TRAINING IN GERIATRICS - MY OVERSEAS EXPERIENCE IN USA

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Summary
As a trainee in geriatric medicine enters into the phase of higher professional training, it is essential for him to gain adequate experience and becomes competent in clinical management of elderly patients. It is recommended that arrangements should be made for training in overseas geriatrics department in order to broaden the trainee’s knowledge in geriatric practice and this is now considered an indispensible part of the requirements of a trained geriatrician.

Introduction
When awarded the overseas training grant to the University of California, Los Angeles (UCLA) in U.S.A in April, 1996, I was excited at the prospect of spending three months in another country. Since hearing of this kind of overseas clinical attachment four years ago when I joined the specialty of geriatrics, it had been my ambition to gain this opportunity offered by the Hospital Authority. I spoke to several senior colleagues who had completed their overseas training and all of them were very enthusiastic about their experience in different countries.

Overseas study leave is part of the higher professional training in geriatrics to broaden the trainee’s views of the specialty. Moreover, the importance to gain insights in some recent advance of the specialty and some perspectives of the medical practice in a different country cannot be over-emphasized. I undertook my overseas training in Geriatric Research and Education Clinical Centre (GRECC), Veterans Affairs Medical Centre, Sepulveda, UCLA, School of Medicine under Professor Laurence Z. Rubenstein (professor of geriatric medicine) for three months from 15th April to 14th July, 1996. In this article, I will try to give a summary of my experiences of the medical field, travel and also my comments and acknowledgement.

Geography and People
I flew to Los Angeles in mid-April, 1996. I was very aware that in travelling from Hong Kong to Los Angeles I was going almost halfway round the world. The outdoor temperature in Los Angeles was around 90°F, the relative humidity was low and I had to take off my sweater and jacket immediately when I left the airport. My accomodation had been arranged through the assistance of Professor Rubenstein and Dr. K.M. Yeung of Hong Kong and I was very fortunate to stay with a kindly 62-year-old lady called Geri L. Eyer. Her house was in Encino and was about 20 minutes from the hospital by driving. I rented a room in her over 2000 square feet apartment. The environment is pleasant with a separate study room and toilet round the corner, a telephone and thankfully a fan and air conditioner.

Los Angeles is a large city on the west coast of U.S.A. It is highly metropolitan and people there come from different parts of the world. Although English is the official language there, many people speak Spanish (because of its proximity to Mexico) and both English and Spanish are the most common dialect within the Los Angeles county. As the area of Los Angeles is large and the places are highly scattered, transportation is a problem to me because I do not drive and the public transportation there is very primitive (mainly by bus with very limited service). Fortunately, with the help of Geri, Professor Rubenstein and his colleagues, I am able to obtain different schedules of many bus routes so that I can make up my way to the hospital and different areas.

The first decision to be made on arriving Los Angeles was how to spend my thirteen weeks in geriatric medicine. In the first introductory week, Professor Rubenstein had consolidated an itinerary for me so that I can visit different medical facilities of UCLA School of Medicine and meet his staff. The centres that I have visited include Veterans Affairs Medical Centre, Sepulveda, Veterans Affairs Medical Centre, West Los Angeles, UCLA Medical Centre, Jewish Nursing Home for the Aging, Olive View Medical Centre, UCLA and Encino Hospital. They are some of the teaching centres under the auspices of the Department of Veterans Affairs and the Multicampus Program in Geriatric Medicine and Gerontology of the Department of Medicine, UCLA School of Medicine. As they are
offering a broad array of geriatric services, I have to concentrate on a limited number of them. From the second week onwards, I made up my own itinerary. In the second to fourth week, I spent my time in the geriatric outpatient clinic, diabetic clinic, sexuality clinic and dementia clinic in Veterans Affairs Medical Centre, Sepulveda. From the fifth to last week, I concentrated myself on the activities of the Academic Nursing Home Care Unit, Hospital-based Home Care Program in Sepulveda and the Neurological Rehabilitation and Research Unit (NRRU) in Neuropsychiatric Institute, UCLA Medical Centre, Department of Neurology, UCLA School of Medicine under Professor Bruce H. Dobkin (professor of neurology). This was a special arrangement by Professor Rubenstein because the caseload in Sepulveda had decreased dramatically after the inpatient hospital building was severely damaged by the Northridge earthquake in 1994.

I shall discuss my training in Sepulveda first. Next I shall talk about the experience in NRRU. I shall emphasize the difference of their systems as compared to that of Hong Kong.

**Experience in Veterans Affairs Medical Centre, Sepulveda**

This VA medical centre includes comprehensive acute medicine, surgery and psychiatric services, and is a major teaching facility for the UCLA School of Medicine. In conjunction with the Geriatric Research Education and Clinical Centre (GRECC), geriatric medicine services include:

- geriatric evaluation unit
- academic nursing home unit
- outpatient clinics
- Centre for Ambulatory Rehabilitation and Education Unit (CARE)
- Hospital-Based Home Care Unit (HBHC)

There is currently no inpatient service in this medical centre due to the reason mentioned before. Patients who require inpatient treatment after attending the emergency room will be transported to hospitals nearby, others will be offered appropriate follow up in the specialist outpatient clinics. Actually the trend of medical development in the United States is shifting towards outpatient and subacute care (especially within the VA system).

They attempt to maintain the more frail and dependent patients at home and delay institutionalization as long as possible by providing support to caregivers. So far everything seems to be running smoothly in Sepulveda despite the absence of inpatient care and they have no intention to rebuild the inpatient building.

1. **Outpatient clinics**

The primary care of the United States is very well developed and thus the caseload of the specialty clinics is relatively low compared to that in Hong Kong. Most patients had their diagnostic workup almost completed before they are being referred to the specialists. On average, each physician sees three or four patients in each outpatient clinic section and the history and physical examination of new patients will be performed by physician assistants beforehand. The assessment offered to each patient is rather comprehensive and whenever necessary they will be referred to other disciplines and specialties. In the dementia clinic which is under the geropsychiatrists, patients with mental impairment will be assessed by neuropsychologists with batteries of neuropsychological tests, nurse practitioners, medical social workers and occupational therapists before they are being evaluated by geropsychiatrists. A multidisciplinary case conference will be held afterwards with diagnosis established if possible and management plan formulated and discussed with the patient and family members or caregivers. All clinical information, medications, investigation results, follow up appointments are computerized so that information retrieval is efficient and communication between different specialties and primary care physicians are very effective.

2. **Academic Nursing Home Care Unit**

This is basically a skilled nursing facility under the care of a hospital geriatrics department with full time geriatricians, nurses and therapists. The setting is more or less like that of care and attention home or infirmary in Hong Kong. 120 beds are available and are divided into 4 teams. The services included rehabilitation, hospice and respite. Weekly ward round and multidisciplinary case conferences are offered for each inmate when the results of assessment and weekly progress are discussed and management plan reviewed and updated. There is a very strong psychiatric input and twice weekly psychogeriatric rounds are conducted jointly with psychiatrists for patients with behavioral problems. Teaching conferences are held thrice weekly with topic presentations by physicians, nurses and pharmacists on rotation basis.
3. **Hospital-Based Home Care Unit (HBHC)**

Home care has been the fastest growing segment of the health care industry, budget, and an increasingly large part of geriatric practice in the United States. It provides preventive, therapeutic, restorative, or supportive health care in the home of patient. In the broadest sense, it includes that provided by informal caregivers, formal health services ranging from trained professionals to semi-skilled and unskilled aides. There are different agencies providing home care in the United States which include government sponsored, not-for-profit and Visiting Nurse Association, proprietary agencies and hospital based services.

For HBHC in Veterans Affairs Medical Centre, Sepulveda, they receive elderly patients being referred from primary care physicians and other specialties. They will only entertain those who live within 30 miles from the medical centre for obvious geographical reason. Usually, patients are those with multiple medical problems being stabilized but cannot attend follow up due to various reasons. The team is led by geriatricians and includes nurse practitioners, medical social workers, physical therapists, occupational therapists, pharmacists, dietitians and they paid regular home visits and assessments for each patient. New referrals are seen by occupational therapists first and then by other team members. Team meetings are held weekly for updating individual patient’s progress and care plan. Home visits for each patient are paid at least monthly and progress reviewed at least three monthly, more frequent visit and evaluation will be offered as deem appropriate.

The scope of services provided include early detection and management of medical problems, nursing assessment and treatment, health education and promotion, psychological and social support.

The above approach actually is quite similar to that of community geriatric assessment service (CGAS) in Hong Kong but the target group is different (community dwelling elderlies in HBHC versus institutionalized elderlies in CGAS). Moreover, there is more comprehensive input in HBHC from other disciplines such as pharmacists, dietitians which are not usually available in Hong Kong.

4. **CARE (Centre for Ambulatory Rehabilitation and Education) unit**

This is similar to the setting of geriatric day hospital in Hong Kong. The daily attendance is around 25 - 30 patients. Besides geriatricians, nursing staff and therapists, speech pathologists, pharmacists, clinical psychologists, neuropsychologists and dietitians are also available.

**Observation in UCLA Medical Centre**

The UCLA Medical Centre is a large medical complex located within the UCLA campus. The heart of the complex is the Centre for Health Sciences (CHS), a 680-bed academic teaching hospital. Adjacent to the CHS is the UCLA Neuropsychiatric Hospital and Ambulatory Care Complex. In addition, it had two community-based sites, the Eichenbaum Health Centre and the County Villa Westwood Skilled Nursing Facility providing primary care to frail older persons.

Geriatric services includes:
- Geriatric Special Care Unit
- Geropsychiatry Unit
- Ambulatory Geriatric Services
- Geriatric Assessment and Rehabilitation
- Continence Evaluation
- Geriatric Neurology
- Affiliated Proprietary Skilled Nursing Facility

**UCLA Neurological Rehabilitation and Research Unit (NRRU)**

The NRRU offers comprehensive rehabilitation services for patients with stroke, spinal cord injury, traumatic brain injury, neurological disorders, major multiple trauma, and other debilitating conditions. It is staffed by a multidisciplinary team of physicians, nurses, physical therapists, occupational therapists, speech pathologists, clinical social workers, and clinical neuro-psychologists. They have 11 beds for inpatient neurorehabilitation. The suitable candidates are taken over from other wards through consultation basis after assessment by neurology trainees. The first priority which they take into account before transferring patients for rehabilitation is that the prospective candidate must have good social support so that their rehabilitation effort will not be wasted after they are being discharged. The rehabilitation input is rather intensive and each patient receives at least 4 to 5 hours of training per day by various disciplines. The team regularly discusses each patient, shares ideas, and designs a coordinated, individualized care program. The patient’s unique and individual needs and goals are taken into account at each weekly treatment team meeting and in all care decisions. In addition, periodic family conferences are scheduled to discuss the patient’s progress, short-
and long-term goals, and treatment plan. They incorporated the Body Weight Support Treadmill Training (BWSTT) for gait restoration in stroke sufferers who cannot walk in addition to the orthodox rehabilitation modalities in their Functional Assessment Laboratory and the preliminary results are quite promising. The average duration of stay for each patient is around three to four weeks. Once a discharge date has been set, training sessions are scheduled to discuss the patient’s continuing care and provide instruction in rehabilitation techniques and equipment use. Afterwards, patients’ may be offered additional training in outpatient setting or therapists may pay home visit to patients and give rehabilitation at their homes. An outpatient follow-up visit or telephone conversation is scheduled for two weeks after discharge. An additional telephone follow-up may be made within three months of discharge as part of evaluation of the program’s long term effectiveness.

Comments
The overseas training is quite a useful exercise in the training of a geriatrician. It enables the trainee to broaden the knowledge in geriatric practice, allows exposure to different modes of delivery of geriatric services in different socioeconomic circumstances and to be aware of recent advance of the specialty. I consider my study leave in VA Medical Centre, Sepulveda and NRRU in UCLA Medical Centre successful in attaining the above objectives and that overseas experience is an opportunity that one cannot afford to miss in his professional career.

Acknowledgement
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DOGMA — A GUIDE OR A TRAP?

“Being not helpful” is better than “doing harm”. Sometimes, we do bad works on patients despite good intentions behind. Being thinking geriatricians we have to justify but not rationalize on our treatments. “Action is meaningless without the substratum of the idea” (Nick Miller, 1986) The key theme of our practice is not only to add years (quantity) to life but also add life (quality) to those years. Relying solely on outdated doctrines is malpractice if not dangerous. “A clash of doctrines is not a disaster - it is an opportunity” (Alfred North Whitehead, 1861-1947) The following are some examples encountered during our practice of stroke rehabilitation:

‘Poor motivation’
The diseased is always the scapegoat but the problem actually lies on the rehabilitation professionals sometimes if not often.

Spasticity is lessened by sitting correctly’
It is beneficial provided that it is not prolonged. Remaining in one position for prolonged periods (> 2 hours) actually invites abnormal posturing and development of pressure sores. Prolonged sitting will enhance the flexor pattern and Positive Supporting Reaction making future walking difficult if not impossible.

‘Squeezing a metal ball’
It is not uncommon to see stroke’s relative or friend buying metal balls of different sizes for the stroke victim’s training hand strength, sometimes actually advised by misguided professionals. The effect is actually harmful if not disastrous. It actually promotes the primitive grasp reflex resulting in a flexed, unrecoverable hand and escalating spasticity of the whole upper limb.

The above is just the tip of an iceberg. “We think in generalities, but we live in detail.” (Alfred North Whitehead, 1861-1947). A coin has two sides. Treatment has its pros and cons. We have to weigh the benefits against the drawbacks. Every patient’s management has to be individualized. The life is so short but the craft is so long to learn. Keep up!

References

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