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Geriatrics Continuing Medical Education Interest Among Primary Care Physicians in B.C.

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Abstract

Background
To help the Division of Community Geriatrics at UBC respond to the CME and research needs related to care of the elderly, a needs assessment was undertaken.

Methods
A self-administered questionnaire survey was sent to all physicians identified by the B.C. College of Physicians & Surgeons database as either having a Certificate in the College of Family Physicians of Canada and/or being without specialist qualification (n=4192). Two mail-outs and a reminder were sent between May and September 1999. The main outcome measure is the proportion of respondents indicating an interest in Continuing Medical Education on a particular topic.

Results
There were 961 respondents, of which 899 were eligible for inclusion, for a response rate of 21.4%. Psychogeriatric topics and skills were among the top CME priorities, as were managing chronic illness and medications. Most primary care physicians were interested in the broad topics of cognitive impairment, dementia and depression, while those with a particular interest in geriatrics were interested in more specific aspects of care, such as competency assessment.

Conclusions
Family physicians are interested in Continuing Medical Education in the field of geriatrics, especially psychogeriatric topics and complex medical care. The depth of educational detail within a particular topic was related to the physicians' background training and identified interest in geriatrics.

Key Words
Family Practice
Geriatrics
Questionnaire Survey
Continuing Medical Education.

Introduction
The number of Canadians over the age of 65 is expected to double in the next 25 years, with the most rapidly growing segment of the population being that over 80 years of age.[1] This is due to both an aging cohort ('baby boomers') and an increase in life expectancy.

It is important that family physicians are adequately prepared to respond to the health care needs of this group. Not only will geriatrics need to assume a greater importance in the undergraduate and post-graduate medical curricula, but also resources must be in place for the continuing education of physicians in geriatric care.

Participation in Continuing Medical Education (CME) activities is a requirement for continued membership in the College of Family Physicians of Canada. In accordance with principles of adult learning, individuals identify and pursue their own learning needs. It is important then, that these needs are anticipated and communicated to those involved in the planning, delivery and evaluation of CME programs.

Several geriatric CME needs assessment surveys have been reported in the past few years. They have employed innovative approaches, for example, involving patients and community informants[2,3] or asking about the learning needs of one's peers.[4] A recent needs assessment survey attempted to get physicians to identify gaps between perceived current knowledge and desired knowledge.[5] Although useful in helping clinicians identify their education needs, there is no evidence that these assessments can be relied upon to predict CME participation. This pre-supposes that 'knowledge' is the aim of such educational activities. Pendleton[6] argues this may not be the case for practicing physicians:

"The professional is only interested in that subset of understanding which is relevant to the problem which he or she is currently seeking to solve or manage."

Furthermore, a previous needs assessment for CME in geriatrics showed a low correlation between perceived urgency of need and intention to pursue CME in that area.[3] In the current survey, the Division of Community Geriatrics at UBC sought to identify priority areas for research and continuing education as they pertain to the primary care of seniors in British Columbia. Respondents were simply asked if they were interested in CME on particular topics.

Methods

Questionnaire

The research team developed a self-administered questionnaire that was divided into four sections. Part A consisted of practice patterns related to care of the elderly and an overall assessment of the healthcare system as it pertains to care of the elderly. In this part, questions required choosing between multiple options, graded responses and yes/no answers, with space for other responses if desired. Where time allotment was asked, percentages were requested to add up to 100%.

To define priority areas for research and CME, Part B, 69 priority areas for research and CME were divided into nine broad categories: General; Clinical Practice Issues; Psychogeriatrics; Major Systems; Womens' Health; Other Clinical Problems; Ethical/Legal Issues; Continuity of Care; and Special Topics. The topics and categories drew on a previous review of geriatric content in general medical and geriatric/gerontology literature.[7] CME interest indicated by yes/no response. Part C asked about interest in the Community Geriatrics Research Partnership and Part D requested non-identifiable demographic information. Rurality was defined by postal codes containing a zero.

The questionnaire was piloted for clarity with six family physicians working at the Geriatric Short Term Assessment and Treatment Centre at Vancouver Hospital. A full copy of the questionnaire can be obtained from the corresponding author. Ethics approval was granted by the University of British Columbia Behavioural Ethics Review Board.

Participant selection & implementation

Family physicians were identified by the College of Physicians and Surgeons of B.C. database, 1999, as either having a CCFP and/or having no other specialty certification. Completion of the questionnaire implied consent. Although questionnaires were anonymous, those interested in becoming involved with research and/or requesting results of the survey were asked to complete a separate return card.

The survey was mailed to all B.C. family physicians in May 1999 with a postage-paid return envelope. A reminder notice followed the initial mail out in week three. Non-respondents were sent a second survey mailing in week six. The B.C. Association of Geriatric Care Physicians sent an additional mailing to their membership. Completed surveys were accepted until September 30, 1999 (end week 19).

No follow-up of non-respondents to determine eligibility was done.

Statistical analysis

Data was entered into MS Excel and prepared for analysis on SPSS Version 8.0. Outliers were identified and rechecked. In addition, a random sample of approximately 5% (42) were rechecked, with seven non-systematic data entry errors found from a total of 8,022 (.087%). This did not have a significant effect on results. Final analysis was performed using SPSS Version 10.0.

Respondents were excluded from analysis they were not currently engaged in primary care practice. Locums and those on temporary leave were included in the analysis.

CME interests were determined by multiple response tables and subgroups were compared using the Chi-Square test for goodness of fit. The number of CME topics chosen were counted and compared using the t-test, or ANOVA and rechecked using the Mann-Whitney U or Kruskall-Wallis test for non-normal distributions.

Results

Response rate

The survey was sent to 4,192 physicians with 916 respondents, of whom 899 were eligible for inclusion (21.4%). Of the 17 respondents who were excluded, 16 were retired or engaged in administration or specialty care and one was a nurse practitioner. Five hundred and twelve questionnaires were completed (57.0%) with a further 206 (total 79.9%) completing 95% or more of the questions.

Respondents

Respondents ranged in age from 26 to 80 (mean 46.0± 10.0) with between two and 58 years since graduation (mean 19.3±10.5). A summary of respondent characteristics is presented in Table 1. Members of the College of Family Physicians of Canada and of the B.C. Association of Geriatrics Care Physicians were more likely than non-members to respond. Women were also slightly over-represented when compared to the total population of B.C. primary care physicians.

Continuing medical education interests

On average, respondents indicated interest in 28 potential CME topics. Fifteen per cent (136) were not interested in any topics and 5.3% (48) were interested in all 69. Table 2 lists the number of topics chosen overall and by subgroup. P values are based on Kruskall-Wallis or Mann-Whitney U test, given the non-normal distribution of the results. Women and those with a practice estimated to include more than 30% of patients over the age of 65 tended to choose more topics. As a subgroup, those who had completed a family medicine residency were also more likely to choose more topics (p=0.006), but this was not true of certificants of the College of Family Physicians of Canada in general (p = 0.119).

The list of CME topics chosen most frequently is presented in Figure 1. As the aim was to discriminate between various CME priorities, these percentages refer to the percent of respondents who had any CME interest (N=763). Sub-group analysis was prepared by age, gender; practice location (rural vs. urban); practice composition (estimated per cent of practice over 65 years of age); completion of a family medicine residency; completion of a special skills course in geriatric care; certification in the Collage of Family Physicians of Canada (CCFP); and membership in the B.C. Association of Geriatric Care Physicians (BCAGCP). Although this survey is descriptive in nature and formal comparisons are inappropriate, some trends were noted.

Those who demonstrated a particular interest in geriatrics by membership in a specific association or completion of additional training in geriatrics expressed different CME needs than the rest. For those in the BCAGCP (n=55), competency assessment was the most frequently cited followed by medications, cognitive functioning and movement disorders. For those with a special skills course (n=56), the most common needs were assessment techniques, managing chronic illness and medications.

There was no clear pattern of differences related to practice composition, gender or age with the exception that those physicians over the age of 55 (n=133) were more interested in learning more about leisure activities ($_^{2}$ = 17.3, p<0.001). Those in rural practice (n=97) were more interested than their urban colleagues in breast cancer ($_^{2}$ = 10.5, p=0.001), palliative care ($_^{2}$ = 9.9, p=0.002) and rural issues ($_^{2}$ = 43.1, p<0.001). Members of the CFPC (n=356) were more interested in receiving additional education in all the ethical and legal topic areas: advance directives ($_^{2}$ = 9.3, p=0.002), competency assessment ($_^{2}$ = 11.7, p=0.001) and driving assessment ($_^{2}$ = 5.8, p=0.016). This was not mirrored by those who had completed a family medicine residency (n=296), for whom no specific trends emerged.

The group (n=136) who did not indicate an interest in any of the geriatric topics were diverse, with all subgroups equally represented. It did not appear to indicate a lack of interest in the survey nor in geriatrics generally, as 72% (98/136) identified at least one very important priority for research related to geriatric primary care.

Discussion

Limitations

The response rate to the survey was low, but not inconsistent with other long, untargeted surveys of this type.[5] Those who are more interested in geriatric care were over-represented as evidenced by the high response rate from members of the B.C. Association

of Geriatric Care Physicians. While this may result in an overestimate of the proportion of primary care physicians interested in a particular topic, this response bias should not affect planning priorities.

CME priorities

Family physicians recognized both the unique psychogeriatric topics and the chronic, complex nature of geriatric care through their identified CME priorities. As with a previously reported needs assessment,[3] they were primarily concerned with technical aspects of care rather than the process of care.

Psychogeriatric topics were particularly highlighted, with depression (rank 4), dementia (rank 1) and the associated topics of cognitive functioning (rank 3), competency assessment (rank 8), driving assessment (rank 11) and delirium (rank 13) identified as a need for over 60% of eligible respondents.

The presence of multiple and complex and often chronic medical problems in the elderly pose a challenge to their primary care physicians and indeed many respondents were interested in managing chronic illness (rank 2) and medications (rank 5). Furthermore, as geriatric assessment is focused on syndromes rather than specific diagnoses, one would expect those topics to be of interest. While urinary incontinence (rank 9), dizziness (rank 10) and pain (rank 14) would fit into this category, there was less interest in other 'syndromes' such as mobility, sensory impairment and function (ADL/IADL).

Physicians in the BCAGCP and those with a previous special skills course in geriatrics, were interested in more specific aspects of geriatric care. For example, they expressed more interest in learning skills related to competency assessment rather than just education regarding dementia as a whole. It is likely they were able to refine their self-assessed needs in light of prior training and experience. This group may need to be targeted with specific CME offerings, however, there does not appear to be a need for targeting CME programs by age, gender or practice location.

These results are similar in some respects to those recently published in the *Journal of the American Geriatrics Society*. With far fewer suggested topics, the top priority identified by physicians attending the American College of Physicians (ACP) and American Academy of Family Physicians (AAFP) was dementia. Despite the consistent need to learn more about dementia care, neither group was particularly interested in advance directives.

Some differences were noted between the two groups. While B.C. family physicians placed hormone replacement therapy near the top of their priorities (rank 6), it was 15th out of 16 topics for our American counterparts. They were also more interested in functional assessment, falls and sensory impairment.

The current study is also consistent with results reported from Ontario,[3] where physicians were more interested in those topics related to the technical aspects of care rather than the process of care, for example, communication and health policy issues.

Future directions

While it is evident that further research is needed into the validity of needs assessment tools for CME, the Division of Community Geriatrics will use the current information to help plan its on-going medical education programs for its clinical faculty and plan educational offerings in conjunction with the BCAGCP.

Conclusions

Primary care physicians are interested in Continuing Medical Education on a broad spectrum of geriatric topics, in particular psychogeriatrics and complex geriatric care. There does not seem to be a need to target specific groups within the community for such education, with the possible exception of those with identified interests or background in geriatrics who appear to require education on more specific aspects of care. Primary care physicians in this survey remain more interested in updating skills and knowledge rather than in professional development in the process of care for their geriatric patients.

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Table 1 - Characteristics of Respondents

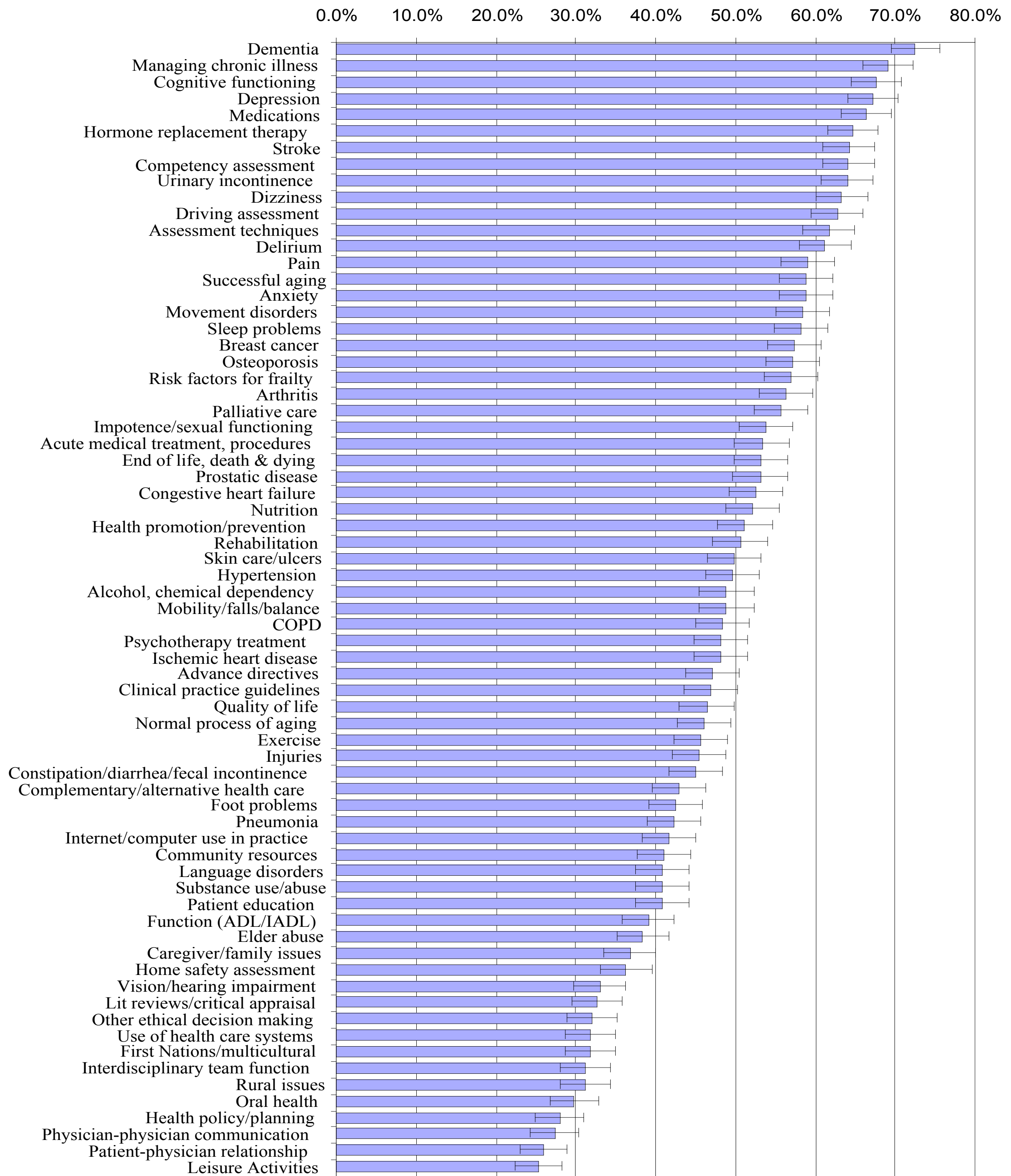
		Respondents		All B.C. GP/FP's	
		N	%	%	
Total		899	21.4%		
Age	<35 Years (%)	117	13.0%	16.3%	*
	35-54 Years (%)	583	64.8%	60.1%	
	55+ Years (%)	175	19.5%	23.4%	
	Unknown	24	2.7%	0.2%	
Gender					
	Female	298	33.1%	30.8%	†
	Male	582	64.7%	69.2%	
	Unknown	19	2.1%		
Member of CFPC					
	Yes	413	37.7%	31.5%	*
	No	465	51.7%	68.5%	
	Unknown	21	2.3%		
Member of BCAGCP					
	Yes	61	6.8%	2.1%	‡
	No	819	91.1%	97.9%	
	Unknown	19	2.1%		
Practice Location					
	Urban	622	69.2%	89.8%	
	Rural	104	11.6%	10.1%	
	Unknown	91	19.2%		

Notes
* Rollcall 99. Based on full, temporary and special register, non-postgraduate physicians (8)
† Rollcall 99. Based on full, temporary and special register GP's & FP's

Table 2 Number of CME topics chosen

		N	Mean	SD	p
Gender					
	Female	298	31.4	22.1	
	Male	582	27.5	22.3	0.010
Agegroup					
	<35	117	32.9	23.1	
	35-55	583	28.7	21.6	
	55+	175	27.0	22.3	0.058
Practice Location					
	Rural	662	35.0	21.7	
	Urban	104	31.8	21.3	0.159
Family Practice Residency					
	Yes	339	31.5	22.2	
	No	543	27.3	22.2	0.006
Certificate in College of Family Physicians					
	Yes	413	30.2	22.1	
	No	465	27.9	22.5	0.119
Membership in BC Association of Geriatric Care Physicians					
	Yes	61	31.0	21.8	
	No	819	28.8	22.4	0.430
Special Skills Course in Geriatrics					
	Yes	67	32.4	23.8	
	No	812	28.7	22.2	0.268
Percent of Practice over age 65					
	<10%	201	25.7	21.9	
	10-30%	438	28.2	22.0	
	30%+	260	31.1	23.1	0.035
	Total		28.5	22.4	

Figure 1 - CME Priorities (percent of respondents)



0.0%
10.0%
20.0%
30.0%
40.0%
50.0%
60.0%
70.0%
80.0%
Dementia
Managing chronic illness
Cognitive functioning
Depression
Medications
Hormone replacement therapy
Stroke
Competency assessment
Urinary incontinence
Dizziness
Driving assessment
Assessment techniques
Delirium
Pain
Successful aging
Anxiety
Movement disorders
Sleep problems
Breast cancer
Osteoporosis
Risk factors for frailty
Arthritis
Palliative care
Impotence/sexual functioning
Acute medical treatment, procedures
End of life, death & dying
Prostatic disease
Congestive heart failure
Nutrition
Health promotion/prevention
Rehabilitation
Skin care/ulcers
Hypertension
Alcohol, chemical dependency
Mobility/falls/balance
COPD
Psychotherapy treatment
Ischemic heart disease
Advance directives
Clinical practice guidelines
Quality of life
Normal process of aging
Exercise
Injuries
Constipation/diarrhea/fecal incontinence
Complementary/alternative health care
Foot problems
Pneumonia
Internet/computer use in practice
Community resources
Language disorders
Substance use/abuse
Patient education
Function (ADL/IADL)
Elder abuse
Caregiver/family issues
Home safety assessment
Vision/hearing impairment
Lit reviews/critical appraisal
Other ethical decision making
Use of health care systems
First Nations/multicultural
Interdisciplinary team function
Rural issues
Oral health
Health policy/planning
Physician-physician communication
Patient-physician relationship
Leisure Activities