

Training experience and views of recently appointed consultants in geriatric medicine

ABSTRACT—A postal survey of 71 recently appointed consultant geriatricians was undertaken in spring 1991. Several respondents were concerned about the adequacy of training in domiciliary visiting and continuing care, and about the time allocated for research and study. A high proportion felt they had been poorly prepared for the administrative and organisational components of their consultant post, and 75% of respondents advocated training in managerial skills for senior registrars. These findings are relevant to the planning of future training for senior registrars in geriatric medicine.

A survey of consultant geriatricians was undertaken during February to May 1991. Contact was made with the Department of Public Health Medicine of each Regional Health Authority or Health Board in Britain, and a group of 108 recently appointed consultants was identified. Survey questionnaires were sent to each of these in February 1991, and a second questionnaire was sent to non-responders in May 1991.

Results

A total of 79 responses (73%) were received. Two were from non-geriatricians and were excluded; six further responders were excluded as they had been appointed less recently than our arbitrary definition of 'recently appointed', ie 36 months before the start of the survey. Thus 71 responses (65%) were received from consultant geriatricians or consultant physicians with special responsibility for the elderly (PWSRE) who had been appointed during the preceding three years. Mean duration since appointment was 20 months (range 0–36 months).

Of the 71 consultants, 52 described themselves as pure geriatricians, 16 as general physicians with special responsibility for the elderly, and three as academic geriatricians. Thirty-four described their working location as urban, 14 as rural, and 23 were working in a combined urban and rural environment. Each respondent classified his/her post as hospital-based; there were no community-based respondents. Most of them (48) worked on split sites, while 21 were employed

purely at district general hospitals and two individuals entirely at peripheral hospitals.

All the recent appointees are contracted for an 11-session week with the exception of one part-time appointment (six sessions). Among PWSREs the mean allocation of sessions to internal medicine is four (range 1–7 sessions). The average number of beds over which a recently appointed consultant exercises direct control is 92 (range 20–270 beds). This includes a mean of 29 for acute medicine of the elderly (range 0–87), 28 rehabilitation beds (range 0–63 beds) and an average of 33 beds for 'continuing care' (range 0–205). In some units clear distinction between acute geriatric and rehabilitation beds is not possible, and thus for five respondents only the total bed complement is known. An average of three domiciliary assessments per week are undertaken (range 0–12 per week) and 31 day-hospital places are available for use (range 0–110) each day.

Previous training

Sixty-eight respondents gave details of their previous senior registrar (SR) training. The average total time in the SR grade had been 41 months (range 2–120 months), with a mean of 28 months spent as SR in geriatric medicine (range 0–120 months), and an average 13 months (0–91) in a general medical SR post. Responses to questions on the adequacy of their training in various topics are represented in Fig. 1.

Training in psychiatry of the elderly was available to 55 of the 67 respondents, but was not available to the remaining 12 (18%). Five of these 12 thought that training in psychiatry of the elderly ought to have been available to them. The organisation of training in psychiatry varied widely from occasional clinical sessions arranged on the initiative of the SR in post to a co-ordinated programme involving two sessions per week for a year.

In general, 53 respondents (76%) thought their training package had been adequate, while 17 of the 70 completing this question thought it inadequate.

Research experience and attitudes

Nineteen of the respondents had acquired a higher degree: an MD in 15 instances, a PhD in three, and an MSc in one. The number of papers published at the time of appointment ranged from none to over 40.

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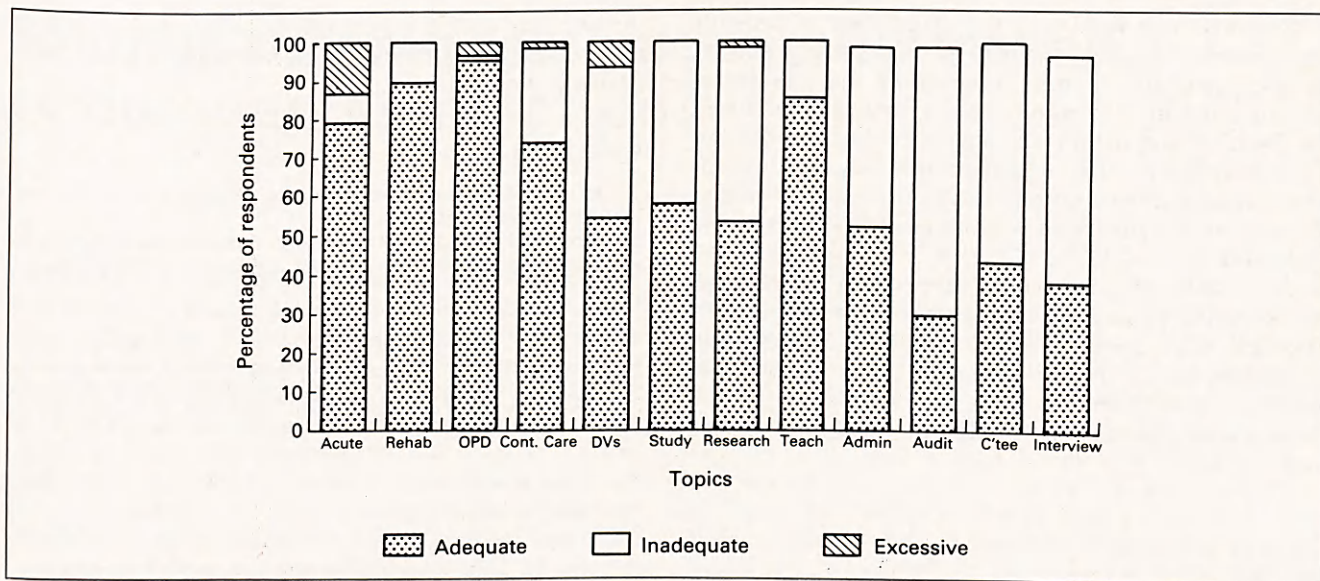


Fig. 1. Views of recently appointed consultants on the adequacy of their training (n = 68)

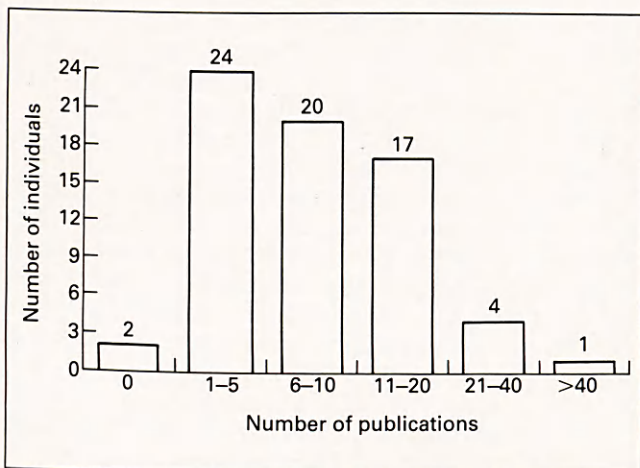
The mean number of publications was 11, although those with a higher degree had published twice as many papers (15) as those without (7).

In total, 47 of 65 respondents felt that their research experience had been of value in their clinical post. This included 16 of the 19 (84%) respondents with a further degree, and 31 of the 46 (67%) without additional qualifications. The number of publications by the time of appointment is detailed in Fig. 2.

Suggestions or comments on training

Further comments on training or advice to senior registrars were sought and the responses are summarised in Table 1.

Fig. 2. Number of publications by consultant appointment (n = 68)



Discussion

Estimating the effectiveness of a training programme which does not have a clearly defined and measurable end-point is difficult. This paper attempts to quantify the views of recently appointed consultants with responsibility for elderly patients on the appropriateness of their senior registrar training to their present consultant post.

Acute geriatric medicine, rehabilitation of the elderly, and outpatient work appear to be satisfactorily covered in almost all training programmes. A proportion felt inadequately trained in continuing care and domiciliary visiting. Concern was also expressed by many at the inadequate allowance of time for research and free study. Training in psychiatry of the elderly has concerned senior registrars in geriatric medicine in serial surveys since 1977 [1]; this was not available to 12 of 67 respondents, but only five of them felt that this had been an important omission in their training.

Table 1. The more frequent advice and training suggestions offered to senior registrars by recently appointed consultants; n=60

Suggestion or advice	Frequency of advice (%)
More management/administrative training	76
Broaden experience including subspecialty experience	13
Ensure publications/higher degree	12
Assess all aspects of consultant post	12
Dual accreditation	10

Perhaps most striking is the proportion of recently appointed consultants who feel inadequately trained in administrative matters, committee matters, interviewing, and medical audit. This is further emphasised by the high proportion who suggested further training in management and organisational issues. Many of these results mirror closely the information obtained from a recent survey of senior registrars in geriatric medicine [2].

In a rapidly evolving health care system it is perhaps not surprising that such emphasis is placed on acquiring skills that are required to adapt to a developing health service. It is reassuring that major aspects of clinical training appear to be adequately covered in most training programmes although some deficiencies

persist. These deficits should be addressed in widely disseminated guidelines for higher medical training in geriatric medicine.

References

1. Sandler M. Senior registrar training in geriatric medicine. *Age Ageing* 1991;**20**:(Suppl 1) 27.
2. Sandler M, Castleton BA, Ritch AES. Senior registrar training in geriatric medicine 1977-1990. *J R Coll Physicians* 1991;**25**:304-5.

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