Care of the elderly training

Implications for family medicine

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ABSTRACT

OBJECTIVE To examine the practice patterns and clinical and academic roles of family physicians who have care of the elderly training.

DESIGN Cross-sectional survey.

SETTING Family medicine practices or specialized geriatric services programs.

PARTICIPANTS Fifty-two family physicians, surveyed in 2005 and 2006, identified as having 6 or 12 months' care of the elderly training.

MAIN OUTCOME MEASURES Self-reported practice type and description of clinical and academic roles.

RESULTS Surveys were sent to 103 physicians; the response rate was 50.5% (N=52). Respondents were relatively young, with a mean age of 42 years. Slightly more respondents had completed 6 months of training than had completed a full year of training (54.9% vs 45.1%). More than half (55.8%) described their medical practice areas as "general family medicine." The remainder worked in "restricted practices" (25.0%) or provided "specialist care" (17.3%); 1 physician was no longer practising medicine. Many provided some care within specialized geriatric service areas, most commonly in-hospital consultation and rehabilitation. More than half (51.9%) provided active hospital care, and a substantial number worked in long-term care facilities as physicians or medical directors. More than 20% provided newborn care, although only a small percentage (7.7%) performed obstetric services. Respondents were actively involved in teaching and other academic activities, including resident supervision.

CONCLUSION Care of the elderly physicians provide comprehensive family medicine services, but also often provide care in other areas currently facing physician shortages. Care of the elderly physicians play relevant clinical and academic roles in both family medicine training and specialized geriatric services.

EDITOR'S KEY POINTS

- Most respondents reported having changed the nature of their practices since completing care of the elderly training, most commonly to focus on care of seniors.
- Despite concerns that enhanced skills training would negatively affect comprehensive family medicine practices, a surprising number of trainees remained involved in either general family medicine or important roles (academic and administrative) often filled by family physicians.
- Considering the growing number of geriatric patients, care of the elderly training would offset physician shortages in senior care and allow for improved geriatric services within the realm of family medicine.

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Formation en soins aux personnes âgées

Incidences sur le médecin de famille

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RÉSUMÉ

OBJECTIF Examiner les modes de pratique et les rôles cliniques et universitaires de médecins de famille ayant suivi une formation en soins gériatriques.

TYPE D'ÉTUDE Enquête transversale.

CONTEXTE Cliniques de médecine familiale ou programmes spécialisés en soins gériatriques.

PARTICIPANTS Cinquante-deux médecins de famille identifiés, dans le cadre d'une enquête en 2005 et 2006, comme ayant suivi une formation de 6 ou 12 mois en soins gériatriques.

PRINCIPAUX PARAMÈTRES À L'ÉTUDE Déclaration des médecins sur leur type de pratique et description de leurs rôles cliniques et universitaires.

RÉSULTATS Le questionnaire a été envoyé à 103 médecins; 52 ont répondu (50.5 %). Les répondants étaient relativement jeunes (moyenne: 42 ans). Ceux qui avaient suivi une formation de 6 mois étaient un peu plus nombreux que ceux qui avaient eu une année complète (54,9 % vs 45,1 %). Plus de la moitié (55,8 %) disaient pratiquer une « médecine familiale générale ». Les autres avaient des pratiques « restreintes » (25 %) ou donnaient des « soins spécialisés » (17,3 %); un médecin avait cessé de pratiquer. Plusieurs prodiguaient des soins dans des unités spécialisées en gériatrie, le plus souvent sous forme de consultations ou de réadaptation à l'hôpital. Plus de la moitié fournissaient activement des soins hospitaliers, et un nombre considérable travaillaient comme médecins ou directeurs médicaux dans des unités de soins de longue durée. Plus de 20 % s'occupaient de nouveau-nés, quoiqu'un faible pourcentage seulement (7,7 %) faisaient de l'obstétrique. Les répondants participaient activement à l'enseignement et à d'autres activités universitaires, y compris la supervision de résidents.

CONCLUSION Les médecins qui traitent les personnes âgées fournissent des services de médecine familiale variés, mais ils œuvrent aussi dans d'autres domaines où la pénurie de médecins devient un problème. Les médecins des personnes âgées jouent des rôles clinique et universitaire importants dans l'enseignement de la médecine familiale comme dans les services spécialisés en gériatrie.

POINTS DE REPÈRE DU RÉDACTEUR

- La plupart des répondants ont déclaré qu'ils avaient changé leur mode de pratique après avoir suivi une formation en soins aux personnes âgées, le plus souvent pour s'occuper davantage des soins aux aînés.
- Même s'ils craignaient que l'aspect « général » de leur pratique familiale souffre de l'apprentissage de ces nouvelles habiletés, un nombre surprenant des médecins formés ont continué de pratiquer une médecine familiale générale ou de jouer des rôles importants (enseignement, administration) souvent joués par des médecins de famille.
- Vu le nombre croissant des patients gériatriques, la formation en soins aux personnes âgées pourrait pallier la pénurie de médecins dans ce domaine et permettre une amélioration des services gériatriques au sein de la médecine familiale.

***Le texte intégral est accessible en anglais à www.cfp.ca.**

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Care of the elderly (CE) programs were developed in 1989 with the intention of providing family medicine residents with the option of improving knowledge and skills relating to care of frail and complex older patients. It was hoped that the programs would help recruits provide better senior care in their family medicine practices and in settings such as hospitals and long-term care (LTC) facilities. Care of the elderly programs are currently offered at 13 universities in Canada and present options of 6 or 12 months' additional training. At the time of this survey, the College of Family Physicians of Canada (CFPC) estimated that 130 physicians had completed CE training.

Given the national shortage of family physicians, concerns have been raised about whether third-year family medicine training programs will affect the number of physicians providing care in traditional community practices.[1] Family physicians with training in emergency medicine and anesthesia have been surveyed to discover their practice patterns. Family physicians who completed third-year emergency medicine programs commonly restricted their practices to work in emergency departments,[2] whereas most of those providing anesthesia care maintained family practices with reduced hours.[3]

The role of family physicians in the care of frail older patients is well recognized.[4] However, there is a shortage of geriatricians in Canada and human resource concerns in LTC facilities.[5,6] Many specialized geriatric programs have family physicians providing care or acting in academic or leadership positions. Family physicians with CE certification can play important roles in these settings.

The practice patterns of physicians with CE certification have never been studied. A better understanding of the roles of CE physicians will help guide the objectives and curricula of training programs across the country and will allow for better planning of funding and access to CE positions in the future.

The goal of this study was to examine the practice patterns and clinical and academic roles undertaken by CE physicians. Whether or not CE training affects "traditional" family medicine practice compared with restricted or specialized practices was also examined.

METHODS

A questionnaire was developed based on previous studies of physician practice patterns.[2,7-10] The survey was either mailed or e-mailed to physicians identified as having CE certification. There were considerable challenges to identifying and contacting family physicians with CE training. The CFPC does not maintain a listing of all CE physicians, and identification through departments of family medicine was not possible because of privacy policies. A request for names of CE physicians was made at the Canadian Geriatrics Society annual general meeting. Names of physicians without personal contact information were obtained from care of the elderly program directors when possible. Contact information was sought via the 2008 Canadian Medical Directory.[11]

A total of 103 surveys were distributed, between January 2005 and April 2006, using a modified Dillman method. Follow-up of nonrespondents occurred by mail or e-mail at 4 and 8 weeks after the surveys were initially distributed.

Ethics approval was obtained from the Queen's University Research Ethics Board.

RESULTS

Fifty-two CE physicians completed the questionnaire. Respondents were relatively young (mean age 42 years). The mean years of completion of family medicine training and CE training were 1993 and 1997, respectively. Most CE physicians who responded were members of the CFPC (86.5%). Slightly more respondents had completed 6 months of training versus a full year of training (54.9% vs 45.1%). Most reported working in centres with populations larger than 100 000. Further demographic and personal information is found in **Table 1.**

Table 1. Demographic characteristics of respondents: *N = 52.*

DEMOGRAPHIC CHARACTERISTICS	N (%)
Sex	
• Male	23 (44.2)
• Female	29 (55.8)
Age	
• ≤ 35 y	17 (32.7)
• 36-45 y	16 (30.8)
• 46-55 y	13 (25.0)
• 56-65 y	5 (9.6)
• > 65 y	1 (1.9)

More than half of respondents described their medical practice areas as "general family medicine" (55.8%). The remainder worked in "restricted practices" (25.0%) or provided "specialist care" (17.3%); 1 physician was no longer practising medicine. Other characteristics of respondents' environment are provided in **Table 2.**

Almost half of respondents provided some specialized geriatric services, most commonly in-hospital geriatric consultation and rehabilitation; more than half (51.9%) provided active hospital care; and a substantial number worked in LTC facilities as physicians or medical directors. More than 20% of respondents provided newborn care, although only a small percentage (7.7%)

Table 2. Respondents' professional environments

CHARACTERISTIC	n/N* (%)
Population of practice area	
• < 10 000	4/49 (8.2)
• 10 000-100 000	16/49 (32.7)
• > 100 000	29/49 (59.1)
Type of practice	
• Solo	6/51 (11.8)
• Group	18/51 (35.3)
• HSO or CCS	10/51 (19.6)
• Other	17/51 (33.3)
Medical area of practice	
• General family medicine	29/52 (55.8)
• Restricted practice	13/52 (25.0)
• Specialist	9/52 (17.3)
• No longer practising medicine	1/52 (1.9)

HSO—health services organization, CCS—comprehenisve care site.
*Not all physicians provided answers to these questions. Percentages might not add to 100, owing to rounding.

performed deliveries. Types of care provided are outlined in **Table 3.**

Most respondents (73.1%) reported that they had changed the nature of their practices since completing CE training, typically to focus on areas of senior care—reasons for these changes are outlined in **Table 4.** It should be noted that dissatisfaction with family medicine was listed as an important reason for practice restriction by only 18.4% of those respondents. A small number of respondents had considered changing their practices in the previous 2 years (17.3%), and about one-third shared concerns about how enhanced skills training would affect the provision of comprehensive family medicine care. Most CE physician respondents were actively involved in teaching and other academic activities; **Tables 5** and **6** summarize their various academic and administrative roles as well as factors related to changes in practice patterns. Respondents' satisfaction with their work was positively and significantly associated with activity in academic spheres ($P < .027$). There was no positive or negative association between administrative roles and job satisfaction.

DISCUSSION

To our knowledge, this is the first survey of practice patterns of CE physicians. This is likely because identification of physicians with CE training and certification is difficult. Despite concerns that enhanced skills training will affect comprehensive family medicine, a surprising number of respondents were either involved in general family medicine or had assumed important roles often filled by family physicians: home visits, working in LTC

Table 3. Practice characteristics of respondents: *N* = 52.

PRACTICE CHARACTERISTICS	N (%)
General care provided	
• Counseling	27 (51.9)
• Minor surgery	15 (28.8)
• Surgical assists	5 (9.6)
• Psychotherapy	16 (30.8)
• Newborn care	11 (21.2)
• Postpartum care	10 (19.2)
• Shared antenatal care	6 (11.5)
• Uncomplicated deliveries	4 (7.7)
Geriatric care provided	
• Home family medicine visits	18 (34.6)
• Medical director of LTC facility	8 (15.4)
• LTC physician	21 (40.4)
• Complex continuing care	16 (30.8)
• Other	10 (19.2)
Specialized geriatric services	
• Inpatient geriatric rehabilitation	18 (34.6)
• Day hospital	11 (21.2)
• Geriatric clinic	17 (32.7)
• Outreach services	13 (25.0)
• Hospital consultation	22 (42.3)
• Other	7 (13.5)
Care of hospitalized patients	
• Active	27 (51.9)
• Supportive	15 (28.8)
• Concurrent	9 (17.3)
Emergency room care	
• Full-time	1 (1.9)
• Shift work	3 (5.8)
• On-call coverage	7 (13.5)

LTC—long-term care.

Table 4. Reasons why physician respondents changed or restricted practices after CE training: *N* = 52.

REASON*	N (%)
Job availability	12 (23.1)
Appeal of alternate practice	26 (50.0)
Family reasons	10 (19.2)
Financial reasons	4 (7.7)
Dissatisfaction with family medicine	7 (13.5)
Job location	2 (3.8)
Other	11 (21.2)

*Reasons are not mutually exclusive.

Table 5. Other professional activities of respondents: *N = 52.*

ACTIVITIES	N (%)
Current academic activities	
• Teaching	35 (67.3)
• Research	16 (30.8)
• Writing review articles	10 (19.2)
• Resident or student supervision	36 (69.2)
• None	6 (11.5)
• Other	13 (25.0)
Current administrative roles	
• Medical director of LTC facility	8 (15.4)
• Hospital administration	14 (26.9)
• CFPC committees	6 (11.5)
• Specialized geriatric program administration	12 (23.1)
• Community administration (Alzheimer board, DHC)	9 (17.3)
• CMA committees	1 (1.9)
• Other	17 (32.7)

CFPC—College of Family Physicians of Canada, CMA—Canadian Medical Association, DHC—district health council.

Table 6. Factors affecting practice patterns of physician respondents (N = 52): *39 respondents (75%) were satisfied with their current practices; only 3 (5.8%) were unsatisfied.*

FACTOR*	N (%)
Regional or provincial health policy	18 (34.6)
Completion of care of the elderly program	38 (73.1)
Concerns about how enhanced skills training will affect numbers of physicians providing general primary care	18 (34.6)

*Factors are not mutually exclusive.

facilities as physicians or directors, or providing active hospital care were commonly reported, all of which represent important parts of the primary care continuum.[12]

On the other hand, 17.3% of respondents worked as "specialists" with little overlap with traditional family medicine care. Combined with those reporting restricted practices as a result of CE certification, this number does have implications for health human resources planning, especially if the number of CE physicians increases. It is hard to compare this study with studies of other enhanced skills programs,[2,3] but it appears that fewer CE physicians eliminated comprehensive family medicine from their practices than emergency medicine trainees did. As respondents to our survey did not quantify the hours spent weekly in comprehensive care, it is hard to compare CE training to anesthesia training with respect to family medicine resource planning. It should be noted that although family medicine anesthetists frequently continued providing comprehensive care, the amount of time spent in this area was relatively small (mean 5 to 8 hours per week spent on "family medicine").[3]

Care of the elderly physicians appear to play important roles in a number of niches. It is well recognized that there is a shortage of geriatricians in Canada.[6] The clinical roles of geriatricians are varied but include acute care consultation and care in outpatient hospitals and inpatient rehabilitation units. These roles were reported by a substantial number of CE respondents. Indeed, given the skills needed for these roles, family physicians are well suited to working collaboratively in specialized geriatric programs. By providing clinical and educational services outside their general practices, CE physicians might be helping to offset the substantial shortfall of geriatricians in specialized services and geriatric medicine divisions.

Concerns and challenges

Recent papers have summarized the challenges of educating medical trainees in geriatric issues and care.[13,14] A large percentage of CE respondents reported being involved with resident supervision and some form of teaching at undergraduate or postgraduate levels. This teaching role might be focused on geriatric issues in restricted practice but almost certainly includes role modeling and geriatric care in family medicine. The link between positive exposure to geriatric care in career training and practice choices has already been discovered.[13,15] The involvement of CE physicians in education might improve care provided by trainees as well as positively influence pressing human resource shortages in this field.

The involvement of CE physicians in LTC and continuing care is similarly very relevant given concerns about an impending shortfall in physician human resources in this sector.[5,16] A potentially crucial role for these physicians is as medical directors, particularly considering the enhanced clinical and administrative experiences provided by CE training. A relatively small proportion of respondents (15.4%) were medical directors; as such, program directors should actively enhance trainees' experiences in LTC and expose them to the medical director role. However, when added to the number of physicians reporting other administrative roles, a substantial number of respondents had assumed some sort of leadership or administrative position relating to care of seniors in hospitals, communities, or at the national level. Given the relatively young age of respondents, it is possible that an even higher proportion might fill the role of medical director later on in their careers.

Care of the elderly training is a relatively new option for family physicians and the mean age of respondents (42 years) was young compared with other physician populations.[5] Given the varied roles of the respondents, CE training appears to offer interesting career

opportunities. These varied roles could increase physician stress if practices become fragmented and require travel between sites. Almost one-fifth (17.3%) of physicians who responded had considered a change in practice in the last few years; this number is lower than reported by other physician surveys.[17]

Given the professional roles of respondents, CE program curricula should try to link trainees to family medicine practices as a way to increase the likelihood of continued provision of comprehensive care. Programs should include experiences in education and administration, as these appear to be relevant roles that can affect recruitment to the field as well as improve care provided in core family medicine programs. Ensuring exposure to LTC and medical director roles might increase trainees' comfort with these roles.

There is a relatively small number of family physicians with CE expertise and a growing number of geriatric patients. Concerted efforts to improve both recruitment and re-entry opportunities for practising family physicians into CE programs are required. Removal of return-of-service requirements for provincial re-entry programs would decrease barriers for practising physicians. Alternate funding plans for physicians with certification would offset the costs of additional training and decrease the challenges of focusing care on frail seniors. This will help improve the care provided in general family practices and allow for specialized geriatric services within the realm of family medicine.

Limitations

The biggest limitation of this study was the identification of CE physicians. Until recently, the CFPC did not maintain a listing of CE graduates. Privacy policies prevented CE program directors from releasing graduate contact information or even names. If names were identified, it was difficult to discern where to send the surveys, making successful follow-up with nonrespondents an even bigger challenge. We were unable to clarify how many surveys were actually received and therefore we were not able to accurately assess a true response rate. When the project began, the CFPC estimated that there were 130 physicians who had completed CE training; therefore, the calculated response rate still represents a substantial proportion of the overall target population.

Conclusion

Care of the elderly physicians fill a variety of clinical and academic roles in family medicine and specialized geriatric services. Although most work in larger centres, they do focus their clinical practices on family medicine care. A substantial proportion also provide care within specialized geriatric services, including rehabilitation centres and day hospitals. Respondents reported active involvement with resident and undergraduate education. Care of the elderly physicians play important roles in academic settings, both as educators and role models, help increase interest in geriatric care, and alleviate human resource shortages in geriatric medicine and LTC.

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Contributors

Dr Frank conceived and developed the research methodology, including the survey tool, prepared the ethics submission, and participated in the analysis and write-up of the results. **Ms Seguin** also conceived and developed the research methodology, including the survey tool, prepared the ethics submission, conducted the analysis, and participated in the write-up of the results.

Competing interests

None declared

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