Teaching Geriatric Care: Report on an Experimental Second-Year Elective

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To help fill the growing need for medical school instruction in geriatric care, the Departments of Family Medicine and Community Medicine at the College of Medicine and Dentistry of New Jersey-Rutgers Medical School, in cooperation with Roosevelt Hospital, a nearby county-supported chronic disease facility, joined to develop an experimental second-year elective, given for the first time in the fall of 1976. The curriculum involved 11 three-hour sessions covering a variety of medical and socioeconomic topics. Enrollment was limited to 12 students. Reaction was positive on the part of students, patients, and faculty, especially with respect to student attitudes toward the elderly. Improvements are suggested in six major areas.

"The average medical student meets his first older person as a cadaver." This harsh criticism of the current status of geriatrics in medical education, quoted in a 1976 newspaper story,[1] may be an exaggeration but the essential point is well taken.

The need for instruction in geriatrics was recognized as early as 1944.[2] In 1973, the Committee on Undergraduate and Continuing Medical Education of the Gerontological Society published a suggested "Model Curriculum for an Elective Course in Geriatrics."[2] As late as 1971, however, six years after passage of Medicare with its multibillion dollar commitment to the medical care of the elderly, a survey revealed that "instruction in geriatrics, with a few exceptions, ranges from the fragmentary to the nonexistent."[2]

By contrast, the need for physicians interested in and trained in the special health and medical problems of the elderly is increasing year by year. In 1975, 10.4 percent of the US population, nearly 23 million persons, was 65 years of age or over.[3] Between 1900 and 1975, the percentage more than doubled. At present death rates, this total is expected to rise to 31 million by the year 2000. If current low birth rates continue, by 2020, when most of the large cohort of postwar babies will be 65 years or over, they will constitute about 17 percent of the total population.[4] About eight percent will be 75 years of age or older.

Even today, the elderly represent over 12 percent in eight states, notably Florida, with more than 16 percent over 65 years of age.[3] The physician who is determined to escape from elderly patients must go to Alaska or Hawaii, the only states with less than seven percent of the population over 65 years of age.

But the problem is more than just one of numbers. Old people require a disproportionate amount of medical money, space, and talent. The field of geriatrics is assuredly one of the most complex in the entire field of medicine. In addition

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to instruction in basic biomedical, behavioral, and clinical sciences, the student must be familiarized with a complex set of epidemiological, socioeconomic, administrative, ethical, legal, and political issues which constitute the controlling environment in which the geriatrician must care for his/her patient.

Recognition of this complexity probably constitutes one of the major obstacles to the faster development of geriatrics as a regular component of the medical school curriculum. There is also the widespread prejudice against old people, a prejudice all too often shared by physicians.

> There are many reasons for this: the aspirations of a young country, the demands of youth, the demise of the extended family, and medical training that has focused on problem-solving rather than problem-coping . . . . Then, too, old people remind us of our own dissolution. We become frustrated when we cannot control the variables and when we can no longer be assured of a happy outcome. We do not like to acknowledge that the most heroic of our efforts are often as feeble as the bodies of our patients. We do not want to be involved with variables that are outside the traditional range of scientific medicine: housing, income, mobility, and place in society.[5]

In contrast to this prevalent faculty view, there appears to be a growing student demand.[6]

The CMDNJ-Rutgers Experiment

Curricular Content

In an effort to fill the vacuum at one school, the Departments of Family Medicine and Community Medicine at the College of Medicine and Dentistry of New Jersey-Rutgers Medical School (CMDNJ-Rutgers) joined to develop an experimental elective in geriatric medicine, offered for the first time in the fall semester of 1976. The stated goals were: (1) to promote awareness and understanding of the special health problems of the elderly, (2) to influence positively student attitudes toward working with the elderly, and (3) to integrate basic and clinical sciences in this area.

Enrollment was limited to 12 second year students, most of whom had already participated in a first-year family medicine elective, "Introduction to the Patient," which provided extensive family practice office observation. In addition to the authors of this article, who developed the program, the faculty included three family physicians, two internists, a specialist in physical medicine, and two professors of community medicine. All had a special interest in older people and they were asked to attempt to convey their attitude as well as their subject matter.

The curriculum involved 11 three-hour sessions on Thursday afternoons. The majority were held at Roosevelt Hospital, Metuchen, a 300-bed chronic disease facility operated by Middlesex County, about 30 minutes from the medical school. Topics covered included theories of aging, stroke syndromes and rehabilitation, arthritis, dementia, nutrition, terminal care, role of the family and the family physician, and socioeconomic factors.

In general, the first hour of each session was devoted to a didactic presentation of one topic, and the final hour to clinical rounds of patients with problems appropriate to that topic. For the Roosevelt sessions, the students spent the second hour with a patient whom they were instructed to follow for seven weeks. They were asked to visit with the patient's family if available, and to learn as much as possible about the patient's medical and socioeconomic background; also to review the charts and speak to the physicians, floor nurses, and occupational and physical therapists. A written case study on the patient was required at the end of the course.

One of the two socioeconomic sessions was held at Middlesex General Hospital, a 360-bed community hospital with a special discharge planning floor and a good home-care program; the other session was held at the Edison Nursing Home, a 300-bed institution with a reputation for better-than-average care.

Special features included showing the movie "Peege," (Phoenix Films, Princeton, NJ) at the orientation session to allow the students quickly to

get in touch with their own feelings and to promote a positive attitude toward the elderly. At the "Death and Dying" session a patient, who had recovered from a near-death episode followed by a two-year struggle for partial rehabilitation, met with the students, as did the widow and daughter of a patient who had died 18 months earlier. At the final session, one of the students, with a master's degree in English literature, led a discussion of aging in poetry.

The course syllabus, distributed in advance, included an outline of the major topics for each session and a list of required and recommended readings. The former averaged about 50 pages weekly.

Student Evaluation

Student reaction to the course was, on the whole, very favorable. An end-of-course questionnaire indicated satisfaction with the goals, and the general organization. Reaction to individual topics varied from most favorable for "Death and Dying" to least favorable for the socioeconomic sessions.

Opinion as to the value of following one patient for seven weeks was mixed. Several felt frustrated over their inability to communicate with deaf or demented patients. Some would have preferred to see a different patient each week. On the other hand, several developed an excellent relationship with "their" patient, took him or her on outdoor walks or wheelchair rides, and suggested improvements in his or her care. One patient was discharged during the course, which helped to destroy the myth that long-term care facilities are inevitably one-way institutions with entrances but no exits. The students' case studies also indicate that they were able to learn from the difficult experience of trying to communicate with the "uncommunicable." Following are several excerpts:

Dealing with Mrs. B. five times on a personal basis has been one of frustration, being uncomfortable with having to shout to be heard, and anxious as to whether I was really helping her in any way. There can be no question that dealing with a 90-year-old person is quite humbling, especially one who is essentially in good health. . . .The 'sounds of silence' were excruciatingly painful to me. Indeed, I fled after 10 to 15 minutes.

I have yet to figure out a good way of handling the situation—especially since her nephew never comes to visit and Mrs. B. does not seem to have any friends among the third-floor patients. Environmental stimulatory deprivation seems to me to be a major point of concern in Mrs. B.'s treatment.

Mr. S.'s medical history reads like a primer on chronic diseases. He has: arteriosclerotic heart disease with congestive heart failure, chronic obstructive pulmonary disease, chronic constipation, chronic cough, severe hypertrophic osteoarthritis, diverticulosis of the colon, cholelithiasis, compression fracture of L-2, skin condition, polyps, and orthopnea. He has also had his gall bladder and prostate removed and had a bilateral iliac thromboendarterectomy and sympathectomy . . . . He is an old-world Italian, a 78-year-old rebel. He came to this country when young and worked as a presser in a clothes factory for 45 years. He was a heavy smoker (5 packs a day) and often spent his free time in taverns. He stopped smoking and drinking about 15 years ago.

Mr. S. taught me a lot concerning the problems of being old. He was always an independent person, and now must depend on others. He is also alone, but compensates well by making friends easily. He made me laugh (He kept asking me, 'You think I'm crazy, don't you? I'm not crazy!') and almost cry, and I thoroughly enjoyed meeting with him and perhaps filling some of his loneliness.

Mrs. K. (73) was difficult to rouse, and I felt reluctant to try. The hell with her, I thought; why waste time on someone so unresponsive, so indifferent to one's efforts? How natural to react thus: how much more difficult to imagine how and why she had become this way: how dulling and deadening two years on one's back in a hospital room can be. We like the old when they fulfill our fantasies—when they are wise and cracker-barrel humored, when they tell the sentimental stories or shower us with attention. This woman was depressed, tired, and already slowed by Parkinsonism. Moreover, perhaps she had never been particularly scintillating. Who would ever know?

I also came to realize that although Mrs. T. (60) is rather disabled, she still can do a great deal and shouldn't be allowed to fall into a self-centered attitude.

I found myself feeling overly sorry for her. I don't think that type of attitude would help a patient. It could contribute to crippling them emotionally. A doctor should sympathize with his/her patients to a point but then stress and encourage their potentials, not their shortcomings.

Prior to my sixth visit with Mrs. Z (89), I discussed these problems with the nurses. They told me that my patient had few visitors besides her daughter. Her grandson, a doctor, very rarely shows any interest in her. No one visits on weekends and the loneliness really hurts. With the help of the head nurse, I took Mrs. Z. in her wheelchair outside for a walk. I talked to her this time as another person, not as a helpless patient. She responded well and smiled most of the time. When I left that day, unlike any other time, she asked me when I would return to see her.

One question of some concern at the outset was the wisdom of offering the course in the first semester of the second year before the students had formal instruction in medical history-taking and physical diagnosis. By the end, both faculty and students were agreed that the second-year placement was successful. Given a choice of first, second, or fourth year, ten students indicated preference for the second; only one for the fourth. All agreed on the value of the earliest possible exposure to patients, stressing the importance of this experience in arousing interest in the more specialized areas of study.

Patient Reaction

Nurses at Roosevelt Hospital were asked to check on patient reaction to their student visitors. By the time of the nurse's interview, one patient had been discharged, one had died, and several were too confused to remember or answer coherently. Of the five responses, all were favorable and said they would like to participate another year.

Three of four nurses also said they would like to be more fully involved in the future. None reported any interference with her work. Personnel at the nursing home were especially enthusiastic over their session and eager to cooperate in future teaching plans.

Major Issues for the Future

While student and patient reaction to the first-year experiment was generally satisfactory, the faculty, especially those responsible for developing the course, have been working on improvements for the next academic year. The major immediate points at issue include: (1) overall length of the course, (2) improving the socioeconomic sessions, (3) inclusion of additional diagnostic topics, (4) value of following a single patient throughout the course, (5) maximum size of enrollment, and (6) increasing exposure to community practice.

1. All but two of the students urged a longer course for the future. Five suggested 12 sessions (three months); three, 15 sessions (one semester); and one, 30 sessions (one year). Most of the faculty also agreed that more time would be desirable. A tentative decision has been made to increase to 15 weeks.

2. The principal problem with the socioeconomic sessions was the effort to crowd too much into too short a time. With only two sessions, an effort was made to give the students an indepth view of a large nursing home (patients, administration, medical direction, nursing, social work), a hospital-based home-care program (sitting in on an interdisciplinary review conference), and an innovative hospital discharge program, as well as an overview of the demographic and socioeconomic status of the elderly in America, the organization and financing of their care, and the nature and shortcomings of current US health policy for the elderly. As might be expected, the results were something less than spectacular.

The problem of time constraints can be eased by adding more sessions to this segment of the course. Of the new total of 15, four (two additional) will be allocated to socioeconomics with major topics as follows: (a) Demographic and socioeconomic data base, (b) Nursing homes and other

institutional facilities, (c) Home-care, day-care, and other noninstitutional facilities, and (d) Financing: Medicare, Medicaid, and private health insurance.

In addition to the nursing home and community hospital discharge planning program, there will be a site visit to either a housing project for the elderly or a day-care center. The home-care session will involve accompanying visiting nurses on actual home visits.

Far more difficult is the problem of reconciling the apparent conflict in basic philosophy between the socioeconomic and medical sessions. While the primary aim of the latter was to increase the student's sensitivity and responsiveness to the special needs of the *individual* elderly patient, the primary aim of the socioeconomic sessions was to increase sensitivity and responsiveness to the needs of the nation's *23 million elderly* and to increase understanding on how best to meet those needs in a context of limited resources.

For example, some students were restless and even irritated during meetings they attended of the hospital and home-care admissions and review committees. Inevitably, these involved an element of triage or rationing which appeared in conflict with the "do everything possible" philosophy of individual care.

These are, of course, not contradictory but complementary considerations. Humane personalized care for the great majority of elderly individuals is only possible within a context of rational use of resources which, in turn, calls for maximum attention to prevention and social policies which assure equity to all, not just to a lucky few. This implies a combination of socioeconomic, epidemiological, and clinical considerations and a philosophy that has been called "statistical compassion."

In a sense, this is one of the basic challenges to all medical education today, a challenge which departments of community medicine and preventive medicine have conspicuously failed to meet, partly because they have generally been treated as peripheral rather than integral components of the total educational experience. The challenge is particularly urgent and difficult in the case of geriatrics.

This is not an easy pedagogical objective, however, since it requires high-level input from all three vantage points: clinical, epidemiological, and socioeconomic. There is no assurance that the CMDNJ-Rutgers course will succeed in meeting it any better the second year than the first. However, it will address the problem more forthrightly and with a larger segment of the total effort.

3. The question of including sessions on cardiovascular disease, cancer, diabetes, or other conditions obviously arises, the possible number of such additions being great. The Gerontological Society's "Model Curriculum" includes separate sessions on some 20 different diseases or diagnostic categories.[2]

With the tentative decision to expand the course to 15 sessions, two more sessions will be available for additional diagnoses.

4. Student opinion on the value of following a single patient for several weeks was divided; three thought it very valuable, one, of no value, the others, in-between. The differences are understandable and probably relate primarily to the patient's ability to speak and communicate with the student. Whatever doubts there may have been, however, were resolved by the quality of the written reports which would not have been possible without such an assignment. As one student put it,"It was a chore but caused things to gel."

In 1977, the general concept will be continued but with two adjustments: (a) no patient will be included for this purpose who cannot communicate orally, and (b) the time allotted for this purpose will be reduced from 60 to 30 minutes. This will permit more time for general rounds, thus meeting the suggestion of those students who wanted more exposure to different patients with different diseases.

5. With respect to size of class, most of the faculty as well as students agree that 12 was big enough. Indeed, there was a good deal of feeling that the number was too large for bedside teaching and should be reduced to three to five students. On the other hand, several faculty were willing to accept 15, provided this was acceptable to the staff at Roosevelt Hospital. An effort will be made to enlarge the group to 15 in 1977, although this will mean dividing up rounds and thus more work for the faculty. An effort will also be made to bring more patients to the classroom.

The problem of size for future years is difficult. With the growing interest in gerontology and geriatrics, there will probably be increasing pressure on medical schools to integrate such courses into the basic curriculum for all students.

The authors share the hope of those who would like to see this done. However, a successful geriatrics course cannot simply be mandated with x number of lectures divided up between x number of existing departments. The essence of the geriatric approach—a subtle interweaving of physiological, psychological, and socioeconomic factors—is likely to be lost in such an undertaking.

Nor is it possible, under typical medical school teaching arrangements, to provide meaningful clinical geriatric experience for over 100 students at one time. The CMDNJ-Rutgers program was fortunate in having access to a good chronic disease hospital, nursing home, and home-care program in the immediate vicinity. However, all of these arrangements depend on informal personal contacts and a particularly cooperative spirit among the participating physicians in these institutions. Like most other schools, CMDNJ-Rutgers lacks affiliation agreements with a sufficient number of long-term facilities to permit a course of this type to be generalized to the entire class. The development of such relationships cannot and will not be accomplished overnight.

6. In order to give the students a more balanced view of normal geriatric practice with patients who are in relatively good health, two of next year's sessions will be held in community settings, probably a day-care center and a housing development for the elderly.

Conclusion

The CMDNJ-Rutgers experience suggests that any medical school considering development of a geriatrics course might consider two preliminary steps: (1) a small elective program to permit experimentation with different mixes of subject matter, faculty, and teaching design, with special attention to the difficult problem of integrating the socioeconomic aspects into the mainstream of the course, and (2) development of a network of associated long-term facilities and community programs that will permit observation of a broad range of geriatric problems, creative clinical teaching, and personal student-patient interactions.

Without the last the heart of the geriatric experience would be lost. No matter how brilliant the didactic expositions, how well organized and funded the observed health-care programs, if the student is not touched by the frail humanity he must deal with—his own as well as his patient's—the course will not have achieved its primary goal. It is well to be reminded of the words of St. Paul to the Corinthians:

> Though I speak with the tongues of men and of angels, and have not love, I am become as sounding brass, or a tinkling cymbal.

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