Training for Primary Care of Mentally Handicapped Patients in US Family Practice Residencies

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Background: **As a result of managed care mandates for primary care and the growing community presence of the 6 million mentally handicapped persons in the United States, primary care of this population will increasingly be provided by family physicians. How much family practice residencies emphasize training for care of this population is the focus of this study.**

Methods: **A questionnaire was mailed to each family practice residency program in the United States asking about didactic teaching, clinical activities, and faculty and curriculum planning related to care of the mentally handicapped population.**

Results: **Seventy-one percent of questionnaires were returned. Only 32 percent of respondents teach related didactic sessions, 24 percent plan clinic patient care for this population, and 42 percent affiliate with a residential care facility. The most frequently listed didactic topics were delayed infant assessment and seizure care. Comprehensive management of the mentally handicapped adult, family issues, behavioral problems, and long-term planning had low ratings compared with the first two topics. Psychiatrists were rated higher than family practice faculty for training in this area.**

Conclusions: **There is little enthusiasm among residency directors about the need for training in care of mentally handicapped patients. Topics that are most valued, however, were those that are generally within the purview of specialists. A low value was placed upon training for helping families access services, behavior management, or comprehensive long-term planning—areas most often addressed by family physicians. Further studies are needed to assess the training needs of family physicians in caring for mentally handicapped persons. (J Am Board Fam Pract 1997;10:333-6)**

The responsibility for primary medical care of the 6 million mentally handicapped persons in the United States is poorly defined.[1] Traditionally this role has been shared by neurologists, pediatricians, and various primary care and specialty care physicians. There are reasons to believe that family physicians need to be more active in care of the mentally handicapped population. In recent years care for mentally handicapped persons has shifted from large state hospitals to smaller facilities in the communities[2] (eg, group homes); managed care might well include Medicaid and Medicare recipients, with a mandate for primary care; and longer life expectancy for this population means that mentally handicapped persons will age through more life stages, requiring a physician familiar with the problems that occur from childhood through older ages. Special care patients and their families need continuity of care from physicians with whom they are familiar, as there are indications of lower medical complication rates among mentally handicapped patients who have a continuous relationship with a generalist health care provider.[2]

Because basic clinical skills are largely acquired during residency, family practice residencies will play a key role in providing the training necessary to meet this need. How well the US family practice residencies are preparing trainees to take care of persons who are mentally handicapped is not known. Whether there is a planned effort to include relevant training to meet this need is a question that should be addressed. To this end, this study was designed to determine the extent and methods of teaching primary care of mentally handicapped patients to residents training in family practice.

Methods

A questionnaire was sent to the residency directors of the 403 family practice residencies listed in the *Directory of Family Practice Residency Pro-*

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grams.[3] The questions elicited information on the type of program, the planned didactic sessions, the time allocation and relevant topics taught, and the perceived importance of the training. Also, the respondents were asked to rank the order of importance of various teaching professional resources. Most responses were recorded on a Likert scale that ranged from 1 to 5.

The questionnaires were kept anonymous by name but were coded by number so that nonresponders could be spotted. A second mailing was sent after 6 weeks to nonresponders.

Results

Seventy-one percent of the questionnaires were returned. Of the respondents, the distribution by type of program (university, community-based, military, etc) reflected the distribution of all programs.

We found that only 32 percent of the responding programs included planned didactic sessions specific to the care of mentally handicapped persons. Of all respondents, 8 percent offered the related topics as grand rounds, 7 percent as group discussions, and 22 percent as a resident seminar series; 5 percent used other meeting types. Twenty-four percent of respondents included administratively scheduled clinical activities specific to teaching care of the mentally handicapped patient, whereas 76 percent included no such clinical activities. Clinical activities included preselected clinic patients (14 percent), sessions at other specialty care facilities (14 percent), sessions at specialty clinics (4 percent), and elective rotations with relevant specialists (4 percent).

Forty-two percent of programs had a formal affiliation with a group home or other facility providing care for mentally handicapped persons. Of those who did have affiliations, the average number of patients was 48. (One program reported caring for 500 mentally handicapped patients.)

The following topics (and the percentage of responding programs including each topic) were offered to residents within the past 2 years as lectures, grand rounds, or other didactic sessions: assessment of the delayed infant (69 percent), seizure workup and management (73 percent), genetic counseling for families of mentally handicapped persons (23 percent), overview of care of mentally handicapped persons (20 percent), family issues around the mentally handicapped patient (18 percent), syndrome recognition of the mentally handicapped patient (18 percent), ethical issues associated with mental retardation (18 percent), functional assessment of the mentally handicapped patient (15 percent), behavior management of the mentally handicapped patient (15 percent), long-term care planning for the mentally handicapped patient (9 percent), and research topics in the care of mentally handicapped patients (2 percent).

Responses to questions regarding the importance of training showed that 33 percent of respondents believed the training to be less than important, 47 percent believed it was important, and 20 percent believed it was very important. In rating topic areas, a Likert scale was used in which 1 = not very important, 2 = somewhat important, 3 = important, 4 = very important, and 5 = mandatory. The following are the mean weighted scores: assessment of the delayed infant (3.97), seizure workup and management (3.95), community services available to the mentally handicapped patient (3.51), an overview of care of mentally handicapped patients (3.23), family issues around the mentally handicapped patient (3.23), genetic counseling for families of mentally handicapped patients (3.04), functional assessment of the mentally handicapped patient (3.03), ethical issues associated with mental retardation (3.00), behavior management of the mentally handicapped patient (2.96), syndrome recognition of the mentally handicapped patient (2.75), and research topics in the care of mentally handicapped patients (1.85).

When asked what year a block rotation in the care of mentally handicapped patients should occur, 57 percent said third year, 37 percent said second year, and 3 percent said first year. The following values were placed on various clinical sites for training in care of mentally handicapped patients (on the same Likert scale as above): family practice center (3.65); visits to group homes, nursing homes, or other residential facilities (3.04); visits to day care centers for mentally handicapped persons (2.70); specialty clinic, pediatric (2.63); specialty clinic, neurology (2.31); visits to community government offices providing services to mentally handicapped persons (2.16); specialty clinics, psychiatry (2.05); and other (3.78). Potential faculty and mentors were ranked in the following order of most to least importance

for teaching overall care of mentally handicapped patients: psychiatrists, physical therapists, neurologists, nurses with substantial experience in this field, pediatricians with a special interest in the field, and family physician faculty with special interest or training in the field.

Discussion

The results of this study show a low to moderate level of enthusiasm among many family practice residency directors regarding training in the care of mentally handicapped persons. More than two thirds of the programs do not include planned topics in this area. The topics being taught paralleled those topics that were most valued, indicating that the value level drives the choices of topics in the programs. On the other hand, the value assignment might well derive from familiarity. Most residency directors probably were not trained in the lower-rated areas, and these areas remain low-value areas. Similar results have been found in earlier studies of teaching geriatrics in family practice residencies.[4,5] Geriatrics surveys show, however, that teaching the various components has increased with time, perhaps because the specialty has grown aware of how important geriatrics training is as a result of the very publication of the studies.

Some of the survey findings deserve comment. The results regarding the relative values of the topics revealed that assessment of the delayed infant and seizure workup and management were valued much more highly than overview of care of the mentally handicapped patient, family issues in dealing with the mentally handicapped patient, or functional assessment. Behavior management of mentally handicapped patients and ethical issues had low values as teaching topic areas. Yet these issues are encountered more often by primary care providers than are the more highly valued areas. Assessment of the delayed infant is generally carried out by a pediatric neurologist upon referral, and a diagnosis is usually established during that encounter. Likewise, seizures are often assessed at well-spaced intervals by a neurologist, who makes a diagnosis and management plan. On the other hand, behavioral management, family concerns, and ethical issues can be encountered almost daily in the lives of mentally handicapped persons and in the practices of family physicians. Even the topic of community services available for the mentally handicapped patient rated somewhat lower than assessment of the delayed infant. Families, however, rely greatly upon primary care physicians for information about those community services, which could be a key factor in the family's well-being.

Family practice centers were rated highest for training in the primary care of mentally handicapped patients. This finding contrasts with psychiatrists, physical therapists, and neurologists being rated highest and family practice faculty rated lowest as teachers, even if they had a special interest or training in the field. It is possible that the inconsistent outcomes from those two questions point to a need for faculty development of all family practice faculty in this area.

A review of the existing literature on the topic of physician preparation for care of persons who are mentally handicapped is in accord with the findings of this study. A review in 1985[6] showed "serious gaps and omissions" in physician training in related course work and clinical practice. The same authors point out that behavior problems, seizures, and skin problems are common in this population. Rubin and Crocker[2] found that residency training programs do not provide adequate preparation, accurate knowledge, or sufficient familiarization regarding persons with developmental disabilities.

In the teaching of internal medicine and family practice, Rubin and Crocker note that "experience with handicapped and multiply handicapped patients is sparse and nonsystematic." These same authors further describe the problems encountered in acute care of a mentally handicapped patient, especially in the emergency department or hospital where the familiar provider is missing. According to Rubin and Crocker the primary care physician can smooth the process of acute care management to a large degree by being present in that setting.

Further studies are needed in the appropriate training of family physicians who care for persons who are mentally handicapped. As has been found in the field of geriatrics,[7] surveys of practicing community physicians might show that there is a discrepancy between the actual need and the perception of the need in family practice training programs to prepare physicians to do good primary care for this challenging patient population.

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