Training general practitioners in geriatric medicine

FROM THE BRITISH GERIATRICS SOCIETY AND THE ROYAL COLLEGE OF GENERAL PRACTITIONERS

1. Terms of reference

To enquire into the geriatric content of vocational training for general practice and to make recommendations for its implementation.

2. Introduction

2.1 By the year 1991 the pensionable population of the UK will reach 9,905,000, an increase of 850,000 (9·4 per cent) in 20 years. The population aged 75 and over, however, will increase even more dramatically by 901,000 (34·5 per cent) over the same period, the greatest percentage increase (43·5 per cent) being seen in those aged over 85. Indeed, the number of those aged 85 and over will continue to increase until after the year 2011, while the number in the younger pensionable age groups will fall after 1991 (Office of Population Censuses and Surveys, 1975).

It has been shown (Akhtar *et al.*, 1973) that more than 80 per cent of those aged 85 and over were unable to live at home without help, and nearly three quarters of those classed as very severely handicapped (Harris *et al.*, 1971) were aged 75 and over. These changes have most important implications for the future general practitioner and the primary health care team.

2.2 It is a matter of great concern, therefore, that undergraduate teaching pays scant attention to the elderly. No one can fail to see the point of this statement: "During his undergraduate days the practitioner was taught to regard the very young as a special part of his practice. A greater involvement of geriatricians as teachers at both undergraduate and postgraduate level is of the utmost importance if the next and subsequent generations are to see the care of the elderly in a similar perspective" (Elliott and Stevenson, 1973). Students are, on the whole, well disposed to the elderly in general. However, a short time after graduation these attitudes alter as career prospects become defined (Gale and Livesley, 1974).

2.3 The doctor intending to enter general practice is inevitably affected by his early postgraduate experience when he often finds unfavourable attitudes to the elderly. It is frequently stated by those seeking vocational training schemes that they reject those offering geriatrics as part of the rotation.

2.4 The reality, therefore, is that the young general practitioner whose work will inevitably lie more and more with the elderly may well have little or no formal training in their care. At the same time there is a danger that his attitudes towards them may at best be lukewarm and at worst be hostile.

2.5 All vocational training must provide training in geriatric medicine. The training may be obtained in teaching practices, in junior hospital posts, and in day-release courses.

2.6 The training required to equip the young general practitioner for his role in the care of the elderly must be determined by the aims of that care. The Royal College of Physicians of Edinburgh has defined these aims as the maintenance of independence, comfort, and contentment of patients in their own homes, and when independence begins to wane to support them by all means necessary for as long as possible (Royal College of Physicians of Edinburgh, 1963). The achievement of these aims requires a system of care that will identify the elderly in the community, assess their needs, and meet their needs within the resources available. A continuing system of care of this nature involves a multidisciplinary approach. However, as Ashworth concluded in 1959: "It is the general practitioner's responsibility to see that all forces are mobilized to keep the patient healthy and happy at home". Forsyth and Logan (1964) found that the range of services and depth of patient care varied

directly with the quality of the family doctor. Their conclusion was similar to Ashworth's, that it is the general practitioner who should accept continuing responsibility for the care of the elderly, not only in prevention and delaying the onset and progress of disease, but also in postponing disability and reducing handicap.

2.7 In his training the young general practitioner should learn how to diagnose and manage illness in physical, psychological, and social terms. He should be familiar with the wide range of supporting services and be able to employ these services to the best advantage of the patient. He will require special expertise in the organization of his practice to take account of the needs of his elderly patients. He will also need to acquire the attitudes and skills necessary for the development of harmonious and effective working relationships with his consultant colleagues and other professionals involved in the care of the elderly, especially those in the social services.

2.8 In those places where departments of geriatric medicine play a full part in vocational training it is noteworthy that many trainees come to these departments with foreboding, are pleasantly surprised by their experience, and by the end of the appointment remark that the post has been one of the most enjoyable and valuable they have had. This is the case in departments with beds in the district general hospital taking acutely ill patients from the community and able to offer well organized rehabilitation and day hospital facilities. Some departments of geriatric medicine still lack adequate facilities and can offer little more than custodial support for the acute specialties. Such units are unlikely to gain approval for training purposes.

3. Present opportunities for training

3.1 The demographic trends referred to in the introduction will dictate the pattern of medical care in this country until the end of this century and well into the beginning of the next. The present scant regard paid to the training of doctors in the total care of the elderly is both deplorable and alarming.

3.2 There are 192 vocational schemes at present (1977) recognized by the Royal College of General Practitioners. Only 15·5 per cent of those schemes include any obligatory hospital posts in geriatric medicine while 57 per cent have no post in geriatric medicine at all. (Appendix I).

3.3 The contrast with training in paediatric medicine is stark. The joint British Paediatric Association/Royal College of General Practitioners Working Party (1976) on paediatric training for general practitioners reporting in 1975 noted that vocational training scheme organizers regarded paediatrics as one of the four most important hospital appointments along with adult medicine, psychiatry, and obstetrics and gynaecology. At the end of 1973 they found that, for instance, 90 per cent of individual programmes in the Oxford region and 85 per cent in the Newcastle region included an appointment in paediatric medicine.

3.4 The assumption must be that some vocational training scheme organizers consider that experience in adult medicine adequately covers the care of the elderly. This Working Party has no doubt that in many instances this confidence is misplaced, most notably in the outdated attitudes to the problems of the elderly patients which are still taught to holders of many posts in adult medicine.

4. Training of general practitioners—objectives

It seems appropriate, in considering the care of the elderly, to re-order the five areas defined in *The Future General Practitioner—Learning and Teaching* (RCGP, 1972).

1. Human development.
2. Human behaviour.
3. Medicine and society.
4. Health and diseases.
5. The practice.

At the conclusion of his vocational training the doctor should be able to:

4.1 Human development

1. Describe, discuss, and compare the theories of ageing.

2. Describe and relate the physical, psychological, and social changes which may occur in old age.

3. Relate these changes to the physical, psychological, and social adaptations which the old person makes, and to the breakdown of these adaptations.

4.2 Human behaviour

1. Describe the ways in which physical, psychological, and social changes in the environment of the old person manifest themselves early as changes in behaviour.

2. Describe the tendency to disengage in old age, and the interplay between the previous personality and experience of the patient and the present tendency to disengagement.

3. Describe in terms of the patient's behaviour the consequences of an awareness of deterioration in sociability, motivation, mood, or sexual function.

4. Describe the effects of these behavioural changes in old age on family relationships.

5. Describe those changes in behaviour which may be the first manifestation of disease processes likely to occur in old age.

6. Exhibit appropriate attitudes to the care of old people, and manifest these attitudes in the doctor–patient relationship.

4.3 Medicine and society

1. Describe the influence of culture and social class on the status of old people in the family and in society at large.

2. Describe how current medical education determines the personal care of the elderly by the profession.

3. Describe and illustrate the relationship between the attitudes of society towards old people, and the allocation of medical and social resources.

4. Describe the development of social and medical care for the elderly in our society.

5. Describe the major medical and social agencies, statutory and voluntary, and specify their particular activities and areas of concern in the care of the elderly.

6. Demonstrate the uses of epidemiology (for example as described in *The Future General Practitioner—Learning and Teaching* (RCGP, 1972) in the care of the elderly.

4.4 Health and diseases

1. Describe the physical factors, particularly diet, exercise, temperature, and sleep, which affect the health of the old person.

2. Describe the social factors, including previous occupation, financial status, housing, social involvement, and marital status, which influence life in old age.

3. Describe those threats to the integrity of the old person, such as retirement, bereavement, isolation, institutionalization, and impending death.

4. Construct appropriate programmes of preparation for retirement.

5. Describe the features, peculiar to the elderly, which modify the presentation of diseases, their course and management.

6. Describe and illustrate the ways in which doctors may wrongly ascribe the natural process of ageing to disease processes, or the converse, and list the unwanted consequences of such mistakes.

7. Illustrate the way in which a number of different disease processes commonly occur in the same old person.

8. List the peculiar difficulties of taking a clinical history from an old person, with due regard to its slower tempo and possible unreliability, and the evidence of third parties, and demonstrate the appropriate skills required.

9. Describe the special features of prognosis of diseases in old age and relate these to an appropriate plan for further investigation and management.

10. Describe the way in which the management of disease processes in old age is influenced by the psychological state and the social situation of the old person.

11. List the special factors associated with the absorption, metabolism, and excretion of drugs given to the elderly.

12. Describe the hazards of drug treatment in old age, including the problems posed by multiplicity of drugs, non-compliance, and iatrogenic disease.

13. Demonstrate an appreciation of the uses and the limitations of surgery and rehabilitation in the treatment of diseases of old age.

14. Describe the special features of psychiatric diseases in old age, including an appreciation of the features of brain failure, and the effects of disorders of physical function on the mental state.

15. Demonstrate the skills of taking a psychiatric history from an old person, including the skill of assessing intellectual function.

16. Demonstrate the skills required in the management of old people with a psychiatric disorder such as:
i) Deciding on the appropriate milieu of treatment.
ii) Listing the indications for specialist psychiatric or geriatric care.
iii) Describing the indications and procedures for compulsory admission under the Mental Health Act (1958) and Section 47 of the National Assistance Act (1948).
iv) Assessing the quality and motivation of those persons available to care for the patient.
v) Advising on testamentary capacity, and advising on the management of affairs.

4.5 The practice

1. Organize his practice for the benefit of his elderly patients so as to ensure ease of contact, appropriate timing of appointments, and satisfactory cover for emergencies.

2. Develop policies for the primary care team, so as to ensure control of repeat prescriptions, the appropriate use of screening or case-finding programmes, and the care of old people in all forms of residential accommodation.

3. Advise individual patients about the available types of appropriate residential accommodation.

4. Effectively use the various statutory and voluntary services for support of the elderly in the community.

5. Effect liaison and co-operate with the many different disciplines and persons involved in the care of the elderly.

6. Demonstrate an effective use of local hospital resources, including general-practitioner beds.

7. Ensure that the provision of care promotes the patient's sense of identity and personal dignity.

5. The continuum of education

5.1 The intention in constructing a syllabus of vocational training is to underline and extend with practical and relevant instruction, knowledge, skills,

and attitudes which have been acquired by the undergraduate.

5.2 Little information is available about the quality and effectiveness of the educational experience in the various stages of education.

5.3 Undergraduate education

The first university department of geriatric medicine was established in Glasgow in 1965. Between 1970 and 1976 university departments were established in Manchester, Southampton, Newcastle, Birmingham, Liverpool, London, Belfast, Edinburgh, and Nottingham.

5.4 Formal teaching programmes introduce undergraduates to the subject of geriatric medicine and gerontology. There is much variation in time allotted and in content of the courses organized by university departments of geriatric medicine.

5.5 Proper professional attitudes in the care of the elderly will not be formed until geriatric medicine is adequately represented in undergraduate education and demonstrated as being both intellectually stimulating and emotionally satisfying.

5.6 Postgraduate training

This comprises training for junior hospital doctors, vocational training courses for trainee general practitioners, and opportunities for continuing education for established practitioners.

5.7 The intention of this training will always be the same. The difficulties of achieving the intention will vary with the type of undergraduate experience provided.

5.8 Junior hospital posts

The number of pre-registration house officer posts in departments of geriatric medicine is small (1977) and the opportunity for this form of training is at present available to few newly qualified doctors. There are a large number of senior house officer posts in departments of geriatric medicine and these two grades will be considered together.

5.9 The house officer post should give the opportunity for a concentrated experience of all aspects of geriatric care. The house officer should gain experience in the investigation, assessment, and management of the elderly patients including the care of the dying. Opportunity should exist for experience in outpatient clinics and in the day hospital for the observation of the effects of planned programmes of rehabilitation, and in the organization of continuing care in the hospital and support and preventive services in the community.

5.10 The advent of 'Merrison'-style general professional training will increase the time spent training in junior hospital posts and will encourage more inter-departmental rotation within hospitals. This will allow greater scope for experience in departments of geriatric medicine than has been possible in the single pre-registration year.

5.11 Vocational training hospital posts

These posts may offer a first introduction to hospital geriatric medicine or expand on experience already gained in other junior hospital posts, including the need to relate experience gained in hospital to care within the community. Our studies show that the majority of course organizers do not incorporate senior house officer posts in geriatric medicine in their schemes. Two possible reasons for this are:

i) A reluctance among course organizers to use any senior house officer posts in geriatric medicine.

ii) The lack of suitable senior house officer posts in the specialty (Appendix 2, 3). The Working Party believes that every vocational training scheme should contain a suitable senior house officer post in geriatric medicine which should be recognized for general professional training.

5.12 Day-release courses

Course organizers and tutors are responsible for ensuring that the problems of the elderly are adequately covered in these programmes, which vary in length from 40 to 120 meetings during the trainee's three-year membership of a scheme. The Working Party believes that day-release teaching should extend throughout the three years of vocational training schemes. It is essential that trainees are released for attendance at those courses. The Working Party's enquiries indicate a substantial deficiency in the geriatric emphasis of such courses (Irvine, 1977; Taylor, 1977; personal communications; Appendix 3).

The general-practice year

General-practitioner trainers are responsible for introducing their trainees to the domiciliary and community aspects of the care of the elderly, including the use of project teaching and visits to practices providing high standards of care of the elderly.

5.14 Continuing education

The doctor also learns from domiciliary consultations, correspondence relating to outpatient referrals and hospital discharges, and attendance at postgraduate meetings. The British Geriatrics Society and the Royal College of General Practitioners have considered the forming of a liaison committee to advise on the teaching of established practitioners as well as trainees. Joint educational meetings should be promoted.

6. Recommendations

6.1 The achievement of the educational objectives in geriatric medicine described in this report is essential in the vocational training of general practitioners.

6.2 Training in geriatric medicine should begin at the undergraduate level and should be reinforced throughout the postgraduate career.

6.3 Training in geriatric medicine in all vocational training schemes should be monitored by the Joint Committee for Postgraduate Training.

6.4 Where the content of vocational training schemes is insufficient to fulfil the objectives of training described in this report action should be taken by the appropriate bodies to:

a) Ensure proper emphasis on care of the elderly as part of general-practice experience.

b) Review the content of geriatric medicine in day-release and intensive courses.

c) Encourage the establishment of hospital posts in geriatric medicine where appropriate standards and facilities can be ensured.

6.5 Appropriate hospital posts in geriatric medicine should normally be able to take acutely ill patients, should place an adequate emphasis on rehabilitative techniques, and be recognized for general professional training.

6.6 Continuing and end-point assessments of vocational training should reflect the importance of the care of the elderly in general practice.

Addendum

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Appendix 1. Appointments in geriatric medicine in 192 vocational training schemes approved by the RCGP (1976).

	Number	Percentage
No appointment	110	*57.3*
Insufficient detail given	32	*16.7*
Voluntary appointment available	20	*10.4*
Compulsory appointment for 6 months	23	*12.0*
Compulsory appointment for 3 months	7	*3.6*
Total	192	*100*

Source: Royal College of General Practitioners (1977). Unpublished Report of the Education Committee.

Appendix 2. Suitability of hospital posts for general professional training.

Posts approved	
Geriatric medicine	202
Geriatric medicine with another specialty	29
Total posts	231
Posts deferred	41
Percentage deferred	*17.75*

Results of inspection by the Royal College of Physicians of London of house officer and senior house officer posts in geriatric medicine, and geriatric medicine combined with another specialty, from 11 regions in England.
Source: Winner, Dame A. (1977). Personal communication.

The number of established posts ranges from three in one region to 32 in two regions.
The percentage of posts deferred ranges from nil in three regions to 83·3 per cent in one region.
Deferral of posts may be for from one to five years.

Appendix 3. Postgraduate training in geriatric medicine in Scotland 1975.

Vocational training posts	
Option in geriatric medicine	7 *(16)*
Half-day release courses including geriatric medicine	20 *(45)*
Teaching in geriatric medicine in the general-practice year	44 *(100)*
Total	44
Postgraduate courses	All contained some geriatric medicine

Source: Stevenson, J. S. K. (1976). *Teaching of Geriatric Medicine to Medical Students and General Practitioners in Scotland 1975.* Unpublished Report of a Working Party.