Family Medicine Training in the Care of Older Adults—Has the Retreat Been Sounded?

Charles P. Mouton, MD, MS; Robert W. Parker, MD

The population of adults ages 65 or older in the United States has steadily increased over the last several decades. This population has grown from 3.1 million in 1900 (4.1% of the total population) to 35 million in 2000 (12.4% of the total population), with estimates showing an increase to 70 million by 2030 (20.6% of the population). Of particular interest to the specialty of family practice, 25% of office visits to family physicians were made by adults ages 65 or older; projections show that by 2020, 30% of office visits to family physicians and 60% of family practice hospitalizations will consist of these older adults. In addition, with Medicare payments accounting for 26.7% of all physician income, knowing how to care for older adults is an essential skill for family practice survival.

Despite these statistics, a consistent cry across the landscape of family practice training has been “How do we (and in some cases, should we) appropriately train our residents in geriatrics?” It has been argued that geriatrics is an integral part of family practice training. The trend in family practice training, however, and in particular the trend from the Residency Review Committee for Family Practice (RRC), suggest a shift away from required geriatrics training.

The Trend Away From Geriatrics Training

The training program requirements for family practice residents state:

... programs must be specifically designed to meet the educational needs of medical school graduates intending to become family physicians and must provide experience ... in those areas of medicine that will be of importance to their future practice. The goal of the family practice training program is to produce fully competent physicians capable of providing care of high quality to their patients.1

If the goal is truly to provide family physicians with training in areas of medicine that will be important, then with 25%–30% of visits relating to geriatrics, a concerted effort to enhance geriatric training is necessary.

Unfortunately, as pointed out by Li et al in this issue of Family Medicine,2 the program requirements for geriatric education in family practice training were downgraded in several areas from “must” to “should” recommendations, thereby weakening the requirements for geriatrics training. This is in contrast to the requirements for training in areas like obstetrics, for which strong “must” requirements are in place (Table 1).3 The differential emphasis on geriatrics and obstetrics is surprising, given that nearly all family physicians provide care to older adults, while only a minority provide obstetrical care.

The study by Li et al also shows that residency directors respond to these changes in RRC requirements. Indeed, 48% of family practice residency program directors reported being influenced by the “downgrading” of geriatrics training.

Failure to Seize an Opportunity

The article by Warshaw et al, also in this issue, emphasizes again that a quarter of the visits to family physicians are made by adults ages 65 or older. While many of these visits are by older adults in relatively good health, approximately 80% of these older adults will present with chronic medical conditions that require a special set of skills for continuous, high-quality management.4 Care for the frail, older adults provides an ideal training model for teaching residents to manage complex chronic diseases. Indeed, no other training model provides as great an opportunity to develop skills in managing drug-drug, drug-disease, and disease-disease interactions, physical frailty, functional impairment and disability, palliative care, and end-of-life issues simultaneously. Care for older adults also reinforces essential family practice elements, such as the biopsychosocial model of care, intergener-
ational caregiving, and understanding the dynamics of one’s life course in the care of illness.

Unfortunately, our family practice training programs have been slow to seize this opportunity. Since family physicians see more ambulatory visits than any other specialty, the specialty of family practice should be leading the way in innovations for the care of older adults—but it is not. Family physicians should be leading the way in teaching medical students and residents how to care for older adults—but we do not. Instead, the desire of family physicians to be exclusively general and, as one non-family practice colleague put it, “be everything to everybody,” has eroded the desire of family practice to focus on and provide adequate training on any specific area of care, including geriatrics.

Indeed, the article by Li et al in this issue points out that family practice residency directors are concerned about the generalist breadth of family practice training pushing geriatrics out of the curriculum. These pressures are compounded, as pointed out by Gazewood et al in this issue, by the RRC’s apparent movement away from a commitment to ensure a full scope of geriatric training for family practice residents. The time constraints on training, currently 3 years, have forced family practice programs to adapt their curricula to focus on essentials (ie, those categorized as “must” recommendations by the RRC). Each time RRC recommendations recategory a component of the curriculum from “must” to “should,” programs respond by changing curricula to meet the shifting tide of the minimum required standards, in this case, to decrease the focus on geriatrics training.

### What Constitutes Acceptable Training in Geriatrics?

If we are to fulfill our obligation to the older adults we serve and reclaim a leadership position in geriatrics, what elements of geriatrics training should our family practice residency programs contain? Gazewood et al provide a minimum framework for family practice geriatrics training, but our family practice flagship programs should be doing far more geriatrics training than the bare minimum.

In addition to a longitudinal long-term geriatrics care experience that spans all 3 years of training, family practice residents should be exposed to specific experiences in geriatrics. Ideally in the first postgraduate year (PGY), residents should spend at least 1 month rotating through an ambulatory, comprehensive, geriatric evaluation and management (GEM) clinic. This experience might best benefit PGY-1 residents, because it will provide them with the skills to use in their family practice continuity clinics. Family practice residents’ continuity panels should include at least 20% older adults. Any less and there is a risk of insufficient experience dealing with the problems seen in geriatric patients. A second month of experience in the ambulatory GEM clinic in PGY-3 should be included to focus on cognitive assessment and management, urinary incontinence, rehabilitation, or inpatient geriatrics consultation. Finally, residency programs should consider a required month-long block rotation in medical direction (ie, training residents to serve as nursing home directors), a skill that many family physicians find they need in the years following graduation from residency; this rotation would be best offered to PGY-3 residents. This all sounds like a lot of geriatrics training, but it is far below the 9 months of geriatrics training recommended in past reports by the Institute of Medicine.

Beyond these curricular elements, family practice residencies should seek additional opportunities for trainees to interact with faculty who possess special skills or interest in geriatrics. Residents can be encouraged to participate in after-hours sessions, small-group discussions, special geriatrics journal clubs, annual meetings of state and national geriatrics and gerontology societies, and geriatrics research training. These additional activities can foster an interest in geriatric fellowship training.

### Fitting Geriatrics Into the Residency Curriculum

In this issue of Family Medicine, Warshaw et al address how programs can develop the curricula

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<th>Obstetrics</th>
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<td>Required rotations</td>
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necessary to produce the ideal model of geriatric training in residency. With various competing demands on curricular time faced by program directors, real choices must be made regarding the amount of time dedicated to various aspects of family practice residency training. If the RRC realigns residency training guidelines to address the realities of current and future family practice, care of older adults would receive the highest level of emphasis in most training programs to assure that family physicians have adequate skills to care for the growing elder population. Increasing geriatrics training also requires a faculty that excels in the basics of primary care, as well as in several broad areas unique to the care of older adults within the context of family medicine. Assuring sufficient family medicine faculty with the requisite skills to teach geriatrics has been a problem for family practice residency training. The study by Li el al shows that this is still a problem; a mean of only 1.44 faculty per program had a certificate of added qualifications in geriatrics, and the faculty effort devoted to geriatrics teaching was only 1.05 full-time equivalents per program.

This lack of faculty is not unique to family practice residency training in geriatrics. How many family medicine faculty are on the cutting edge of obstetrics, cardiology, or behavioral health? Yet, we manage to teach about, and give high priority to, those other topics in our residency programs. Why not geriatrics?

Programs that enhance their geriatrics training may reap additional benefits. More than 96% of adults are covered by Medicare at age 65. For programs that serve a large number of the uninsured and underinsured, caring for a large percentage of older adults can provide an important source of new clinical revenue. Retaining adults as they turn 65 years old in continuity clinic panels through the provision of skilled geriatrics care may allow financially strapped programs to generate more clinical revenue through Medicare reimbursement. Although the current threat of Medicare cutbacks (5.4% for 2002) makes caring for older adults seem less profitable than some private, commercially insured patients, caring for Medicare recipients provides more income than nonreimbursed care.

If family practice is ever going to fulfill its promise to care for patients in the context of the family, all family practice training programs need to emphasize caring for older adults. Geriatrics training cannot be added to the curricula as an afterthought or include only patchwork experiences in the long-term care environment. We need to move to a model of training that capitalizes on how family physicians practice and give our trainees full exposure to older patients.

**Final Comment**

Caring for older adults is in harmony with the core values and future direction of family practice. Since its inception, the discipline of family medicine has prided itself on caring for the whole family. Family practice programs have been struck with the challenge of meeting this goal while training future family physicians in the context of a compartmentalized postgraduate training environment. This compartmentalization has resulted in “farming out” family practice trainees to subspecialists to provide them with bits and pieces of exposure to aspects of family practice in hopes that someday these trainees can integrate their experience into a comprehensive program of care for the families that they treat. If care of the whole family is a goal of training family physicians, then care for older adults is an appropriate model in light of the fact that the family plays a major role in caregiving for most (80% of men and 58% of women) older adults.

**References**