Big ‘G’ and Little ‘g’ Geriatrics Education for Physicians

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In the July 2016 issue of this journal, Dr. Mary Tinetti proposed that geriatric medicine abandon attempts to increase the numbers of board-certified geriatricians and change focus to the development of a “small elite workforce.” What would be gained and what sacrificed by accepting this challenge? We agree that the best clinical use of a scarce resource, specialty trained geriatricians, is to care for frail, complex, severely ill elderly adults and to help design and study novel interventions in research, education, and care models to improve the care of all older adults, but for this to happen, all other providers must attain specific competency in the care of older adults. This article responds and discusses alternative pathways for teaching geriatrics care, training specialists, and geriatrics fellows. J Am Geriatr Soc 65:2313–2317, 2017.

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In the July 2016 issue of this journal1, Dr. Mary Tinetti challenged the field of geriatrics to reconsider its approach to the training and marketing of the discipline. Here the implications of her suggestions for geriatrics education and, in particular, geriatrics fellowship are discussed.

Dr. Tinetti proposes abandoning attempts to increase the numbers of board-certified geriatricians (which she refers to as big “G” Geriatricians) and focusing on developing a “small elite workforce that discovers and tests geriatrics principles through our research, that teaches these geriatrics principles to all health professions and to the public, and that disseminates and implements these geriatrics principles through our health system and health policy leadership.” This proposed change acknowledges what has been clear for years: Geriatricians are unlikely to provide the majority of primary care for older adults. Nor do they need to. The best clinical use of a scarce resource, specialty trained geriatricians, is to care for frail, complex, severely ill older adults, not those who are relatively healthy, and to help design and study novel interventions in research, education, and care models to improve the care of all older adults. For this to happen, all other providers must attain specific competency in their care of older adults (little “g” geriatrics; or primary care geriatrics, similar to primary palliative care).2

What would be gained and what sacrificed by accepting this challenge? What would be needed to meet the physician workforce training needs so that all older adults receive care in line with geriatrics principles? What then are the implications for fellowships in geriatric medicine?

GERIATRICS TRAINING STRATEGY

As a discipline, geriatrics has been fortunate to receive funding from multiple foundations and government entities, resulting in career development for clinician-educators, incorporation of geriatrics training into undergraduate and graduate medical education, and development of curricula and geriatric subgroups within specialties. These endeavors have produced many educational materials, more than 1,600 of which are freely available on the Portal of Geriatrics Online Education (www.pogoe.org); medical trainees fluent in geriatric topics; well-trained medical educators with access to turn-key educational products; and specialty and subspecialty geriatrics champions, but this has not translated into an increase in board-certified geriatricians.

What training changes would be needed to ensure competence in little “g” geriatrics?

A national curriculum would be necessary, but not sufficient, for effective and efficient education.

Geriatrics competencies (now called curricular milestones) have been defined for medical students3; internal,
family, and emergency medicine residents; surgeons; and geriatrics fellows. The web-based Geriatrics Education Modules (web-GEMs), developed by 56 geriatrics educators from 27 medical schools and based on the medical student competencies, is the national on-line geriatrics curriculum that Dr. Tinetti called for. In July 2017, web-GEMs will be available by subscription through MedU, a nonprofit consortium that, in conjunction with specialty associations, develops and distributes virtual patient courses tied to national curricula in multiple medical disciplines. Revenue from web-GEMs will support the development and maintenance of new educational efforts by the American Geriatrics Society (AGS) and the Association for Directors of Geriatrics Academic Programs (ADGAP).

The web-GEMs can provide core content and aid in developing geriatric clinical reasoning for students at subscribing schools, but training to competency or training to certify achievement of a predefined skill set requires deliberate practice with observation and feedback. This must be done at every training site, so each site will require at least one skilled, experienced assessor. There could be some observation, feedback, and discussion of clinical reasoning using synchronous video calls or review of video files, but role modeling the approach to a patient, facilitating a difficult conversation, or assessing a skill in the moment requires an onsite preceptor. Train-the-trainer models and integrated and mini-fellowships could ensure little “g” competency across specialties and practice sites, but a preceptor does not have to be a geriatrician. As noted above, many specialties, aided by career development awards supported by the National Institute on Aging have geriatrics champions who are increasingly taking responsibility for teaching their trainees core geriatric content to provide quality care for older adults. The principles-of-change theory suggests that this is the most effective way to mainstream geriatrics into these disciplines. Accrediting integrated fellowships for specialty physicians and surgeons would create a pipeline for these leaders, as the American Board of Internal Medicine (ABIM) integrated geriatrics and palliative medicine pilot or the successful combined geri-oncology pathway has modeled. Standardizing and obtaining accreditation for existing programs that require an exemption from ABIM, such as geri-gastroenterology, or that boards do not recognize, such as geri-emergency medicine training, would mainstream these career paths. Similarly, practices such as orthopedic and trauma surgery co-management models, transitional care management practices provide excellent opportunities to role model, assess, and provide feedback and coaching to trainees on real-time geriatric care. Incentives to emphasize this care in specialty training programs could include geriatrics subscores on board and in-service training examinations or system-wide dashboards that highlight geriatrics quality measures such as delirium, falls, and pressure injuries for all clinicians, including trainees.

Busy physicians are responsible for providing care to the majority of older adults, yet many have little geriatrics training. One effective model has been the American Board of Post-Acute and Long Term Medicine (formerly the Certified Medical Director curriculum). Another successful innovation for reaching these clinicians is a variation of the Chief Resident Immersion Training program, called the reverse mini-fellowship. Developed by the four Reynolds’ Faculty Development to Advance Geriatric Education schools, a small group of outside geriatricians provides a customized 2- to 3-day on-site course to 10 to 14 attending physicians in different disciplines (e.g., hospitalists, emergency medicine, surgery) who care for older adults at the same medical center. The courses include some faculty development and quality improvement brainstorming sessions, often resulting in identifying specific quality improvement projects to improve geriatric care in their health system. Another way to reach these practitioners would be to adapt the web-GEMs curriculum to target practicing clinicians, who could complete web-G2ms cases on their own time and earn Continuing Medical Education or Maintenance Of Certification credit. The Geriatrics Workforce Enhancement Program that the Health Resources and Services Administration has funded has focused on training physicians in practice; the results of these programs are pending.

Consensus Building: An Imperfect Tool Is Better Than No Tool

As Tinetti says, geriatrics must identify specific screening tools for geriatric syndromes. This is not only important clinically for use in electronic medical records (EMRs), but is also necessary if it is desired that national certifying examinations test competency in these areas. For example, the National Board of Medical Examiners has said (unpublished data) that they would consider including a geriatric syndrome in their Step 2 Clinical Skills examination if students from different schools evaluated the syndrome in a uniform fashion.

It appears that consensus has been reached. When creating web-GEMs, specific tools for primary clinicians were chosen based on test characteristics, time needed to conduct the test, and ease of performance for busy clinicians. These were essentially the same choices that 2015 Reynolds Grantees Annual meeting attendees and individuals who developed the well-received Geriatrics Competency Workshops that AGS members developed and presented at the American College of Physicians (ACP) and other meetings made when asked to list screening tests to include in EMRs. Consensus screening tools include the Mini-Cog for cognition (followed by the Montreal Cognitive Assessment, or the Mini-Mental State Examination); the Patient Health Questionnaire-2 for depression; the “Get Up and Go” for mobility, gait, and balance; and activity of daily living and instrumental activity of daily living screen for overall function. These tools could be included in EMRs as quality measures and be integrated into the geriatricized history and physical that Tinetti calls for.

How Would This Affect the Content and Numbers in Big “G” Geriatrics Training?

Roles for Geriatricians Are Shifting

With the increased knowledge base of trainees, the expected knowledge and skill set of a big “G” Geriatrician must also develop and grow. As described in the
accompanying article by Simpson and colleagues, the job roles of the 2025 Geriatrician—complexivist, consultant, health system leader and innovator, functional preservationist, and educator for little “g” and big “G” education needs—draw from the current skill set of geriatricians and the needs that the healthcare system’s impending shift to value-based care and achieving the “Quadruple Aim” compel.\textsuperscript{21,22} Furthermore, these roles predict the shift of site of care away from hospitals and toward skilled nursing facilities, continuing care retirement communities, and the home environment—locations where geriatricians have led and thrived. Preparing future big “G” Geriatricians for these roles, as well as that of a physician–investigator, will require innovation and flexibility in fellowship training.

Creating new types of accredited fellowships, as discussed above for specialty physicians and surgeons, is relatively easy, but training family medicine and internal medicine (IM) graduates to be future leaders in geriatrics will be difficult within the confines of the current 1-year Accreditation Council for Graduate Medical Education (ACGME) geriatrics fellowship requirements. One option would be to develop a standard geriatrics track within IM and family medicine residency programs. The Medical College of Wisconsin, the University of Pittsburgh Medical Center, and other sites have Geri-IM residencies\textsuperscript{23} that could maintain geriatrics interest during residency. Early exposure and competency attainment would enable the fellowship year that follows to be focused more on skills development. These initiatives are a type of clinical “fast tracking” similar to the ABIM cardiology–IM residency being piloted. Combining training tracks with health system fellowships or health policy training or seeking partnerships with health systems that will benefit from complexivists, preservationists, and the other skills of a 2025 geriatrician, could help leverage potential downstream savings into a second year of training that can include leadership and education for “geriatricizing” the workforce.

**Changes in Training Could Recruit Hospitalists, Primary Care, and Midcareer Physicians to a Big “G” Path**

Developing and testing more-flexible models of training might increase the appeal of geriatrics fellowships. For example, State University of New York Stonybrook\textsuperscript{24} has developed a form of “interrupted” training for hospitalists, during which they alternate a geriatrics fellowship and being an attending hospitalist over a 2-year period. This type of training could also be attractive to other hospital-based professionals, including surgeons.

Although ACGME fellowships require on-site training, in these days of competency-based education, a nonresidential option might be developed for midcareer primary care practitioners. Technological innovations could combine on-line content with intermittent in-person coaching, supervision, and assessment of competency. For example, the American Board of Post-Acute and Long Term Medicine model melds American Medical Association or American Academy of Family Physicians content in geriatrics, palliative care, and others with on-line and in-person medical directorship training through the Certified Medical Director Core Curriculum.\textsuperscript{17} As the move is made to competency-based training, it is likely that the amount of time in training will be less of a concern. Long-distance methods of receiving audit and feedback can be developed. These might be similar to executive MBAs, where nonresidential fellows spend a week four times a year at an accredited fellowship program. These types of programs could offer a flexible approach to attainment of the skill set needed while drawing on the advantage of prior clinical experience.

**Does an Elite Workforce Equal Fewer Fellowship Slots?**

The concept of an elite workforce is appealing—and probably necessary to ensure competency of the greater workforce. It is tempting to consider restricting fellowship positions to major academic centers that house larger geriatrics programs, multiyear fellowships, and elite research and education training, but there are drawbacks. Undererved areas would remain underserved, including the community hospitals and affiliated postacute and long-term care facilities where geriatrics expertise is most lacking. It would demand geographical flexibility for trainees at a life stage where many cannot leave the place they have made home. Although distance programs are possible for assessments, there will always need to be local assessors and role models. In addition, many programs have trained fellows who initially intended a career in clinical practice but, when exposed to an academic mission, change course to education, health systems leadership, or research. It is counterproductive to reduce the total number of slots in an attempt to project exclusivity. Admittedly, ratios of applicants to positions are low (0.6 applicants per position), but this is similar to other “non-procedural” specialties, where ratios may hover in the range from 0.9 to 1.1, including infectious disease, rheumatology, and endocrinology. Limiting fellowships may help ratios but at the cost of narrowing opportunities. Perhaps the solution will be in changing the ACGME Residency Review Committee requirements to meet the new definition of a geriatrician; programs that can shift, change, and meet the new requirements will persist, and those that cannot will no longer be accredited.

A reasonable alternative is to have academic geriatrics fellowships share positions and network with smaller, community-based programs that can provide more-multifaceted clinical training and supervision. This is happening at Michigan State University, where training, curriculum, didactics and journal club, and evaluation resources are shared among four accredited fellowships throughout the state.\textsuperscript{25} The purpose of this network is to extend geriatrics expertise to residents interested in geriatric medicine who want to stay in their communities and not travel outside the state to further their training. The overarching goal of these networks is to build sustainable geriatrics programs in areas underserved by geriatricians.

**Implementation**

Several innovations discussed above require approval of accrediting and certifying bodies, as well as buy-in of
individual institutions and programs; the AGS and ADGAP should work with the ABIM, ABFM, American Board of Medical Specialties, and ACGME to create these alternatives to traditional residencies and fellowships. Other innovations in education will require that new payer sources supplement current Graduate Medical Education (GME) dollars to support fellowship training beyond 1 year and to support those who provide little “g” education and training. There are several possible avenues: GME money currently stems from Medicare; it would be reasonable to link GME funding to demonstrated competency in care for older adults in all disciplines. With changes in ACGME requirements, funding for 2-year fellowships could be reconsidered. Furthermore, for novel training and assessment structures, including nonhospital training sites, GME money would need to follow the trainees into their environments, including home-based, postacute, and long-term care. AGS and ADGAP could identify and support business plans for reverse mini-fellowships and other innovative faculty and practicing physician development initiatives; these could then protect time for clinician—educators to develop curriculum and, in particular, for role modeling and assessments. Advocacy for a re-envisioned career development award—perhaps requiring engagement with National Institutes of Health funding priorities, primary care settings, or patient outcomes—could bridge development of effective educational materials with improvements in quality of care delivered. Federal and foundation funding earmarked for person-centered care may be an appropriate resource for teaching and supporting geriatrics principles. Finally, engaging hospitals and healthcare systems has been effective for some educators (e.g., initiatives at University of Alabama to “geriatricize” the staff) (unpublished data). Partnering across professions (e.g., leveraging the Nurses Improving Care for Healthsystem Elders program) would broaden the effect.

There are opportunities for geriatricians to guide the development of a healthcare workforce newly focused on value-based care, personalized medicine, safety, and quality—all core geriatrics concepts. As accountable care and extensively models spread, midcareer and senior master educators training the current workforce would help improve quality of care for older adults. Furthermore, co-management or consultative teams could negotiate for supported time for training the workforce while delivering care. By moving into the clinical and administrative space, geriatricians can leverage clinical care to achieve larger training and education goals.

CONCLUSION

Although the structure of health care is changing, the medical needs of older adults have remained remarkably consistent. As the average age of Americans rises, it behooves physicians to remember that there are three critical care needs of older adults. First, they need providers competent to care for most of them (little “g” geriatrics training). This includes primary care, specialty care, and surgical care providers and current practicing providers as well as providers in training. Second, specialty geriatricians are needed to provide care for the most-complex and frailest older adults and those with dementia—including little “g” competencies applicable to individuals with complex multimorbidity. Finally, the healthcare system must embrace person-centered care, optimizing personal goals, and minimizing iatrogenic harm for older adults.

As the D.W. Reynolds, John A. Hartford, Veteran’s Administration, and Health Resources and Services Administration initiatives have improved geriatrics knowledge and as healthcare policy has redefined financial priorities, published AAMC/AGS geriatrics competencies will need continual updating. Alignment with a function-first philosophy27 that prioritizes function over disease may provide a road map for the curriculum of the future. Geriatrician complexivists must also have expertise in the person-centered care of older adults with multimorbidity, as outlined in recent guidelines statements from the AGS and the UK National Institute for Health and Care Excellence.28,29 Restructuring of care for this population may clarify the content and tools that all care providers, specifically geriatricians, must master. Dr. Tinetti and Drs. Allan Huang and Frank Molnar in the Division of Geriatrics at the University of Ottawa have discussed distilling the principles of geriatrics into the 5Ms: Mind (mentation), Mobility, Medications, Multicomplexity (multiple chronic conditions, multiple interacting factors), and what Matters—a good first step for the next curriculum.30

No matter what the format of training is or who the trainees are, the teaching of geriatrics will always be centered on compassionate care of older adults who face the burdens of disease and of disability and the caregivers who support them. It will also rely on clinical decision-making amidst “subtlety and complexity,”31 which requires modeling by master clinicians and educators. By taking the essential undergraduate medical education curriculum that has been identified and determining what can be offered in imaginative and broadly accessible ways, it may be possible to marry technology with at-elbow teaching and assessment and expand the ability to train big “G” and little “g” geriatricians for future generations.

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REFERENCES


