it. Because of that, a lot of students and residents will come to a point where they have not had many useful experiences or positive experiences. By modeling some of the things that you do to be a good physician of older people, there is a lot of opportunity for teaching them things that they have never learned before, that nobody else has taught them, and that’s a satisfying thing, too. The student may be a resident or medical student or could be a nurse’s aide, the LPN at
the nursing home, the director of nursing, the home health nurse, or family caregiver.

I enjoyed exposing students and others to an area that they only had a negative perception about. My goal was to change that perception. I wanted them to see a positive approach to geriatrics, so that, first, they weren’t unappreciative of the older patient, and second, that they didn’t dread seeing older patients, didn’t dread having nursing home patients.

Discussion

How do the six themes help us understand why our informants entered geriatrics and what they like about it? The informants learned by example and expectation early in life that it is right to respect elderly people and to take responsibility for helping them (tradition theme). Consistently, informants were socially engaged in ways that are congenial to academic geriatrics; in addition to liking old people in general (relationships theme), they enjoy working democratically in teams (democracy versus autocracy theme) to help elderly people, whose experience and approach to life informants saw as different in appealing ways, compared with younger patients. Simply put, informants like older people a great deal (distinctive differences theme). At the interpersonal level, patients’ deeply felt appreciation for the help of physicians in this sample was satisfying emotionally; another important satisfaction came in knowing that treating elderly people was a job of significance in society (addressing personal and societal needs theme). Finally, informants enjoyed the intellectual challenge of geriatrics.

What leads people to choose a geriatrics practice or career? The choice of a career is likely a complex decision influenced by a wide range of interactive factors. However, the literature regarding this has tended to rely on survey methods. The relative importance of societal factors, attitudinal factors, and experiential factors has not been carefully studied.

Meaningful physician-patient relationships have been shown to be one of the most important factors in choosing a primary care field. Many studies confirm that medical student clerkships in generalist fields lead to greater interest in those fields. This suggests that discovering one’s talents for an area leads to increased interest. Indeed, impediments to making a career choice include lack of information, lack of support, and not knowing one’s interest or abilities. Conversely, Garrett et al found that students grew stronger in their belief that they wanted to specialize in family practice if they could feel competent and sure of their work. They suggest that it may be important to expose students to family physician role models to demonstrate the competence and comfort of those role models with their specialty’s breadth. It is plausible that this may apply to geriatrics as well: being a good geriatrician could be described as a logical extension of being a good primary care physician. Our findings of relationships and affirmation of expertise as attractive aspects of geriatrics are consistent with these findings.

Our study has several strengths and limitations. Sound, qualitative methods provide abundant, thorough data with a depth not achievable through surveys. However, this small convenience sample from the Midwestern United States limits discovering regional variation; it would be useful to replicate this study in other parts of the country. Moreover, since we interviewed individuals with established careers in geriatrics, some of the comments may reflect reasoning after the fact. Though two of our informants had not received geriatric fellowship training, such individuals may represent a larger proportion of current academic geriatricians. However, there were no obvious differences in responses detected in this sample. If any substantial differences exist, a larger study sample would be required to detect them. Developing quantitative measures based on the themes discovered in our study would be useful for determining the generalizability of our findings and determining the relative importance of the attractive features of geriatrics.

Conclusions

Our findings may be useful in promoting geriatrics to medical students and primary care residents. These interviews are likely representative of a conversation that an academic geriatrician might have with someone exploring academic or practice options. By publicizing the positive, attractive aspects of geriatrics, the results of this study could have direct application in providing greater awareness of geriatrics as an academic discipline and encourage more primary care physicians to include geriatrics in their practices. As one of our informants stated,

We have a long way to go to get people interested, but it’s like obstetrics or pediatrics. Not everybody wants to do obstetrics. Not everybody enjoys doing pediatrics. And not everybody enjoys or is good at doing geriatrics. But I think we need to work so that we can identify those who are and encourage them.

I think it’s easy once you’ve gone through middle-age to appreciate older age. If we can get people to appreciate geriatrics before they’re middle-aged, then we’ve accomplished our goal.

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