

# Realigning training with need

## *A case for mandatory family medicine resident experience in community-based care of the frail elderly*

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**F**railty is a “multidimensional syndrome of loss of reserves (energy, physical ability, cognition, health) that gives rise to vulnerability.”<sup>1</sup> Younger seniors, generally speaking, are not frail. In fact, Canadian seniors between 65 and 75 years of age report limitation in activities of daily living similar to those adults aged 45 to 64 years.<sup>2</sup> However, one-quarter of seniors aged 85 years or older report moderate to severe functional limitation,<sup>2</sup> and the overall weighted prevalence of frailty in older seniors is about 30%.<sup>3</sup> By 2052, the proportion of seniors aged 85 years or older is expected to comprise 6% of Canada’s total population compared with 2% in 2011.<sup>2</sup> This means a substantial increase in frail older adults living in our communities.

We all know that use of health care services rises with age. At a national level, in 2009 to 2010, Canadian seniors aged 85 years or older had a 2-fold higher rate of visiting the emergency department and a 9-fold higher hospital admission rate compared with those younger than 65 years of age.<sup>2</sup> What is more, the rate of seniors’ visits to hospital emergency departments is actually increasing over time.<sup>4</sup> A substantial proportion of this increased use is by frail older adults with multiple comorbidities.

Ironically, this group is least likely to benefit from what a hospital can offer.<sup>5,6</sup> Research has documented the increased risk of pressure ulcers,<sup>7</sup> deconditioning,<sup>8</sup> delirium, and iatrogenesis<sup>9,10</sup> associated with hospital admission of frail seniors. Health systems in virtually every province are focusing on better ways to support this population outside the hospital setting.<sup>11,12</sup>

Given this projected demographic change and the disproportionate use of health services by frail older adults, at least some effort to focus family physician training on community-based care of the frail elderly should be self-evident. Despite this, many new graduates have little or no experience in providing nursing home or housecall (or home-based) medical care by the time they complete their training. And although provincial health systems are increasingly investing in home-care nursing and home support,<sup>11,12</sup> many family medicine graduates have only a vague idea of what

home health teams for the frail elderly actually do, let alone any experience actually working alongside them. How has this come to be?

### Excluded from reform agenda

In 2000, \$800 million in federal funding over a 5-year period was added to the Primary Health Care Transition Fund to stimulate system-level changes and transitional costs to improve primary care in Canada.<sup>13</sup> This was based on a growing recognition of the positive association between the robustness of a health system’s primary care and improved quality of care, access, and cost control.<sup>14-17</sup> These dedicated funds were extended to 2008 and have now been folded into ongoing federal transfer payments. Primary care reform continues to be a high priority for many provinces.

The focus of the first 10 years of primary care reform, at least in urban settings, was on improving chronic disease management. The rationale for this was that because most hospitalizations resulted from suboptimal management of chronic disease, improved guideline adherence would result in reduced hospitalization rates, thereby reducing health system costs and improving quality of care.<sup>18</sup>

There is no doubt that primary care reform has led to more rigorous guideline adherence. Sivanathan et al reported that 1.2% of the 3.6% per year increase in annual laboratory costs in British Columbia during the past decade was explained by practising guideline-recommended care for chronic conditions.<sup>19</sup> During this time, chronic disease guidelines also expanded the definition of who was “diseased,” and treatment rates in British Columbia for 7 chronic diseases increased dramatically—far beyond what would be expected for the changing demographic characteristics of the population.<sup>19</sup> While national data are not available, it is unlikely things are different in other provinces.

However, the frail elderly do not appear to have benefited from this increased focus on primary care. Between 2005 and 2009, the number of family medicine physicians in Canada increased from 99 to 117 per 100 000 people,<sup>20</sup> while the rate of family physicians doing housecalls continued to decline.<sup>21</sup> Furthermore, the proportion of family doctors who reported doing nursing home work “some of the time” declined from 22% to 17%.<sup>22,23</sup> Also, many jurisdictions continue to describe great difficulty in recruiting family physicians to care for nursing home residents.<sup>24</sup>

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While reasons for these changes are likely multifactorial, the numbers suggest that frail older adults appear to have been on the losing end of primary care reform. We speculate that as these individuals are less able to present to the office, owing to being home bound, and with the primary care reform focus on ambulatory seniors with chronic diseases, frail homebound elderly and nursing home patients have become increasingly invisible to the office-based family physician. In many cases, their primary care has become increasingly managed by the home-care and community care sectors, with occasional crisis-driven calls to the family physician. In a few urban centres, some family physicians have begun to restrict their practices to housecalls or nursing home care, possibly compensating—to some extent—for the overall decrease in these services by many office-based physicians.<sup>25-28</sup> However, the availability of these services remains relatively rare.

### Addressing the gap

If a family medicine resident happens to have a preceptor who still does home visits or nursing home work, he or she might get some exposure to this important clinical activity. Or if a resident is keen, he or she might set up an elective in community-based care of frail elderly people. Otherwise, our training programs are failing to meet the needs of this vulnerable and growing population. This of course is not by design but rather a possible unintended consequence of the past decade of primary care reform.

In most family medicine residency training programs, it is of no concern if a preceptor does not do obstetrics because residents' training is supplemented by a mandatory experience in obstetrics. However, if a preceptor does not make housecalls or nursing home visits, there is no such "system backup." It is time to build this. With the various "pulls" on residents' time, simply offering electives in care of frail seniors is unlikely to be enough to address this gap. Clinical time providing housecalls and residential care to this population should be mandatory and longitudinal over 6 to 12 months, for a minimum of 1 to 2 half-days per month. Given that a common visit rate for this population is once to twice monthly, or more frequently if clinically indicated, this time frame would seem to be the minimum necessary to develop a continuous relationship. Beyond the obvious issue of making residents' schedules even more complex than they already are, it is clear that introducing such programs will produce both challenges and opportunities.

### Challenges and opportunities

Probably the greatest challenge of training residents to care for frail elderly people is that there are few


guidelines. Frail populations are understudied and do not generally contribute to the evidence base we use as we strive to teach the science of medicine. Randomized controlled trials have largely excluded people with multimorbidity,<sup>29,30</sup> and studies that focus on frail people are rare.<sup>29</sup> Consequently, usually followed clinical guidelines are often not applicable to frail adults or those with multimorbidity and age-related disability. While there are some useful resources for discovering evidence specific to the frail population,<sup>31-34</sup> there remains little high-quality evidence that includes this population, and a number of scholars have described frailty as an "evidence-free" zone.<sup>5,6</sup>

The teaching opportunities for a mandatory longitudinal experience in community-based care of the frail elderly are considerable. First, residents would have the opportunity to develop their geriatric, internal medicine, emergency, and palliative clinical skills without relying on extensive laboratory tests or imaging. In home-care and residential care settings, the history and physical examination return to centre stage in making a diagnosis. Second, residents would learn to provide the appropriate blend of curative therapy and palliation following discussion with the patient and family—both the art and the science of medicine. Third, homebound and nursing home patients are a captive audience. This makes it easier to develop doctor-patient longitudinal relationships—something that postgraduate programs continue to struggle with in office-based medicine learning environments. Fourth, when residents are exposed to nursing home and homebound elder care, they must also work with a full team of other formal and informal providers. They therefore develop a greater understanding of who does what among the many community-based primary care "players." Fifth, service provision in these settings provides residents with the chance to observe first-hand the "context" of patients' illness experience, the determinants of their health, and their support systems and resources. Finally, understanding and managing frailty will allow residents to contribute to the sustainability of our health care system by helping the growing population of vulnerable seniors to have their medical needs met without the inherent "dangers," as well as the unnecessary expense, of hospitals.

### Meeting the objectives

Family practice postgraduate teaching policy recommendations explain having an intent to address both continuity and service provision outside the office setting. The College of Family Physician of Canada's *Red Book*, which defines the standards common to all Canadian postgraduate medical training in Canada, states, "Residents must be able to provide comprehensive care for the elderly ... in ... institution, and community settings such as the patient's home."<sup>35</sup> Medical school education policy, in

the discussion of accountability, has also identified the frail “elderly” as a marginalized and growing population who “face significant barriers to accessing the care they need.”<sup>36</sup> Finally, the new family medicine Triple C goals of comprehensive, continuous, and patient-centred training are highly consistent with addressing these learning gaps in community-based care of the frail elderly.<sup>37</sup>

Despite these good intentions, many medical schools and family practice residency programs have not implemented the necessary changes to meet these objectives. Family physicians are well suited to play a key role in access, continuity, and coordination of primary care for Canada’s frailest seniors. It is time to implement these goals. Let’s take our trainees to the “coal face” where these seniors reside, and teach them how to make housecalls and visit nursing homes, so that the next generation of family doctors can develop confidence in this increasingly important work. 

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#### Competing interests

None declared

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