Introduction:

Older Adults in Medical Education–Senior Mentor Programs in U. S. Medical Schools

Thomas Stewart, PhD
Cindy Alford, PhD

Senior Mentor Programs (SMPs) are a recent phenomenon in the history of experimentation by geriatrics programs to have impact on medical students and medical school curricula. Beginning in the 1960s, efforts to explore medical student attitudes toward older adults appeared as ageism and emerged as a major theme for both physicians and society in general (Ford, Liske, & Ort, 1962; Ort, Ford, Liske, & Pattishall, 1965; Spence, Feigenbaum, Fitzgerald, & Roth, 1968). Specific curriculum interventions in geriatrics emerged fully in the literature during the 1970s and 1980s with a continuing interest in student attitudes (two reviews provide useful histories of this early period in geriatrics education; Adelman & Albert, 1987; and Coccaro & Miles, 1983). Although the focus on student attitudes continued to be central into the 1990s and turn of the new century, there was also increasing attention given to knowledge and skill elements in this “generation” of geriatrics educational interventions (Burns et al., 2003; Duque, Bonycastle, Nazerali, Bailey, & Ferrier, 2003; Eleazer et al., 2004; Fields, Jutagir, Adelman, Tideiksaar, & Olson, 1992; Intrieri, Kelly, Brown, & Castilla, 1993). The
full range of recent undergraduate medical curricula interventions has broadened substantially as seen in Academic Medicine’s special supplement describing curriculum developments in the 40 medical schools which received American Association of Medical Colleges/John A. Hartford Foundation grants in geriatrics (Anderson, 2004).

The evolution of geriatrics education in this period is necessarily framed by the context of medical education in the United States during the same period, a period noted for substantial change and innovation. In some important respects, SMPs are a natural fit for some of the innovations which occurred in medical education nationally, and, in other respects, SMPs are contributing their own form of innovation.

An example of the former is the relationship between SMPs and the so-called doctoring courses usually offered in the first two years (preclinical) in contemporary medical school curricula. One of the most persistent criticisms of the traditional medical curriculum (pre-1990s) was that the classical division of medical curricula into two discrete stages, the preclinical or basic sciences years followed by the two years of clinical training (the clerkships), was problematic for students. The old model’s total immersion in basic sciences during the first stage left students unprepared for clinical experiences and disengaged from issues which were important for them in the clinical years.

The dialogue for reform in this area focused upon “vertical integration,” that is, clinical work to be conducted in the basic science years and more basic sciences content covered in the clinical years. The most visible response to the call for clinical integration into the basic sciences years was the emergence of the “doctoring” courses (termed variously Introduction to Clinical Medicine, Clinical Integration Course, etc.). Typically these courses included practical experience such as learning communication skills, professionalism sessions (including ethics), clinical reasoning and decision making, and a broad array of other content areas. Some form of exposure to individual patients or patient populations in roles appropriate to the students’ level of capabilities (e.g., students as interviewers or learners, health care coaches, conducting patient screening) was characteristic of the clinical courses. The “doctoring” courses not only provided a sense of clinical relevance for medical students, but also served as an environment for learning practical skills and a context for the integration of the biomedical content students were receiving in their first two years (Littlewood, Ypinazar, Margolis, Scherpber, Spencer & Dornan, 2005). Virtually all of the SMPs discussed in this Special Issue are either a part of their medical school’s “doctoring” course or linked to it.
An area in which the SMPs seem to be innovating in ways which may affect medical education relates to the use of older adults as teachers. As mentioned earlier, many of the “doctoring” courses place students in a variety of roles, not necessarily the traditional role of provider or quasi-provider of services. It is in this creative use of roles that SMPs may make their most influential contribution beyond meeting the needs for geriatrics education. Two of the first publications on senior mentor programs referred specifically to older adults in the programs as “senior professors” or “patient teachers” with the implication that students were clearly the learners (Alford, Lawler, Talamantes, & Espino, 2002; Tomkowiak & Gunderson, 2004). All the programs presented here use older adults either directly as teachers (for instance, presenting a life review to students) or as “sensitizers” to particular issues in medical care of older adults (e.g., polypharmacy among older adults, fall risk assessment and analysis of home safety conditions). Although some programs have students conduct physical examinations of their mentors, the relationship is not modeled on a provider-patient relationship—it is more of a learning relationship with the mentors having a clear teaching function. O’Neill and Holland (2005) see this as one of the prominent features of SMPs and suggest that the programs are part of a wider “expert patient” movement in medical education, that is, using patients to teach medical learners about areas in which patients have expertise—in this case expertise in aging.

In an important respect the SMPs stand in contrast to earlier attempts to incorporate geriatrics into the medical school experience, that is, the extent to which these are strategically linked or related to the formal curriculum. The programs described here are cast within the context of the medical schools’ curricula; they have been negotiated into curricula or stand as a complement or augmentation to them. Several program descriptions refer to previous or current curricular reform either as historical context or as a precursor to the development of their senior mentor program. A number express the aim that the program will become more integrated into their medical school’s curriculum. A serendipitous outcome seems to be greater sophistication for geriatrics faculty who have engaged in negotiating and dealing with curricula: Heflin probably speaks for more than his colleagues at Duke when he indicates that the SMP experience prompted considerable growth in the ability of geriatrics faculty to deal more formally with medical education and the curriculum apparatus.
It is also notable that while these programs demonstrate a commitment to the importance of student attitudes toward older adults, there is also considerable focus upon knowledge and skills. These programs expect to affect student attitudes, but that is not necessarily the sole or paramount focus. Indeed, most of the program descriptions refer in some manner to the American Geriatrics Society core competencies as the guide or standard for their curriculum endeavors, and the standards focus on attitudes, knowledge and skills (American Geriatrics Society, 1998). Indeed, most of the modules described as joint academic activities for mentors and students fall within the knowledge and skill categories. There seems to be a degree of confidence that student (and mentor) attitudes are positively influenced by the senior mentor experience—the focus group and student satisfaction findings in the programs point in this direction.

THE PROGRAMS: CHARACTERISTICS AND ISSUES

A feature clearly shared by all programs is the target pool of older adults. Programs recruit older adults who are basically well, living in the community and exhibit no cognitive issues. Mentors may experience serious medical problems over time, but at the beginning of the relationship with students they are generally in good health. Students engage with older adults who are “aging well” physically and mentally. Recruitment efforts rely on referrals from medical practices of primary care or geriatrics physicians, or occur through local retirement communities and aging organizations. This process allows the programs to rely on physicians and other health professionals to screen and refer healthy older adults without cognitive problems.

An emerging issue for at least half of the programs is the perceived need to develop a more diverse pool of mentors—diversity in terms of racial, ethnic and socioeconomic status of the mentors. For instance, the University of California-Irvine finds that its first cohorts of mentors are not as diverse as its student population. Staff are hoping to use links with a senior community center to recruit more Latino mentors and other programs seem ready to make similar strategic moves. The original recruitment networks described are ones which might be expected to skew the referral process more toward older adults who are from white/Anglo and higher income socioeconomic groups (those associated with established medical practices or living in retirement communities).
A second characteristic crossing programs is the extent to which the relationship between students and mentors is viewed as a defining aspect of the program. Several descriptions comment on the relationship between student and mentor being a vehicle for learning (University of Nebraska and University of South Carolina). The reported mentor and student satisfaction results and focus group findings for a number of the programs mention the importance of the relationship to both groups. The programs provide students and mentors an opportunity for a relationship across generations that each probably would not otherwise enjoy. For some older adults the student relationship has the potential to add to their social lives, a particular attraction for those with a reduced network of family and friends. For students, the relationship allows them a chance to engage outside the notoriously insular social world of medical school. Several programs indicate that mentors and students experience social events beyond the academic activities, that is, dine or attend cultural events together or meet family members. But, beyond enhanced interpersonal satisfactions, it is expected that the relationship will create moments of insight and learning for the students (and mentors) and also attach greater affective meaning to the lessons learned.

Both mentors and students are placed in new roles for them and program staff pay particular attention to role clarity. Several instances of role confusion and transitions are reported by programs. In some cases the role confusion is simple and requires basic clarification. In other cases mentors and students have to respond to role changes as the relationship and the nature of the academic activities evolve. For instance, some South Carolina students face a personally challenging transition from being essentially a friend and listener in the first two years to the conduct of a sexual history and physical examination of the mentors. Ohio State University expects that with each year of the longitudinal relationship the interactions will become more “sophisticated.” The roles expected of students in senior mentor programs are not typical and as such have potential for strong affective learning.

The programs offer students the opportunity to gain a unique perspective on the nature of the doctor-patient relationship and to visualize themselves in doctor-patient interactions. At a minimum, students hear mentors discuss their relationships with doctors and in several programs students observe their mentors during a visit to a physician. This is a rare opportunity for students to reflect on their emerging “professional selves” and on doctor-patient relationships in general. Several programs also use these circumstances to prompt students to consider their mentors’
perspectives of and experiences with the health care system and their expectations of doctors and other providers of care.

Given the potential richness of the relationship for both mentors and students the prevalence of “graduation” or closing ceremonies seems appropriate, particularly for the programs which extend over several years. For students this allows them to express gratitude for the unique contribution of mentors to their education and to experience saying goodbye in a professional relationship (something they will not always be able to do if they are in clinical settings which do not promote continuity of care).

Senior mentor programs and the use of mentors as “teachers” contrasts to the utilization of standardized or simulated patients, a trend which has grown substantially in medical education over the past several decades. The actors playing the patient role are trained to follow a specific protocol of responses for symptoms and other information and it is the standardization which allows faculty to test all the students in a given class or clerkship rotation. The experience which a student has with a senior mentor is not scripted and is an open interaction guided by the educational objectives for planned sessions and the idiosyncratic features of mentors and students. While the general experience reported by mentors and students is one of richness and positive experiences, the mentor-student interaction has the potential for unanticipated or negative experiences on the part of both mentor and student. It then becomes the program’s responsibility to turn that into an effective learning opportunity.

While there are similarities and shared features among the programs, the degree of variety is striking. A single or singular model does not predominate. While some have put longitudinal and/or required programs into place, other programs are thriving as elective efforts to complement or expand on the core curriculum of their medical schools. But, even among the programs which share similarities, they differ on important aspects: for instance, some programs pay considerable attention to “matching” mentors and students on similar interests while others assign mentors and students randomly. The programs described have taken a number of paths or evolved different models, but, the programs still view themselves as more or less successful in their environments. It may well be that the adaptability of the concept to local circumstances, conditions and environments will be a factor in future growth of SMPs in other medical schools.
REFERENCES


