TEACHING GERIATRIC ASSESSMENT IN HOME VISITS: 
THE FAMILY PHYSICIAN/GERIATRICIAN ATTACHMENT

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Background: Geriatric clinical clerkships in Israel teach mostly about the hospitalized elder patient with almost no ambulatory experience. Meanwhile, primary care physicians provide most of the health care to the elderly in the community. This article describes an innovation in the curriculum of the 5th-year family medicine clerkship at Ben-Gurion University Medical School in Israel designed to improve the teaching of geriatrics in the ambulatory setting.

Description: During the clerkship, family physicians perform a home visit to one of their home-ridden elderly patients with a small group of medical students. During this visit, a geriatrician from the local hospital is included to the group for teaching purposes.

Evaluation: Most students rated this experience positively as did the family physicians and geriatricians who participated in this experience.

Conclusions: This liaison-attachment teaching experience allows the students to learn aspects of geriatrics that are spared during their geriatric clerkship, allows the family physician to use this opportunity as a consultation for homebound patients, and allows the tertiary care geriatrician to teach in the community.

The nature of the elderly population and its health care needs are changing radically. More aging people are living longer and surviving acute hospitalization more often. The demand for home visits by physicians raises as the elderly population with chronic diseases and disability increases. Home care is becoming a significant part of primary care physicians' practice and will be even more central in the future. Most home visits initiated by primary physicians are to older people: 28% of patients seen at home are older than 85 years, and only one in five is younger than 60. Although home visits are time consuming for the physician, they provide a good opportunity to assess elements that cannot be seen otherwise. Because primary care physicians in Israel provide most of the health care to older adults in the community, training in ambulatory geriatrics becomes an important part of the discipline's curriculum.

Although students participate in a clinical clerkship in geriatrics, they learn mostly about the hospitalized elder patient with almost no ambulatory experience. The scenario of a home-ridden patient is neglected during the geriatrics rotation, because most geriatricians in Israel do not reach the community.

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During a home visit it is often possible to take a detailed history from relatives and neighbors, visit friends, and visit people who do not usually turn up in the clinic or who may not be seen for some time by doctors in hospital.4

Examination of the mental state may be more satisfactorily performed when the patient is at home than in the unfamiliar setting of a hospital or the clinic, and signs of self-neglect and the smell of urinary incontinence are detected more readily at home than in the clinic.5

Inspection of the house may provide important information: One may find drugs not mentioned or signs of neglect. There may be no fresh food in the kitchen or evidence of alcohol abuse.6 Problems of hygiene; damp, inadequate heating or lighting; and accident hazards may be found. Home visits also provide the opportunity to identify environmental hazards. Are the steps or path too steep? Is there a grab rail on the stairs? Is the seat of the easy chair too low or the bed too high? Are mobility lavatories or bath aids needed? The patient's family and other caregivers can be interviewed and assessed. The family physician may benefit by being able to share the responsibility of managing patients with complex problems and by receiving advice on the medical and psychosocial management of the elderly patients, many of whom cannot be neatly labeled as having acute or outpatient problems.

Summer and colleagues7 have shown that the development of a home visit program for 2nd-year medical students in an existing geriatrics program lead to a positive change. Responses to this program from students, elders, faculty, administration, and community partners have been overwhelmingly positive. In another report, Thom and colleagues8 from Palo Alto, California described a workshop on ambulatory geriatric medicine in which 3rd-year medical students were asked to interview elders in their homes. This workshop was a part of a required 4-week core clerkship in family medicine at Stanford School of Medicine. The challenge of covering ambulatory geriatrics in a single session included focusing the experience on areas not covered within the rest of the required medical school curriculum; covering multiple topics in a short time while preserving coherence; and making the material meaningful for students, most of whom do not choose primary care specialties.

At Ben-Gurion University students have their first contact with geriatric issues during their 1st year in Medical School (doctor–patient communication course). In following years they meet geriatric problems in different rotations and, during their 6th year, they participate in a 2-week clerkship in the geriatric department. Most of these contacts are in the tertiary care setting.

During the 5th year of medical school, students participate in a 6-week family medicine clerkship. An important part of the patients seen during this rotation are older adults, and home visits are performed during regular work and are part of the teaching process. On their final examination, students are asked to present and discuss a case of an elderly homebound patient.

To bridge the artificial dissociation between disciplines, the department of Family Medicine at Ben-Gurion University and the Department of Geriatrics of the Soroka Medical Center designed a cooperative program in which geriatricians from the tertiary care center perform home visits together with family physicians for teaching purposes. This experience gives students the possibility to learn from the geriatrician and the patient’s family physician in the patient’s natural environment, their homes.

This article describes this unique liaison model designed to teach medical students how to provide home care for the elderly, exposing them to the characteristic medical, social, and economic problems of this population of patients.

The Program

Objectives

The objective is to teach students the comprehensive geriatric assessment in a home visit during the 5th year clerkship in family medicine and its implementation as a most adequate approach in treating elderly disabled patients.

Methods

Three geriatricians from the Soroka Medical Center act as consultants in this program, performing teaching home visits with eight senior family physicians from three teaching clinics, in Beer-Sheva.

During the past 2 years (1999 to 2001), 126 students participated in this experience, in six consecutive clerkship rotations. The family physician elected one of his or her elderly homebound patients for the teaching visit. A group of three to five students performed a home visit together with the patient’s family physician and the consultant geriatrician. Each visit lasted around 90 min, starting with the family physician’s presentation of the patient to the geriatrician and students, followed by the home visit and then by a discussion with the students about relevant issues raised during the visit.

A list of issues drawn from the literature concerning functional assessment of geriatric patients9 was prepared, to be covered during these visits. It included:

- Assessment of the elder’s level of autonomy and disability.
- Assessment of activities of daily living (ADLs) and instrumental ADL (IADL).
- Assessment of home hazards, falls prevention, physical activities.
- Nutritional assessment at home.
- Coping with osteoporosis treatment and prevention.
- Cognitive and mood assessment (mini mental test, diagnosing depression).
- Family relations, the concept of caregiver.
- Resources in the community and acknowledgment about legal rights.
- Home rehabilitation, walking aids.
- Sight and hearing (assessment).
- Prevention of pressure sores in the bedridden patient.
- Medications, polypharmacy.
- Prevention and treatment of elders abuse and neglect.

We could not guarantee that all points listed on the checklist would be discussed in every visit, because the geriatrician and family physician discussed only those relevant to the specific patient.

Feedback from Students

During the last day of the family medicine rotation, students filled an anonymous assessment of the clerkship, including an assessment of the home visit experience. Table 1 shows the results of the students’ assessment. The general assessment of the rotation by students during the 2 years was 3.38 and 3.42, respectively, on a scale of 1 to 4: 1 (not satisfied), 2 (partially satisfied), 3 (satisfied), and 4 (very satisfied). The assessment of the home visit activity was 3.81 and 3.6 (the highest among the activities performed during the clerkship).

During the final feedback meeting with the students, they expressed positive feedback and recommended that this activity will proceed in following years.

Another positive feedback came from the family physicians that attended the home visits. They perceived better abilities in geriatric assessment and a positive result in terms of relations with the patients and their families. Although the official aim of the visit was to teach the students, the family physicians had other aims on their agenda and used some of the visits to consult with the geriatrician about their own concerns for the patients. Some issues discussed were dilemmas about prescribing medications for dementia, the prescription of steroids to elderly asthmatic patients, and decisions concerning institutionalization of the elder. Family physicians felt that the geriatrician served not only as a teacher for the students and an invaluable help for their patients but also as a precious consultation possibility for themselves. Geriatricians’ feedback was also very positive and they concluded that teaching geriatrics out of the hospital is essential because, for students, this is the only possible way of understanding the problems of the aging population in the community.

Discussion

One of the main goals in this teaching program was to introduce and emphasize to the students the importance of the functional assessment as well as the early detection of disability with appropriate diagnostic tools and preventive interventions. Dependency and institutional care were considered as an ultimate solution, only after a full evaluation of rehabilitation and community care resources.

The well-being and quality of care at home are better achieved by a comprehensive geriatric approach, so the teaching effort was to emphasize these aspects as a cornerstone in medical education of young doctors.

The program we described is an excellent example of cooperation between two disciplines in medicine for teaching purposes. A similar liaison-attachment was discussed in the past by the authors (H.T., A.B.) between family physicians and psychiatrists. We believe that this model can be developed in other departments of family medicine and geriatrics and that teaching cooperation between departments should be further explored.

As the scope of home visits has enlarged far beyond our original expectations, medical schools and family physicians should revise the ground rules. Home visits may be of great value to the patient, family, family physicians, geriatric consultant, and medical students. Let us ensure that we all derive maximum benefit from them.

Table 1. Students’ Assessment of the Family Medicine Rotation and the Home Visit Experience in Two School Years

<table>
<thead>
<tr>
<th>School Year</th>
<th>No. Students</th>
<th>No. Feedback</th>
<th>General Assessment</th>
<th>Home Visit Assessment</th>
</tr>
</thead>
<tbody>
<tr>
<td>1999–2000</td>
<td>60</td>
<td>52</td>
<td>3.38</td>
<td>3.81*</td>
</tr>
<tr>
<td>2000–2001</td>
<td>66</td>
<td>55</td>
<td>3.42</td>
<td>3.60*</td>
</tr>
</tbody>
</table>

*The assessment was anonymous, on a 1–4 scale: 1 (not satisfied), 2 (partially satisfied), 3 (satisfied), and 4 (very satisfied).

References


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