My husband, Kevin, and I vacationed at Maho Bay on St John, US Virgin Islands, many years ago. The campground’s platform tents, visited regularly by lizards, peacocks, and an occasional mongoose, were accessible by a maze of wooden stairways and boardwalks meandering up the steep hillside. At the base of the hillside lay a pristine, crescent-shaped, white sand beach and the turquoise blue waters of the Caribbean.

Early one morning, our descent crossed paths with a much older couple. They were gray-haired, tanned, and fit, vigorously ascending to their tent after a morning swim. We exchanged greetings. Farther down the path, I couldn’t help but remark that I hoped we were in that kind of shape and on travel adventures when we were their age. Kevin agreed, “They’re our older egos.”

Indeed, older individuals represent what all of us hope to become: older versions of ourselves. Unfortunately, a negative stereotype of age as being fraught with illness, frailty, and incompetence prevails. This stereotype is further strengthened for physicians-in-training, as they are far more likely to encounter elderly persons in hospitals and nursing homes. A five-campus study by David B. Reuben, MD,1 showed that beginning medical students have unfavorable attitudes about older persons. His results indicate the need to improve these attitudes by exposing students to healthy older persons or to interdisciplinary teams early in their medical career.

It has been my experience that medical students and residents who select rotations in geriatrics are the exception rather than the rule, despite the glaringly obvious demographic fact that they are most likely to be caring for older persons during their medical careers. Anecdotally, physicians who choose careers in geriatrics have had close, positive relationships with older persons such as grandparents. In the same way, the increasing lack of intergenerational contact in our fast-paced, mobile, cellular, and Internet-focused world has undoubtedly contributed to trends that show negative responses toward the elderly. Sadly, the generation gap continues to widen.

The geriatric educational series presented to family medicine residents at the Riverside Osteopathic Hospital in Trenton, Mich, by Myral R. Robbins, DO, and described in her article “Training family medicine residents for assessment and advocacy of older adults” (J Am Osteopath Assoc. 2002;102:632-636), is a laudable attempt at influencing positive attitudinal change. Delivering core geriatric medicine content to primary care trainees is vital to the future of healthcare.

Dr Robbins states that presession and postsession surveys fail to show improvement in attitude toward older persons, but she allows that the study group’s small size precludes demonstrating statistical significance. Regardless of results, critical concepts in evaluating and managing older patients were presented, and residents were given the opportunity to demonstrate their competency in geriatric assessment.

As geriatric educators struggle to engage the interest of young physicians, curricula such as those developed by the John A. Hartford Foundation Consortium for Geriatrics in Residency Training provide guidance and process. It is hoped that the Riverside Osteopathic Hospital project will stimulate other primary care residency programs to adopt this and other innovative training models for care of our growing population of elders.

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References

The educational program put forth by Myral R. Robbins, DO, “Training family medicine residents for assessment and advocacy of older adults” (J Am Osteopath Assoc. 2002;102:632-636), resulted in predictable results. Namely, presession and postsession surveys failed to show an improvement in residents’ attitudes toward older persons. As Robbins points out, many in the medical profession agree that future physicians need more extensive training in communication skills and treatment options to deliver better, more effective treatment to their elderly patients. The medical and emotional needs of older adults are vastly different than those of their younger counterparts. As a student’s medical training progresses, awareness of these differences becomes increasingly apparent.

There is so much to learn clinically in medical school and...
through residency training that during rotations, students are encouraged to see as many patients as possible, auscultating hearts and lungs, palpating abdomens, and performing as many neurologic examinations as possible. Although motivated students dive in and are praised for writing copious progress notes, it is uncommon to hear physician-trainers praise those same students for their ability to communicate with patients.

I am fortunate to have four living grandparents. They have acted as surrogate parents, advisors, cheerleaders, and confidantes. As they have aged, I have observed first-hand their experiences and frustrations with illness.

My grandmother recently went to see her ophthalmologist because of failing vision. After examining my grandmother, the ophthalmologist claimed that nothing could be done. Searching for a reason, my grandmother asked, “Why not?” Flustered, the physician responded, “What do you want me to do? You’re too old!”

Certainly, additional training in geriatric issues such as neglect, abuse, and competency must be addressed. Seminars similar to the one established at Riverside Osteopathic Hospital in Trenton, Mich, help in educating students and residents and in bridging communication shortcomings between the generations. Such programs should be required in all undergraduate curricula and residency programs. But that is not enough.

There needs to be a shift in the paradigm used as the basis for training medical students and residents. Greater emphasis needs to be placed on treating both the emotional and physical needs of all our patients. Considering that the current healthcare climate includes managed care and an increasing population of patients older than 65 years, this is a daunting task. Nonetheless, it only takes a few extra minutes with each patient to demonstrate genuine concern as well as medical competency. This philosophy of patient care—treating the patient as a whole, both emotionally and physically—is what makes me proud to say that I am an osteopathic physician.

Once we establish and encourage open dialogue between physicians-in-training and senior citizens, programs like that established at Riverside Osteopathic Hospital will grow and succeed in changing the perceptions and treatment of our senior citizens.

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References