Osteopathic Medicine and the Silver Tsunami: Preparing Tomorrow’s First Responders for the Elder Boom

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In response to the shifting demographics observed in the United States, a variety of organizations have begun issuing consensus statements and patient care guidelines to help health professionals meet the anticipated medical needs of the older population. The authors describe a collaborative effort within the osteopathic medical profession focused on translating geriatric core competencies into curricula guidelines for osteopathic medical education. Osteopathic physicians will likely be the “first responders” for elder care needs in the United States as a result of their disproportionately high rates of primary care practice.


The educational unit of the Gerontological Society of America, the Association for Gerontology in Higher Education (AGHE), has established a Program of Merit (POM) designation intended to recognize high-quality gerontology programs. According to the AGHE Web site,1 this initiative provides gerontology programs with an AGHE “stamp of approval,” which can be used to verify program quality to administrators, students, and others.” The program was launched in February 2000 and a total of 10 programs in the United States currently have AGHE’s POM designation.2

Unfortunately, none of the osteopathic profession’s 25 medical schools have had an opportunity to obtain this designation. It is our belief that there has been a lack of consensus regarding unified geriatrics curriculum guidelines for osteopathic undergraduate medical education—one of the core requirements to apply for the POM, as specified in the AGHE Program of Merit Application Form.3

In response, we developed and drafted geriatrics curriculum guidelines for the osteopathic medical profession that were reviewed by a team of osteopathic physicians (DOs) and medical educators identified through the American Association of Colleges of Osteopathic Medicine (AACOM) for their expertise in geriatric medicine. These individuals were assisted by the National AHEC (Area Health Education Center) Organization (NAO) as well as the AGHE. The outcome of this collaboration is reflected in the penultimate chapter of Standards and Guidelines for Gerontology and Geriatrics Programs, “Geriatrics curricula for undergraduate medical education in osteopathic medicine.”4 A version of this chapter is currently available at the AACOM Web site: http://www.aacom.org/InfoFor/educators/Documents/AGHE%20Excerpt-%20CHAPTER%2011%20.pdf.

Osteopathic Medicine and the “Silver Tsunami”

The most recent statistics on the older population (ie, those aged 65 years or older) indicate that, as of 2006, there are 37.3 million individuals in this demographic group.5 Although this group currently represents 12.4% of the US population, it is estimated that this number will be 20% by 2030 (ie, 71.5 million).5 Commentators6-8 have variously—and sometimes evocatively—described this demographic shift as the “elder boom,” the “gray dawn,” and the “silver tsunami.”

The AGHE defines geriatrics as “the study of health and disease in later life, the comprehensive [healthcare] of older persons, and the well-being of their informal caregivers.” Healthcare utilization rates among older adults has skyrocketed and is expected to increase in the coming years.10 Concurrently, the number of physicians who specialize in treating older patients has declined nearly 30% since 2000.8,11,12

In fact, the American Geriatrics Society (AGS)13 estimates that this trend will worsen considerably. Although there is currently one geriatrician for every 5000 older adults, by 2030, a 50% decline is expected—with one geriatrician for every 7665 patients.13 A study published in 2002 reported that the majority of geriatrics programs in the United States were established in the previous 15 years.14,15 Simultaneously, the number of geriatrics faculty members at medical schools is also in decline.15,16

Indeed, researchers12,17 have reported that there are fewer than 350 physicians being trained in geriatric medicine each year.
year—not enough to replace retiring physicians...or to manage the expected patient care needs of this demographic group. Consensus is building that primary care physicians will soon bear the bulk of the responsibility of caring for older patients.12,18 Medical students in primary care medicine should, therefore, be trained accordingly.

Geriatrics content has not traditionally been a focal point in undergraduate medical education19 and accepted minimum requirements for competency in this field are relatively new to osteopathic medical education.4,20 If the responsibility for providing healthcare to older patients will require primary care physicians to have competency in geriatric medicine (ie, AGS-recommended “attitudes, knowledge, and skills”20), it is essential that curriculum modifications occur in fairly short order.

Family medicine programs at individual COMs have certainly begun to address this need on an ad hoc basis,21-23 but profession-wide agreement has been slow in gaining momentum.4,20 It is only when a curricular program has established (and met) minimum core requirements in geriatric medicine that it has the opportunity to apply for a POM designation through AGHE.

Wider expertise in geriatric medicine is perhaps one more area where osteopathic primary care physicians can demonstrate the value of the DO difference as well as the agility of our profession’s education and training system.24 Osteopathic medicine offers an approach to patient care that emphasizes treatment from an aspect of wholeness and unity while also working to prevent, diagnose, and manage illness, disease, and injury.25,26 It is common practice among DOs to consider the interrelatedness of structure and function25,26 as well as the impact of lifestyle and community27 on patient health—and to work at erasing potential barriers to health.

Of the more than 67,000 DOs in the United States, it is estimated that 65% have chosen a primary care discipline.28,29 Although DOs account for a small percentage of the nation’s physicians, they handle a disproportionate number of primary care visits.24,28 Regardless of the medical specialty chosen by students, COMs have a responsibility to ensure that their graduates are equipped to provide good care for the elderly. Preparing future DOs for the oncoming silver tsunami requires a curriculum in the preclinical (years 1 and 2) and clinical years (years 3 and 4) that would establish foundational knowledge in gerontology and geriatrics for all COM graduates. Emphasis should be placed on learning outcomes and competencies that will result in good provision of elder care.

Current Status of Geriatrics Requirements at COMs

After conducting a literature review in June 2007, we designed a comparative and qualitative curricula review for the present investigation.

Methods

We conducted a review of data available on the Web sites of all COMs and branch campuses (n=26) extant at study initiation. All data were gathered for analysis from readily available online sources. Our study included a basic analysis of current coursework and published competency requirements.

In addition, we reviewed the Web sites of four allopathic medical schools that receive funding from the Donald W. Reynolds Foundation (Las Vegas, Nev) through their Aging and Quality of Life Program. Data from these allopathic institutions were gathered because these schools set the “gold standard” for undergraduate medical education in geriatric medicine as a result of dedicated curriculum-development funding through the foundation.

With the assistance of executives at AACOM’s Office of Medical Education and the NAO, we assembled a six-member review panel of individuals with expertise in geriatric medicine. The Osteopathic Geriatrics Curriculum Review Panel’s primary goal was to obtain consensus on the minimum requirements for geriatrics in the undergraduate osteopathic medical school curricula.

Collected data in undergraduate geriatrics medical education were compared and evaluated in relation to the AGS guidelines provided in Areas of Basic Competency for the Care of Older Patients for Medical and Osteopathic Schools (Figure 1).20

Results

An analysis of the qualitative data we gathered assisted us in identifying which of the AGS basic competencies20 and geriatrics curricular content from the COMs were congruent with osteopathic philosophy and an academically sound geriatrics education. A total of 6 (23%) of the 26 osteopathic medical institutions under review had identifiable content in geriatrics on their Web sites. Two COMs (8%) incorporated geriatrics in their core mission statements.

Conclusion

The majority of osteopathic medical schools do not maintain a focus on geriatrics in their undergraduate medical education curricula. After a professional review of the data gathered during our investigation, the “Minimum Standards for Geriatrics Curricula in Osteopathic Medical Schools” was developed through a consensus process (Figure 2). It is an advantage for COMs to have a mission statement for geriatrics from which instructional goals and objectives are derived.

Comment

It is our hope that osteopathic medical educators will review their curricular models in light of the recommendations made by the AGS in Areas of Basic Competency for the Care of Older Patients for Medical and Osteopathic Schools20 and the more recent—and uniquely osteopathic—“Geriatrics curricula for
undergraduate medical education in osteopathic medicine.”
This latter document paves the way for skill development in geriatrics as well as the provision of comprehensive geriatric care for an aging society through the osteopathic primary care model. Using these tools as a guide in curricular analysis and development will allow the nation’s COMs to ensure that osteopathic primary care physicians are fully prepared to provide high-quality healthcare as the silver tsunami approaches. Regardless of their future choices with regard to medical specialty, our students need to learn about and gain experience in the full continuum of patient care.

In addition, these resources will prove useful to osteopathic medical educators should their institutions opt to pursue a POM designation from the AGHE. A nationally recognized, high-quality geriatrics curriculum would be an asset and a “feather in the cap” of the entire osteopathic medical community.

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References
An idea of health that does not generously and gracefully accommodate the fact of death is obviously incomplete.

Wendell Berry, “Some Notes in Conclusion,”
Life is a Miracle: An Essay Against Modern Superstition

Editor’s Note: The New York Times recently featured the “Learning by Living” program, which was created in 2005 by Marilyn R. Gugliucci, PhD, at University of New England College of Osteopathic Medicine in Biddeford, Me. The August 23 article, “Experiencing life, briefly, inside a nursing home,” by Katie Zezima, focuses on the recent experience of Kristen Murphy, OMS II, who, as part of her training in geriatric medicine lived for 10 days as a nursing home resident at Sarah Neuman Center for Healthcare and Rehabilitation in Mamaroneck, NY. In addition, William V. Vogt, OMS III, was interviewed about his experiences in the program last summer at the Veterans Affairs hospital in Augusta, Me.