Experience and opinions on post-graduate dementia training in the UK: a survey of selected consultant geriatricians

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Abstract

Introduction people with dementia are more likely to come into contact with a geriatrician than any other hospital specialty. Whilst it is known that there are some geriatricians with a special interest in dementia, it is unclear how this group of clinicians gained experience, and what their opinions are on current training.

Methods we obtained a list of geriatricians known to have an interest in dementia care (known as dementia champions) from the British Geriatric Society Dementia and Similar Disorders Special Interest Group. We contacted 100 ‘dementia champions’ with an invitation to respond to a questionnaire relating to their role, experience and opinions on current training in dementia within geriatric medicine.

Results fifty-five geriatricians responded. Ninety-one per cent were consultant physicians, and 71% were not involved in outpatient diagnostic services. Fifty-six per cent reported that their experience was via clinical attachments with old age psychiatry, and 47% regarded themselves as ‘self-taught’. The majority felt that current training was inadequate with a need for more structure and time spent on attachments, less geographical variation, more training at undergraduate level and throughout other specialties and better collaboration with psychiatry.
Discussion this is the first survey of the views of geriatricians leading on dementia care in acute hospitals within the UK. It gives a useful insight into how they have gained their own experience, and their opinions on how training may be improved. Equipped with the right training and expertise in diagnosis and management of dementia perhaps geriatricians may feel more confident in taking a lead in dementia care.

Keywords: dementia, training, experience, geriatrics, older people

Introduction

Dementia is common, with ~800,000 people living with the condition in the UK [1], and with our ageing population, the prevalence is expected to almost double by 2050 [2]. People with dementia currently occupy up to a quarter of hospital beds at any one time equivalent to ~24,000 patients. A study in 2009 of emergency medical admissions showed that 42% had dementia, though only half of these had a diagnosis [3]. The same study found that short-term mortality rates were three times higher [3], and there are higher rates of other adverse outcomes in these patients such as delirium, incontinence and rates of new institutionalisation [4]. The newly implemented dementia Commissioning for Quality and Innovation scheme in England and Wales aims to encourage a dementia risk assessment for all patients over 75 years of age admitted to the acute hospital setting with evidence to suggest any memory problem [5]. It is hoped that this will increase diagnostic rates for dementia. Benefits to diagnosing dementia include access to treatment options, appropriate multidisciplinary care and facilitating future care planning [4].

A 2010 census determined that there were 1111 geriatricians employed in the UK [6]. Geriatricians come into contact with those with undiagnosed and diagnosed dementia in both the outpatient and day patient settings [7]. Current training at both undergraduate and post-graduate levels is generally accepted to be inconsistent, with scope for optimisation [8]. Hence, training of the current senior workforce and particularly training for geriatricians of the future in dementia care, management and diagnosis is an increasingly relevant issue.

Whilst it is known that there are some geriatricians with a special interest in dementia in the UK, and some involved in specialist dementia diagnostic services, it is currently not clear how this group of clinicians gained experience. The main aim of this paper is to determine how geriatricians gained their specialist expertise in this field. Our secondary aims are to seek their opinions on current training provision.

Methods

We obtained a list of consultant geriatricians known to be actively involved in dementia care across the UK from the British Geriatric Society Dementia and Similar Disorders Special Interest Group (SIG). The list comprises senior clinicians involved in the national dementia audit and members of the SIG. This group is referred to as ‘dementia champions’. We developed a questionnaire which was reviewed by members of the dementia SIG. We contacted the ‘dementia champions’ electronically with an invitation to reply to six questions (Table 1) relating to their role, experience and opinions on current training in dementia within geriatric medicine.

Results

Response rate

Fifty-five clinicians responded to the survey out of 100 contacted. In terms of their role, 91% were consultant physicians, 72% described their role as dementia ‘lead’ or ‘champion’, six were geriatricians with a special interest in dementia, four were geriatricians who reported no specific interest in dementia. Eighteen per cent were involved in running a specific memory clinic, 11% saw dementia referrals in their own geriatric clinic and 71% were not involved in outpatient diagnostic services.

Experience

Fifty-six per cent respondents stated that the majority of personal dementia training was from clinical attachments during their registrar training. Many of these were clinical attachments with old age psychiatry. Some had used time abroad to gain this experience. Forty-seven per cent described themselves as self-taught via ‘on the job’ learning including their own reading, audit and continuing professional development. Thirty-one per cent stated that they had attended specific conferences and courses. Fifteen per cent had conducted research specifically relating to dementia either in clinical fellow or academic lecturer posts or by completing a master’s degree or PhD. Two stated that they had no particular training in dementia.

Views on specialty training

The majority of respondents felt that training within the specialty of geriatric medicine in dementia was inadequate with

Table 1. Dementia skills survey questions

<table>
<thead>
<tr>
<th>Question</th>
<th>Response</th>
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<tbody>
<tr>
<td>(1) What is your title?</td>
<td></td>
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<tr>
<td>(2) What is your specialist role (this may include dementia lead)?</td>
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<tr>
<td>(3) Do you have an academic role?</td>
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<tr>
<td>(4) Are you involved in a memory or specialist dementia clinic?</td>
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<tr>
<td>(5) What particular specialist training have you had in dementia? Please give details including timescales, location etc.</td>
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<tr>
<td>(6) What are your views on training in dementia in geriatric medicine?</td>
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only five replies stating that the training was ‘good’ or ‘improving’. There were five main themes to the dissatisfaction in current training.

1. Lack of formal and structured training.

   … there should be routine … attachments in old age psychiatry … seeing acute in-patients with delirium and dementia and depression since this is what we as geriatricians … have to deal with on a daily basis

   … scope for improvement, with a more structured module being included rather than the ad-hoc arrangements people have been making to get the relevant training

2. Variability across the geographical region with a need for trainees to seek out their own training opportunities

   … it is informal and they need to motivate themselves to do it

   The current … training … offers … excellent training opportunities … but I am not sure whether trainees are utilising this to full extent and there are geographical variations

   Depends on where you train as to the quality and quantity of training

3. Inadequate training at undergraduate and post-graduate level

   … dementia training is going to be important for all trainees - not just those in geriatric medicine.

   … bad at all grades from med students upwards

   Needs to be recognised both at undergraduate and postgraduate level

4. Inadequate time spent on dementia as a sub-speciality

   … I have looked at the curriculum and all the right stuff is in there, but it seems trainees are not gaining the knowledge and skills that they should do …

   It is a core part of our work. Geriatricians should be able to diagnose and manage dementia … We need to change training to make this happen …

   … additional dementia related training needs to be included in … curriculum for geriatric medicine

5. Lack of collaboration with psychiatry in dementia training

   Not enough collaboration between the geriatric side and psychiatric sides in training geriatricians … devolving of treatment decisions to the liaison psychiatry service and GP rather than … something that … should be part of basic geriatric medicine

   Exchanging training posts with old age psychiatry trainees for minimum of 6 months … should be the norm.

   Needs better integration between trainees in psychiatry and elderly medicine

Along with these responses, there were several specific recommendations to improve training. These included development of specific training courses or modules or a formal qualification, mandatory (longer) attachments as part of the curriculum, clearer objectives stated in the curriculum, more exposure at undergraduate level and during core training. Some provided examples of their own work on improving training:

   … we provide 2 weekly memory clinics for specialist registrars here, including memory MDT (multi-disciplinary team) with psychiatrists/OT/psychologist/pharmacist

   We encourage our specialist registrars to attend our dementia UK training days on advanced skills and communication skills and soon our training will be all in house so our specialist registrars can go to these. Presumably there is a specialist registrar training day dedicated to dementia

   I have old age psychiatry registrars join me to gain some medical expertise- there is a lot of room for cross fertilisation here.

**Discussion**

This is the first survey of the views on dementia training of geriatricians leading on dementia care in acute hospital trusts within the UK. A significant number of the group held an academic role, teaching or research, accounting for 38%. The majority were not involved in an outpatient diagnostic service for dementia. Around half had gained training in dementia through clinical attachments linked to old age psychiatry but many were ‘self-taught’ ‘on the job’ training.

In the main respondents were dissatisfied with the current training of geriatricians in dementia. This was predominantly due to a lack of perceived structure to training or time spent on dementia as a sub-speciality both in undergraduate and post-graduate training as well as widespread variation in trainees’ experiences and a lack of collaboration with psychiatry. Many provided suggestions as to how training could improve, these generally focussed on providing more structure to training and more time exposed to the specialty at all levels.

The 2010 update to the geriatric curriculum saw an increase in the number of core outcomes to be achieved in dementia and delirium from 21 to 48 suggesting recognition in the need for training to be improved. It also provides an appropriate structure for optional higher level learning [9].

The primary limitation to our study is that only a select group of geriatricians were surveyed, those with high levels of interest in dementia. However, this group is well placed to
provide useful information in this area. Second, our response rate was 55%, a letter or interview-based study may have yielded a higher response rate. Future surveys of trainee geriatricians could offer additional insights.

Detecting dementia not only leads to improvement of hospital-based care but may lead to longer term benefits. Collaboration with primary care and old age psychiatry as well as co-operation with social services, carers and community teams should result in earlier diagnosis and treatment and clearer patient pathways. By developing a geriatric medicine workforce trained in the management of cognitive disorders, we could envisage delivering clinical leadership in this field translatable as improved outcomes for people with dementia and their carers.

Key points

- Dementia is common and people with dementia are more likely to come into contact with a geriatrician than any other specialty.
- Geriatricians with a special interest in dementia have a wide range of differing experiences contributing to their expertise.
- Geriatricians feel that current training in dementia is inadequate.
- Suggestions to improve training include dedicated time and structure to training and better collaboration with psychiatry.

References

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