GERIATRIC MEDICINE SENIOR RESIDENCY

TRAINING REQUIRMENTS

(A) INTRODUCTION

The medical specialty of geriatrics focuses on health care of elderly people, specifically to promote health by preventing and treating diseases and disabilities in older adults.

A geriatric medicine specialist must have proficiencies in managing elderly patients across the continuum of care.

The Geriatric Medicine Residency training program is 3 years.

(B) PROGRAMME OVERVIEW

The total duration of training required is as follows:

1. 2 years ACGME-I (R4 – R5) and
2. 1 year JCST accredited (R6)

(C) TRAINING REQUIREMENTS R4 – R5

Clinical Experiences

1. 12 months of education must be devoted to clinical experience.
2. Each fellow must have clinical experience in the management of elderly patients, including:
   a) direct care for patients in ambulatory, community, and long- term care settings, and consultative and/or direct care in acute inpatient care settings;
   b) care for persons who are generally healthy and require primarily preventive health care measures; and,
   c) care for elderly patients as a consultant providing expert assessments and recommendations for such patients' unique care needs.
3. Fellows must have exposure to sub-acute care and rehabilitation in the long-term care setting.
4. Each fellow's longitudinal experience must include participating in in-home visits and hospice care, including organizational and administrative aspects of home health care and experience with continuity of care for home or hospice care patients.
5. Each fellow's longitudinal experience should include:
   a) diagnosis and treatment of the acutely- and chronically-ill and frail elderly in a less technologically sophisticated environment than the acute-care hospital;
   b) structured didactic and clinical experiences in geriatric psychiatry;
   c) working within the limits of a decreased staff-patient ratio compared with acute-care hospitals;
   d) increased awareness of and familiarity with sub-acute care, physical medicine and rehabilitation;

e) addressing clinical and ethical dilemmas related to the illness of the very old;
f) interacting and communicating with a patient's family and/or caregiver; and,
g) using palliative care and hospice in caring for the terminally ill.

6. Each fellow must have experience participating as a member of a physician-directed interdisciplinary geriatric team in more than one setting.
   a) This team must include a geriatrician, a nurse, and a social worker or case manager.
   b) This team should include representatives from disciplines such as dentistry, neurology, occupational therapy, pastoral care, pharmacy, physical medicine and rehabilitation, physical therapy, psychiatry, psychology, and speech therapy.
   c) Regular geriatric team conferences must be held as dictated by the needs of individual patients.
7. Additional Fellow Experiences
   a) As fellows progress through their education, they should have the opportunity to teach other health professionals and trainees, including allied health personnel, medical students, nurses, and residents.
   b) Each fellow should receive autopsy reports completed on their patients.
   c) Fellows should have Involvement in other health care and community agencies related to geriatric medicine.
8. Each fellow should, on average, be responsible for no more than eight-to-12 patients during each half-day ambulatory session.
9. Fellows are strongly suggested to have a structured continuity ambulatory clinic experience that exposes them to the breadth and depth of geriatric medicine. If provided:
   a) this experience should average one half-day each week throughout the 24 months of accredited education;
   b) this experience must include an appropriate distribution of patients of each gender and a broad older age range;
   c) each fellow should be responsible for four-to-eight patients each week;
   d) fellows must provide care in a geriatric clinic to elderly patients who may require the services of multiple medical disciplines, including audiology, dentistry, gynecology, neurology, ophthalmology, orthopaedics, otolaryngology, physical medicine and rehabilitation, psychiatry, podiatry, or urology; and,
   e) the continuing patient care experience should not be interrupted by more than one month, excluding a fellow's vacation.

10. Fellows should participate in the administrative aspects of long-term care, including:
    a) introductory instruction to the role of the nursing home medical director;
    b) nursing home regulations;
    c) completing a quality improvement project; or, d) attending team meetings.
11. Fellows should have experiences in relevant specialty and subspecialty clinics, such as psychiatry and neurology, and those that focus on the assessment and management of geriatric syndromes, including falls, incontinence, and osteoporosis.
12. Fellows should have clinical experience in day-care or day-hospital centers, life care communities, or residential care facilities.
13. There should be at least 40 calls over the 3 year GRM residency period. Service calls are not counted.

ACGME-1 Competencies	R4 – R5
1. Patient Care	Fellows must be able to provide patient care that is compassionate, appropriate, and effective for the treatment of health problems and the promotion of health. Fellows must demonstrate clinical competence in: 1. assessing older persons for safety risks, and providing appropriate recommendations, and when necessary, referrals; 2. assessing the cognitive status and affective states of geriatric patients; 3. assessing the functional status of geriatric patients; 4. peri-operative assessment and management; 5. providing appropriate preventive care, and teaching patients and their caregivers regarding self-care; 6. providing care that is based on a patient's preferences and overall health; 7. treating and managing geriatric patients in acute-care, long-term care, community, and home-care settings; and, 8. use of an interpreter in clinical care.
2. Medical Knowledge	Fellows must demonstrate knowledge of established and evolving biomedical, clinical, epidemiological, and social-behavioral sciences, as well as the application of this knowledge to patient care. Fellows must demonstrate knowledge in: 1. the current science of aging and longevity, including theories of aging, the physiology and natural history of aging, pathologic changes with aging, epidemiology of aging populations, and diseases of the aged; 2. aspects of preventive medicine, including nutrition, oral health, exercise, screening, immunization, and chemoprophylaxis against disease; 3. geriatric assessment, including medical, affective, cognitive, functional status, social support, economic, and environmental aspects related to health; 4. activities of daily living (ADL); 5. instrumental activities of daily living (IADL); 6. medication review; 7. appropriate use of the history, physical and mental examination, and laboratory results or findings; 8. the general principles of geriatric rehabilitation, including those applicable to patients with cardiac, neurologic, orthopaedic, pulmonary, and rheumatologic impairments; a) These principles should include those related to the use of physical medicine modalities, exercise, functional activities, assistive devices, environmental modification, patient and family education, and psychosocial and recreational counseling. 9. management of patients in long-term care settings, including palliative care, administration, regulation, and the financing of long- term institutions, as well as the continuum from short- to long-term care; 10. the pivotal role of the family in caring for many elderly, and the community resources (formal support systems) required to support both patients and families; 11. home care, including the components of a home visit and accessing appropriate community resources to provide care in the home setting; 12. hospice care, including pain management, symptom relief, comfort care, and end-of-life issues; 13. behavioral sciences, including psychology and social work; 14. topics of special interest to geriatric medicine, including cognitive

	impairment, depression and related disorders, falls, incontinence, osteoporosis, fractures, functional impairment, malnutrition, pain, pressure ulcers, senior (elder) abuse, sensory impairment, and sleep disorders; 15. diseases that are especially prominent in the elderly or that may have atypical characteristics in the elderly, including cardiovascular, infectious, metabolic, musculoskeletal, neoplastic, and neurologic and disorders; 16. pharmacologic problems associated with aging, including changes in pharmacokinetics and pharmacodynamics, drug interactions, over-medication, appropriate prescribing, and adherence; 17. psychosocial aspects of aging, including interpersonal and family relationships, living situations, adjustment disorders, depression, bereavement, and anxiety; 18. patient and family education, and psychosocial and recreational counseling for patients requiring rehabilitation care; 19. the economic aspects of supporting geriatric services, including capitation, and cost containment; 20. the ethical and legal issues pertinent to geriatric medicine, including limitation of treatment, competency, guardianship, right to refuse treatment, advance directives, designation of a surrogate decision maker for health care, wills, and durable power of attorney for medical affairs; 21. basic principles of research, including research methodologies related to geriatric medicine, such as clinical epidemiology and decision analysis, and how research is conducted, evaluated, explained to patients, and applied to patient care; 22. iatrogenic disorders and their prevention; 23. cultural aspects of aging, including knowledge about demographics, health care status of older persons of diverse ethnicities, access to health care, cross-cultural assessment of culture-specific beliefs and attitudes towards health care, issues of ethnicity in long-term care, and special issues relating to urban and rural older persons of various ethnic backgrounds; and, 24. behavioral aspects of illness; 25. socioeconomic factors; and, 26. health literacy issues.
3. Practice-based Learning and Improvement	Fellows must demonstrate the ability to investigate and evaluate their care of patients, to appraise and assimilate scientific evidence, and to continuously improve patient care based on constant self-evaluation and life-long learning.
4. Interpersonal and Communication Skills	Fellows must demonstrate interpersonal and communication skills that result in the effective exchange of information and collaboration with patients, their families, and health professionals.
5. Professionalism	Fellows must demonstrate a commitment to carrying out professional responsibilities and an adherence to ethical principles.
6. Systems-based Practice	Fellows must demonstrate an awareness of and responsiveness to the larger context and system of health care, as well as the ability to call effectively on other resources in the system to provide optimal health care.
7. Teaching	Fellows must demonstrate involvement in teaching juniors and medical students and attend at least 1 faculty development course.

(D) TRAINING REQUIREMENTS R6

Across the three clusters, the R6 GRM Senior Residency will comprise the following:

1. Geriatric Medicine Subspecialty rotations. This rotation will help the senior resident further develop their clinical and academic subspecialty interest.

2. Clinical Research development. This can occur concurrently as part of the subspecialty rotation or as a separate elective period during R6. Clinician scientist program for selected residents may also be incorporated within the year.

3. Electives eg Geriatric Psychiatry elective, Community Geriatrics elective etc. This is aimed at deepening clinical exposure in various aspects of Geriatric Medicine.

4. General Geriatric Medicine rotation. This is to consolidate the senior residents' skills and knowledge in preparation for the final Geriatric Medicine Exit Examination at the end of the R6.

5. Institutional/cluster requirements eg. Internal Medicine Rotation.

The R6 training is resident-centred and allows a degree of customization based on the individual stage of competency, career aspirations and institutional requirements. The senior resident will continue run his/her continuity clinics throughout the year.

Evaluation and Assessments:

All senior residents will undergo continuous formative evaluations according to individual program requirements. Final summative (exit) assessment will be as determined by GRM RAC at the end of R6 .

(E) LOG OF OPERATIVE / CLINICAL EXPERIENCE

All residents must to keep a log of their operative / clinical experience in the electronic logging system.

(F) ASSESSMENT AND EXAMINATIONS

I. Supervisors Assessment

The supervisor's evaluation of the resident should be performed at the end of every rotation using the designated form and submitted to the RAC for review.

II. Feedback

Residents should perform a yearly evaluation of teaching faculty and the training programme using the designated forms. These forms must be submitted to the RAC and kept absolutely confidential.

(G) CHANGES IN TRAINEESHIP PERIOD AND LEAVE OF ABSENCE

I. Changes in Training Period

Residency should be continuous. If a training programme is interrupted for any reason whatsoever, the RAC may at its discretion, require the resident to undergo a further period of training in addition to the minimum requirements of the programme or terminate the residency altogether. All residents are required to conform to the residency training plan as approved by the RAC and complete all the exit and training requirements within the maximum candidature.

II. Leave Of Absence

All residents are to comply with the prevailing MOH policy on Leave of Absence.

III. Overseas Postings

Overseas attachment during Senior Residency training is not permitted with the exception of Radiation Oncology and Neurosurgery (*refer to JCST Circular 114/14*).