ERIES SPECIAL SERI
ECIAL SERIES SPECI

Teaching Aging in Professional
and Academic Education - No. 4

INTERNATIONAL SYMPOSIUM ON THE TEACHING OF AGING IN MEDICAL EDUCATION

In cooperation with ESHEL and the Israel Gerontological Society

S-24-85

JOINT (JDC) ISRAEL -
BROOKDALE INSTITUTE OF GERONTOLOGY
AND ADULT HUMAN DEVELOPMENT

JDC HILL, P.O.B. 13087
JERUSALEM 91130, ISRAEL

THE INSTITU

is a national ce
gerontology an
the American
assistance of t
the State
multidisciplin

The Institute
alternative s
to bring tog
officials an
implementat

The findings
do not purpo
groups asso

International Symposium
on the Teaching of Aging
in Medical Education

סימן הפרסום

BR-S-24-85 c.2

שם המחבר

שם הספר International Symposium on the Teaching of Aging in Medical Education

שם השואל	תאריך	חתימה

International Symposium

on the Teaching of Aging in Medical Education

JDC-Brookdale Institute of Gerontology and Adult Human Development in Israel

December 23, 1984

In cooperation with ESHEL and the Israel Gerontological Society.

ABSTRACT

A symposium sponsored by the Brookdale Institute, the Israel Gerontological Society and ESHEL (Association for the Planning and Development of Services to the Aged), held on 23 December 1984, dealt with various aspects of teaching aging in medical education, and the state of geriatric training in different parts of the world. Yitzhak Margulec (Medical Advisor, Joint-Israel) served as moderator. This publication contains the lectures given in the symposium and a summary of the ensuing discussion.

The first speaker was Robert Kane (UCLA Medical School), who surveyed the history of geriatrics in the U.S. in the past 10 years. Despite the great progress in that field, geriatrics in the U.S. still has a very long way to go. While stressing the importance of clinical training in geriatric medicine, Prof. Kane also suggested that the main events in geriatrics today take place outside the hospital and that the academic world's reactions are slow.

An entirely different approach was presented by Bernard Isaacs (Birmingham University, Geriatric Medicine Department). Direct contact between students and the elderly is the focus of a program offered by this department. Contact of this kind helps students overcome their prejudices and fears, and develop a warm, empathetic and understanding attitude towards the elderly.

Arnold Rosin (Shaarei Zedek Hospital) said that geriatrics in Israel is now taking its very first steps. He reviewed the geriatrics training programs in Israel's medical schools and called for raising the prestige of geriatric medicine.

The last speaker was Marian Rabinovitz (Sheba Hospital), who focused on some of the more philosophical aspects of the treatment of the elderly. These include changing the attitude of our consumer society towards those who have stopped producing, and creating genuine concern among physicians even towards those whose life expectancy is short.

The ensuing discussion raised several other important topics, such as ways of attracting medical students to geriatrics, and multi-disciplinary frameworks for training geriatric physicians.

Table of Contents

Introductory Remarks

Professor Yitzhak Margulec, Medical Advisor, Joint-Israel

Ladies and gentlemen and dear foreign guests:

I greet you today in place of Professor Michael Davies, who was unfortunately taken ill and is now recovering. We send him our best wishes for a speedy recovery. His absence is certainly felt, since he is a fine educator in Israel. He is now the Director of the School of Public Health and Community Medicine of Hebrew University, and his interest in geriatrics was highlighted by his former position as Director of the Brookdale Institute. His main task now is to train epidemiologists who are interested in geriatrics.

In our workshop on the problem of education and training in the field of geriatrics, we have the great opportunity to listen to experts from abroad and to learn from their experience. We've started to adopt some of their ideas, and we are planning to adopt others, some which you will probably hear about today. And it's only a beginning. We were well aware for years that programs for training geriatricians and other professionals who work with the aged are one of the keys to providing proper care for the elderly in this country.

To present an overview of geriatric medical education in the U.S., we've invited Professor Robert Kane of the School of Medicine at the University of California in Los Angeles.[1] He is also Professor in

---

[1] Professor Kane is now Dean of the School of Public Health at the University of Minnesota in Minneapolis.

Residence in the Department of Medicine and Senior Researcher at the Rand Corporation.

Professor Bernard Isaacs is Professor of Geriatric Medicine at the University of Birmingham in England and is Chairman of the Department of Geriatric Medicine there. He is one of the leading scholars in this field and is very much involved in extensive research on the clinical process and the assessment of needs in the organization of geriatric services.

To describe the state of geriatric medical education here is Israel, we've invited two speakers, Professor Arnold Rosin, of the Shaare Zedek School of Medicine in Jerusalem, and Dr. Marian Rabinowitz, of Tel Hashomer Hospital in Tel Aviv.

Geriatric Medical Education in the United States

Professor Robert Kane

Geriatric medical education in the United States over the past decade can be described by the optimist as having made tremendous strides and by the pessimist as having a long way to go. Ten years ago virtually no one in American medical education talked about aging. Courses on care of the elderly were extremely rare and even a reference to elderly persons was uncommon in the curriculum of the average medical school. Ten years later we face a situation in which it is not only socially acceptable to talk about teaching courses on aging, but it is an expectation to the point that one has to apologize for not having such offerings in one's medical curriculum. Diseases of the aged, barely discussed a decade ago, are now being widely and actively investigated.

At the same time, much remains to be accomplished. Even modest projections of need for geriatric physicians are far from being achieved. In 1980 there was a projected need for at least six thousand trained geriatricians by 1990 (Kane et al., 1981). At the present time we are producing in the United States no more than 100 such physicians per year. Studies of teaching programs in geriatrics have traced a general growth in attention to this subject, but the impact of such teaching on the overall curriculum is still very modest at best.

The need for more and better geriatric training has been recognized by both the government and the medical schools. The

National Institute on Aging's Report on Education and Training in Geriatrics and Gerontology (1984) calls for the development of educational leaders in geriatrics for both education and resesarch. The report recommends more and better training at all levels, from medical students through mid-career training, to increase skills and knowledge in aging issues.

The Proceedings of the Regional Institutes on Geriatrics and Medical Education sponsored by the Association of American Medical Colleges (1983) urged medical schools to pay increased attention to the aging process and elderly patients. A body of knowledge suitable for a curriculum was identified, along with the need for trained faculty and suitable clinical settings, to demonstrate the variety of elderly and medical needs.

Efforts to support geriatric education have come from a number of federal agencies since 1979. The National Institute on Aging has supported geriatric faculty development through a variety of grant programs to encourage faculty at both senior and junior levels. The Administration on Aging has provided funds to support faculty development and fellowship training. It has funded model programs at 11 medical schools designed to develop long-term care gerontology centers which more closely link the universities with community aging programs. The Veterans Administration has put a high priority on training a variety of health professionals for care of the aging veteran, and it has established a network of geriatric research, education, and clinical centers (GRECCs). The VA funds the largest group of fellowship programs for geriatric physician training. Many of the models of innovative geriatric practice have been developed

under their auspices, as have training programs and interdisciplinary team training for care of the elderly. The Bureau of Health Professions has sponsored curriculum development projects and more recently a series of regional medical education centers to train faculty in geriatric education.

All of this investment of money and effort has certainly increased the visibility of geriatrics. One can scarcely pick up a journal in the United States without reading at least one advertisement for a continuing medical education course in geriatrics. If the hallmark of new interest in a field is the appearance of text books, geriatrics has certainly come of age. Each month seems to bring a new compendium of knowledge about aging and how to care for the aged patient.

However, closer examination of the actual extent of training may produce a more somber picture. In a recent study, several UCLA faculty have looked closely at the depth of geriatric training in the country's medical schools. Data from departments of medicine, family practice, and psychiatry in 125 medical schools indicate that there was a clinical program in geriatrics in at least one department in 70% of the schools responding. Of the departments of internal medicine, only 35% had no clinical program, or did not sponsor at least some instruction in geriatrics. For family practice the corresponding figure was 41% and for psychiatry, 50%. These figures present a rather optimistic picture. Compared to data collected in 1979-80, the 1983-84 data suggest almost a doubling of efforts in geriatrics. However, when the data are examined more closely, the depth of the training raises some concern. Among the internal medicine programs, only 2% were required. Among family practice and psychiatry programs,

none were required. In fact, 86% of the overall programs were simply electives. The average number of students electing geriatric programs represent only about 2% of all third and fourth year students (Vivell et al., in press).

It thus appears that although geriatrics has gained some stature, there is still a great deal to be accomplished. In part, geriatrics may be the product of its own success. The presence of a program specifically designed to offer training in the care of the elderly has prompted other disciplines to respond with efforts of their own. Within family practice for example, specialty certification requires three months' exposure to geriatrics as part of the basic training package for residents. A similar requirement for training in internal medicine, recognized by certificate of special competence in geriatrics, is under active consideration.

One of the issues that must be carefully considered in developing geriatric training programs is the clear definition of what we mean by geriatrics. On the one hand there is certainly a need to increase students' awareness about the problems associated with aging and to make them more sensitive to the difficulty of separating changes associated with "normal" aging and pathology. There are basic principles that make up at least part of the cognitive package of information with regard to geriatrics. These include the geriatric paradigm of the confluence of multiple simultaneous interactive problems, that is, the decreased ability of an older person to respond to a variety of stresses and thus to maintain homeostasis (this phenomenon is sometimes referred to as "homeostenosis"). There are a number of special problems which seem to disproportionately affect the

elderly. These include clinical problems such as dementia, urinary incontinence, and falls.

At another level the neophyte physician must be taught how to appreciate both the capacity of the older person to cope with a variety of exigencies and the value of the physician in supporting the older person. Geriatric education thus walks a very fine line. On the one hand, we want to encourage students to appreciate the importance of a variety of components that contribute to overall functioning of the older person. In such a context the role of medicine may be secondary to many other social activities and supports. On the other hand, one does not want to create in the student a sense of nihilism with regard to the role of the physician in caring for the older person.

This distinction is a very difficult one to bring into practice. Geriatrics appropriately emphasizes the importance of functioning as the summary measure of the effectiveness of treatment. The emphasis on function distinguishes geriatrics from most other medical training, which tends to emphasize diagnosis. At the same time, an overemphasis on functioning may artificially deemphasize the importance of making precise ideologic diagnoses as an important step in addressing correctable problems in older patients. It is important that the student appreciate that geriatrics requires both accurate diagnostic efforts to remediate the remediable, as well as a more general management strategy which mobilizes a variety of environmental supports (both physical and social) to facilitate functioning.

One of the great fears in geriatric education is the danger that students will become so overwhelmed by the enormity of the problems faced by older patients that they feel unable to intervene. This

perceived impotence can lead to a sense of frustration and even hostility directed toward the patient. There is reasonable evidence on which to hypothesize that individuals develop negative feelings about strangers who they feel are unable to help. This "innocent victim syndrome" can find an easy application in the care of the elderly (Lerner & Simmons, 1967). We hear a great deal about the problems of negative biases toward the elderly. For health professionals, a sense of impotence may exacerbate these negative feelings (Lerner & Lichtman, 1968).

One important strategy to counter such negative feelings is an emphasis on practical tools to facilitate the management of these complicated multi-faceted problems. We have put great stress on developing written materials to facilitate the collection of information, to develop data bases that remind medical practitioners about the wide range of activities and items to be covered (Kane, Ouslander, Abrass, 1984). We have begun to demonstrate that organized efforts using structured approaches can indeed produce scientifically demonstrable differences in the outcomes of older patients, particularly those at greatest risk of institutionalization. An example of this kind of research is typified by the randomized control trial of the geriatric evaluation unit conducted recently at the Sepulveda VA Hospital (Rubenstein et al., 1984).

Of the medical disciplines, family practice has made a substantive change in its educational programs and requirements for certification, which now call for three months of geriatric experience. Internal medicine is actively considering a certificate of special competence in geriatrics.

There is now tremendous interest in the United States in the problem of dementia. But our interest has preceded our ability to supply a sufficient number of geriatricians, especially geropsychiatrists. Dementia, as we know, is the purview of everybody and nobody. A few years ago nobody wanted to touch the demented elderly; now everyone sees them as an interesting group to study. We have neurologists, geriatricians and psychiatrists all claiming to have appropriate talents that can be directed toward dementia. There is some interest in finding better ways to treat demented persons.

Outside the academic world, interestingly enough, an active market has emerged for people with skills in managing the elderly. Ironically, at the same time that the academic world has been slow to do anything very meaningful about geriatrics, the real world, where people are taking care of patients, has recognized that this is a very important issue. The elderly now represent over half the visits to many clinics and hospitals and are projected to represent even more. As a result there are constant requests for people skilled in the care of the elderly to head geriatric units of hospitals and new forms of care such as HMOs. In addition, hospitals see themselves as eventually becoming medical centers; and centers for acute and long-term care, health-maintenance, and other forms of pre-paid care are becoming increasingly popular. The real activity, in terms of developing something novel and innovative, has occurred in the field rather than in academe.

REFERENCES

Association of American Medical Colleges. 1983. "Proceedings of the Regional Institutes on Geriatrics and Medical Education." Washington, D.C.

Kane, R.L.; Ouslander, J.C.; and Abrass, I.B. 1984. Essentials of Clinical Geriatrics. McGraw-Hill, New York.

Kane, R.L.; Solomon, D.H.; Beck, J.C.; Keller, E.; and Kane, R.A. 1981. Geriatrics in the United States: Manpower Projections and Training Considerations. DC Heath, Lexington, MA.

Lerner, M.J.; and Lichtman, P.R. 1968. "Effects of Perceived Norms on Attitudes and Altruistic Behavior Toward a Dependent Other." J. Personality Soc. Psychol. 9:226-32.

Lerner, M.J.; and Simmons, C.H. 1966. "Observer's Reaction to the 'Innocent Victim': Compassion or Rejection?" J. Personality Soc. Psychol. 4:203-210.

National Institute on Aging. 1984. "Report on Education and Training in Geriatrics and Gerontology."

Rubenstein, L.Z.; Josephson, K.R.; Wieland, G.D.; et al. 1984. "Effectiveness of Geriatric Evaluation Unit: A Randomized Clinical Trial." New England Journal of Medicine 311:1664-1670.

Vivell, S.; Robbins, A.S.; Solomon, D.H.; and Beck, J.C. (in press) "Education in the Clinical Years: Delusion or Reality." Bulletin of the New York Academy of Medicine.

Geriatric Medical Education in Britain

Professor Bernard Isaacs

Undergraduate Training

The success of developing geriatric medicine in Britain has been quite impressive. Undergraduate teaching in geriatric medicine in the United Kingdom was recently surveyed. Of the 30 medical schools in the U.K., geriatric medicine is taught in 28, half of which include an academic department in geriatric medicine which is usually headed by a full professor, although one or two departments are headed by people whose status is less than that of professor.

Of the academic departments, 13 are described as Department of Geriatric Medicine, and two are described as Health Care of the Elderly. The latter is a euphemism for geriatrics, but the professors of medicine in these medical schools believe that there is no such thing as geriatric medicine, just old people who need to be looked after.

In one of these Departments of Health Care of the Elderly, the professor is not a physician; he is a psychiatrist, Professor Tom Arie, and he heads a comprehensive department in Nottingham in which psychiatrists and physicians in geriatric medicine work together. There are, in addition, two academic departments in the psychiatry of old age, one at the great center of psychiatry, the Maudsley Hospital (a surprising development for a highly academic center), and in Guy's Hospital,another major London teaching hospital.

So almost every British medical student receives instruction in geriatric medicine, most of them in a properly structured academic

department with a full-time professor and one or two other full-time senior staff. That, at least, is a start.

The following data came from a survey of the number of undergraduate hours of in ruction received by students of geriatric medicine. The average is 69 hours and the range extends from zero to 171.

Hours of Instruction	Number of Schools
0	2
Less than 25	4
25-49	6
50-74	6
75-99	4
100 or more	7

Average 69 hours

Maximum 171 hours

Birmingham 74 hours

Between the two major surveys on this subject in 1975 and 1981, the average number of hours of teaching doubled and the number of academic departments doubled.

	1975	1981
Average hours of teaching	36	69
Academic departments	6	14

These rates cannot continue to double every five years, and we may have neared capacity in both areas.

Content of Courses

The following is an outline of the course for medical students at the University Department of Geriatric Medicine at Birmingham.

Year of Study	Course	Activity	Hours	Percentage of Class
I	Medicine as Science and Service	Lecture	1	100
		Project	20	10
III	Clinical Methods	Bedside	2	12
	Introduction to Old Age	"Grandparents" Brains Trust	2	100
			1	100
IV	Geriatric Medicine	Clinical Visits	40	100
	Social Medicine	Project	20	10
	Coordinated Studies	Lectures	10	10
	Elective	Research	8 weeks	1
V	Psychogeriatrics	Clinical	3	20

Our main contribution is in the fourth clinical year, when we offer our major course in geriatric medicine. This is a two-week course with some 60 hours of student contact, and is described below. Our contributions at other times include a course called "Medicine as Science and Service," which is a general introduction to the work of doctors in the community. This course, which used to be based on lectures only, is now a project course. The students may choose projects in child care, pre-natal care, terminal care, or any subject that interests them, for about 20 hours. About 20 of the 160 students choose a topic related to old age. Although they are not yet clinically trained, many have had previous experience in working with the aged. Some have worked in geriatric wards or in our equivalent of a Beit Avot. Others are interested in strokes, physical handicaps,

blindness, or deafness, and we give them the opportunity to work in these areas. All students in the course receive a one-hour lecture that presents an introduction to geriatric medicine.

The second year is devoted mainly to anatomy, physiology, biochemistry, and pharmacology. In the third year, when they start clinical work, we have an opportunity to meet some of them through the clinical introductory course. We also contribute to the course in Social Medicine and another called Coordinated Studies, which is jointly taught by all the clinical teaching departments. All students in the department can do eight weeks as an elective; they can choose any subject and go anywhere in the world. I try to send some of them to Jerusalem or Beersheva, but most go to India, Africa, or the United States. We also get elective students from other universities who come to work with us. In their final year the students take on psycho-geriatrics, which until now I have taught. Since I am not a psychiatrist, they don't learn much about psychiatry but they do get another opportunity to learn about old people. In the near future we will have a lecturer in psycho-geriatrics who will relieve me of the responsibility for that course.

Program for Two-Week Course

I will now fill in the details of the main two-week course in the fourth year. The 160 students enrolled each year come to us 10 at a time for a period of two weeks each, so that we teach a different group every two weeks over a 32-week period. I subdivide the 10 into 10 units of one, because I am in the very fortunate position of having 10 colleagues who are consulting physicians in geriatric medicine, who are all fully trained and accomplished and all of whom work a short

distance from the university. We can allocate one student to each teacher, who arranges and supervises his detailed program.

We have agreed upon a set of simple objectives and methods of meeting them:

Objectives

To learn that: Most old people are not ill.

Most ill old people are not in hospitals.

Most care is given by people who are not doctors.

Methods

Get out of the hospital.

Meet old people in their own homes.

Visit community services.

Meet the caregivers.

We try to teach them that most old people are not ill and that those who are ill are not in hospitals; they are being cared for at home, not by doctors, but by relatives, domiciliary services, nurses, home-helps, and so on.

We try to rid them of the ideas with which they come to us and to teach them that old people used to be young people and still have many of the attributes of young people - they want to live at home and they want to function as reasonably as they can. What we do for them must be seen in the light of what they value rather than what we as doctors value. To learn these things, the students need to get out of the hospital and into the homes of old people; they also need to visit the community services that care for the elderly and meet the caregivers. This is indeed a novel experience for the students. They like doing it very much and we hope they learn something from it. I

always remember the girl who said to me at the end of her two-week course, "You know what I've learned during these last two weeks? It's all out there!" And I said, "That's exactly what we wanted you to learn!" Things that really matter for old people are happening out in the community, not in the hospital.

There are additional objectives of the two-week course:

Talk to Old People:	Overcome inhibitions, anxieties. Don't patronize, don't underestimate.
Talk to Caregivers:	Understand their frustrations. Admire their contribution.
Talk to Domiciliary Staff:	Absorb their enthusiasm. Respect their professionalism.

I have been surprised to find how frightened the students are of old people. I suppose we are so used to talking with old people that we do not realize what students fear. They are afraid of themselves; they do not feel secure talking to old people. They come to our classes in the first week with their white coats on and their stethoscopes sticking out of their pockets. This reassures them. I have to tell them, "Take these white coats off. You are a person, not a doctor, and when you are with us you don't need armor plating to protect your personalities. Go out and meet these people. You'll find them easy to talk to. They're only too happy to talk to you. Try to get rid of your hang-ups."

I then tell them not to patronize, because when they do talk to patients they are very patronizing. For example, when they talk to an old person, even in the ward, they stand up and talk. I tell them, "You must sit down! If they are lying down or sitting, and you are above them they are looking up to you. That's not a relationship.

You've got to sit beside them, talk to them, touch them, be on the level with them, and don't underestimate them." There's an immediate assumption that they are all confused. Some old people cannot answer a question such as, "How long have you been in the hospital?" because they may not even know that they are in the hospital. Yet the student's first question to them is invariably, "How long have you been in the hospital?" This is something simple they've got to learn - not to patronize and not to underestimate.

Our students also have to learn to talk to caregivers. They assume that caregivers try to dump onto doctors problems that they should be handling themselves. They seem to look upon caregivers with an innate hostility. They need an opportunity to meet them and understand the frustrations, stresses, and strains that they suffer. It's desperately important to learn that if a woman says, "I've been looking after my mother for the last three years and have suffered for it; now it's time for the hospital to take over," it's not because she's heartless or selfish or lazy or couldn't care less; it's because she's broken and exhausted. And we have to understand that when people are broken by having no sleep at night, worrying about their parents, their own families, and their own jobs and future, then they react to us differently than they would if they were as free from trouble as we are. All this is something that students must try to learn.

Thirdly, they must learn what domiciliary staff are like - the people who work out in the community whom they have never seen before. They have read about them and know that there are such people as home-helps and community nurses, but they have never actually met them.

And they do not recognize how much these people know and how much they have to offer.

And so the challenge of our program is really a logistical one - not what we ought to do but how can we achieve it, how can we get students out to the community. We can do this only by imposing on the kindness of these professionals. We ask the home nurse, for instance, to take one of our students with her when she visits her patients; we get the domiciliary physiotherapist, the home-help supervisor, and as many of these people as we can to do the same, one student at a time.

I can summarize the advice we give to students who go out on home visits in this way: no white coats, no stethoscopes, no notebooks. If they start to write things down, the old people will conclude that they've come from the Social Security Department and are going to cut their grants or something like that. They're not there to be officials; they're there to be people and to react as people. Old people in Britain have a habit of keeping very ferocious dogs, and one of the major hazards of being a geriatrician is the danger of being assaulted by one of these beasts as soon as you ring the doorbell. I always say to the student, "Go into the house first." This is part of the technique of being accepted and is vitally important to getting the information they want to collect. If they kick the dog or run away, they won't get to know much about the patient. They stand a better chance of success if they play with the dog or pay attention to photographs in the home: "Are they your grandchildren, oh they're so nice, what are their names?" They will not only endear themselves to the patient but will also be giving an intelligence test, because very often patients can't remember the names of their own grandchildren. I think that's a much easier way of doing it than to administer the

Wechsler Adult Intelligence Scale, which I myself can't do. These are just common sense things but are things that students need to be reminded of.

We tell students to look at the medicines during home visits. In Britain there is a rule that medicines must be distributed in child-resistant containers. They often find that old people cannot open child-resistant containers and have to get a child to help them. And once the containers are open, the patients keep them open and then are likely to mix them up. The students have to see what food is in the house. I tell them to use the toilet when they're there, because it will give them some idea of the physical difficulties that the patient has in using the toilet. I also tell them to be sure to see the stairs. If they have a good look around the house, they learn quite a lot of what is germane to the world of the old person. All these little things are very important aspects of compliance, and our students learn a good deal about that. We can't manage to fit in all our objectives in the course of the two weeks; but this is our goal.

The consulting physician in geriatric medicine very frequently goes out to a patient's home at the request of the family doctor to assess the need for admission. This is very characteristic of the practice of geriatric medicine in the United Kingdom, and it's a very good event for the student to witness or even to do himself. When a patient is nearly ready to be discharged from the hospital, it's common for the occupational therapist, the social worker, or the physiotherapist to take the patient home for an hour or two and watch how he functions on his own before making the final decision on discharge. That again is a good opportunity for the student to be

present. Another is to accompany the liaison nurse who visits the patient's home after discharge to assess his functional ability at that time. Students may also accompany the social worker or home-help supervisor, who assess applicants for home-help and determine how much they require. The following is a list of home visits to patients, all of which are open to student participation:

Purpose	Visiting Caregiver
Assessment for admission	Consulting Physician
Pre-discharge assessment	Occupational Therapist Social Worker Physiotherapist
Post-discharge evaluation	Liaison Nurse Health Visitor
Assessment of need	Social Worker Health Visitor Home-Help Supervisor
Provision of service	Physiotherapist Occupational Therapist Community Nurse "Incontinence" Nurse Home-Help Speech Therapist Voluntary Visitor

One of our students told me that she'd gone on home visits with a selection of these caregivers and she'd noticed that if she went out with a doctor, the patient usually thought that she was a doctor and spoke to her as if she was a doctor. But if she went out with a home-help, they thought she was a home-help and spoke to her as if she were a home-help. She said that she communicated differently with each patient, depending on which role she was masquerading at the time.

We also encourage students to visit institutions in the community that contribute to the care of the elderly. Although we don't get all

students into these places, we try to reach as many as possible: residential homes, day hospitals, centers for rehabilitation after amputation, centers for rehabilitation of the blind and deaf, centers for elderly ill and physically handicapped, and so on. Every community institution that provides a service is a potential resource for teaching and research. Every time I learn of a new initiative in our region, I immediately go to see it in order to judge its potential as a teaching resource for our students.

In addition to arranging home visits and institutional visits, we require all of our students to do a project of their own. They are only with us for two weeks, and I set aside two days at most toward the end of this period for them to do their own project. In fact, they usually have only one day to carry it out. The project can be on anything at all that is concerned with old age. They are told to do it not in the library, but in the field and to do something that requires original, reasonably systematic observations. They can use questionnaires or any other procedure they favor.

On the final morning of the course, all ten students from the ten different locations come together in our department's seminar room and each of them has about ten or fifteen minutes in which to present the results of his original research. I also require them to produce a short written version, 500-1000 words, no references - just a statement of what they have done and what they have found. When you ask them to do this, they are horrified - how can they possibly do it, far too little time, it's a real imposition, etc. But, in fact, they enjoy doing it very much indeed and they're absolutely superb. It's quite amazing how much enthusiasm they invest in this little enterprise and what a tremendous amount they get out of it and I get

out of it from listening to what they've done.

We've been requiring these individual projects for four years, and with 160 students, we must have accumulated about 500 projects already. I will indicate just some of the subjects they've dealt with. Attitudes toward death and dying - I mention this first because one student has just completed her work on this topic and she's one of the few who have chosen it. She went into a ward and asked many old people what they felt and thought about their own death, how they viewed the future, whether or not they believed in life after death, what they feared about death, and so on. This surprised the rest of the class who said, "How in the world did you have the nerve to ask these questions?" But she'd found it surprisingly easy and she learned a lot and taught the others that this was possible. Many of her questions dealt with beliefs - what do old people believe about their bowels and what do they think about the various illnesses, including cancer; what do they think about diet and smoking. She got amazingly informative material. Another student was interested in how much income the elderly received and how they spent it. Someone else pursued the laundry services in a hospital and went down to find out how the sheets are laundered, how they are lost, and what happens to personal clothing. Someone else was interested in the problem of crime and how it affected old people; he talked to them about it and went to see the police to talk about crime and old age. This is just a tiny fraction of the tremendous range of the things these students do. They not only vie with each other in doing it well; they vie with each other in trying to be original, to think of something that nobody else has done. Before we required these projects, we had 50%, maybe

60%, attendance in class. We now have 100% attendance. Every single medical student who's been through Birmingham University in the last four years has completed one of these projects, and the great majority of them have done very well. A few of them have been quite superb, and, in fact, several have been published in a local journal.

What we offer our students is not a systematic study of geriatric medicine, and I make no apology for that. You can always go to a library and read about something systematically. I decided against this approach to teaching them clinical medicine of old age in order to avoid opposition: "Why do we have to do all this? We've done it all already; there's nothing different." It's very difficult for us to prove that we give better medical care to old people than they do in general medicine. I'd much rather give them experiences and try to change their attitudes. Although none of them, or very few of them, will become geriatricians, all of them will look at old people in a different way. That's what we're trying to achieve.

We have also got to teach them some epidemiology and demography, subjects that I find difficult to make interesting for students. And if they are not interested, they will not come and will not learn anything. I set aside one morning to teach the whole class something about the elderly population. I racked my brains as to how to make this interesting. I decided we could base the lesson on a demographic sample that we would construct from the students' own grandparents. We call this the Grandparents Survey, and it has worked quite nicely for a number of years. The objectives are:

To demonstrate aspects of data collection:
- Sampling bias
- Sources of sample
- Definitions
- Subject's recall

To demonstrate major epidemiological and social facts:
- Longevity of females
- Causes of death
- Living arrangements
- Low institutionalization rates

To provide correct perspectives:
- High incidence of sensory handicap
- Low incidence of incontinence and dementia
- Great majority "content on the whole"

The students generate the demographic sample themselves by providing information about their own grandparents. This, of course, produces a biased sample, and half of the fun is teaching the students to identify the biases within the sample. While they always identify the social class bias and the age bias, they very seldom identify the most important bias: if they use this sample as a basis for generalizing about the larger population of elderly, then by studying only grandparents they have ommited the vital group of old people who never had children. The method is very simple. We have devised a form that we hand out to students a week before the class. They can complete it in a few minutes; they just tick off a few things about their deceased grandparents and about their living grandparents. The completion takes only a few minutes; our analysis takes much longer since we have yet to computerize the process.

We get the following information from the surveys:

Deceased Grandparents
- Age at death
- Cause of death

Surviving Grandparents
- Age, sex, marital status
- Living arrangements - home/hospital
- Number of living children
- Distance from living children
- Stairs in house

Possession of telephone, motor car
State of health (normal/
impaired/severely impaired)
-in relation to: mobility
balance
continence
vision
hearing
cardiac function
intellectual state
On the whole, content or depressed?

From the data on deceased grandparents, you can learn a tremendous amount: the differences between the sexes, the effect of the first World War, and, always, the three major causes of death - heart disease, cancer and stroke. I feel that if the students generate the information themselves, they're more likely to believe it. When students are asked to provide very simple information about the state of health of their grandparents, they frequently put the most common disabilities of old age - vision and hearing - at the bottom of the pile. They find out that 5-10% of the sample are incontinent and about 10% have impaired intellectual state, and these figures match very closely to data that's taken from proper surveys. For the last question - "On the whole, do you think your grandparent is reasonably content or depressed?" - one might think that about 90% of the students would label their grandparents depressed; in fact, 90% of them invariably perceived their grandparents as content, on the whole. I have to remind the grandchildren that they are such nice young people that they are bound to cheer up their grandparents, and their perception of them is bound to be rather biased by this fact. In an hour, we get through quite a lot of epidemiology by this rather simple method; it gives the students the sense that they have been involved in the work and they seem to enjoy it.

Post-Graduate Training

Although we do not offer a formal system of post-graduate training, there has been a tendency in recent years to make the curriculum more rigid. Post-graduate training of physicians in the United Kingdom includes three phases, at the end of which doctors are appointed as consulting physicians in geriatric medicine. The process can be summarized as follows:

Phase	Content	Duration
Pre-Registration (part of under-graduate program)	House Officer (intern) in surgery	6 months
	medicine	6 months
General Professional Training	Senior House Officer (Junior Resident) in acute internal medicine and medical specialties Pass MRCP Exam	1-2 years
	Registrar (Intermediate Resident) in internal medicine	2-3 years
Higher Specialist Training	Senior Registrar (Fellow-ship) in geriatric medicine (may include 1-2 years in internal medicine)	3-4 years

All young graduates, whether they plan to be family doctors, epidemiologists or obstetricians, start with the pre-registration year - six months in medicine and six months in surgery. Those who wish to specialize in general internal medicine or any special aspect of it, including geriatric medicine, go through a period called General Professional Training, which usually lasts about three or four years. This period can be divided into two; in the first, students are called

senior house officers, about the equivalent to resident status in the United States. This is usually a rotation which may or may not involve a few months in geriatric medicine. In the course of their work, they have to pass an examination for Membership of our Royal College of Physicians (MRCP). They become registrars in the next period (a status like that of senior resident), in internal medicine, or some combination of medical specialties.

At this stage, they have to decide on an area of specialization; if they wish to specialize in geriatric medicine, they have to apply for a post as senior registrar, which is like a fellowship in the United States. Senior registrarship in geriatric medicine lasts three or four years. They remain in this sphere until they succeed in obtaining a post as consulting physician, a position for which they begin to apply toward the end of the three or four year period. As senior registrars, they can either spend their time entirely in geriatric medicine or can spend part of their time studying internal medicine and another part in geriatric medicine. The post-graduate program in our department is as follows:

Senior Registrars	9
Lecturers	2
Training Posts	
Geriatric Medicine	10
Internal Medicine	5
University	2

Program for Senior Registrars

Year 1 Geriatric Medicine in chosen post

Year 2 Options
- (i) remain in same department
- (ii) move to other department of geriatrics
- (iii) move to internal medicine

Year 3 As year 2 but with additional option of move to university department

Year 4 As year 3

We are responsible for the training of all physicians in geriatric medicine in that part of Britain called the West Midlands. This includes Birmingham and a number of other cities and rural areas in a region with a population that is greater than that of Israel, about five and a half million.

The program includes nine posts for senior registrars and two other posts for lecturers in the university department who are equivalent to senior registrars. We have more posts than people, and more places for training than people in training. That allows us to rotate and to give doctors the opportunity to choose where they wish to be trained. We have 10 training locations in geriatric medicine, five in internal medicine and two in the university. In the first year of our four year program, the students work in geriatric medicine in any of the 10 locations. In their second year, they can stay on, go to another geriatric medicine department, in a large city or rural hospital, or change to internal medicine. In their third year, they can repeat the second year program, and we then offer an additional option: if the person who is appointed to the university department wishes to move to a clinical location, then one of the people in the clinical rotation can move into the university department and spend a year or two teaching and conducting research, with some clinical work as well. In the final year, the students are free to choose again what they want to do; this gives them a great deal of flexibility in their training.

It is a very popular program. When we advertise a vacancy we get

up to 30 good applicants for the post, and it has become extremely difficult to choose; we have to turn away a lot of very good people. It has, of course, taken years for this state of affairs to develop. The reasons are not entirely due to the fact that we offer a good program; there is also a great deal of pressure on young doctors today, and they cannot get posts on their first tries. Many of them would rather be cardiologists or nephrologists or endocrinologists; but the vacancies in these fields are very limited.

In summary, we now have quite a lot of experience in training for geriatric medicine. We have been able to see a big change in the country, where students have begun to look upon geriatric medicine in a positive way. After their participation in the undergraduate course, many students will do some postgraduate work in geriatric medicine in the course of their rotation, regardless of their future plans for specialization. Increasing numbers are coming forward for comprehensive training in geriatric medicine, and I now seek funding in order to expand the program for the next generation.

Geriatric Education in Israel

Professor Arnold Rosin

Geriatrics in Israel is, of course, not the same success story as it is in England because it's still in its fledgling stages. When I came here 15 years ago, however, I was impressed by the fact that there were two professional geriatric societies - the Israel Gerontological Society and the Israel Society for Geriatric Medicine. But there was hardly any organization of services for the elderly. So even if we haven't a success story, we do have movement from the embryo stage to the fledgling stage of geriatric medical training. I will concentrate on three aspects: undergraduate training, post-graduate training, and the development of geriatrics as a specialty.

Four university medical schools in Israel offer undergraduate training in geriatrics. One is in Jerusalem, one in Tel Aviv, and the others in Haifa and Beersheva. Among the disciplines at theses schools, geriatrics is still one of the least developed. But for many years, Tel Aviv University has had a faculty of geriatric nursing, and it has gone from strength to strength. As long as 12 years ago, the faculty of nursing was organizing joint courses with the School of Social Work in Geriatric Health Care. Haifa University as well is one of the leaders in promoting gerontological education in the fields of social work and nursing; but it is still years behind in the education of medical students. I am going to devote my remarks mainly to the other two medical schools, at the University of Beersheva and at the Hebrew University in Jerusalem.

Ben-Gurion University Medical School in Beersheva was developed

with an emphasis on the family doctor. It may be an Israeli tradition to open every new medical school by saying, "This medical school will be different because it will emphasize family medicine." But in Beersheva they really meant it; they emphasize basic science, public health and clinical medicine. They obviously teach clinical medicine as well and attempt to integrate primary medical care into the whole spectrum of medical education.

Beersheva has an advantage, perhaps, over other cities because of its isolation - it has a complete monopoly on all services in the district, both logistically and administratively. The Beersheva hospital, Soroka Hospital, is operated by Kupat Holim but serves the municipality; since there is no other government general hospital in the area, it serves everybody, and being the only one attached to the university, it is therefore a teaching hospital.

The Geriatrics Department at the hospital was developed by Professor David Galinsky, who specialized in internal medicine, and became a geriatrician through his appointment to an old age home. He went the course of many geriatricians in Israel - to Scotland, to England, and back to Israel. The program he created thrives not only in the general hospital, but also in the community. His unit consists of 20 beds, mainly for rehabilitation, and acts as a secondary referral unit. The local old age home, which was started a few years ago by ESHEL, has developed into a multi-geared system for active, infirmed, and nursing aged. In addition, they developed very active, multi-disciplinary home care teams. This is the background for the general program of medical studies in which students encounter a broad range of medical attitudes and, already in the first year,

have some kind of contact with what care of old people is about.

The program includes a course on nursing procedures for old people. They also have some lectures on evaluation (David Galinsky insists that his residents take the socks off their patients in order to examine their toenails, an indication of their capacity for self care.) They are also told how to evaluate general appearance and cleanliness, as well as a patient's ability to look after himself. They are also told about practical functional assessment in the elderly; this is taught in a non-clinical way since, as first year students, they have no clinical knowledge. They are exposed to the elderly in different settings - in the community, clubs, in their homes and in the old age home.

In the second year, they have clinical exposure in the wards of Beersheva and Ashkelon hospitals, which also house small geriatric units. The third year includes no specific geriatric teaching but does expose students to general internal medicine through the family medicine and physical diagnosis programs. Then, in the fourth year, there are clinical rounds. They're exposed to domiciliary visits, the homecare team, and the kind of multidisciplinary approach that the geriatric unit emphasizes. (Some of Professor Galinsky's experience in teaching medical students has been published in a number of medical journals).

The Hebrew University Medical School, located at Hadassah Hospital, had no geriatric program until 1982, when a committee of physicians approached the faculty with a request to introduce geriatric teaching into the curriculum. We spoke to them about the impact of the elderly on health services and of the recognition of geriatrics as a medical specialty. We recommended that there be reference to the

aged in various pre-clinical courses in the undergraduate program, but this has not yet come about. In addition, there should be an introductory course, a theoretical course in gerontology and/or geriatrics, and there should be a clinical clerkship. In 1983, as a result of our efforts, two out of eight groups of final year students were assigned to a two-week geriatric clerkship, one at Shaare Zedek and the other in the geriatric rotation at Ezrat Nashim. This included two weeks of full-time instruction in a program which we were free to plan. In addition, we agreed to undertake a gerontology program for the fifth year of the six-year medical course. Today, the program includes 12 lectures on gerontology and geriatrics, and it includes two lectures on demography and epidemiology by Professor Davies of the School of Public Health.

Another activity which has become part of the undergraduate program is the study of internal medicine at Shaare Zedek hospital by two of the eight groups of fourth year medical students. Since the geriatric department is part of the internal medicine department, they do three out of these 12 weeks in the geriatric department. There they learn medicine and not geriatrics specifically; but surely some geriatrics must rub off onto them!

In his address, Professor Isaacs spoke of the great effort in Birmingham to bridge the gap between the hospital and the community. This is something that is lacking here; there is still a tremendous gulf betwen the hospital and the community, and our efforts are much further back on the scale. Our goal is essentially to let the student feel that the geriatric patient is not a case to be given to a second-class doctor. Geriatric medicine is a respectable subject, a diffi-

cult subject, and a subject which demands the attention and respect of students. One of the impressions by a student on the first day in a geriatrics ward was, "Well, I suppose they're all depressed anyway here." I said, "Not necessarily; we have perhaps one or two cases only that could be diagnosed as depression." We feel that it is important to teach that old age has its illnesses and diseases which are diagnosable, and that these must be diagnosed in order to be treated.

In Haifa, there is very little geriatric teaching, and this is mainly in the area of physical diagnosis; the situation in Tel Aviv will be described by Dr. Rabinowitz.

There are also faculties of continuing education. The faculty in Tel Aviv, which has expanded over the last few years, was developed for teaching evening courses to general practitioners and/or hospital specialists. Another faculty of continuing education, funded by Hebrew University and Kupat Holim, offers a series of courses on various medical subjects, including geriatrics. Geriatricians throughout the country have run one to three-day study sessions in their own institutions, to which general practitioners or physicians in internal medicine come to learn something about geriatrics. This is not a formal course; it relies on the individual initiative of its participants. This Institute has applied for specific funding for geriatric programs, but this has as yet not come into being.

ESHEL, the Association for the Planning and Development of Services for the Aged in Israel, is in the forefront of organizations that not only think about but also practice services for the aged. There is a great awareness at ESHEL of the importance of training manpower, a field in which doctors have lagged behind almost every

other profession. ESHEL has promoted and funded many community projects, such as courses in gerontology for directors of residential institutions for the aged, for house-mothers, etc. It has also agreed to participate in the funding of new posts for residents in geriatrics. It funded a geriatric dental program at Hadassah, will partially fund a psycho-geriatric program which is scheduled to be completed within the next year or two, and has proposed the creation of a geriatric institute, for which it would provide funding for individual research. ESHEL has also given some funding to a geriatric institute I have founded at Shaare Zedek which runs a wide range of educational programs in aging, many on a multi-disciplinary basis.

The acceptance of geriatrics as a specialty in Israel did not come about without a struggle. For many years there was on-going difference of opinion between physicians who were interested in geriatrics or were responsible for care of the aged and the Scientific Council of the Israel Medical Association, which is responsible for determining the standards for medical specialties. A breakthrough came about five years ago, when the Association accepted geriatrics in the family medicine specialist program as an elective sub-specialty for periods of two to three months.

I will explain further the training system in Israel, which is unlike that in Britain and more like that in America. When a doctor finishes his internship or pre-registration year, he then undergoes a period of specialist training. During that time, he is called a house physician or a house surgeon, a position which reaches a status similar to that of senior registrar in England. Very often these periods are spent in the same hospital, often in the same unit, but

there may be some rotations among a few units.

At the end of their training, the newly qualified specialist attains the rank of chief physician, an appointment that becomes tenured after three or five years. In 1981 the constitution of internal medicine specialization was changed, and among the changes was the inclusion of geriatrics among the elective sub-specialties. At about the same time, in 1980, the scientific council of the Israel Medical Association decided at last to move on the question of geriatrics. They set up an ad hoc sub-committee under the chairmanship of a head of the Internal Medicine Department at the Kfar Saba hospital, the late Dr. Gutman. This committee consisted of two people with experience in geriatrics, one in physical medicine and two in internal medicine. The committee was to decide whether or not geriatrics merits a specialist training program and merits being called a specialty. The committee examined the issue by visiting 12 geriatric centers, mainly hospitals, from which they received details on staffing, patients' conditions, patient turnover, laboratory facilities, X-ray facilities, cleanliness, and so forth. Their conclusion was that geriatrics is a necessary subject, is deserving of professional recognition, and is a part of internal medicine and should not be divorced from it. It recommended that geriatrics be recognized as an additional sub-specialty for doctors who have finished their internal medicine training. In other words, after five years of internal medical training, a doctor with a specialist certificate could then elect to study geriatrics as an additional specialty- this would take him a further two years. Geriatrics, according to the committee, would be part of internal medicine but would be recommended as an independent sub-specialty. The committee

also recommended places of training, and, based on their observations, recommended that training programs include inter-disciplinary team meetings, a day hospital, a home-care program, and that the department include a staff psychologist or psychiatrist, a speech therapist, and must engage in clinical research.

Incidentally, Dr. Gutman, the internist who chaired this committee, told me that his personal opinion when he took on the job was that geriatrics should not be a specialty nor should it be a sub-specialty; perhaps, he thought, physicians in internal medicine might be made more aware of the problems of the aged, but nothing more than that. During the course of the visits and deliberations, he changed his mind, concluding that geriatrics as practised in Israel in 1980 already had a firm professional basis which could well match that of Europe, America and Britain.

The scientific council of the Israel Medical Association did not completely accept the recommendations of the sub-committee; they went a step further to say that geriatrics should be recognized as a full specialty with its own program of training. This proposal was brought before the Ministry of Health, which endorsed the idea by publishing it in its protocols of specialist training. They suggested that in addition to being a specialty in its own right, geriatrics should also be included in the general residency programs, as it was before. The recommended syllabus, however, was rather strange: First, two years of internal medicine, not in a geriatric unit, but in an internal medicine unit; then, a year of sub-specialties in internal medicine, and then two years in geriatrics. Of the two years in geriatrics, nine months would be spent on three of the following sub-specialties:

neurology, psychiatry, urology and rehabilitation. A syllabus committee, appointed by the scientific consul, objected to this proposed syllabus with multiple sub-specialty and recommended that more time be spent in geriatric departments.

All this activity took place in 1981 and 1982, and since then nothing much has happened. Recognition of formal training programs hinges on the committee's recommendations for defining the qualifications of a geriatrician and for its approval of training sites. The wheels are now beginning to move; the committee last year recommended a number of physicians to the Ministry of Health, and they were recognized as geriatric specialists. One has to start with either the chicken or the egg, and they're starting with some chickens, who are called geriatric specialists, and they are the first generation! Later, doctors will apply on their merits and will become geriatricians according to a committee decision. Once a training program gets underway, students will undergo two years of internal medicine, pass the internal medicine exam at the first stage, and then complete their geriatric training and exam; in that way we will gradually produce some geriatricians.

The last comment I would like to make pertains to an article in this week's Jerusalem Post, based on an interview with the head of Kupat Holim, Professor Doron, regarding the national convention of Kupat Holim. In the words of the author, "Doron, who heads the health fund, which represents 95% of the wage earners in Israel, intends to ask the fund to accept responsibility for medical, nursing and community services for the country's aged." And further, "Doron's plan will ask the fund to increase hospital bed capacity for long-term hospitalization by at least 1,000 beds, to set up an additional 10 day

care centers for the aged, to double home nursing care services, and in general to revamp the geriatric care system in Israel." Now this is a revolutionary program, a leap forward. The implication is that there will be a tremendous market for geriatric doctors. And that, as simple as it may be, is what will really give the push to geriatric specialization. You can be interested in the subject, you can be a "meshugeneh" about the subject; but what will really create geriatric training and education in Israel will be the need. And it looks as if that need might soon come to fruition.

Development of Geriatric Education in Israel: Possibilities and Limitations

Dr. Marian Rabinowitz

I would like to begin this discussion in the following way: I shall enumerate the main challenges, in my opinion, confronting training in geriatrics, and suggest some approaches to deal with these.

The first challenge is geriatrics in a consumer society. I would formulate the issue in this way: if the value of a man in a consumer society is a function of how much he produces and how much he consumes, what is the value of the underdog? Is the chronically disabled less valuable because he does not produce and is no more than consumers of beds, drugs and the national budget?

Or, to put it differently: what is the value of someone who, according to modern standards, has become a burden? And, making the extrapolation to geriatric medicine, how can students and practitioners be taught that the geriatric and the chronically disabled patient remains a member of the family of man, even when evicted from the family of consumers?

But the consumer issue has another aspect. In our society consumers are powerful, not only because they consume goods, but because they have the ability to complain and protest. The elderly and chronically disabled are weak protesters. How can caregivers be taught to give serious consideration and attention to someone without the ability to complain? I shall postpone the answer to that for the

time being.

The second challenge is that of Being and Having. It is startling how much of our education, beginning with childhood, and going through various schools, including medical school, emphasizes Having. Someone "has" a limp, "has" a capacity, "has" a disease. We usually grossly neglect the Being, its intensity and the fluctuation of its intensity. We think of the individual as a conglomeration of possessions; he ceases to be a "being" and becomes a possessor.

The following are random quotes from gerontological journals: "...variables studied included knowledge, disability, pain and number of visits to a physicial for arthritis..."; "...the relationship between bone mineral density, physical activity, smoking...". In other words, people "have" bone mineral density, social interactions, depression, and so on. In my opinion, good geriatric medicine can be carried out if we deal with "possessors" of qualities or defects.

How can we teach future geriatricians, and medical students in general, to relate to the Being, and not to the Having? My answer is to teach them, incessantly and insistently, existential philosophy; teach them the art of Being (and remember that there are some excellent existential theologians as well).

The third challenge stems from what I would call "institutionalization of concern." All of us are imbued with the slow-acting poison that institutions give to care - government, district authorities, hospitals, offices, projects. The students who come to us come first to our hospital; they are trained by universities which happen to have teachers. Sometime, somewhere, we lost the truth that concern cannot be given by institutions, but rather by people. The best an institution can do is to facilitate the

work of care-givers, but nothing more. Institutions cannot be authentic; only some of the people can. So, what I am terming "institutionalization of concern" is in fact false - because the very moment concern becomes institutionalized, it has ceased to be concern. How can we train future geriatricians in concern? By sending them only to those institutions where authentic people and teachers are in charge.

The fourth challenge is created by our prejudiced and distorted view of Time. We relate with reverence to the beneficiaries of longer life, to those with greater life expectancies. The longer one lives, the greater our investment in him. Time becomes an amount, not a quality. How should we inculcate in future geriatricians that, in their particular field, Time has an entirely different dimension? One of the greatest Jewish philosophers, Rabbi Nahman of Bratslav wrote that our ordinary intelligence does not comprehend Time; it believes that 70 years of life are indeed 70 years. Only superior intelligence, he wrote, can grasp that 70 years can be unrelated to Time. A higher wisdom annihilates Time. Rabbi Nahman should be included in the teaching of our students.

The next challenge stems from the huge difference between training and education. Universities do train today, but do they really educate? To convey information about a nosological entity, about a category, about something non-existent dressed in words, is a relatively easy task - provided the proper cosmetic is found.

I do not deny the need for categorization and generalization. They are needed for conveying information. But geriatrics should be taught as the science and art of dealing with situations, with the

infinite combination of miseries, defects, biochemical abnormalities, hope and development. It is impossible to put this extraordinary variability of alternatives into so strict an arrangement of drawers as conventional medicine does. The answer to that dilemma is: try to teach geriatrics according to situations and not diseases. This relates well to the issue of Having and Being. The geriatric individual is not a person "having" a disease, but is a "being" in a situation.

The next challenge is that of Compassion. If good medicine cannot be properly performed without compassion, the performance of geriatrics without compassion will simply lead to catastrophe. I am among those who believe in value education, with one reservation. Compassion cannot be taught, but it can be stimulated in those who possess it in a dormant form. How can we carry this out with students and practitioners? By a continuing program of sensitivity training and enhancement.

The last challenge cannot be formulated more precisely than in one short word: WE - ourselves. Those who sit here today - how much are we worth? Are we genuinely interested in the improvement of man's condition through geriatrics? This is intricately and intimately related to improvement of quality of life, and not only with improvement of function.

Who among us today believes in that? Who tries simply to seize an opportunity for, let us say, an academic career, or some form of glory, even ephemeral? To that challenge there is no universal answer. Each of us has to give his personal answer, after some soul-searching - if he is able.

With these challenges in mind, I visualize education in

geriatrics as follows. The consumer society is going from bad to worse. Nothing can be done. Because of our mentality of Having, we imbibe the first drops in early childhood, and there the geriatricians have no access.

Institutions exist and cannot be denied. The more institutions a society has, the prouder it is of itself. And to delegate concern to institutions is a time-honored gimmick for unburdening the conscience of the individual. Universities are also here to stay.

What about Compassion? My suggestion is as follows: The first exposure to geriatrics should be given during the preclinical years, with a stronger boost in the third year, immediately before stepping into the first medical ward. Every group of students, no larger than 10 in number, should be ascribed to one geriatrician who will accompany them throughout their clinical years. He should be their watchdog, their spiritual mentor; he should annihilate the impact of cynical clinical teachers, the showing off of medical prima donnas, the destructive effect of Having a disease (and not Being). The accompanying geriatrician should be a constant reminder of concern as an individual responsibility during the period when students are protected and overpowered by institutions. He will be responsible for their general education, for tapping their dormant compassion.

It is a difficult task. It cannot be resolved by money, nor by sophisticated equipment. It is difficult because it requires something very special of geriatricians. It requires personal stature and a certain amount of Don Quixotism; and, presuming the geriatrician may not Have these qualities, but Be them, whence could he derive his strength? By being on the faculty staff and at the same time declining any formal academic appointment.

Discussion & Questions

Betty Kauf (Hadassah Hospital): I'm a representative of a different profession, I'm a nurse-educator from the Hadassah-Hebrew University Nursing Program. We found that it's amazing how interesting geriatrics and gerontology become when there's an infusion of funds, just as happened in America. I'm sorry to be so cynical. Some of us who've been interested in gerontology and geriatric nursing have, fortunately, been awarded a grant from ESHEL to increase the emphasis on geriatric nursing and gerontology in the nursing program. With the infusion of funds, plus the enthusiasm of several people, we're on our way.

Moderator: For Dr. Rabinowitz, that enthusiasm is called compassion.
Betty Kauf: Yes, compassion is part of it. But the compassion, I'm sorry to say, just isn't enough if you don't have some resources. We found that medical schools in America became very interested in geriatric medicine when there were funds available from the Federal Government. It may take something like that here.

Dr. Stessman (Ezrat Nashim Hospital & Hadassah Hospital, Mt. Scopus): We at Ezrat Nashim have a Department of Geriatrics of approximately 100 beds: approximately 30 beds for geriatrics patients, 12 for acute/sub-acute geriatrics, and 47 for psycho-geriatrics. Ours is a joint program with the Department of Medicine at the Hebrew University-Hadassah Medical School, in which all students get three months of training in geriatrics during their period of specialization

in internal medicine. In Israel, everybody speaks about geriatric medicine, but the physicians are reluctant to enter the field of geriatrics. Kupat Holim, which employs the largest group of doctors in Israel, does not recognize geriatrics as a speciality. We wanted to invite some of those who work with the aged for training in family medicine. Such training was not part of their studies, since a clerkship/practice in family medicine is not yet recognized. The hospitals are forced to treat the problems that Kupat Holim cannot. I think that everybody here knows this problem. We don't have geriatric specialists. And we don't yet have recognized departments in order to train physicians for specialization in geriatrics. When this circle is broken, we will truly begin geriatric education in Israel.

Professor Kane: This raises a particularly important point. There's a danger in these kinds of meetings that we talk about something as though we knew what we were talking about. We need to describe this entity that has a sort of amorphous quality, and, the discussion begins to take on a theological or philosophic tone, content-free. I'm convinced, certainly in the United States and I suspect in this country, that if geriatrics is really going to gain some kind of a foothold it must first do this in the primary care disciplines which are its only opportunity for large backing. In order to do that, the real test is one's ability to state very specifically what is cognitively and behaviorally distinctive about care which is rendered by people who are geriatrically trained and to develop some method for identifying this care in a relatively traditional format, which for lack of a better method at the moment, is examination. We came very close in California. We missed by just one political step,

unfortunately, in the last vote. We were trying to develop a special examination for the licensing of physicians in which they would have to demonstrate confidence in geriatrics. One may feel that examinations are not good measures of the quality of doctors, and I certainly do not defend examinations, but it was amazing how the motivation and the interest of people in geriatrics began to change dramatically once you began to hint that there was going to be an examination on the subject. I think that only when one develops good clinical laboratories, as Hadassah University has done in Social Medicine, one begins to build very practical, transferable skills that can be easily recognized. We have to strive for those same kind of goals in geriatrics. If we don't discuss the subject in a more tangible and specific manner, we may be in danger of talking only to each other.

Professor Rosin: I'd like to make a comment and ask a question. I agree with the problem-focussed approach of Dr. Kane; perhaps one gets cynical and more pragmatic as one gets older. I agree that money does a lot and job demand does a lot, whatever the effect of good intentions and philosophy. I think that one of the best ways to push geriatrics into the system is by a system of rotations, as Bernard Isaacs mentioned, whereby physicians in training do some time in geriatric wards. Dr. Rabinowitz's distinction between having and being is correct; you need to be in geriatrics, to live geriatrics for a time. I think that's more important than hearing about it or writing about it - just live in the ward; assuming its a good ward, of course. These values don't need to be taught, they just need to be learned. In this way we can overcome prejudices and inject geriatric

thinking into the general medical field.

I'd also like to ask a question of both the British and the American participants. Some work has been done on multi-disciplinary teaching projects. Dr. Wedgewood published something some years ago on a teaching program for medical students which involved nurses and physiotherapists. I think similar things have been done in the United States. What is the current thinking on this? Is it good in practice, or does it simply sound good?

Bernard Isaacs: In answer to Dr. Rosin's last question, multi-disciplinary teaching is probably a very good thing, but its logistical and time-keeping difficulties have utterly defeated me, as well as many others who would like to try it. The simple problems of getting people together at the right time, at the right place, and at the right stage, are overwhelming. I haven't been able to do it; but I agree with it in principle, because if people are going to work together in teams they need to learn together in teams. They may, in fact, each get something different from the experience because of their different backgrounds; but I'm sure it would be highly desirable if it were practical.

If you take a medical student into a multi-disciplinary case conference he will come away saying, "That was a waste of a lot of people's time." But if you take him out, as we tried to do, with an individual member of that team, if he spends a little time not in a multi-disciplinary team but in a bi-disciplinary group, then the multi-disciplinary case conference experience will be more meaningful.

Professor Kane: On the American side, although there's great enthusiasm for teamwork, very little evidence shows that it makes any difference. Coordinated education it is extremely difficult on at least two grounds. Number one, it turns out that the different professions rotate at different rates; they don't have the same lengths of clerkship. They also mature at different rates, so you have a greater chance of merging incompetence than you do of creating professional appreciation. We have tried to do this on a number of occasions and it's very difficult to find people at the same stage of professional development so that the experience of working with others is a positive one, without one group following another. I think it's much more effective for medical students to be a bit humbled by having colleagues with greater competence show them specific ways of managing patient problems.

The other question is whether or not you want to use multi-disciplinary teams in actual practice. A great deal of effort has been devoted to training people with team skills; that implies that that's the way one wants to deliver care. There is, however, very little evidence that those kinds of skills for multi-disciplinary teamwork are clearly effective, and even less that such care is efficient. So I approach it with a great deal of caution, whereas inter-disciplinary respect is a trait much to be sought after.

Moderator: What is about the Geriatric Association? What kinds of plans have been developed recently to promote the training of geriatricians?

Dr. Rabinowitz: I can say that two days ago we finally got the approval from the scientific council of the Israel Medical Association

to activate the two committees, one for recognizing training sites in geriatrics and the other for approving the first wave of names to be recognized as geriatricians. This was the announcement we have been waiting for for the last two years. We will probably convene in about 10-14 days. I'm in charge of the committee for recognizing the sites. Geriatrics may become just another medical specialty. It is forbidden to do so, to treat it as a physical thing. It could become a formal success but a real failure.

Moderator: What do you want to develop as a geriatric specialty?

Dr. Rabinowitz: I envision a situation in which a geriatric specialist can diagnose, list priorities, educate students about what to treat, glimpse into social, cognitive and environmental problems, and talk to his students regarding time and compassion. Do I require too much, according to the participants?

Professor Isaacs: We inherited a problem in the United Kingdom in a National Health Institute which someone had to start. Now there are second thoughts. Do we want to divide medicine into two fields - one for the young and one for the old? There are two views on geriatrics: 1. Yes, it's proved itself as a specialty with advanced knowledge and level of care. 2. No, geriatric medicine has separated itself, has disadvantaged old people by creating an artificial rift. After all, geriatricians aren't treating all old people. I have seen newspaper ads for both the following: 1. a doctor specializing in geriatrics; 2. a doctor with responsibility for elderly, indicating that the doctor is first in importance and concern for elderly is second.

Moderator: The climate is better today regarding professionalization of geriatrics; Kupat Holim is also recognizing this more.

* * *

Summary Remarks

Professor Yitzhak Margulec

I will briefly summarize our very interesting session on the problems of education in the field of geriatric medicine.

Professor Bernard Isaacs of Birmingham presented us with a detailed and interesting portrait of medical education in Great Britain, a program which has become a model for many European countries and for Israel as well. Professor Kane, from the United States, told us about the growing awareness in his country of the necessity of training physicians in geriatrics. Repeating his summarizing words, at this point he sees "the cup as half empty rather than half full." It is also worth mentioning again the report of the U.S. Institute of Medicine, which recommended that geriatrics be developed in U.S. medical schools, but not recognized as a separate specialty area.

Professor Rosin briefed us about progress made in the teaching of geriatric medicine to medical students in the Ben Gurion School of Health Sciences in Beersheva. He also told us about the launching of an undergraduate teaching program in geriatrics at the Hebrew University-Hadassah Medical School in Jerusalem. Dr. Rabinowitz presented us with the main challenges that now confront training in geriatrics. The first is to deal with a consumer society, the second he formulated as a challenge of Being and Having, and the third challenge stems from the institutionalization of concern. The remaining challenges include the issue of time (Dr. Rabinowitz cited

Rabbi Nachman of Bratslav as saying that "higher wisdom annihalates time"), the difference between training and education, and the challenge of compassion. Dr. Rabinowitz also briefed us about the progress in preparing a training program at the Sackler Medical School of Tel Aviv University, where a curriculum has already been prepared by a special committee appointed by the Dean of the Medical School and headed by Professor Aronson, the future Caretaker-Professor of Geriátric Medicine (now the Professor of Living Sciences).

In the ensuing discussion, Dr. Stessman of Ezrat Nashim Hospital described the geriatrics program there and stressed the importance of completing the work on accreditation of departments for training physicians in geriatric medicine. Professor Kane described plans in the U.S. for developing a special licensing examination for physicians in which they would have to demonstrate knowledge in geriatrics. He believes that this method would motivate physicians to become interested in geriatric medicine. Obviously, there is also a need to develop good clinical laboratories. Professor Rosin suggested a system of rotation whereby physicians-in-training would spend some time in geriatric wards. He also raised the possibility of multi-disciplinary teaching projects. Professor Isaacs agreed that multi-disciplinary teaching is desirable, but said that it is difficult to implement. He suggested that students spend some time in bi-disciplinary groups.

I think that we now have a better climate in Israel for starting a program of medical training in geriatrics, and, as we heard, three years ago geriatrics was recognized as a specialty by the Scientific Council of the Israel Medical Association. I will close with the

optimistic note that my organization, the Joint Distribution Committee, is very interested in promoting geriatric medical education programs in Israel.

מיוחדת סדרה מיוחדת
סדרה מיוחדת סדרה

הוראת זיקנה בתכניות לימודים מקצועיים
ואקדמיים - חוברת מס' 4

סימפוזיון בין-לאומי
על הוראת הזיקנה
במסגרת החינוך הרפואי

בשיתוף עם אש"ל והאגודה הישראלית לגרונטולוגיה

מ-24-85

ג'וינט ישראל
מכון ברוקדייל לגרונטולוגיה
והתפתחות אדם וחברה

גבעת-ג'וינט ת.ד. 13087
ירושלים 91130

המכון

הוא מכון ארצי למחקר, לניסוי ולחינוך בגרונטולוגיה והתפתחות אדם וחברה. הוא נוסד ב־1974 ופועל במסגרת הג'וינט האמריקאי (ועד הסיוע המאוחד של יהודי אמריקה), בעזרתן של קרן ברוקדייל בניו־יורק וממשלת ישראל.

בפעולתו מנסה המכון לזהות בעיות חברתיות ולהציב להן פתרונות חילופיים בשירותי הבריאות והשירותים הסוציאליים בכללם. אחד מיעדיו הוא להגביר שיתוף הפעולה של מומחים מהאקדמיות והממשלה, עובדי ציבור ופעילים בקהילה כדי לגשר בין מחקר לבין מימוש מסקנות מחקר הלכה למעשה.

המימצאים והמסקנות המוצגים הם של המחבר או המחברים וללא כוונה ליצג את אלה של המכון או של פרטים וגופים אחרים הקשורים למכון.

סימפוזיון בינלאומי על הוראת הזיקנה בחינוך הרפואי

ג'וינט-ישראל - מכון ברוקדייל לגרונטולוגיה
והתפתחות אדם וחברה

23 בדצמבר 1984

בשיתוף עם אש"ל והאגודה הישראלית לגרונטולוגיה.

תוכן העניינים

תקציר

סימפוזיון בינלאומי בחסות מכון ברוקדייל, האגודה הישראלית לגרונטולוגיה וא.ש.ל., שנערך ב-23 בדצמבר 1984, דן בצדדים שונים של הוראת הזיקנה במסגרת החינוך הרפואי, ומצב ההכשרה לרפואה גריאטרית במקומות שונים בעולם. הנחה את הסימפוזיון הפרופ' מרגולץ, היועץ הרפואי של ג'וינט-ישראל.

פתח הפרופ' קיין מביה הספר לרפואה באוניברסיטת קליפורניה בלוס-אנג'לס, שסקר את תולדות הגריאטריה בארה"ב בעשור האחרון. הוא הודה שעל אף ההתקדמות הרבה בשטח זה, על הגריאטריה בארה"ב עדיין לעשות דרך ארוכה מאוד. הוא הדגיש את חשיבות ההכשרה הקלינית של הגריאטר, אך עם זאת הודה שעיקר ההתרחשות בתחום הגריאטריה כיום הוא דווקא מחוץ לכותלי בית-החולים, בעוד שהעולם האקדמי מגיב באיטיות.

גישה שונה לחלוטין הביא הפרופ' אייזקס מהמחלקה לרפואה גריאטרית באוניברסיטת בירמינגהם שבאנגליה. במוקד התוכנית שמציעה אוניברסיטה זו נמצא המפגש הבלתי אמצעי בין הסטודנטים והקשישים. מפגש זה מסייע לסטודנטים להתגבר על דעות קדומות ופחדים ויוצר אצלם יחס חם, פתיחות והבנה כלפי הקשישים.

הפרופ' רוזין, ראש המחלקה הגריאטרית בבית החולים שערי צדק בירושלים, סבור שבישראל עושה הגריאטריה כיום את צעדיה הראשונים. הוא סקר את תוכניות הלימודים בגריאטריה באוניברסיטאות השונות בישראל וקרא להעלאת היוקרה של הרפואה הגריאטרית.

אחרון המרצים, הד"ר מריאן רבינוביץ, מנהל השירות הגריאטרי בבית החולים ע"ש שיבא בתל השומר, התמקד בצדדים היותר פילוסופיים של הטיפול בקשישים: כיצד לשנות את יחסה של החברה הצרכנית כלפי אלה שכבר חדלו לייצר, כיצד ליצור אצל הרופאים אכפתיות אמיתית גם כלפי אלה שתוחלת החיים שלהם קצרה, ועוד.

בדיון המסכם הועלו עוד כמה נושאים חשובים, כגון: דרכים למשוך סטודנטים לרפואה לתחום הגריאטריה ומסגרות רב-מקצועיות להכשרת רופאים גריאטריים.