Family Practice Forum

Geriatric Training in Family Medicine

John W. Denham, MD, and Bradley B.F. Sakran, MD
Winston-Salem, North Carolina

Geriatrics is different enough from the rest of medicine to require special attention during medical training. Shifts in clinical norms and atypical disease presentations in the geriatric population are not mere textbook oddities; they are a practical body of knowledge with which a physician must be acquainted if he is to avoid errors in clinical judgement. The analytic axioms that are relatively safe in mainstream practice fail in geriatric medicine because of the complexities of combined and interacting diseases. Therapeutic standards are likewise unique in the geriatric population. As in pediatrics, many customary adult therapies are not appropriate. Norms for response to therapy also change as the aging body's own reparative processes wane.

The geriatric population also brings a unique set of life problems to the medical care setting, problems that the traditionally trained physician may not perceive or act on. Not only does the elderly person's bodily integrity undergo a gradual dissolution, but also orienting environmental cues and sustaining social relationships fade with the passing years. Moreover, family mobility frequently removes the most cherished source of sustenance. Self-esteem is undermined by a society that honors productivity, but furnishes few outlets for the many elderly people with remaining productive potential. Demeaning also is a youth worshiping culture that hides the embarrassing reminders of age behind cosmetic masks and nursing home shutters. In addition to a multitude of socially generated pains, older people face socially generated disabilities. They must contend with growing social powerlessness as well as ebbing bodily strength. Bereft of influence, they are neglected and even exploited.

When family physicians treat elderly patients, they confront issues that other physicians can perhaps more easily escape or deny. The physician who limits his practice to younger patients can dismiss the personal implications of their diseases as statistically improbable for himself. The specialist with older patients can limit his attention to the diseases themselves, abstract adversaries that medicine will one day conquer. But the family physician faces these patients as whole persons, and in so doing confronts the unpleasant certainty of his own decline and death.

Clinical decision making in geriatrics cannot be so secure and tidy as in other areas of medicine. The physician accustomed to making decisions on the basis of commonly applied values and proba-

From the Department of Family and Community Medicine, Bowman Gray School of Medicine, Wake Forest University, Winston-Salem, North Carolina. Requests for reprints should be addressed to Dr. John W. Denham, Department of Family and Community Medicine, Bowman Gray School of Medicine, Wake Forest University, 300 South Hawthorne Road, Winston-Salem, NC 27103.

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bilities loses much of this objective support when he treats elderly patients. Geriatric decisions must be based on an awareness of value shifts as the patient's finite span approaches its terminus, as his social contributions weaken, and as his consciousness dims or fills with pain. Making such value judgements is a taxing responsibility, often avoided by applying the same therapeutic energy to all situations. On the other hand, therapeutic enthusiasm may be diminished by a stereotypic devaluation of all old patients or by godlike value dictates that exclude the patient's voice. Clinical decisions in geriatrics must also rest on increasingly uncertain probabilities. As the odds favoring the efficacy of technologic therapies grow increasingly slim, chance may be the only predictor of decision outcome. Where the science of medicine begins to fail in the terminal years of life, the physician must rely more on the art. In geriatrics, intuition is often a better instrument than empirically based deduction, and caring more effective than technology.

Family medicine provides an appropriate medical school departmental base for a geriatric program. As a comprehensive discipline, it is sensitive not only to the biological aspect but also to the affective and social aspects of illness, which are increasingly important in old age. Family medicine is also in a position to administer and coordinate the team effort needed in helping elderly patients. In responding to suffering that does not fit the disease model, the family physician works closely with a variety of helping agencies outside the medical hierarchy.

Although family medicine is a discipline that opposes a narrow specialty focus, it is paradoxical that much of its training remains based in the more limited specialties. This ultimately fragments a discipline striving for wholeness. Family medicine faculty should be able to model geriatric competencies appropriate to the family physician's role.

If geriatric training is kept within family medicine and taught by each faculty member, residents can more easily realize this part of their identity as family physicians. In most programs residents do follow geriatric patients under the tutelage of family medicine faculty. However, geriatric standards of care are tacit, and supervision is variable. The resulting uncertainty generates the "need" to delegate a rightful part of family medicine to a geriatrician. However, an explicit definition of geriatric standards of care for specific geriatric problems could function as a base for both faculty practice and resident learning of geriatrics in family medicine. A standard of care becomes a competency to be followed and learned and an objective criterion against which practice and progress can be measured.

Values and attitudes deserve special attention in geriatrics. Values should probably temper decisions in geriatrics more than in other areas of medicine, but because they lie outside the objectivity of science, they are often ignored and decisions are made on the basis of clinical estimates alone. Value judgments that do not violate the patient require that the physician invest enough of himself to know the patient's unique personhood, and that he feel a compassion which risks real anguish. Instead, patients are often stereotyped or valued on the basis of an abstract classification, which permits dispassionate and painless decisions.

Negative attitudes toward the elderly population have been a major obstacle to geriatric education and practice. These attitudes are often based on superficial or erroneous information. Many ill founded and glib generalizations would collapse if measured against the findings of gerontologic survey research. Trainees should be presented this information to facilitate empathy and dispel denigrating stereotypes.

Death is generally abhorred by medicine, and survival of the personality ridiculed by science. The elderly patient may sense these attitudes in physicians, even if they remain tacit. An elderly person seeking to come to terms with this final reality may despair if he senses physician denial and cynicism. Physicians in training need exposure to the wisdom beyond science—to the reality that the underpinnings of science itself are beyond proof and that all systems for finding meaning rest ultimately on belief.

Examination of these issues could occur in an elective seminar. Although values and attitudes can be learned on a conceptual level, a trainee cannot be coerced into making them a part of his own life and practice. Commitment beyond the level of understanding is more visceral than cerebral. It is less likely to occur after objective and rational discussion than after observing fervent commitment in a mentor. The enthusiasm of faculty is therefore an invaluable part of geriatric training.