

Geriatric Training in Family Practice Residencies

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The Department of Family Medicine at Earl K. Long Memorial Hospital and affiliated LSU Medical Center Hospital, in conjunction with the Department of Family Medicine at the LSU Medical Center in New Orleans recently surveyed all United States family medicine residency programs to determine how many family medicine residencies and affiliated medical schools throughout the United States presently have mandatory or elective curricula in geriatrics and clinical experiences in geriatrics and how many planned to develop such curricula.

Methods

In April 1979, questionnaires were sent to the various program directors and the department chairmen of 351 family medicine residency training programs and 105 medical schools. The questionnaire included 14 parts: six questions dealt with rotations in geriatrics for the family medicine residency program, another six dealt with medical school curricula involving geriatrics, and two concerned the need for geriatric training in family medicine residency programs and whether such training should be required or elective.

Results

Of the 351 family medicine residency training programs and 105 medical schools polled, 252 (about 55 percent) responded. Not all of the questions were answered by each respondent. Over three fourths of the residency training programs did not have a current required teaching rotation in geriatrics, and of those, only 29 percent had plans for developing such a rotation. Of those who had or were planning to develop a required rotation in geriatrics, more than half stated that the program is or would be formal (assignment to a nursing

home rotation, mandatory or elective block of geriatrics, or inpatient rotation, ie, geriatric unit), and another 38 percent stated that the program is or would be informal (care of nursing home patients, home health visits to patients). A small percentage combined the formal and informal programs. Almost half (46 percent) stated that the geriatric rotation was or would be in a combined form of training, involving first, second, and/or third year residents, whereas another fourth favored the instruction to be in the third year of training. Most of the mandatory rotations in geriatrics included or planned to include home visits to elderly patients. From 41 to 60 percent used or planned to use audiovisual teaching aids, written evaluations, oral evaluations, didactic lectures, and inpatient geriatric unit experience. Twenty-nine percent had or planned to have definite allotted time (four to six weeks) devoted solely to teaching of geriatrics, and a third used other experiences (particularly nursing home experience).

Only nine of the medical schools with which the responding programs are affiliated had a definite mandatory rotation for geriatrics. In eight of those nine medical schools, the rotation was a combined integrated program, not separated into first-, second-, or third-year experiences. The other medical school offered the rotation in the second or third year of training. Time was presently not allotted for didactic lectures in geriatric medicine in the first or second year of medical school training in 43 percent of the affiliated medical schools. Of those programs whose affiliated medical schools presently had no definite mandatory rotation for geriatrics, about two thirds stated that the medical school had plans for developing such a curriculum. Sixty-nine percent of the affiliated medical schools had no definite division or department of geriatrics at present. In 14 instances, geriatrics was a division of another specialty—six in internal medicine and eight in family medicine.

A large majority (94 percent) of family medicine

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residency program directors responded positively to the need for geriatric training in family medicine residency programs. Sixty-four percent believed that geriatric training should be a required rotation; 21 percent favored an elective rotation; about 11 percent stated that it should be presented in another form (primarily an integrated or a longitudinal form of training); and 3 percent favored a combined form of training (ie, an elective and required rotation, an integrated and required rotation, or an elective and integrated rotation). The percentage of geriatric patients in the family patient populations of the various polled residency training programs in family medicine ranged from 1 percent to 55 percent (based on 214 responses on the questionnaires).

Conclusions

This survey reflects the fact that the vast majority of family medicine residency training programs do not have a required rotation in geriatrics, and that a perceived need for developing such rotations exists. The consensus was that such a geriatrics component should be evenly divided between formal and informal rotations or be a combination of the two. About half of the respondents believed that the geriatric rotation should be in the form of combined residency training, and an equal number believed that it should be given either in the second or third year or a combination of these two years of the residency training program. Most program directors believed that the mandatory rotation should include home visits to elderly patients, as well as didactic lectures. Many program directors also believed that it should in-

clude audiovisual teaching aids, oral evaluations, and in-hospital geriatric unit experience. Some program directors believed that it should include definite four- to six-week geriatric rotations and nursing-home experience.

The overwhelming majority of the affiliated medical schools had no definite rotation for geriatrics. Of the few that did, it was in a combined form of training and not relegated to one class-level of training. The main reason for no mandatory rotation in the medical schools was that no time was allotted. About two thirds of responding residency program directors believed that medical schools should have current plans for development of geriatric curricula. Again, about two thirds of the medical schools do not have a formal division or department of geriatrics, and of those who did, nearly all program directors agreed that there was a definite need for geriatric training in family medicine. Many believed that it should be required, whereas some thought that it should be an elective rotation, and a few thought it should be in the form of integrated and longitudinal training. The number of geriatric patients being treated in the model family practice units of the various family medicine residency training programs varies widely depending on the preponderant age group in the locale of the family medicine residency program, the socioeconomic status of these patients, and related demographic factors in the communities. According to this survey, the actual percentage range of patients of the geriatric age group treated ranged from less than 1 percent to 55 percent.

Faculty Twinning by Private Physicians

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During family medicine's first decade most teachers of family medicine were drawn from private practice.¹⁻³ In the past few years increasing emphasis has been placed on filling these positions with young, residency trained family physicians.

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Fortunately, an increasing number of family practice residents are interested in teaching, research, and other academic pursuits. Many of these same residents, however, are also interested in private practice. A dilemma becomes apparent: a full-time private practice offers little time for teaching, research, and other academic pursuits, while a full-time faculty position provides too little time for patient care and includes too many administrative duties. Many young graduates interested in aca-

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demetic medicine choose private practice because of a justifiable concern for ensuring their own clinical development and credibility. This communication describes a reproducible model that offers simultaneous careers in both private practice and academic medicine.

Description of the Model

Two of the authors (D.A.P. and D.L.R.) are recent graduates (1979) of the family medicine residency at the Medical University of South Carolina in Charleston. As residents both had considered future academic careers, but independently had determined that the experience of creating and developing one's own private practice was an experience without substitute. The two residency graduates wished to establish a private practice but were willing to commit an equal amount of time and effort to teaching and other academic pursuits. They entered into an agreement with the chairman of the department (H.B.C.) that together they would fulfill the responsibilities of one full-time faculty member. At the same time they would be building a private practice, both sharing duties in the two areas equally.

The agreement became effective July 1979. Each spends 50 percent of his time in the private practice setting (Mt. Pleasant Family Practice Associates, Mt. Pleasant, South Carolina) and 50 percent of his time in the academic setting at the Family Medicine Center, Medical University of South Carolina in Charleston. The practice was established *de novo*. As a partnership they offer to the community full-time office hours with 24-hour emergency coverage, and each family can identify with a personal physician. Each physician spends half of each day at the private practice. Thus the patient flow and office management resemble those of a solo practitioner in size.

The other 50 percent of their time is spent fulfilling the responsibilities of a full-time family practice attending physician. The two are co-team leaders of one of the patient care groups in the residency. They are the responsible attending physicians for the group's outpatient and inpatient activities as well as the group's administrative activities. On a larger scale they participate as attendings for the clinic as a whole and are also active as lecturers and advisors. As young faculty members they have assumed an appropriately larger role in teaching and have become less in-

involved in administrative duties than more senior faculty members. They are actively involved in committee work, and in interviewing prospective residents and faculty for the department. In addition they each have their own research projects and personal teaching interests. Thus, together, they fulfill duties at least equivalent to one full-time faculty member.

Comment

This innovative model permits young graduates to be deeply involved in both teaching and private patient care by sharing equally both types of responsibilities. This allows a mixing and sharing of the realities of private practice and the idealism of academia which are useful to all. The experience has potential for preparing excellent future academicians in family medicine.

In this teaching-practice combination the residency profits from energetic practice models who are actively involved and well known in the training program and in the community. By having both major areas of interest (teaching and private practice) met, young graduates who adopt this model may be less likely to leave either setting in order to test the other.

In the standard team leader approach the young faculty member sees patients within the residency program. He, therefore, does not experience the management and practice issues inherent to a "real world" setting. In addition, in most cases the true volume of patients seen by the faculty member is too small to develop, or even adequately maintain, patient care skills. His style remains constrained by the compromises involved in a large group practice within a teaching setting.

Informal evaluation of the first year of this faculty-twinning concept by the department and the private physicians has been very favorable, and the program is scheduled to continue through another academic year. Further evaluation and experimentation with the model are necessary, but initial results suggest that it can become an important alternative that may have a positive impact on future faculty development in family medicine.

References

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this point of view, it has much to say to family physicians everywhere. It is in the pathophysiology and medical management that the book has deficiencies and should be used with discretion.

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Techniques in Skin Surgery. Ervin Epstein, Ervin Epstein, Jr. Lea & Febiger, Philadelphia, 1979, 203 pp., \$18.00.

This book is intended to be a brief manual of techniques commonly used in skin surgery in the office setting. It has been edited by two dermatologists who have contributed much of the work, along with ten other authors of chapters, almost all of whom are dermatologists. Their goal was to produce a handy inexpensive volume dealing with common cutaneous surgery procedures and newer techniques, such as electrosurgery, cryosurgery, and chemosurgery. With so many contributors there is some difference of opinion and this adds to the value of the book. In my opinion, the material is more useful to dermatologists than family physicians. It is a better review of what surgery is commonly done by dermatologists than it is a manual of what a family physician can and will do.

I found some portions of the book difficult to follow. For example, the section on buried knot suture technique was confusing.

There are a number of illustrations and most are helpful. The pho-

tographs are in black and white and would have had more educational value in color.

The audience best served will be dermatologists who do office skin surgery. The book will also be valuable for family physicians who use some of these same techniques. Many of the subject areas discussed and the techniques described have some relevance for the family physician, but some could have been presented in a more detailed and informative manner.

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Malpractice: A Guide for Mental Health Professionals. Ronald Jay Cohen. The Free Press, New York, 1979, 337 pp., \$13.95.

While the subject of malpractice is relevant to the entire health care field, this particular book is directed towards mental health professionals as suggested by its title. It is an easily read book, well organized, and filled with considerable information of interest to the practicing physician, resident, or medical student, as well as allied health professionals, but most of the case studies quoted are relevant to the fields of psychiatry, psychology, and sociology. Most health professionals, not involved specifically in the mental health field, would find Chapter 2 to be of the most interest as it is a very clearly written overview of the law and the legal system, particularly as it applies to professional liability.

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