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A Brief, Intensive, Clinically-focused Geriatrics Course during the Third Year of Medical School

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Abstract

During the next several decades the aging of the “baby boom” generation in the United States will result in a dramatic increase in the number of patients over the age of 65 years seeking medical care. However, current projections suggest that the shortage of Geriatric trained specialists will only worsen during this time period. As a result, the care of elderly patients will largely fall to other types of physicians. Consequently, it is imperative that medical school training include exposure to the basic skills needed to safely care for older adults. This goal is challenging as the number of Geriatric Medicine faculty in most academic medical centers is small, and multiple other medical specialties are also vying for time in a busy medical school curriculum. We explored whether a brief three day course conducted during the third year of medical school could teach basic principles of Geriatric Medicine in a time and manpower effective manner. We found that even this brief exposure to Geriatrics could have meaningful impacts on student knowledge of and comfort with Geriatrics.

Keywords

Medical school; Geriatrics education; clerkship

Introduction

By the year 2030 there will be about 70 million Americans aged 65 and older. Among this group the “old old” who are over age 85 will be the fastest growing group (1;2). This dramatic increase in the elderly population will place significant stress on the healthcare system and increase the number of older individuals seen by almost all types of physicians. The problem is compounded by the failure to train a specialized physician workforce sufficient to provide either primary or consultative care of the scope needed. The numbers of young physicians seeking specialized training in Geriatrics is inadequate to meet the coming demand or maintain the current workforce (3-6). Additionally, there is a coming decline in the numbers of practicing

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Author contributions

Alfred L. Fisher analyzed the data and wrote the manuscript. Elizabeth A. O'Keefe, Joseph T. Hanlon, Stephanie A. Studenski, John G. Hennon, and Neil M. Resnick helped in drafting and critically revising the manuscript for important intellectual content.

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primary care physicians who are the current providers of most Geriatric care (7). Consequently, future care of older patients will increasingly shift to specialists and subspecialists who did not initially plan for careers in Geriatrics. As a result it will be critical for all physicians to have the basic skills needed to care for Geriatric patients.

How best to train medical students in Geriatrics is still a work in progress. Strategies employed include introductory experiences during the preclinical years, clinical exposure during third year clerkships such as Medicine, clinical electives, and at a few schools required rotations (8-15). Each approach has strengths and weaknesses with respect to providing academic content and clinical experience. An additional challenge is the relatively small size of the Geriatric trained faculty at most medical schools, roughly 9-10 faculty, which makes some approaches unfeasible (16).

At our institution, an intersession week was added to the third year to synchronize the third and fourth year calendars. Several medical schools have developed these one week intersession periods into an effective forum to supplement content covered in clinical clerkships (17). We were presented with the opportunity to develop an intensive 3 day course in Geriatric Medicine. We utilized this course as means to test whether a brief intensive exposure could be a means to impart basic skills and knowledge and be a strategy consistent with the limited available manpower available at most medical schools.

Methods

Students

Our course was required for graduation from the University of Pittsburgh, School of Medicine for the class of 2009. At the time of the course, the 144 students had completed the two year preclinical curriculum, passed part I of the USMLE boards, and completed approximately half of the third year clerkships. We picked this time point specifically so that the majority of the students had exposure to the clinical care of older patients.

Development of the Geriatric Medicine Course

To develop the course we followed an approach that was similar to that described in "Curriculum Development for Medical Education" by Kern, et. al. (18).

Step 1 – Problem Identification—Our course was the result of a direct request from the Curriculum Committee of the University of Pittsburgh School of Medicine as they perceived the coverage of Geriatric Medicine in the curriculum to be inadequate.

Step 2 – Needs Assessment of Learners—A committee consisting of faculty drawn from the Divisions of Geriatric Medicine and Geriatric Psychiatry along with several fourth year medical students with a strong interest in Geriatric Medicine engaged in strategic planning sessions for the curriculum. These two divisions were responsible for the Geriatrics content of the required clinical curriculum so the involved faculty were familiar with current content and areas of need. Student involvement provided corroboration of faculty perceptions and offered advice on needs. We also sought input from the University of Pittsburgh School of Medicine curriculum committee as the course was created due to their perception of need. The committee developed the course to provide exposure to the diagnosis and management of Geriatric syndromes, principles of Geriatric clinical pharmacology, and the ethical and communication skills involved in dealing with complex patient situations like the evaluation of decision making capacity. These topics represented important topics that were missing from other clinical courses. Additionally, the medical school curriculum at the University of Pittsburgh lacks any exposure to long-term care so we included a trip to a long-term care facility with exposure to

patients in assisted living, post-acute hospital rehabilitation, and a dementia unit. Finally, groups of students were assigned one of three patient cases that included surgical, medical, psychiatric, and social issues and were asked to develop a care plan for the patient. Work on the case spanned the course and involved group work outside of class time. The goal of this activity was to demonstrate how Geriatric Medicine skills learned in the course could be used in a variety of patient care situations. This project also provided an opportunity to integrate new knowledge and skills with those learned in other clerkships.

Step 3 – Goals and Objectives—Our strategic planning sessions led to the development of the learning objectives for the course which are shown in Table 1.

Step 4- Educational Strategies—Based on our learning objectives we developed a Geriatric Medicine course consisting of three eight hour days divided into morning and afternoon sessions (Figure 1). Overall, our educational strategy was to use adult learning theory and to organize the course in interactive, small group sessions that built upon third year experiences. Monday morning consisted of a brief course introduction and pre-test, a structured patient interview conducted by a faculty member, and a two hour small group session used for the start of the case project. During the patient interview, a patient from our clinical practice was asked about his experiences during a prolonged illness that involved multiple hospitalizations and transfers to the nursing home. At the time of the interview, he had completed rehabilitation and was again living independently in the community. The purpose of the interview was to establish the clinical focus of the course, demonstrate how Geriatric patients can move through the continuum of care, provide the patient's perspective on the experience with illness and dependency, and remind students that the frail elders they have seen in other clerkships can recover health and function with proper care. The case project was introduced at the end of the session. The case project was a team learning project designed to provide exposure to topics not directly covered in the course, a means to integrate new knowledge with material from other clerkships, and an opportunity to practice the topics covered in the course (Table 1).

Monday afternoon focused on Geriatric syndromes. A brief overview lecture was used to define the term and establish the importance of syndromes (Table 1). A small group discussion session followed where half of the students used a review article on falls and half used a review article on delirium to answer a question about the etiology, risk factors, evaluation, or therapeutic approach for a patient with recurrent falls or delirium. These were chosen both because of their importance and their omission from the clinical curriculum. The students then returned to the large lecture room to present the answers of the questions to the other groups. This activity was designed to emphasize the similarities between two very different syndromes, the multi-factorial nature of syndromes, and how a similar approach can be used to evaluate and treat most syndromes. These concepts were reinforced in a summary lecture that focused on a third syndrome, incontinence.

Tuesday morning and Tuesday afternoon were repeating sessions consisting of a trip to a long-term care (LTC) facility and a session on Geriatric clinical pharmacology. The class was split into two groups to make the number of students at the facilities more manageable. The LTC trip was to one of three facilities staffed by members of our division. Students rotated through 50 minute real-life experiences in assisted living, rehabilitation, and a dementia unit (Table 1). The assisted living experience consisted of an interview by pairs of students of an assisted living resident focused on assessing IADL and ADL function and cognition via the Mini-Cog instrument (19). The goal was for the students to be able to explain to a faculty mentor why a given patient was in assisted living instead of more independent or dependent levels of care. The rehabilitation experience consisted of a brief presentation about assistive devices followed by direct observation and interaction with physical, occupational, and speech therapists

working with patients. The dementia unit experience was led by a Geriatric Psychiatrist who gave a brief talk about behavior problems in demented patients and then demonstrated an interview with a patient with dementia.

The Geriatric clinical pharmacology session consisted of a lecture and a small group problem-solving exercise. The lecture dealt with changes in pharmacokinetics and pharmacodynamics in older people, common drug-drug and drug-disease interactions, drug-induced Geriatric syndromes, drugs to avoid in older adults, principles of optimal prescribing for elders, how to take a medication history and determine adherence, and the Medicare part D coverage of prescription medications (Table 1). The lecture material was reinforced by a small group session where students were asked to work on a case involving a patient with multiple medications and symptoms that might reflect side-effects of one or more medications taken by the patient. The students were also asked to critically review a complicated older person's medication regimen by using the Medication Appropriateness Index (20). At the end of the session faculty facilitators met with each group to review the case work-up, provide further teaching, and answer questions.

The Ethics and Communication session used film clips to serve as a spring-board for small group discussions about several common situations in the care of older patients (Table 1). Specifically, a clip from "Going in Style" was used to illustrate the experience of being old, how younger people view older people, and the losses that accompany aging; a clip from "The Trip to Bountiful" was used to illustrate the evaluation of decision making capacity; a clip from "Sunset Story" was used to illustrate the difficult discussions involved in taking care of frail and even terminally ill patients; and a clip from "Driving Miss Daisy" was used to illustrate the approach to the impaired driver and giving up driving privileges. Each small group included a faculty facilitator and the spouse of a patient who is or was a patient in an inpatient palliative care unit staffed by a member of our division. The inclusion of a patient family member provided the viewpoint of a non-physician elder who has dealt with one or more of the situations illustrated in the film clips. This helped the group step outside of the "physician viewpoint" to consider the viewpoint of the senior and their family and other caregivers.

The last afternoon consisted of a course wrap-up which included the end of the cases and a multiple choice final exam. The end of the case involved a 30-40 minute presentation based on the case evaluation performed by each group. As there were 12 small groups and 3 cases, we divided the class into 4 groups for the presentations so that each of these larger groups had a small group that would present each of the three cases. The goal was that students in the other groups would learn about the unique topics covered in the other cases.

Course materials are available at
http://navigator.medschool.pitt.edu/34_viewModuleAll.asp?moduleID=881919100&nobars=true.

Step 5 – Course Implementation—Our course was instituted at the request of the Curriculum Committee at our institution, so we had the full support of the Office of Medical Education at the School of Medicine. They provided assistance with scheduling the rooms for the course, limited administrative assistance for syllabus preparation, copying, and exam administration, and financial support for buses used in the LTC trip. Our academic division also provided administrative assistance with copying and organizing course materials for the syllabus. No external funding was used for course development or implementation.

The course involved twenty five faculty drawn from the divisions of Geriatric Medicine and Palliative Care in the Department of Medicine and division of Geriatric Psychiatry in the Department of Psychiatry. Faculty were volunteers and were not directly compensated for their

time. Our Dean provides some compensation directly to each department to partially offset faculty time for teaching.

Step 6 - Evaluation—To assess learning of course material, we used a pre and post-test. The post-test consisted of 20 multiple choice questions drawn from the didactic material of the course, and the pre-test was a subgroup of 5 questions from the post-test drawn at random to reflect topics from the course. The exam was drawn from course material and reviewed by several faculty experienced in exam preparation to ensure face validity of the questions. The main goal of the exam was to establish student grades. To evaluate acceptance of the course by the medical students, we used a voluntary questionnaire at the end of the course which assessed opinion regarding the overall relevance and success of the course at improving comfort with caring for older patients. We chose these evaluation methods because we were specifically asked to not perform a more detailed evaluation by the education administration at our institution due to prior adverse student reaction to education research. As the course was new to the curriculum, the administration was particularly interested in student feedback and allowed us to invest more effort in this task.

To evaluate the acceptance of the course by involved faculty, we used a voluntary questionnaire which assessed opinion about the course and the impact of time invested in the course on other patient care, research, or administrative duties.

Results

Student Evaluation of the Course and Content

At the end of the course, the students were asked to complete a written evaluation of the course, individual learning activities, and individual lecturers. From this evaluation, we found the students found the sessions on Geriatric Syndromes, Geriatric Clinical Pharmacology, and Long-term Care the most useful. Interestingly, the Long-term Care session proved to be the most popular part of the course both in written comments and subjective feedback from individual students. The students reported that the final case presentations were the least useful part of the course. This opinion was consistent with the observations of the course director.

As an alternate means of gauging course need and impact on medical education, the course evaluation included five Likert-type statements which the students completed (Table 2). This part of the evaluation revealed that 97% of the students agreed that learning how to care for older patients was important and that 87% of the students felt that caring for older patients was different from other patient populations. Additionally, 84% of the students left the course with a better understanding of Geriatric Medicine as a specialty. Importantly, 74% of the students felt more comfortable with addressing Geriatric issues as a result of the course. Finally, 69% of the students reported seeing a situation in another clerkship where knowledge from the course could have helped their approach to patient care. Together these results suggest that students believe learning about Geriatric Medicine is important, and that even a brief course can impact student comfort regarding Geriatrics.

Faculty Evaluation of the Course and Workload

Most faculty (73%) reported that they enjoyed teaching in the course and would be willing to be involved the next year (82%). Importantly, most faculty (82%) did not feel that involvement in the course distracted from other work.

Discussion

An important challenge in educating the current generation of physicians is ensuring that all new physicians have the basic skills needed to safely, effectively, and compassionately care for older patients. The optimal approach for teaching the principles, attitudes, and skills of Geriatric medicine is unclear given curricular and faculty constraints. At the University of Pittsburgh School of Medicine, we attempted to provide training in the fundamentals of Geriatric Medicine to the entire third year class over a three day period. This strategy allowed the introduction of a new course in an existing curriculum without any impact on the time allotted to other specialties. Furthermore, it was achieved without any major impact on the clinical productivity of the division as faculty members only had to commit a relatively small amount of time to teaching. The location of our course within a third year intersession period is also attractive to other schools looking to develop content for these sessions as the interdisciplinary nature of Geriatric Medicine is very consistent with the original spirit of the intersession (17).

Our experience suggests that even a brief but intensive exposure to basic concepts in Geriatric Medicine during the third year clerkships can improve student comfort with caring for older patients. Importantly, student evaluation indicated that they believed the skills taught in the course were important for their careers and could be readily applied to clinical settings in other clerkships. While we did not assess this outcome, a group from the UK found that an intensive eight day course in Geriatric Medicine was able to increase interest in Geriatric Medicine careers (21). We specifically wished to conduct our course during the third year instead of the fourth year as career plans are still fluid at this time.

In terms of manpower requirements, the third year class for our course consisted of 144 students, and we chose to divide the students into groups of twelve for small group sessions. As a result, the efforts of at least twelve faculty or fellows were needed to successfully conduct the course. Our course involved twenty five faculty including faculty from Geriatric Psychiatry and Palliative care, but this arrangement was driven more by available and interested faculty than need. The requirement for a minimum of twelve faculty is very consistent with the faculty numbers available in Geriatrics divisions in U.S. medical schools (16). Even for schools with fewer faculty, it is likely possible to locate or briefly train sufficient faculty from other divisions such as General Internal Medicine, Neurology, or Family Practice. Alternatively, voluntary faculty with significant clinical experience in caring for older patients in practice could serve as preceptors for small group sessions. The most labor intensive part of the course was the planning and development of course materials. To help allow other institutions to adopt our approach, we have made our materials freely available on the internet at the web address listed in the methods section. These can be modified or adapted to the needs and interests of individual schools.

We gained important knowledge from our implementation of the course and student/administrative feedback. As the course was new to the curriculum, we also shared our experiences and student evaluation with the curriculum committee for review. Overall, the course ran fairly smoothly and our educational administration was pleased with its success as a new course. Students were supportive of the course, but did have specific written suggestions. In particular, they found working on the case project to be useful, but did not like the final presentation aspect of the project. As a result of our reflection and student comments, we have modified our course this year to remove this project. We have enhanced the small group learning activities and added a Geriatric Assessment lecture this year to accomplish some of the goals of the case project. Another common suggestion was to reduce the number and length of breaks during the course. These had been inserted based on suggestions from our education administration. We have followed through on this student suggestion and used the additional

time to add additional small group time to the Clinical Geriatric Pharmacology and Geriatric Syndromes sections of the course. Several students were frustrated with receiving a Honors/Pass/Fail grade for a three day course, wanted course expectations better clarified, or simply wanted vacation instead of another course. The course grading was dictated to us by the school's administration who felt students do not take short courses seriously without grades being at stake. One of our goals for this year is to enhance the syllabus as a guide and student resource. A pleasant surprise from the student comments was the popularity of the LTC trip. We have retained this part of this course, and would suggest incorporating a similar experience into Geriatrics curricula at other institutions. A final aspect of the course that we seek to improve this year is the written exam. The pre-test and especially post-test proved to be fairly easy for the students (mean score pre-test 76.8%, post-test 90.9%), and were also too brief to clearly demonstrate gains in knowledge during the course. For this year we are making test questions more challenging and increasing the length of both exams.

Conclusion

A three day intensive course in Geriatric Medicine has been developed by our faculty and was well accepted by students and faculty. At the end of the course students reported being more comfortable with approaching common Geriatric issues and having a better understanding of what Geriatric specialists do. The ratio of one faculty preceptor to 12 students was reasonable for conducting effective small group sessions. Since approximately half of U.S. medical schools have student class sizes of 144 or smaller, it is likely that smaller schools will have sufficient faculty with experience caring for elderly patients who could serve as small group preceptors and thus the strategy of utilizing a brief intersession course for teaching basic geriatric skills and knowledge should be a viable option. Future studies could examine the longer-term impact of the course and adaptation of the course to other schools.

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Monday	Tuesday	Wednesday
Course introduction Start of Case Project	LTC trip - Rehabilitation - Assisted Living - Dementia Unit	Ethics and Communication
Geriatric Syndromes	Geriatric Pharmacology	Project Presentations Exam

Figure 1.

Structure of the Geriatric Medicine course. The course consisted of three eight-hour days divided into morning and afternoon sessions. The name and location within the course of each session is shown.

Table 1

Learning Objectives for Course Sessions

<u>Session</u>	<u>Objectives</u>
Case Project	1) Students will discuss how to incorporate patient wishes, functional capabilities, and co-morbid illnesses in a treatment plan.
Geriatric Syndromes	2) Students will recognize and address common Geriatric problems (depression, dementia, caregiver stress, and alcoholism) embedded in a complicated medical/surgical case.
	1) Students will be able to define and recognize common Geriatric syndromes
	2) Students will recognize the multi-factorial nature of syndromes and describe common contributing factors.
	3) Students will be able to outline a work-up and treatment plan for falls and urinary incontinence.
Long-Term Care	1) Students will be able to explain similarities and differences between assisted-living, post-hospital rehab, and a dementia unit and the patient characteristics associated with each.
	2) Students will demonstrate a basic functional and cognitive assessment of a patient.
	3) Students will be able to outline a treatment approach for behavioral problems in demented patients.
	4) Students will be able to discuss the indications for prescribing assistive devices for mobility.
Geriatric Clinical Pharmacology	1) Students will be able to describe changes in pharmacologic parameters that occur with aging.
	2) Students will be able to obtain a medication history from a patient.
	3) Students will work up and discuss a clinical case involving multiple potential drug-drug and drug-disease interactions.
Ethics and Communication	1) Students will discuss positive and negative biases about older people that physicians, patients, families, and society may hold.
	2) Students will discuss ethical issues and patient emotional reactions involved in decisions regarding driving privileges.
	3) Students will consider unmet medical, social, and psychological needs of patients with serious or terminal illnesses.
	4) Students will discuss balancing patient autonomy and decision making capacity in mildly-moderately impaired patients.

Table 2
Student Evaluation Of Course In Context Of Their Other Clerkships And Overall Medical Career.

Question	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree	N
It is important for a practicing physician to know how to care for older patients.	75%	22%	3%	0%	0%	125
As a result of this course I feel more comfortable approaching common Geriatric issues.	26%	48%	18%	6%	1%	125
I have seen a situation in my clerkships where something I learned in the course would have helped.	24%	45%	22%	9%	0%	125
I see caring for older patients as a unique clinical challenge.	38%	49%	9%	4%	0%	125
I have a better understanding of what Geriatric specialists can do for patients.	34%	50%	15%	1%	0%	125

Students completed a written course evaluation at the end of the course that included the above questions. They were asked to identify on a 5 point scale whether they agreed or disagreed with each statement. N indicates the number of responding students.