GERIATRIC TRAINING IN COMMUNITY HOSPITALS AND STEP DOWN CARE

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The Family Medicine Fellowship Programme (Aged Care) or FMFP (Aged Care) was first conceived in year 2000 in recognition of the need for training of family physicians for geriatrics skills to manage community geriatric problems. As Geriatrics was largely the domain of acute hospitals, there was a growing necessity to develop geriatrics in step down care and eventually to primary care. The comparison between the FCFP Ambulatory Family Medicine and the Aged Care Programme had been addressed in a previous publication in *The Singapore Family Physician* [Academic Prog of the College of Family Physicians Singapore. *The Singapore Family Physician* 2001:27(3) 68-71]

COMMUNITY HOSPITALS

The first Community Hospital started in 1993. Ang Mo Kio Community Hospital began conceptually as a "district hospital" where specialists and family physicians would complement each other in managing patients. However, it instead filled the vacuum of intermediate care for patients requiring longer stay since and the original intention of the hospital gave way to the concept of community hospitals as we know today.

The community hospital of today is largely a geriatric and rehabilitative hospital catering mainly to post stroke rehabilitation and rehabilitation of hip fractures, leg amputations, deconditioning after acute illness and subacute patients. This intermediate type of medical care is now becoming increasingly relevant, as health providers see the need for specialised rehabilitative units catering to the elderly who require both rehabilitation and holistic care, including medical social work-up and follow-through.

COMMON MEDICAL PROBLEMS IN COMMUNITY HOSPITALS

Many community hospital patients are admitted with medical problems common to the elderly eg confusion, depression, incontinence, instability and falls and immobility, in addition to the acute episode precipitating the admission. Many have chronic medical problems like hypertension, diabetes and heart disease in various stages and with varying severity. Recognition of clinical, functional and psychosocial problems and expert medical assessment and diagnoses of geriatric patients are important in management. The geriatric training of family physicians during basic traineeship was not sufficient for such institutional care. These doctors have to be intensively trained in geriatrics and garner enough exposure for the necessary skill-sets to be able to manage the wards in community hospitals independently.

HIGHLY SPECIALISED CARE TO HOLISTIC CARE

Increasingly, the acute hospital management are becoming highly specialised. Intermediate care supplement the highly specialised environment of acute hospitals when there is a need to adjust patients back to the community in terms of function and continuing care. The holistic care and the slower pace of the community hospital enables a more complete work-up of the patient's medical, therapy, follow-up and social needs. Thus the community hospital provides an environment close

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to the training of family physicians. But more importantly, it provides the interface of physician with the rest of the rehabilitation team. Doctors have a role but as part of the team; there are areas in which the nurse, therapist and medical social worker do very much better because they are specialised to provide that part of the treatment.

GERIATRICS IN PRIMARY CARE

Our geriatricians must be credited for their recognition of the role of such trained family physicians. Their contributions, expertise and collaboration with the College of Family Physicians and Graduate School of Medical Studies (now called Division of Graduate Medical Studies) to start the Diploma of Geriatric Medicine (later called the Graduate Diploma in Geriatric Medicine or GDGM) formalised training of Family Physicians and general practitioners in geriatrics. This one year long part-time course in geriatrics equipped practising family doctors with geriatric knowledge and skills but was tailored generally to all family physicians. Clearly, family physicians who desired to work in community hospitals, nursing homes, home medical and long term care need added exposure to institutional Geriatrics. Family physicians who by this time had moved into community hospitals, long term care and home medical hence had to be trained more intensively in an advanced programme.

GERIATRICS IN STEP DOWN CARE

Thus towards the end of year 2000 and into year 2001, the College and interested geriatricians initiated meetings for the FMFP (Aged Care) programme leading to the FCFP(S). The first batch of three trainees started in year 2001. The training for the FMFP(Aged Care) was rigorous. It included a compulsory one year long GDGM course and a 6-month posting in an acute geriatrics unit. It was considered important to train such doctors to be skilled in managing community hospital patients, in particular subacute medical patients, the numbers of whom were increasing in community hospitals due to Ministry of Health's intention to increase the proportion of subacute patients in community hospitals to as high as 30% if possible.

The need for rigorous training necessitates commitment by institutions to send their doctor or doctors for such training. However, such inconvenience and short term expense must not be sacrificed for the long term good of the hospital and it is imperative that the quality of training must not be at the expense of convenience and ease.

THE FUTURE

In the long term, each good size community hospital would require about 3-4 such trained doctors at least and the aim is to train at least 20-30 such doctors for community hospitals. It is hoped that the numbers will increase because there is a need to have such trained doctors to manage and assess patients in nursing homes, home medical and long-term care besides community hospitals. Doctors who are interested in these areas of care would find it necessary to be trained to a very high level of skill in order to bring the "centre of gravity" to the community level. This will improve care and enable a multiplier effect in which family

physicians will train their peers in the management of the elderly. It will also bring the very important added dimension to family practice as geriatrics becomes increasingly needed in a rapidly aging population. The net effect is also preventive as awareness of the pitfalls in managing the elderly and the problems they face will enable many primary care physicians to prevent potential health disasters like osteoporotic fractures and falls and the side-effects of different drugs in the elderly. Skilled geriatric management will also help reduce morbidity and deterioration in many problems of our elderly.

Hence, it is hoped that more family physicians with MMed (FM) will take up the advanced traineeship in Aged Care, especially those who have a calling to care for the elderly in intermediate and step-down care.