Learning about the elderly

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SUMMARY. I visited nine medical schools on an Upjohn Travelling Fellowship to see how medical students were learning about the care of the elderly. I found a great variety in methods, a variation in quality of teaching, a dearth of educational aims, and little or no evaluation of the students' learning.

DURING the lifetime of doctors who are qualifying now, the proportion of the elderly in the community will greatly increase and influence the way in which those doctors practise medicine. Undergraduate training should now be preparing them for this work.

I visited medical schools to find out how students were shown the problems of the care of the elderly, and to see how much teaching was appropriate to such care in the community, rather than in hospital. In Southampton the students are taught both in a busy academic geriatric department and by general-practitioner teachers, who show the students how the old are cared for at home.

The Upjohn Travelling Fellowship enabled me to visit four medical schools in London and five in other parts of England and Scotland. I use the term 'provincial' to mean that the school was outside London. 'Academic' means a doctor employed by a university and 'consultant' means a doctor employed by the NHS, having responsibilities both for the care of the elderly and for teaching medical students. Several of the medical schools, and particularly the London schools, commented that it was confidently anticipated that the subject would have a greater priority in years to come than at present. One old-established London medical school told me that there was no geriatric teaching for its medical students.

When do students learn about geriatrics?

Geriatric teaching took place at widely different times in the clinical course. In some schools it was divided into two or more parts, the last sometimes being used as a revision course in physical diagnosis just before the final examination. The duration of teaching varied, the average being about a fortnight, but this was often interrupted by simultaneous teaching in other hospital departments.

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What do the teachers try to show to medical students?

Most teachers said that they tried to demonstrate as wide a range of geriatric problems as they could. One London school managed to fit into a period of just over a week visits to a day hospital and to an assessment ward, a terminal care hospital, old people's homes, and a day centre, and also several case conferences. The London schools all used domiciliary visiting by consultants as an opportunity to teach. One provincial school had stopped this because it was said that general practitioners would not attend. One London academic told me, however, that a domiciliary visit would not be done by his department unless the general practitioner agreed to come, and he commented that they nearly always did so. The social worker and the health visitor were sometimes involved as well. I was sorry to see that three provincial schools did not make use of domiciliary visits for teaching at all.

How do the teachers teach?

All the schools use ward rounds to teach, and one provincial school offered nothing but teaching on conventional ward rounds to groups of 20 students at a time in a geriatric ward. Most of the departments gave some formal lectures, but one provincial school had no geriatric lectures at all, and a London academic told me that "at St Blank's we don't believe in lectures". Most schools have occasional films on geriatric subjects but make little use of video or closed-circuit television, and only two schools have developed tape-slide teaching. A provincial academic told me that they had tried to organize case conferences involving general practitioners, but "the general practitioners never come anyway". Only one provincial school used problem

orientated medical records. Most courses seemed to have too much teaching by the teachers and not enough time for the students to say what they think and feel.

Who does the teaching?

In every school I visited part of the responsibility for teaching fell to NHS consultants. NHS senior registrars, registrars, and some senior house officers taught, as well as academics. I was encouraged to see that almost all schools used social workers, occupational therapists and physiotherapists, and some schools used nurses, as teachers; their contribution was often small and informal. Four schools included teaching from sociologists, two from psychogeriatricians and one from a community physician.

I had hoped to see general practitioners helping in teaching about the elderly, but I was disappointed. In one London school four general practitioners took students out for a "geriatric afternoon" and showed them their practice geriatric screening programmes and a variety of clinical problems. This seemed to be a popular part of the course at this school. At an end-of-course seminar that I attended at a London school several student nurses were present. The medical student and the student nurse act as a team and make a joint presentation of a patient to the group. This seemed to me to be a promising step, because the student and the nurse are learning early what the other can bring to the patient's aid. A provincial school involved nurses in tutorials on the care of the dying.

How are teachers trained to teach?

"If you have passed the final MB you are assumed to be able to teach."

London consultant

It was sad to find how little contact departments of geriatrics had with educationalists, and how little instruction the teachers—both academics and consultants—had received in the skills of teaching. To test a teacher's ability to teach, a senior consultant or academic usually sat in on the newly-appointed lecturer's talk and discussed it with him afterwards. I did not feel that this was done often, nor that it was effective. Student feedback was said several times to be the most accurate test of the teacher's ability, but I think that it is unfair to leave to the student the testing and proving of the teacher's skill.

My impression was that teaching of geriatrics is divorced from the mainstream of educational theory and practice and is effected by means which are educationally suspect or even bad. I met only one person, a community nurse tutor, who had been trained as a health educator.

What are the teachers trying to teach?

Several departments had written aims. One London school had no such written aims but said that its approach was governed by: first, the whole-patient approach; secondly, the team approach; and thirdly, the need to get the students through the final MB.

There was a wide variety of student involvement in the planning of the medical course in general, and of geriatric courses in particular. Another London school spoke of a "strong and articulate student voice" to be heard on the curriculum committee. By contrast, in some schools teachers have succeeded in dominating the medical course and muting the voice of the student. My impression of the effectiveness of the various courses could not, however, be related to the apparent strength or weakness of the students in making their views felt. Students were often asked to comment on the content, relevance, and usefulness of their course and most courses had an informal end-of-course discussion or feedback session. One London consultant commented, "At the end of the students' course there is no way of distinguishing happiness from apathy".

When I asked teachers whether the aims that they had expressed were being met, I was often told, "Our aims are being met in part, but we have so little time". There seemed, however, to be a widespread lack of concern among teachers in finding out what the students had learnt during their courses. It is surprising that so little is being done generally to evaluate the teaching activity of the medical schools.

How do we find out what they have learnt?

"Yes, we assess the students: I ask them 'Is there such a disease as senility?' and if they say 'Yes', they fail."

London consultant

The teachers seemed to have no idea of the best way of assessing the learning that was going on in their departments. "Informal assessments" are made in six schools; in addition one had an end-of-course viva, another used a clinical examination and multiple choice question paper, and a third used problem orientated records as a basis for assessment, which also included informal assessments of the students made by occupational therapists, physiotherapists, and other members of the team. The medical schools themselves should be evolving methods, perhaps from the most basic levels, to assess the validity of the teaching which they are undertaking.

What do the learners think of geriatrics as a specialty and as a career?

"The students see general practice and geriatrics as the last refuges of the medically and mentally destitute."

Provincial academic

Most teachers thought that the students were at best neutral in their attitude to geriatrics, with occasional sparks of enthusiasm. Geriatrics has recently suffered a published onslaught from a distinguished general physician challenging the whole concept of geriatrics as a separate discipline (Leonard, 1976), and one provin-

cial school was, perhaps understandably, distressed by this.

Generally, assessment of the students' attitudes was sketchy and informal. It was not possible to get a clear idea either from students or teachers of how many of the students will eventually make a career in the treatment of the elderly. With regard to hospital recruitment, most teachers found that, at house officer and senior house officer level, there was no difficulty in attracting good quality native-born recruits. But even the teaching departments were sometimes unable to attract native-born applicants of sufficient skill and ability for registrar posts, and relied heavily on what appeared to be a large supply of well qualified and skilful expatriate doctors.

A postgraduate dean mentioned that geriatrics was occasionally an unpopular option in a vocational training scheme, and one which was difficult to fill. It seems, therefore, that the medical student, in spite of the changes in attitude that occur at qualification (Gale and Livesley, 1974), carries with him into his career a considerable degree of goodwill for elderly patients and a willingness to work in geriatrics at least temporarily.

What do the learners think about the elderly?

It seems that teachers recognize a sequence of attitudes to the elderly that many students undergo:

1. Initial fear of the elderly patient and difficulty in communicating with him, especially when he is handicapped by deafness or blindness.

2. The strong influence of domestic and personal attitudes, which are related to his personal, family, and cultural experience.

3. Growing confidence and happiness in dealing with elderly patients and an increasing awareness of their social needs.

4. A swing away from the more dehumanizing aspects of 'technical medicine'.

5. After qualification, a realization of the difficulties encountered by the house officer in "unblocking his beds", and a change of attitude towards the elderly ill.

What about the 'politics' of geriatrics?

In some medical schools it was apparent that conflict had arisen between the department of geriatrics and other interests. One London consultant spoke bitterly about the reaction in his medical school that had occurred to prevent an increase in geriatric teaching time, which the general physicians justified by saying, "We all look after elderly patients; *we* must be geriatricians, too". In one provincial school, however, an academic geriatrician regularly visits the general medical wards with the physicians to discuss the problems of the elderly, and in another school geriatricians may be asked to see surgical patients before operation.

What do the learners see of geriatrics outside the hospital?

"We don't teach on minor illness—unless it's serious, of course."

Provincial consultant

It is fair to say that the teachers I spoke to had little idea as to how teaching on the care of the elderly outside hospital could become part of a geriatric course. Apart from the occasional domiciliary consultation and the influence of the small number of general practitioners involved, geriatric teaching at present concentrates largely on hospital care. In a few cases only, departments of geriatrics and general practice had established effective links in teaching. In one provincial school I attended a students' report-back session chaired jointly by the director of the department of general practice and an academic geriatrician. I heard some distressing comments from the geriatricians on general practice in the city centres. For instance, a provincial consultant said to me, "The standard of general practice in . . . . . is pretty shocking; the general practitioners all use the emergency service and have lock-up surgeries; they don't visit elderly patients unless they are sent for, and they don't prescribe what I suggest."

What are the students going to learn in the future?

Wherever I went I was impressed by the wide divergence of views as to what geriatrics is and what geriatrics should be in the future. One teacher pointed out to me, "We have to do a holding operation to teach the general physicians how to be geriatricians, until we have enough geriatricians to serve." Some teachers foresaw much stronger training links with other health professionals. Others saw a change of emphasis in teaching away from traditional patterns towards a greater freedom of choice in the medical student's course, with more electives and with greater emphasis on chronic disease.

What should we do?

Drawing conclusions is difficult but necessary. This is how each of three groups of people might, in my opinion, improve both the teaching and the learning of geriatrics.

Medical students

Medical students should now make their voices heard in planning courses. They should ensure that their teachers give enough time to showing them the ills of the elderly. Teaching that seeks to show only the sign of the illness, and not the person that surrounds it, should be rejected. Continuity and responsibility should be requested.

Geriatricians

Geriatricians must first identify their own skills and

decide how they are best to be used. To ensure the student's present interest and future involvement, the best of both the science and the art of geriatrics must be shown. Both the teaching and the student's learning should be evaluated.

Family doctors

Family doctors should remember that, without their help, the student may learn about the elderly person only when he has become ill and frail. When teaching, they should show how they and the hospital combine, and not compete, in the care of the elderly.

References

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Vaccination against whooping cough

Calculations based on the mortality of whooping cough before 1957 predict accurately the subsequent decline and the present low mortality. Notifications of incidence, though variable and incomplete, follow the same pattern of steady decline in the UK and are unaffected either by small-scale vaccination, beginning about 1948, or by nationwide vaccination, beginning in 1957.

When valid comparisons can be made, attack rates may be lower and complications fewer in vaccinated children, but allowance has to be made for overcrowding and socio-economic differences which may be more important as determinants of attack rates. No protection by vaccination is demonstrable in infants. Adverse reactions and neurotoxicity following vaccinations were studied in 160 cases. In 79, the relationship to pertussis vaccine was strong. In 14 of these cases reaction was transient but characteristic of a syndrome of shock and cerebral disturbance, which, in the other 65 cases, was followed by convulsions, hyperkinesis, and severe mental defect.

It seems likely that most adverse reactions are unreported and that many are overlooked. Precise information about the efficacy and safety of this vaccine is lacking, because existing provisions, national and international, for epidemiological surveillance and evaluation are inadequate. The claim by official bodies that the risks of whooping cough exceed those of vaccination is questionable, at least in the UK.

Reference

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