Geriatric Teaching in Family Practice Residencies

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The inclusion of geriatrics training in family practice residency programs has become a mandate. Indeed, the American Academy of Family Physicians and the Society of Teachers of Family Medicine formed a task force on aging, and in December 1979 they charged all training programs to offer in-depth training in problems of aging and the medical care of the aged.[1] Several articles have appeared that describe the format of individual programs in geriatric training in family practice residencies,[2-4] and others have discussed educational goals and approaches to curricular development,[5,6] but there is no current information covering how the teaching of geriatrics is accomplished in family practice programs. In 1979 a survey by Cefalu et al[7] reported on the extent of geriatric training in family practice residencies, but many new programs in geriatric teaching have been developed since then and there are areas not included in that study that need to be surveyed. This communication describes the results of a survey of the teaching of geriatrics in the family practice residencies in the United States.

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Methods

A questionnaire was prepared that sought information about geriatric training in family practice residencies, covering six areas: time allotment, facilities used, faculty, didactic teaching, evaluation, and funding. This questionnaire was preassessed by 12 faculty members, including six from a faculty in family practice and six from a faculty in geriatrics. Each faculty member was asked to fill out the questionnaire and to comment on its clarity, appeal, and coverage of the subject. These comments were considered and suggested modifications were made in the questionnaire.

A revised questionnaire was mailed to each of the 383 family practice residencies. After six weeks nonrespondents were sent a follow-up questionnaire. Each questionnaire was self-addressed and stamped, and each was identified by a number so that nonrespondents could be identified and programs could be categorized by type of affiliation.

Results

Of the 383 programs, 311 (81 percent) responded. The difference between return rates by types of family practice residency (community based, university based, and military) was not statistically significant.

Seventy-six percent of the programs offered geriatrics training specifically identified as such. The likelihood that a program offered geriatrics

training did not vary by type of program. Of those offering geriatrics training, 47 percent described it as continuous training throughout the residency, 11 percent described it as a block rotation, and 42 percent described it as both. Of those having a block rotation, 71 percent preferred its being done during the second or third years, with only 11 percent preferring to include first-year residents. Eighteen percent expressed no preference of postgraduate year. In 81 percent of the programs, geriatrics training was mandatory, while 19 percent described it as elective. There was no association between the type of program and whether a geriatrics rotation was elective, nor was there an association between those having block rotations and whether the rotation was mandatory. Where both a block and a continuous rotation was offered, however, the block rotation was frequently designated as an elective rotation.

In 75 percent of the programs offering geriatrics training, the rotation was in the department of family practice, while in 7 percent it was in the department of internal medicine. Eighteen percent of the programs used both family practice and internal medicine departments for geriatrics training. Facilities identified for geriatrics training (with the percentage of programs specifying each facility) were nursing homes (78 percent), general adult wards (64 percent), home visiting teams (47 percent), preceptors' offices (21 percent), day care facilities (14 percent), special outpatient clinics (12 percent), and special inpatient wards (8 percent). Block rotations tended to be done in nursing homes more frequently than on general wards.

Forty-six percent of the programs used all family practice-appointed faculty, 51 percent used faculty from family practice as well as other disciplines, and only 3 percent used faculty all from outside the department of family practice. Only 4 percent of the programs had faculty all having formal training in geriatrics. The majority of the programs identified informally trained family physicians as the physician faculty who teach geriatrics. Fifty-four percent of the programs identified one or more nonphysician faculty members who teach geriatrics.

Ninety percent of the programs included core lectures (averaging 12 hours per year) and 46 percent utilized grand rounds for didactic teaching (averaging 9 hours per year).

Comment

Seventy-six percent of the family practice residencies offer a geriatrics experience, and 62 percent require such training. According to the report by Cefalu et al[7] five years ago, fewer than one fourth of the programs had a required teaching rotation in geriatrics. Assuming that the interpretations of the two questionnaires were equivalent, this indicates an impressive increase in such training.

Most programs have a mandatory, continuous experience over one or two years, with a block rotation of a few weeks as an elective rotation. Nearly all programs teach geriatrics within the family practice department, utilizing family practice faculty. Nursing homes are heavily utilized as teaching facilities for geriatrics.

Nearly 50 percent of the programs utilize home visiting team involvement for resident training. It is hoped that this involvement will encourage these primary care trainees to explore alternatives to nursing home placement for their dependent elderly patients, an outcome that seems highly desirable in primary care.

One implication of these results is that since the training is largely continuous in the family practice centers and general wards, the patients would not be grouped in such a way that a faculty member with special expertise in geriatrics would always be present at the time clinical geriatrics teaching is needed. Such lack of patient grouping suggests the need for faculty development to acquaint each faculty member with the core patient care and teaching objectives necessary for such teaching.

References

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