

medicine

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Fall 2001

A PUBLICATION OF THE UNIVERSITY OF MICHIGAN MEDICAL SCHOOL



WORKING WONDERS

Life at one of the nation's leading children's hospitals



by Jeff Mortimer

The Newest Challenge for Young Physicians: Understanding What It Means to Be Older

When, in 1980, Willard Scott, the affable NBC-TV weather announcer, first began recognizing Americans for the rare achievement of reaching their 100th birthday, he received a handful of letters from centenarians and their families. Today he receives more than 100 letters every month. The number is likely to keep going up: Americans over 85 are the fastest growing segment of the population.

For some, like comedian George Burns, who happily quipped his way to 100, life was a joy almost to the very end, and a continuing source of new one-liners (“I get a standing ovation just for standing!”).

For others, becoming their older selves is not so funny, not the triumph of productivity and recognition that Burns experienced to the end. Aging, like so many other factors that influence our physical and mental health, is a very individual thing.

Given the very large numbers of much older Americans on the horizon (it is predicted that within 10 years most physicians will spend half their time caring for older patients), the challenge for those charged with training the next generations of physicians is large indeed. How to teach a young physician, who will not personally experience the profound effects of aging for another half-century, what it means to be old? How to treat the old? How to give older patients the best care possible?

No medical school in America is taking these questions more seriously than the University of Michigan, where geriatrics has had strong leadership for almost 20 years and where a new \$2 million grant will energize the weaving of geriatrics into every fabric of the school’s curriculum.

“The goal is to see defined curriculum and content in place that is a documented part of the education of every student who graduates from the University of Michigan Medical School and every resident who completes residency training in a relevant discipline,” says Jeffrey Halter, M.D. In 1984, William Kelley, M.D., then head of internal medicine at the

Medical School, recruited Halter from the Seattle Veterans Affairs hospital to begin assembling the U-M Geriatrics Center, an umbrella organization for geriatrics research, education and patient care in the U-M Health System. The Geriatrics Center was approved by the U-M regents in 1987 and continues to be directed by Halter.

When Alan Mellow, M.D., Ph.D., associate professor of psychiatry and chief of the division of geriatric psychiatry, arrived in Ann Arbor in 1988, the U-M’s collective geriatrics consciousness had already been conspicuously ahead of the curve for a decade or more, in the Medical School as well as in public health and the basic and social sciences. Both the Turner Geriatric Clinic and the Institute of Gerontology have been around since the late 1970s.

“When I came to Michigan to start our program,” Mellow says, “I emphasized to my department chairman that this was a ‘growth industry,’ an area in which it was important for Psychiatry to have strength in the coming years.”

The neighboring VA system, a longtime U-M partner in both education and clinical care, had also been selected in 1988, after a national competition, as a site for a new Geriatric Research, Education and Clinical Center (GRECC), one of 21 national centers of excellence in the VA system. A year later, the U-M Pepper Center was launched, the first federally funded Claude D. Pepper Geriatrics Center in the nation.

This rich historical matrix was crucial to the Geriatrics Center’s recent successful bid for a four-year, \$2 million grant from the Nevada-based Donald W. Reynolds Foundation, established in 1954 and now one of the nation’s largest private foundations. Donald Reynolds owned more than 100 businesses, primarily in the newspaper, radio, television and outdoor advertising industries, known as the Donrey Media Group. The money — along with significant support from the Medical School, another key factor in securing the award — will be used to infuse geriatrics consciousness ➤



Photo: Martin Vioet



Photo: Martin Vioet



JEFFREY HALTER

ALAN MELLOW

MARK SUPIANO WITH HOUSE OFFICER JEREMY BUCKLEY

into almost every facet of the medical training the U-M provides. In the process, standardized models will be developed for teaching and testing trainees everywhere else.

“There is a long tradition of interest in aging here at the University of Michigan,” says Halter. “For many years, a lot of people across the campus have been interested in aging — the social aspects, epidemiology, the impact on society and on Social Security, in addition to issues directly related to health. The Medical School initiatives that started here in the late 1970s have not been happening in isolation.”

Ironically, U-M’s tradition was almost a liability in getting the Reynolds grant, says Mark Supiano, M.D. (Residency 1987), director of the GRECC, associate professor of internal medicine and senior associate research scientist in the Institute of Gerontology. Supiano directs the Reynolds grant’s geriatrics initiative in medical student education, while Brent Williams, M.D., also an associate professor of internal medicine, heads the comparable effort for house officers. “The Reynolds Foundation was interested in stimulating geriatrics in institutions where there was perhaps less of a geriatrics presence,” Supiano says. “One of our concerns was that we were viewed as having too much, and wouldn’t need additional funding to support these activities.” Michigan’s long history of success in geriatrics won the day.

Williams expresses his charge simply and dramatically. “The University of Michigan has around 800 house officers at any given time,” he says. “Of those, only about 200 are in programs that include any form of training in geriatrics. The purpose of this project is to move as close to the 800 as we can get.” Mellow adds, “The strength of the program we’ve gotten funded is that it’s really going to infuse this at every level of the Medical School curriculum, from the day future physicians walk in the door as medical students up to the time they are out in practice or even on the faculty.”

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-BRENT WILLIAMS

The support of the Dean’s Office was also key to receiving the Reynolds grant. “We’ve had a significant decrease not only in revenues to support graduate medical education but also in clinical dollars that, in the past, would have also been available to support education broadly. But we really thought it was important for us to make the commitment to invest in this educational enterprise,” says James Woolliscroft, M.D. (Residency 1980), executive associate dean, director of graduate medical education and a professor of internal medicine. Woolliscroft notes, as do many others, that “a lot of the credit really goes to Jeff Halter. He came here when geriatrics was just beginning to emerge, and he’s developed a very strong section of geriatrics that is recognized internationally.”

Faculty development is at the core of the Reynolds initiative, and that work has already begun through faculty training from geriatricians as well as instructors in other specialties and subspecialties (principally internal medicine, psychiatry and neurology) which already include geriatric skills in their training.

Those identified as “core” faculty will train their colleagues in other disciplines how to apply geriatrics knowledge to discipline-specific needs. This helps with both instructional credibility — students will be learning from “their own” teachers rather than “outside” geriatricians — and with long-term sustainability.

“This is a huge project,” says Karen Hall, M.D., Ph.D. (Residency 1997), an assistant professor of internal medicine and a research scientist at GRECC. Hall is possibly the only person in North America who is board-certified in internal medicine, gastroenterology and geriatrics in both the U.S. and Canada. “We’re talking about disciplines as disparate as ob/gyn, emergency medicine and surgical subspecialties, and then medical students from year one to year four. Our hope is, if we can do this successfully, it will get medical students so oriented to geriatric issues that they won’t have any problem identifying them, thinking about them and dealing with them. Right now, if you ask most students or residents what it’s like to care for an older person, they find it intimidating.”

Treating Older Patients:

Not just 'older versions of younger adults'

When she works with residents in their rotation through the VA system, says Karen Hall, “there’s something I hear again and again: they say their heart sinks when an older patient with multiple problems comes into their clinic. They’re thinking the assessment will take hours, that they don’t feel comfortable dealing with incontinence or dealing with dementia, and they’re often overwhelmed by all the social problems these patients face.”

That’s because “they don’t feel that they know what to do, they don’t have a plan,” she says. Raising that comfort level by putting geriatric skills front and center in their training is one of the Medical School’s major curriculum revision initiatives.

Hall is one of a cadre of faculty who are playing a key, early role in the implementation of “geriatrics infusion” at the house officer level. “We don’t want to turn everyone into geriatricians,” she says, “but we do want to raise their awareness of some common geriatric issues that might affect their particular fields.

“The thinking was, years ago, that elderly people are just older versions of younger adults. But older people have changes in their ability to metabolize drugs and their normal day-to-day physiology



KAREN HALL

that make them different. You can’t treat them the same way.” They are more likely to have multiple disorders, chronic conditions, cognitive dysfunction, a difficult living situation, and adverse reactions to the array of medications that they may or may not be taking as directed. Caring for them thus requires treating the whole person, rather than a disorder or system, and often necessitates the involvement of other physicians, as well as other health professionals and the patient’s family and friends.

“Although most physicians take care of older people, they often take care of them in a fragmented fashion,” says Brent Williams, who heads the house officer phase of the Reynolds geriatrics project, “and yet older people, especially, don’t do well under limited and overly focused care because they often have multiple problems, and the problems often interact with each other. You can’t pick off one of them and treat it independently of the others. If you do, something else gets stressed.”

But new physicians will need to think even more globally, enlisting the aid of a variety of other caregivers and loved ones who might once have been regarded as interlopers in the doctor-patient relationship. “One of the defining characteristics of geriatrics is the involvement of a multidisciplinary team,” says Mark Supiano, who directs the medical student component of the Reynolds geriatrics initiative.

And not just medical disciplines. For example, Norman Foster, M.D., professor of neurology and a member of the project’s executive steering committee, says one of the specific skills for managing a patient with dementia is “the ability to involve other informants or caregivers in obtaining a medical history and to form an alliance with other individuals, other care providers, in providing care. These techniques are not typical of medical practice. Physicians usually see adult patients by themselves; they don’t know how to go about involving other people in the evaluation or management of adult patients, and many physicians would view this as being intrusive.”

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“Sensitivity to psychiatric disorders in older patients, such as depression, anxiety, cognitive impairment and psychosis, is critically important to a comprehensive understanding of their health care needs,” says Alan Mellow, also a member of the executive steering committee for the Reynolds project. “Such disorders often complicate both the presentation and outcomes of other medical illnesses. Many of the biases and myths concerning older people — for example, that it is ‘natural’ to be depressed as one ages — often create barriers, erected both by health care providers and patients themselves, to adequate diagnosis and treatment.”

Not all, or even most, elderly people suffer from dementing disorders, of course; that seems to be a common misconception both within as well as outside of the medical profession. “There is a lot of confusion among the general public and also among physicians about what is expected for normal aging,” says Foster. “Studies show that physicians both over- and under-diagnose dementia. In other



NORMAN FOSTER WITH EVANGELOS ATHANASIOU

words, they’re not very good. They have stereotypes derived from their training and their own biased experience.” Adds Hall, “Thirty-five or 40 percent of 90-year-olds have some memory problems or impairment in thinking, but that still leaves a lot of people who don’t.”

Communicating effectively with that majority also entails special skills. “Older people are more thrown off by jargon because when they were young, much of it didn’t exist,” says Hall. “Part of the process of explaining to patients why you’re recommending a test or treatment is getting them to understand what the point of it is. When you use a lot of jargon, they may feel you’re putting them down or that you don’t care to explain it. I think older people need more time to think about things, too. They often want to go and talk to someone else, get some advice. Sometimes residents get frustrated because a person doesn’t say ‘yes’ right away or goes off on a tangent. To me, that’s a sign that they may not be ready to deal with the issue, and if it’s not vital to be taken

care of this minute, or unbelievably life threatening, I say, ‘Why don’t you think about it and we’ll discuss it again?’”

Hall says she became interested in the practice of geriatrics while she was doing a research fellowship at U-M. “I started to realize that I really enjoyed talking to older patients,” she recalls, “and I also enjoyed the challenge of trying to balance the benefits of treatment for multiple problems.” There’s a personal dimension, too. “I’ve always believed pretty strongly in people designing their lives to fit what they really want,” says Hall. “Some doctors have a really hard time not treating something; they feel guilty or frustrated or that they’re not doing a good job if they can’t persuade someone to have treatment. My feeling is that my job is to identify a problem and help the person deal with it. Dealing with it may involve not treating it. If that’s their choice, and if I can be convinced that it’s a reasonable choice, I’ll go along with it.”

Photo: Bill Wood



BRENT WILLIAMS

Photo: Bill Wood



JAMES WOOLLISCROFT


“Attitudes may be the heart of it,” says Williams. “If you could open up resident physicians’ attitudes so they automatically, reflexively, look at the whole person, where they came from, how they function, what their goals and needs are as a person, then everything else would be easy, because they would ask the right questions and strive to find the answers.”

Of course, the desirability of “looking at the whole person” isn’t limited to the treatment of elderly patients. Just as the geriatrics initiative is expected to produce exportable instructional models, so geriatrics techniques themselves are applicable to medical practice in general.

“I think part of the Medical School’s support for this initiative and what we’re planning to do related to the Reynolds grant is that a number of the things we’ll be teaching the students about the health care of older people apply to health care more broadly,” says Halter. Happily, the grant intersects with, and nicely complements, a three-year review of the Medical School curriculum whose goal is a better alignment with the real world of contemporary practice.

“We’re emphasizing to a much greater degree the socio-cultural aspects of the individual and how that relates to their wellness and their care,” says Joseph Fantone, M.D., associate dean for medical education and a professor of pathology. “We want our students to think of the patient in the context of his or her social and cultural environment and overall health status.”

“Our goal is to provide a meaningful geriatrics experience for every graduating U-M medical student,” says Supiano. “We don’t want our students to say, ‘Yeah, I did a one-week rotation in geriatrics and I now know how to take care of older people.’ We want them to gain a real sense of what it means to be a good physician to an older person.”

“Geriatrics is inherently patient-centered,” says Williams. “The unit of caring is the whole patient, which was the baseline for traditional medicine. Now, in many practices, the unit of caring is an organ system or a practice context, like a single emergency room visit or a single consultation/referral. It can be bound by anatomy or it can be bound by time, but it shifts away from the patient as the center of focus. The Reynolds grant provides an opportunity to do the two things I love most: develop new programs for teaching physicians at the residency level to do better medicine, and teach people to take care of the whole patient.” 

Tom Fitzgerald, Ph.D., and his colleagues in the Department of Medical Education have their work cut out for them. One of their most pressing jobs right now is to think about how the Medical School will evaluate its success in raising the geriatrics consciousness of its students and house officers. While most of the techniques are familiar, some of them aren’t.

“There are two things I’m going to be evaluating,” says Fitzgerald, an assistant professor and assistant research scientist in the Department, as well as associate director for education and evaluation at the VA’s Geriatric Research, Education and Clinical Center. “First are the learners, by making sure that they’re proficient in their knowledge and skills about geriatric patients. Second is our curriculum, to make sure that the learning environment is appropriate for the students and also to evaluate each educational component to see which things are working and which are not working, so we can change them.”

And, he points out, there are three different components of evaluation – one for medical students, one for residents, and one for faculty. Plenty of tools exist for the former, and the Medical School has faculty development models from similar initiatives in the past. Assessing the residents’ progress, however, is almost terra incognita.

“What we’ll do there is look at what kind of curriculum each residency program designs and the problems they have implementing it,” says Fitzgerald, “so we can figure out for the residency directors what things work, what things don’t work, and what the barriers are, anticipated and unanticipated. We’ll be developing benchmarks. This is a new area. In our search through the literature, we found nothing quite like this.”

The whole effort of weaving geriatrics into the curriculum is kind of daunting; a major shift in the wind, if not a sea change. “We’ll establish demonstration of proficiency in these competencies as a requirement for graduation,” says Mark Supiano, an associate professor of internal medicine who heads the medical student component of the initiative. “We want to send the message clearly to our students that they should take this seriously.”

Says Norman Foster, professor of neurology and a member of the steering committee for the project: “As a geriatric neurologist, my particular interest is to make sure that all physicians who treat adults are able to recognize individuals who have cognitive disturbances, particularly dementia or memory problems, and that those are handled appropriately. Not everyone will be treating Alzheimer’s disease, but everyone will be treating someone who has Alzheimer’s disease.”

How will we know what works and what doesn't?

Learners and methods alike will be evaluated for success.

The consciousness-raising will begin “on day one of entry into the University of Michigan Medical School,” says Supiano. Specific activities in the curriculum will address the core competencies established by the American Geriatrics Society, and “medical students will be told that they are expected to successfully complete each of these activities over the course of four years. To cut to the chase, there will be a separate line item on their transcript that designates proficiency in caring for older people.”

Using the Web, as the Medical School increasingly does in many areas of the curriculum, for both training and assessment is one of what Supiano calls “several innovative approaches to get the geriatric message across to the students.” Students rotating through internal medicine outpatient clinics would report – on-line to a geriatric consultant – their encounters with older patients who presented with a geriatric problem or condition. The Web-based program will allow students to get feedback from the geriatric consultant, participate in on-line discussions, and link to a library of resources.

“One other element is the standardized patient-instructor,” he says. “These are individuals who are trained to act as patients, and trained to provide feedback to the student as they’re being evaluated by the student. We’ll develop a design for a standardized patient-instructor to cover the area of geriatric functional assessment.”

Incorporating geriatrics training at the house officer level will be a bit more complex. Brent Williams, associate professor of internal medicine and a geriatrician, heads that aspect of the program. “Our basic commitment is to develop the educational programs in the places where the residents are doing their current clinical work—in the subspecialty clinics, in the hospital before and after an operation, in the emergency room and so forth, so that the residents will integrate geriatrics into what they perceive as their daily work,” he says. “And that is a huge challenge.”

“We’ll work with the core faculty within each department to identify the issues related to geriatrics that are most salient in their own practice and how to get that information across,” says Foster. “There’s really been very little done in this so far. There’s been considerable work done to try to train people in the geriatrics specialty, but this is a little more sophisticated issue – trying to apply geriatrics knowledge and the skills of geriatrics to discipline-specific needs.”

Luckily, the human resources for such a task are relatively abundant at Michigan. “One of the reasons the Reynolds Foundation came to this center is that we actually have a very large faculty of multidisciplinary people who either have certification or a strong interest and training in geriatrics as well as other areas of medicine, or areas outside medicine,” says Karen Hall, one of those faculty members who will be training their colleagues. “There probably aren’t many centers in the U.S. that could marshal as large a group of people.”

Those specialties – such as internal medicine, psychiatry and neurology – whose histories have inherently included a higher level of geriatric awareness will provide the bulk of the training for what might be called the “consumer” specialties. “In internal medicine, we’re going to be starting with hematology/oncology, nephrology and rheumatology, with the idea of then moving on

Photo: Martin Vloet



TOM FITZGERALD

Photo: D.C. Goings



EVE LOSMAN

through all the other subspecialties,” says Jeffrey Halter, director of the U-M Geriatrics Center and of the deployment of the Reynolds grant. “Outside of internal medicine, we’re starting with obstetrics and gynecology and emergency medicine. Our selection doesn’t necessarily reflect priority for need; it’s more of a practical issue of which departments have expressed interest and have identified individuals to begin to participate in this process.”

One of the individuals who came forward in emergency medicine is Eve Losman, M.D., (Residency 1999), a clinical instructor. “What interests me is looking at geriatric patients as a special population with special needs where a special skill set is needed to take good care of them and developing that skill set in faculty as well as residents,” she says.

“To be perfectly honest, a year ago, I never thought, ‘Gosh, geriatrics is going to be my area of expertise,’” Losman adds. “I was much more interested in learning more about educating people in the medical profession. But as I read the literature and did some research on my own about geriatrics and emergency medicine, I realized the need was enormous. The baby boomers are going to get old.” [m](#)

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