Geriatrics in Family Practice Residency Education: An Unmet Challenge

John D. Gazewood, MD, MSPH; Bruce Vanderhoff, MD; Richard Ackermann, MD; Charles Cefalu, MD, MS

The aging of the US population poses one of the greatest future challenges for family practice residency graduates. At a time when our discipline should be strengthening geriatric education to address the needs of our aging population, the Group on Geriatric Education of the Society of Teachers of Family Medicine believes that recent guidelines from important family medicine organizations suggest that our discipline’s interest in geriatric education may be waning. Barriers to improving geriatric education in family practice residencies include limited geriatric faculty, changes in geriatric fellowship training, competing curricular demands, and limited diversity of geriatric training sites. Improving geriatric education in family practice residencies will require greater emphasis on faculty development and integration of geriatric principles throughout family practice residency education. The Residency Review Committee for Family Practice should review the Program Requirements for Residency Education to ensure that geriatric training requirements are consistent with current educational needs. The leadership of family medicine organizations should collaboratively address the need for continued improvement in training our residents to care for older patients and the chronically ill.

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Writing in Family Medicine in 1995, the Group on Geriatric Education of the Society of Teachers of Family Medicine (STFM) argued that geriatrics was an integral component of family practice. The authors emphasized the growing number of older patients and the importance of a comprehensive approach to older patients with chronic disease. They noted little emphasis on geriatrics training in medical school, family practice residency training, or continuing medical education, as well as a shortage of family medicine faculty with expertise in geriatrics.

In family medicine, we note limited progress in geriatric education. The Hartford Geriatric Initiative has funded efforts by the American Academy of Family Physicians (AAFP) Residency Assistance Program (RAP) to strengthen geriatric training in family practice residencies. These efforts include training family physician-geriatrician consultants, providing on-site geriatric curriculum consultations to family practice residency programs, presenting geriatric medicine faculty development workshops, and organizing a series of retreats with the Association of Family Practice Residency Directors to bring together family practice program directors to develop expanded standards and new strategies for enhancing geriatric education.

Unfortunately, despite the aforementioned interventions, there has been little other progress made in geriatric education in family practice residencies. A variety of reasons may explain the lack of progress. These include financial pressures, an emphasis on other educational priorities, and previous success in geriatric education leading to a complacency in this area. In response to the need for strengthening geriatric education, we have prepared this paper as a “position statement” on geriatric education. While not an official statement from STFM, the draft of the paper was circulated to the STFM Group on Geriatric Education for

From the Department of Family Medicine, University of Virginia (Dr Gazewood); the Department of Family Medicine, Ohio State University, and Grant Medical Center (Dr Vanderhoff); the Department of Family Medicine, Mercer University (Dr Ackermann); and the Department of Family Medicine, Louisiana State University (Dr Cefalu).
comment and review, and comments from group members were incorporated into the final document.

**Background**

**Family Medicine’s Historic Commitment to Geriatric Education**

In 1979, when the Residency Review Committee for Family Practice (RRC) adopted guidelines requiring a geriatric curriculum in family practice residencies, less than 25% of those residencies required geriatric training.1 By 1985, 76% of programs had a geriatric rotation, and 62% had a required nursing home rotation.4 A 1990 survey found that 80% of family practice programs, but only 36% of internal medicine programs, had a geriatric curriculum.5 Similarly, a 1994 survey of nursing home training found that 86% of family practice programs required a nursing home experience, compared with 25% of internal medicine programs.6 The RRC geriatric education requirements thus increased emphasis on geriatric education in family practice residency programs.

**Compilinacy in Geriatric Education**

Recent changes in the program requirements for family practice residencies raise concern that there may now be complacency toward geriatric education in family practice. The RRC specifies curricular guidelines at three levels of importance. “Must,” “shall,” or “essential” indicate absolute requirements. “Should” indicates requirements that are important enough that their absence must be justified. “Suggested” or “strongly suggested” indicate requirements that are urged but not required. Institutions can be cited for failing to comply with “must” or “should” requirements but not with “suggested” requirements.

In a previous version of the RRC’s program requirements, which went into effect on July 1, 1997, the RRC downgraded continuity experience in the nursing home from a “must” to a “should” recommendation. The RRC also removed the requirement for geriatric education to occur throughout the curriculum.7 In the current program requirements that went into effect in July 2001, these changes have not been reversed.8 Another example of possible complacency about geriatrics is found in the action plan for residency education of the Academic Family Medicine Organizations/Association of Family Practice Residency Directors (AFMO/AfPRD). This plan makes no comment about the importance of or need for geriatric education in family practice education.9

**Family Practice Residency Education**

The growth of the older population,10 coupled with a growing number of effective interventions11-13 and evidence that older patients are not receiving effective interventions,14-16 makes clear the need for improved geriatric education in our residencies. There are, however, a number of barriers to improving geriatric education. First, there is a serious and growing shortage of geriatric faculty.17-18 In 1992, family practice programs reportedly needed, on average, 2.2 geriatrics faculty.3 Currently, programs now have an average of 1.05 full-time equivalent (FTE) geriatrics faculty (unpublished data). While geriatric fellowship training is a potentially valuable source of geriatric faculty, current trends suggest that fellowships will not provide sufficient numbers of faculty in the near future. Indeed, there are only 21 family practice-based geriatric fellowships in the United States, with a total of only 42 fellows, half of whom are international medical graduates.19 Historically, about half of geriatric fellowship graduates entered faculty positions.18 Since most fellowships are now 1 year instead of 2 years, with less time devoted to faculty development, and since fellows who are international medical graduates may not be able to choose faculty positions because of visa restrictions, it seems likely that the percentage of geriatric fellows choosing faculty positions will decline and that the number of fellowship-trained geriatric faculty will also decline.

A second obstacle to increasing geriatric education is a curriculum that is already “too full.” Other obstacles cited include a lack of interest among faculty and residents, poor reimbursement for geriatric care, and difficulty obtaining adequate numbers of older patients for continuity clinics.2,5,6,20

A final barrier is the limited diversity of sites used for geriatric teaching. For many of our residency programs, nursing homes are the only site available for geriatric education; fewer than half of programs have access to outpatient or inpatient geriatric assessment units.5,6

Today’s family practice residents will be at the peak of their careers when the baby boom generation is swelling the number of Americans over age 85.20 Geriatrics and chronic disease care must be an essential part of their training.21 The 1994 Institute of Medicine (IOM) report on geriatric education recommended that family practice residencies include 6 months of geriatric training by 1996 and 9 months of geriatric training by 1999.18 While these recommendations highlight how important adequate geriatric training is to our residents and their future patients, we are far from achieving the extent of geriatric education recommended by the IOM. Further, we believe the IOM recommendations are unrealistic. We believe that a competency-based curriculum, based on the AAFP Recommended Core Educational Guidelines and the American Geriatrics Society Curriculum Guidelines, would be sufficient if completed by all family practice residents.22,23 These curriculum guidelines call for residency graduates to be proficient in functional assessment, in coordinating care using a multidisciplinary team across a broad spectrum of sites, and
in recognizing and managing common geriatric syndromes.\textsuperscript{22,23}

**Recommendations**

*Every family practice residency should integrate a variety of training sites into a comprehensive curriculum of geriatric education that includes block and longitudinal components.*

The RRC Program Requirements for Residency Education in Family Practice state that “There must be experience with the older adult patient in the hospital, the family practice center, a long-term care facility, and the home.”\textsuperscript{24} Therefore, geriatric education in family practice residencies should extend into all of these arenas. Ideally, residents should have the opportunity to participate in an outpatient geriatric assessment clinic and an inpatient geriatric consultation service. The addition of a block rotation to a longitudinal rotation may be more effective than a longitudinal rotation alone, and we recommend that such a rotation be a component of the geriatric curriculum.\textsuperscript{25} Principles of geriatric care should be taught throughout the curriculum to reinforce and expand on the knowledge and skill gained during the block rotation. Skills needed to manage the chronically ill should be a central focus of family practice residency training.

*The geriatric curriculum should include a longitudinal nursing home experience of at least 1 year’s duration.*

Nearly half of all people reaching age 65 will spend some time in a nursing home, and nursing home care will continue to be provided by most family physicians.\textsuperscript{26} Even though the RRC has weakened the requirement for a continuity nursing home experience, we believe that a continuity nursing home experience is essential for residents to learn basic concepts and skills necessary for care of nursing home patients and their families. In the nursing home, family practice residents learn to manage complex patients with chronic diseases, particularly patients with advanced dementia. The nursing home curriculum should be based on the *Core Educational Guidelines,*\textsuperscript{27} use an attractive, quality nursing home, and be taught by physician faculty and other members of a multidisciplinary team, including geriatric nurse specialists or geriatric nurse practitioners. Residents should participate in a team approach to patient care, observe rehabilitation of older patients from acute illnesses, and assess functional status. The nursing home experience, however, has some educational disadvantages, since nursing home residents are atypical of the overall geriatric population, which may engender negative attitudes.\textsuperscript{28,29} It should not be the only geriatric education site.

*Family medicine faculty should maintain an active home care practice and actively supervise home care provided by residents.*

Both the Core Educational Guidelines and the RRC program requirements expect family practice residents to care for older patients in their homes.\textsuperscript{27} Home visits offer residents the opportunity to learn about community-based services, to examine the home environment, and to gain confidence in providing care in this setting. Recent changes in Medicare reimbursement for home visits and the use of nurse practitioners or physician assistants make provision of these services more financially feasible.

*Hospital teaching rounds should emphasize the unique needs of elders.*

The majority of inpatient visits by family physicians are to older patients.\textsuperscript{17} However, aspects of care unique to this age group are frequently not addressed in inpatient teaching. In addition to emphasizing family involvement and prevention of iatrogenic complications, teaching rounds should address functional assessment, advanced directives, delirium, polypharmacy, incontinence, immobility, pressure ulcers, and malnutrition. Special interdisciplinary units to care for frail older patients, such as an Acute Care for the Elderly unit, have demonstrated improved outcomes.\textsuperscript{30} The strategies used in such units can be used and taught in a typical hospital setting. Further, the participation of therapists, pharmacists, nutritionists, social workers, and nurses can familiarize residents with a model of interdisciplinary care.

*The family practice center’s physical plant and operations should meet the needs of a wide spectrum of older patients, and the center’s leadership should actively work to attract and retain older patients.*

Most older patients live at home or in assisted-living arrangements,\textsuperscript{30} and older people make more visits to family physician’s offices than any other segment of the population.\textsuperscript{27} Barriers to access should be reduced or eliminated by providing convenient parking and drop-off areas with wheelchair access, adequate lighting, and handicap-friendly furniture, hallways, bathrooms, waiting areas, and exam rooms. All staff should display a positive attitude toward seniors. Retaining seniors in the practice begins with emphasizing the advantages of care in a teaching setting: resident enthusiasm, attention to detail, and the fact that residents often have more time to spend with patients. Center directors should try to improve the continuity of care by organizing residents into teams or by employing mid-level providers. The transition of patients from departing residents to new residents should be organized.\textsuperscript{20} Finally, residency programs may consider negotiating with senior housing complexes, assisted living centers,
adult day care centers, and retirement centers to provide geriatric care on-site in those facilities.

All family practice residents should have access to faculty with geriatric expertise. Faculty should be given opportunities and support to pursue additional training in geriatrics.

It is difficult for a single faculty member to be wholly responsible for a residency program’s geriatric curriculum. Programs should support efforts by geriatric faculty to improve the ability of all faculty to teach geriatric care and should encourage all faculty to participate in geriatric education. The Bureau of Health Professions should make faculty development in geriatrics a funding priority for faculty development grants.

We encourage the AAFP’s efforts to foster geriatric education through the Residency Assistance Program. We encourage the AAFP to offer special recognition to members who demonstrate a commitment to geriatrics through practice and continuing education.

We support development of additional geriatric fellowships and “mini-fellowships,” but we recognize that the required time commitment and market forces may prevent many family physicians from pursuing these opportunities. Family practice programs should support and recognize faculty who pursue and achieve additional geriatric training through completion of the American Medical Directors Association’s Certified Medical Director program and the American Geriatrics Society’s Geriatric Recognition Award.

The RRC should review the program requirements and address the need for stronger geriatric training in family practice residencies.

Significant improvement in geriatric and chronic illness training in family practice residencies will not occur without changes in the RRC Program Requirements. We recommend that the dialogue within the AFPRD be broadened to include STFM, the American Board of Family Practice, the American Medical Association’s Council on Medical Education, and the AAFP’s Commission on Medical Education. This dialogue should focus on (1) the relative importance of geriatric education and chronic illness care within the residency curriculum, (2) reaching consensus on goals and objectives for these curricula, and (3) working to translate these goals and objectives into a revised RRC Program Requirement for Family Practice.

Conclusions

The aging of our society, coupled with the growing numbers of chronic illness sufferers, requires that we train our graduates to meet the demands these demographic changes impose. Family medicine needs to assert its leadership as a discipline that regards the care of frail, chronically ill adults as central to its mission.

Corresponding Author: Address correspondence to Dr Gazewood, University of Virginia Health System, Department of Family Medicine, POB 800729, Charlottesville, VA 22908. 434-924-1609. Fax: 434-243-2916. jdg3k@virginia.edu.

REFERENCES