Geriatric Training in Family Medicine: The Natural History of a Developing Program

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During the past three years, the Duke-Watts Family Medicine Program and the Duke University Center for the Study of Aging and Human Development have developed training in geriatric medicine as an integral part of the family medicine residency program. This paper traces the following steps in the development of this program: a survey of resident and faculty interest, institution of a conference series, identification of potential training sites, development of elective rotations, and use of consultants. Principles found helpful in establishing training in geriatrics for family medicine residents include the following: involve residents in planning, start with modest goals, make the program relevant and practical, build on local strengths, include other health care professional trainees, and use ambulatory, acute hospital, and long-term care sites in the training program.

During the past three years, the Duke-Watts Family Medicine Program and the Duke University Center for the Study of Aging and Human Development have developed training in geriatric medicine as an integral part of the family medicine residency program. This paper reviews the development of the program, describes its current status, and outlines general principles which have been found helpful in establishing training in geriatrics for family medicine residents.

Background

Much has been written about the need for training in geriatrics for physicians at all levels of training (eg, medical school, residency, and post-residency).[1-6] At Duke, however, experience was relatively more important than literature in identifying geriatrics as an area for development of training by the Duke-Watts Family Medicine Program. This priority was established as early as 1972 by concerned faculty and residents. Family medicine faculty, all of whom had been in practice, recognized from personal experience that their education had not adequately prepared them to deliver quality medical care to the large number of elderly persons served by the family medicine center (approximately 27 percent of the patients being seen were elderly). Moreover, residents in the program perceived the lack of training in geriatrics as a program deficiency and expressed interest in developing training in this area. In 1972, however, there were few guidelines for the development of training in geriatrics within family medicine residencies. The Duke Center for the Study of Aging and Human Development appeared to be an obvious local resource, and, during 1973 and 1974, discussions between the faculty of

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Table 1. Conference Topics in Geriatric Medicine Requested by Residents

1. Practical problems in the office care of the elderly patient
2. Alternatives to institutionalization of the elderly
3. Sex life in the aging person
4. Psychiatric problems in aging
5. The examination and evaluation of the confused, disoriented, or demented patient
6. Management of depression in the elderly
7. Use of psychotropic drugs in the elderly
8. Management of pain in the ambulatory elderly patient
9. Counseling the family of the geriatric patient
10. Implementing professional home care services
11. Bedside diagnosis of cerebrovascular accidents
12. Drug therapy for cardiovascular disease in the aged
13. Dermatologic problems of the aged
14. Exercise and fitness for the elderly
15. Determining quality care in nursing homes
16. Management of decubitus ulcer in the elderly
17. The biology and physiology of aging
18. Gynecologic problems of the aged female
19. Common symptoms and complaints of the elderly
20. Orthopedic problems in the aged
21. Genitourinary tract problems of the aged
22. Differential diagnosis of dementia
23. Disorders of the digestive system in the aged
24. Hypertension in the elderly
25. The team approach in the health care of the geriatric patient

the Family Medicine Program and the staff of the Aging Center laid the groundwork for future cooperation in designing and implementing training in geriatric medicine specifically for the family medicine resident.

An informal survey of other family medicine residency programs revealed little formal geriatric training. Furthermore, a literature review identified only one reference published before 1974[7] specifically dealing with geriatric training in a family medicine residency program. Faculty members of the Duke-Watts program visited one family medicine residency program which had developed geriatric training for its residents. While this visit confirmed the feasibility of developing geriatric training as an integral part of a family medicine residency, the review of this limited experience of others reinforced a growing conviction that there were no models available for adoption. This required the development of a program using local resources.

In light of the fact that residents were seeing many older patients, it was of interest to know how comfortable the residents were in the management of such patients. How well had their previous training prepared them? Did they have concerns which could be appropriately addressed by a program in geriatric medicine? If so, what should be included in such a program?

Prior to instituting a program, therefore, a survey of resident needs and interest in the area of geriatrics was conducted. In 1974, residents were presented with a list of 53 conference topics drawn from a popular conference series in geriatrics developed by the American Geriatric Society. Residents were requested to rate the topics in terms of their perceived importance as information which would be useful to them in their practice. The 25 topics considered to be most important by the residents are listed by order of interest in Table 1. This survey was timed to coincide with the visit of a consultant geriatrician who discussed the results of the survey in the light of his own experiences in practice. This meeting exposed residents to the broad field of geriatrics and suggested that educational resources were potentially available to address their concerns. This strategy of involving residents in shaping the training program has proven to be very effective, and was used to involve them in developing a workshop designed to address topics of special interest.

The Geriatrics Program

Conference and Follow-Up

As a follow-up to the initial survey of resident's concerns, a day-long conference was held in December 1974. The conference was jointly sponsored by the Family Medicine Program and the Aging Center. It was attended by residents and faculty of the Family Medicine Program, faculty of other family medicine residencies, and practicing physicians.

The program for the conference consisted of the seven topics identified as most important and problematic by the residents in the previous survey (Table 1). Evaluation of the conference was accomplished through use of a form which was completed by those who attended the conference and through informal interviews of the residents after the conference. Both methods of evaluation indicated that the conference was seen as educationally valuable and relevant. But more importantly, the conference stimulated interest on the topics of special interest.

As a follow-up to the day-long conference, the Family Medicine Program instituted a series of monthly conferences relating to geriatrics. The conference topics were selected from those previously identified as important by the residents. These conferences were part of the weekly family medicine conference series.

Identifying Potential Training Sites

In any community a variety of potential sites will be available for training in geriatrics. Sites of special relevance for such training include nursing homes; acute hospitals; ambulatory care facilities, such as family medicine centers; community agencies responsible for delivering care to the aged, such as Mental Health Centers; Departments of Social Service; and, the Coordinating Council for Senior Citizens. In addition to these sites, three additional types of training sites were available locally: geropsychiatry units at a nearby state hospital and at the university hospital; the Older Americans Resource Service (OARS); and the Geriatric Evaluation and Treatment Clinic of the Duke Aging Center. The OARS Clinic offers outpatient assessment and also coordinates delivery of a variety of medical, psychiatric, and social services for the elderly. During 1974 and 1975, discussions were held with representatives of the above programs. All of the programs expressed interest in the training program being developed for family medicine residents, and several offered to collaborate in developing elective rotations for the family medicine residents. The details of the experience in assessing local resources and in choosing a few sites to begin the program are of less importance than the principle that any community has resources which can be part of a training program.

The following questions were helpful in assessing the potential contribution of a training site:

1. Did the site offer the opportunity for the resident to function as a member of a health care team?
2. Could the site be integrated into other aspects of the resident's training? For example, residents already had responsibility for some patients in local nursing homes and the acute hospital.
3. What could a resident learn from a rotation at the training site and how crucial would such knowledge be for his/her future practice?

Several sites were especially attractive for beginning the program. Those chosen were a local nursing home, the general hospital at which the residents took their internal medicine service rotation, the Family Medicine Center, and the weekly Family Medicine Conference series. These selections were based on several considerations, including the fact that residents were already scheduled to rotate through each of them. A conference series was then designed which supplemented existing rotations rather than adding a geriatric rotation which was beyond the program's capability at that time.

Nursing home case conferences are held weekly, and participation is required of residents during the four-month, full-time Family Medicine Center rotation in the second and third years of residency. These case conferences emphasize a team approach to patient care. Faculty supervision of these conferences includes input from a family physician, a psychiatrist, and a social worker.

Weekly case conferences are also held in the acute hospital and attendance is required during the four months that first year residents spend on the internal medicine rotation. This conference series is similar to that given in the nursing home.

Didactic conferences are held weekly during the four months of full-time rotation in the Family

Medicine Center which takes place during the second and third residency years. In addition, approximately 25 percent of the weekly conferences (Grand Rounds) are devoted to geriatric medicine topics. A sample of subjects presented in these didactic conferences includes: depression in the elderly; performing multidimensional functional assessment; rehabilitation of the stroke patient; principles of physical therapy; pharmacology; and organic brain syndrome.

Systematic Training: Initial Elective Rotations

The decision to initially offer electives rather than to immediately develop a required rotation was made for three reasons.

1. It was difficult to determine exactly how a site would function until residents rotated through it;
2. Beginning with an elective assured interested and enthusiastic learners. This was important because many of the training sites had no previous experience with physician trainees and it was important that their first experience be a positive one; and
3. Elective rotations offered the opportunity to experiment with different educational objectives and methods so that pertinent objectives could be selected as requirements for all residents.

In 1974 elective rotations in geriatric medicine were made available to the residents. Electives included month-long rotations in:

1. Two different local geropsychiatry units;
2. Training programs in geriatrics in the United Kingdom;
3. Older Americans Resource Service clinic;
4. Local community agencies; and
5. Local nursing homes.

Goals of the elective rotations included the following:

1. Residents would function as members of a health care team and would work cooperatively with other health care professionals (eg, nurses, social workers, and physical therapists) in formulating and implementing intervention plans.
2. Residents would learn how to use effectively all levels of care for geriatric patients (eg, acute hospitals, long-term facilities, day care, community, and home services).
3. Residents would learn how to identify and use community resources to help patients remain independent. The first residents to take this elective helped perform a survey of local community resources.
4. Residents would learn the special skills necessary for assessing elderly patients from both a physical and psychological point of view.
5. Each resident would present a conference to his or her colleagues after completing an elective rotation so that the entire program would benefit.
6. Each resident would submit an evaluation of the elective describing its potential as a training site for family medicine residents. Residents would also prepare instructions describing how their colleagues who followed them on rotations could get the most benefit from particular rotations.

Prior to beginning an elective rotation, the resident met with the faculty member responsible for coordinating the geriatric medicine training program to formulate a list of educational objectives. During the elective rotation, the resident and faculty coordinator met in at least weekly intervals to assure that the objectives were being met.

These elective rotations were quite successful in increasing interest in geriatrics, and experience from these electives has led to the development of a required rotation scheduled to begin in July 1978. Many of the objectives and educational materials to be used in the required rotation reflect input from the residents who earlier took elective rotations.

The Special Role of Consultants

From 1974 to 1976, a series of geriatrician consultants were invited to visit the Family Medicine Program to increase the exposure of residents to physicians with a wide range of experience in particular settings of geriatric training. A consultant with experience in physician training in long-term facilities evaluated the potential of a local nursing home as a training site; a hospital-based geriatrician evaluated the training potential of the local community hospital; and a consultant with expertise in use of community services, home visits, and ambulatory medicine helped evaluate the local resources in these areas. Consultants were also used as teachers, and they helped focus and maintain interest in geriatrics as the program was developing.

Conclusions

The first three years' experience of the Duke-Watts Family Medicine Program in developing training programs in geriatrics identifies the following principles as important in constructing educational programs in geriatrics as part of family medicine residency training.

1. Involve residents in planning. Residents have an investment in the success of programs they help develop. Programs conceived and produced with resident involvement will also more likely be relevant to resident needs.

2. Start with modest goals. It is better to successfully accomplish modest goals than to fail at ambitious ones, and it is easier to build on success than failure.

3. Make the program relevant and practical. Begin with case conferences and other teaching activities which have an immediate impact on the resident's practice. The program should make the resident's life easier, not more difficult. This is especially true in areas such as geriatrics that are likely to be met with skepticism and resistance.

4. Build on local strengths. Are there physicians in the local hospital with an interest in geriatrics? Is there a local long-term facility which offers outstanding service? Are there local community agencies which show interest and abilities in addressing the special needs of the elderly? It is possible that one program would begin a training program in a hospital, another in a long-term facility, and another in the family medicine center. It is better to build on local strengths than to attempt to duplicate a program which worked well elsewhere.

5. Involve other health care professional trainees whenever possible. One of the characteristics of geriatric medicine is that it requires a team approach to be effective. Training for family medicine residents should include exposure to working with other health care professionals in caring for the elderly. Involvement of other health care professional trainees is an effective method of helping residents learn the team approach to geriatrics. There are often a number of other benefits to including other trainees (eg, nursing care might improve when nursing students begin using a nursing home for a training site).

6. Include ambulatory, acute hospital, and long-term care sites in the training program. While it is possible that the local situation may lead to a decision to emphasize one or another of these sites, the nature of geriatric medicine requires that residents develop proficiency in treating patients in all of these sites. Problems experienced by patients in the different settings are sufficiently different to require that residents be exposed to learning experiences in each site.

7. The training program must have the support of the leadership of the Family Medicine Program. Geriatrics is still a new and only partially accepted area of medical training. New and innovative programs cannot succeed without the enthusiastic support of those responsible for the overall training program.

8. Leadership in the training sites must be involved and supportive.

9. Topics for didactic training should be responsive to residents' perceived needs as they assess the relevance and applicability of their medical training to geriatric patients.

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