

Postgraduate Diploma Courses in Geriatric Psychiatry

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Key words: psychogeriatrics, geriatric psychiatry, postgraduate studies, training

Abstract:

Background: Training in geriatric psychiatry constitutes a fundamental element toward further development of this relatively new branch of medicine. However, it varies both in quantity and quality among different countries, healthcare providers and medical schools.

Objectives: To describe the demographic and professional characteristics of participants in postgraduate diploma courses in geriatric psychiatry, and the perceived contribution of the courses; and to compare these variables among the participants in 1 year and 3 year courses, and between psychiatrists and non-psychiatrists.

Methods: A retrospective self-administered questionnaire was mailed to the 153 physicians who participated in the two courses. The 60 questionnaires completed and returned were analyzed.

Results: Participants in the courses constituted a heterogeneous group in terms of demographic and professional characteristics, with no differences between 1 year and 3 year course participants, or between psychiatrists vs. non-psychiatrists (with the exception of more involvement of non-psychiatrists and 1 year course participants in old-age homes). Most responders indicated both the theoretical and practical benefits and application to daily practice of the material learned. Similarly, most responders indicated that after the courses they definitely used general assessment scales to a much greater extent, particularly cognitive scales, as well as operational diagnostic criteria for dementia. Participants in the 3 year course reported more significant use of assessment scales compared with 1 year participants, and 3 year participants and psychiatrists used the cognitive scales more often. There were no other significant differences between 1 year and 3 year participants and between psychiatrists' and non-psychiatrists' reports regarding general and more specific contributions of the courses.

Conclusion: Postgraduate diploma courses in geriatric psychiatry seem to have a favorable effect on participants, irrespective of course duration or specialty. However, course duration positively influenced the implementation of assessment scales in general, and cognitive scales in particular. A prospective comparative study on this subject is warranted, with stricter definitions of participants' pre-course and post-course background, attitudes, knowledge and benefits.

IMAJ 2003;5:356-359

The importance of education and training of clinicians to develop and expand horizons in geriatric psychiatry was established with the initial conceptualization of this modern medical field and it continues to be significant [1-3]. In two recent consensus statements, the issue of training in geriatric psychiatry holds a prominent place along with assessment, treatment, organization, and research [4,5]. Wertheimer [4] actually affirms that "training in mental health care of older people should be offered at both undergraduate and postgraduate levels and also during continuing professional development." These continuously evolving recom-

mendations have largely been met in some western countries regarding undergraduate and residency training [6-14]. The International Psychogeriatric Association (IPA) developed a classification system for the level of training programs in geriatric psychiatry. In that system Stage 2, the minimum established desired goal, is achieved when "training programs in geriatric psychiatry are beginning to develop." However, a recent international survey among IPA members from 55 countries showed that regarding the development of geriatric psychiatry, only 12 countries achieved a mean score of 2 and above, thus achieving Stage 2 or higher [15].

An effort is being made to match geriatric psychiatry in Israel to international accomplishments [16]. Training in geriatric psychiatry is rarely offered in medical undergraduate programs in Israel [17] and is entirely elective (and chosen by only a few) in residency programs. However, the fact that Israel was ranked by Reifler and Cohen [15] at Stage two is undoubtedly due to the ongoing postgraduate courses that have been offered in geriatric psychiatry during the last decade.

From 1991, the School of Continuing Medical Education at Sackler Faculty of Medicine, Tel Aviv University, began to organize 1 year postgraduate diploma courses in psychogeriatrics (until 1996 there were five courses in all, sponsored by the ESHEL Organization), and during 1996-1999 a 3 year diploma postgraduate course. The main purpose of these postgraduate courses was to provide theoretical and practical knowledge in late-life psychiatry. They were not intended to provide specialty training or to substitute it. Geriatric psychiatry is not recognized as a specialty in Israel. As shown in Table 1, which demonstrates the structural characteristics of 1 year and 3 year courses, the courses were similar in meeting frequencies, emphasis on "frontal" lectures, the topics presented (more in depth in the 3 year courses), visits to psychogeriatric services, and the preparation of a written case report at the end of the course. They differed in the special requirements for registration, location of classrooms, total course hours, and the examinations and practicum required. Participants in the 3 year course had to pass written examinations at the end of years 1 and 2, and an oral examination at the end of year 3. They also had to spend a 1 week practicum in a psychogeriatric outpatient service and 1 week in an inpatient service in order to be eligible for a diploma in psychogeriatrics.

The present study reports on the participants of the postgraduate diploma courses from 1991 to 1999. We describe the demographic and professional characteristics of the participants and the presumed contribution of the courses. In addition,

Table 1. Comparison between structural characteristics of the 1 year and 3 year courses

	1 year course	3 year course
Special requirements	All physicians interested in psychogeriatrics	Specialist in psychiatry (or after Stage 1), geriatrics or family medicine
Place	Margoletz Psychogeriatric Center, Tel Aviv Sourasky Medical Center, Tel Aviv	Sackler Faculty of Medicine, Tel Aviv University, Ramat Aviv
Frequency of meetings	Once-a-week basis, morning	Once-a-week basis, afternoon
Total course hours	160 hours	410 hours
Emphasis on "frontal" lectures	Yes	Yes
Curriculum	<ul style="list-style-type: none"> ● "Basic sciences" (psychology, demographics, sociology, biology) ● Neuropsychology ● Neuropsychiatry ● Neuroimaging ● Assessment and evaluation methods ● Clinical syndromes ● Management and treatment ● Ethical and legal aspects ● Selected geriatric issues ● Other (post-Holocaust survivors, minorities) 	Same topics
Visits to psychogeriatric services	Yes	Yes
Preparation of a written case presentation	Yes	Yes
Examinations (written and oral)	No	Yes
Practicum in out inpatient services	No	Yes

we compare the above variables between participants in the 1 year and 3 year course and between psychiatrists and non-psychiatrists.

Methods

In April 1999 we mailed a cover letter with a structured self-administered questionnaire to all 138 graduates of the five 1 year courses and the 15 graduates of the 3 year course, a total of 153. Thirty-three questionnaires were returned (21.6%) due to "address unknown." Of the remaining 120 (78.4%) that we assume were received, 60 (50%) did not respond. The respondents, whose responses were received by the end of July 1999, constitute our research sample.

The questionnaire covered the following domains:

- Demographic data (age, gender)
- Professional data (country where the respondent studied medicine, main specialty, years of experience in medicine and specialty, location of practice)
- General contribution of the courses: type of contribution (theoretical, practical, basis for career change to psychogeriatrics), application of study material to daily practice (not at all, very little, definitely, a great deal)
- Specific contribution of the courses: general use of assessment scales following the courses (not at all, very little, definite, a great deal), use of cognitive scales (not at all, very little, definitely, a great deal), use of operational criteria to diagnose dementia (DSM-3-3R-4, ICD-10, other, none).

Statistical analysis

All statistical analyses were performed using SPSS-8 for Windows.

To examine group differences, chi-square analysis, Mann-Whitney U-test and independent sample *t*-test, two-tailed, were used for categorical, ordinal and continuous data, respectively. Owing to the multiple comparison test performed, adjustment to the significance level was used. *P* values less than 0.001 were considered statistically significant.

Results

Demographic and professional characteristics

Table 2 shows the demographic and professional characteristics of the participants in total, and divided by course duration (1 year vs. 3 year) and specialty (psychiatry vs. non-psychiatry). About 70% of the responders were over 40 years old. Females and males participated equally. No significant differences in demographic variables were found between 1 year and 3 year courses and between psychiatrists vs. non-psychiatrists.

Most respondents had attended medical school in Eastern Europe – about a quarter in Western Europe, and only one quarter in Israel. Psychiatrists constituted almost half of the participants, followed by geriatricians (23.3%), and general practitioners, family physicians and specialists in internal medicine combined (21.6%). The participants were "veterans" both in medicine and in their specialties (only psychiatrists and geriatricians were considered for this purpose). Most of the respondents worked in several places, especially hospitals (61.7%), followed by outpatient clinics (public) 33.3%, and old-age homes (23.3%).

Non-psychiatrists and participants in the 1 year course worked more in old-age homes ($P < 0.0001$). No other significant differences between participants of the 1 and 3 year course and between psychiatrists and non-psychiatrists were found with regard to professional characteristics.

Table 2. Demographic and professional characteristics

Variable		Course duration		Specialty		Total
		1 year	3 years	Psychiatry	Non-psychiatry	
N		48 (%)	12 (%)	28 (%)	32 (%)	60 (%)
Age	<40	11 (22.9)	7(58.3)	9 (32.1)	9 (28.1)	18 (30.0)
	41–50	24 (50.0)	5(41.7)	14 (50.0)	15 (46.9)	29 (48.4)
	51–60	12 (25.0)	–	5 (17.9)	7 (21.9)	12 (20.0)
	>61	1 (2.1)	–	–	1 (3.1)	1 (1.7)
Gender	Male	22 (45.7)	7 (58.2)	13 (46.4)	16 (50.0)	29 (48.3)
	Female	26 (54.3)	5 (41.7)	15 (53.6)	16 (50.0)	31 (51.7)
Country where studied medicine	Israel	12 (25.0)	3 (25.0)	8 (28.6)	7 (21.9)	15 (25.0)
	W. Europe	12 (25.0)	3 (25.0)	7 (25.0)	8 (25.0)	15 (25.0)
	E. Europe	20 (41.7)	6 (50.0)	11 (39.3)	15 (46.9)	26 (43.3)
	Other	4 (8.3)	–	2 (7.1)	2 (6.2)	4 (6.7)
Specialty	Psychiatry	19 (39.6)	9 (75.0)	–	–	28 (46.7)
	Geriatrics	12 (25.0)	2 (16.7)	–	–	14 (23.3)
	GP/FP/IM	12 (25.0)	1 (8.3)	–	–	13 (21.6)
	Other	5 (10.4)	–	–	–	5 (8.3)
Years of experience in medicine	Mean	19.31	15.25	16.75	20.03	18.50
	SD	8.65	7.08	8.38	8.36	8.46
	Range	2–35	3–27	3–35	2–34	2–35
Years of experience in psychiatry	Mean	11.52	8.38	10.51	–	10.51
	SD	9.32	6.42	8.51	–	8.51
	Range	1–32	3–24	1–32	–	1–32
Years of experience in geriatrics	Mean	8.12	2	–	7.25	7.25
	SD	6.23	1.41	–	6.29	6.29
	Range	0–20	1–3	–	0–20	0–20
Work place	Outpatient (public)	18 (37.5)	2 (16.7)	10 (35.7)	10 (31.3)	20 (33.3)
	Outpatient (private)	7 (14.6)	1 (8.3)	5 (17.9)	3 (9.4)	8 (13.3)
	Old-age home*	13 (27.1)	1 (8.3)	1 (3.6)	13 (40.6)	14 (23.3)
	Hospital	27 (56.3)	10 (83.4)	22 (78.6)	15 (46.9)	37 (61.7)
	Other	3 (6.3)	–	2 (7.1)	1 (3.1)	3 (5.0)

* Chi-square = 11.461, df = 1, $P < 0.0001$

GP = general practitioners, FP = family physicians, IM = internal medicine

General contribution of the courses

Most of the respondents indicated theoretical (68.3%) or practical input (56.7%), and that they definitely (51.7%) or to a great extent (36.7%) applied what they learned in daily practice. Only a minority (13.3%) of the total respondents thought that the courses provided them with a basis for career change to psychogeriatrics. No significant differences between 1 year and 3 year course participants and between psychiatrists and non-psychiatrists were found on questionnaire domains concerning the general contribution of the courses.

Specific contribution of the courses

Most respondents indicated that after the courses they definitely use general assessment scales in their practice to a much greater extent (81.7%), particularly cognitive scales (71.7%), as well as operational diagnostic criteria for dementia (78.3%). Here, however,

graduates of the 3 year course generally used more assessment scales ($P = 0.0004$), and 3 year graduates and psychiatrists used cognitive scales significantly more frequently ($P = 0.003$, $P = 0.008$) than 1 year graduates and non-psychiatrists. No significant differences between 1 year and 3 year course participants and between psychiatrists and non-psychiatrists were found concerning the use of operational criteria for dementia.

Discussion

Course participants were a heterogeneous group in terms of age, place of graduation, specialty, experience, and place of employment. These characteristics were similar for both the 1 year vs. 3 year course participants and psychiatrists vs. non-psychiatrists (with the exception of 1 year course participants and non-psychiatrists regarding practice in old-age homes). Despite this heterogeneity, respondents did not vary (1 year vs. 3 year course

participants and psychiatrists vs. non-psychiatrists) with regard to the perceived general contribution of the courses.

The issue of the specific contribution of the courses is difficult to investigate. We therefore chose to study the use of assessment scales in general and cognitive scales in particular and the use of operational criteria for dementia, since they are currently required in Israel by the Ministry of Health and the health insurance funds for the prescription of anti-Alzheimer's drugs. We were not surprised to find that following participation in the courses, assessment scales and diagnostic criteria have been extensively implemented. In fact, it has been reported that training improves recognition and management of specific disorders (e.g., depression) [18], enhances confidence of participants in assessing and diagnosing dementia [19], and might even affect the criteria used for diagnosis [20]. However, while it might be feasible that graduates of the 3 year course more readily use assessment scales in general and cognitive scales in particular, it is unclear why psychiatrists more often than non-psychiatrists reportedly use cognitive assessment scales. According to a survey conducted several years ago in Israel [21], general psychiatrists used less assessment scales compared to geriatric psychiatrists, geriatricians and neurologists, and we presume that attendance in the courses contributed to this improvement.

The relatively small percentage of respondents (39.2% of all participants or 50% of those who received the questionnaires), though a limitation, is consistent with the generally low to moderate response rate of studies conducted with a similar retrospective design (see the 38% response rate of Reifler and Cohen [15], and the 50% response rate in the study by Goldstein et al. [19]). Our sample, however, lacks data on the entire participant population and might not be representative of the participants of the courses.

Conclusion

Postgraduate courses in geriatric psychiatry seem to have a favorable effect on participants, irrespective of course duration or specialty. Course duration, however, positively affects implementation of assessment scales in general, and cognitive scales in particular. These issues need to be studied prospectively, using a different methodology (e.g., strictly defined criteria regarding background of participants, attitudes, knowledge, and benefits).

Based on our experience with these courses, we would recommend the following:

- Since courses were heterogeneous in specialties, experience and presumably knowledge, some time (at the beginning) should be dedicated to increase and complement various specialized knowledge (e.g., psychiatry for non-psychiatrists, geriatrics for psychiatrists) so that when the clinical subjects of the course are confronted at a more advanced stage the impact will be greater.
- Emphasis should be diverted from "frontal" lectures towards methods of implementation of theoretical knowledge in daily practice.
- Since psychogeriatrics seems to be a multidisciplinary field, the course should strive, in addition to professionalism, to focus on and integrate those inter-disciplinary aspects required for daily practice and management of patients.

Acknowledgment. We are grateful to Dr. N. Notzer, Director of the Medical Education Unit, Sackler Faculty of Medicine, Tel Aviv University for her assistance in preparing the questionnaire; and to Sonia Kasher, Administrative Coordinator, School of Continuing Medical Education, Sackler Faculty of Medicine, Tel Aviv University for the financial support. We acknowledge the assistance of Rena Kurs in preparation of the manuscript.

References

1. Pitt B. Psychogeriatrics. An Introduction to the Psychiatry of Old Age. Edinburgh: Churchill Livingstone, 1982.
2. Arie T. Management of dementia: a review. *Br Med Bull* 1986;42:91-6.
3. Arie T, Lilley J. Education in geriatric psychiatry. *Isr J Psychiatry Relat Sci* 1997;34:87-93.
4. Wertheimer J. Psychiatry of the elderly: a consensus statement. *Int J Geriatr Psychiatry* 1997;12:432-5.
5. Jeste DV, Alexopoulos GS, Bartles SJ, et al. Consensus statement on the upcoming crisis in geriatric mental health: research agenda for the next 2 decades. *Arch Gen Psychiatry* 1999;56:848-53.
6. Finkel SI. Geriatric psychiatry training for the general psychiatric resident. *Am J Psychiatry* 1978;135:101-3.
7. Marin RS, Foster JR, Ford CV, et al. A curriculum for education in geriatric psychiatry. *Am J Psychiatry* 1988;145:836-43.
8. Lebowitz BD, Cohen GD. Education and training in geriatric psychiatry. *Adv Psychosom Med* 1989;19:167-78.
9. Herrmann N, Shulman KI, Silver IL. Intensive early exposure to geriatric psychiatry in residency training: impact on career choice and practice. *Can J Psychiatry* 1992;37:549-52.
10. Thorpe L, Leclair K, Donnelly M, MacBeath L. Geriatric psychiatry: training guidelines and their application. Section on geriatric psychiatry of the Canadian Psychiatric Association. *Can J Psychiatry* 1993;38:90-5.
11. Draper B. Psychogeriatric training in Australia and New Zealand: a survey of psychiatry trainees and training program co-ordinators. *Aust N Z J Psychiatry* 1994;28:121-8.
12. Herrmann N. Mandatory training in geriatric psychiatry: can programs deliver the goods? *Can J Psychiatry* 1994;39:523-5.
13. Takeshita J, Ahmed I. The role of geriatric psychiatry in medical education. *Hawaii Med J* 1998;57:429-30.
14. Kennedy GJ, Goldstein MZ, Northcott CJ, et al. Evolution of the geriatric curriculum in general residency training. Recommendations for the coming decade. *Acad Psychiatry* 1999;23:187-97.
15. Reifler BV, Cohen W. Practice of geriatric psychiatry and mental health services for the elderly: results of an international survey. *Int Psychogeriatr* 1998;10:351-7.
16. Tropper MS. History of geriatric psychiatry in Israel. *Isr J Psychiatry Relat Sci* 1997;34:94-7.
17. Greenberg D, Cohen R. A survey of the teaching of undergraduate psychiatry in Israel. *Isr J Psychiatry Relat Sci* 1999;36:282-90.
18. Butler R, Collins E, Katona C, Orrell M. Does a teaching programme improve general practitioners management of depression in the elderly? *J Affect Disord* 1997;46:303-8.
19. Goldstein MZ, MaLossi RA, Kim K, Young B. A course in dementia for third-year medical students. *Acad Psychiatry* 1999;23:142-50.
20. Kalf AJ, Spruijt-Metz D. Variation in diagnoses: influence of specialists' training on selecting and ranking relevant information in geriatric case vignettes. *Soc Sci Med* 1996;42:705-12.
21. Heinik J, Hes JP, Avnon M. Diagnosis of dementia by different specialties. *Isr J Psychiatry Relat Sci* 1995;32:55-64.

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