Training Requirements for the Specialty of Geriatric Medicine

European Standards of Postgraduate Medical Specialist Training

(old chapter 6)

Preamble

The UEMS is a non-governmental organization representing national associations of medical specialists at the European Level. With a current membership of 37 national associations and operating through 43 Specialist Sections and European Boards, the UEMS is committed to promote the free movement of medical specialists across Europe while ensuring the highest level of training which will pave the way to the improvement of quality of care for the benefit of all European citizens. The UEMS areas of expertise notably encompass Continuing Medical Education, Post Graduate Training and Quality Assurance.

It is the UEMS' conviction that the quality of medical care and expertise is directly linked to the quality of training provided to the medical professionals. Therefore the UEMS committed itself to contribute to the improvement of medical training at the European level through the development of European Standards in the different medical disciplines. No matter where doctors are trained, they should have at least the same core competencies.

In 1994, the UEMS adopted its Charter on Post Graduate Training aiming at providing the recommendations at the European level for good medical training. Made up of six chapters, this Charter set the basis for the European approach in the field of Post Graduate Training. With five chapters being common to all specialties, this Charter provided a sixth chapter, known as “Chapter 6”, that each Specialist Section was to complete according to the specific needs of their discipline.

More than a decade after the introduction of this Charter, the UEMS Specialist Sections and European Boards have continued working on developing these European Standards in Medical training that reflects modern medical practice and current scientific findings. In doing so, the UEMS Specialist Sections and European Boards did not aim to supersede the National Authorities' competence in defining the content of postgraduate training in their own State but rather to complement these and ensure that high quality training is provided across Europe.

At the European level, the legal mechanism ensuring the free movement of doctors through the recognition of their qualifications was established back in the 1970s by the European Union. Sectorial Directives were adopted and one Directive addressed specifically the issue of medical Training at the

European level. However, in 2005, the European Commission proposed to the European Parliament and Council to have a unique legal framework for the recognition of the Professional Qualifications to facilitate and improve the mobility of all workers throughout Europe. This Directive 2005/36/EC established the mechanism of automatic mutual recognition of qualifications for medical doctors according to training requirements within all Member States; this is based on the length of training in the Specialty and the title of qualification.

Given the long-standing experience of UEMS Specialist Sections and European Boards on the one hand and the European legal framework enabling Medical Specialists and Trainees to move from one country to another on the other hand, the UEMS is uniquely in position to provide specialty-based recommendations. The UEMS values professional competence as "*the habitual and judicious use of communication, knowledge, technical skills, clinical reasoning, emotions, values, and reflection in daily practice for the benefit of the individual and community being served*"[1]. While professional activity is regulated by national law in EU Member States, it is the UEMS understanding that it has to comply with International treaties and UN declarations on Human Rights as well as the WMA International Code of Medical Ethics.

This document derives from the previous Chapter 6 of the Training Charter and provides definitions of specialist competencies and procedures as well as how to document and assess them. For the sake of transparency and coherence, it has been renamed as "Training Requirements for the Specialty of X". This document aims to provide the basic Training Requirements for each specialty and should be regularly updated by UEMS Specialist Sections and European Boards to reflect scientific and medical progress. The three-part structure of this documents reflects the UEMS approach to have a coherent pragmatic document not only for medical specialists but also for decision-makers at the National and European level interested in knowing more about medical specialist training.

Introduction

The global population is rapidly ageing, and as a consequence there is an increasing number with age-related (multi-)morbidities. The 2015 World Health Organisation Report on Ageing and Health called for changes to health policies for ageing populations, specifically for health systems to align themselves to the older population that they now serve and for long-term care systems to be developed. In this context, WHO has also launched clear recommendations for health workforce development[2].
There is compelling evidence from large systematic reviews that Comprehensive Geriatric Assessment (CGA) is the most effective way to provide healthcare services for this population. CGA

[1] Defining and Assessing Professional Competence, Dr Ronald M. Epstein and Dr Edward M. Houndert, Journal of American Medical Association, January 9, 2002, Vol 287 No 2

[2] https://www.who.int/ageing/publications/health-workforce-ageing-populations.pdf

has been shown to increase patients' likelihood of being alive and in their own homes after an emergency admission to hospital.

CGA can be defined as a "multidimensional interdisciplinary diagnostic process focused on determining an older person's medical, psychological and functional capability to develop a coordinated and integrated plan for treatment and long-term follow up". Specialists in geriatric medicine are medical specialists with expertise in healthcare of older people, and have a key role in delivery of CGA - central to this is geriatricians' ability to manage multi-morbidity. The essence of managing multi-morbidity is having the awareness that older people require a different type of care to their younger, more physiologically robust counterparts. Clinical and biological signs of disease are different in older people. Diseases are often revealed by non-specific presentations, or via atypical presentations due to abnormal physiological responses to acute illness - a thorough clinical assessment is therefore mandated. CGA is not just a detailed clinical assessment performed by a specialist in geriatric medicine - it moves beyond identification of the patient's needs to the delivery of a multifaceted intervention that seeks to restore wellbeing, participation in activities and independence, and to ameliorate disability and distress.

Historically geriatric medicine has known a different evolution in countries across Europe. In most European countries it is recognised as an independent specialty, some countries have not yet established geriatric medicine, and in the remaining it is a subspecialty of another specialty, mainly internal medicine. In recent years, geriatric medicine has diversified and become increasingly sub-specialised. In hospitals, specialists in geriatric medicine are involved in the acute care for older people, on the emergency ward and acute medical departments as primarily responsible physician, and in cooperation with other specialists in orthogeriatric (orthopedics, surgery), oncogeriatric (oncology), geriatric cardiology and other departments, and as consultant for other specialists, most notably for delirium treatment and rehabilitation related matters. Outpatient services can be hospital based, with focus on geriatric syndromes like memory problems, falls, multimorbidity, polypharmacy, continence care, bone health, neurologic disorders, as well as preoperative surgical assessment and prehabilitation before elective major surgery. In some countries specialists in geriatric medicine work primarily or solely in the community, or as nursing home specialists.

The variance in geriatric medicine training and practice across Europe as described has led to the definition of the European Training Requirements in Geriatric Medicine (ETR-GM). Under the auspices of the UEMS section Geriatric Medicine (UEMS-GMS), the European Geriatric Medicine Society (EuGMS), and the European Academy of Medicine of Ageing (EAMA), a survey across Europe was conducted using three Delphi rounds to establish recommendations for training requirements to become a specialist in geriatric medicine. The final recommendations include four domains: structure and quality indicators, knowledge, additional skills and assessment[3]. The new curriculum requirements are endorsed by UEMS-GMS, EuGMS, EAMA and IAGG-ER (International Association of Gerontology and Geriatrics European Region) as minimum training requirements to become a specialist in geriatric medicine in EU member states. It leaves space for nations to develop national curricula according to local requirements and healthcare systems.

[3] New horizons in geriatric medicine education and training: The need for pan-European education and training standards. JM Fisher, T Masud, EA Holm, et al. Eur Geriatr Med 8 (2017), 467-473

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I. TRAINING REQUIREMENTS FOR TRAINEES

Entry into the training program for geriatric medicine depends on national regulations and should be transparent.

The number of trainees in each national program should reflect the projected workforce needs in geriatric medicine. These depend on the organization of the national health care system and should be sufficient so that patients who need a geriatric specialist care have timely access to it. Trainees must have sufficient linguistic ability to be able to communicate with patients and colleagues. He/she should be able to work in the social and cultural context of the country in which they are based.

Adequate language (according to national regulations), information technology and communication skills are basic requirements for accessing and studying the international medical literature and communicating with foreign colleagues. Moreover, they must be able to communicate and work in an interdisciplinary multi-professional setting.
Basic communication skills with patients and caregivers should have been acquired before entering specialty training and will be subject of continuous professional development.

Basic knowledge of scientific methodology, skills in critical interpretation of study results and experience with current methods such as evidence-based medicine, or lack of evidence in older persons, are required.
The acquisition of organizational skills and knowledge of local medico-legal issues, as well as ethical and palliative issues is encouraged.

Content of Learning

This section lists the primary learning objectives, core knowledge areas, skills, attitudes and behaviours to be attained throughout training in geriatric medicine.

Principal Learning Objectives

The principle learning objectives represent a summary of what the trainee should be able to achieve at completion of specialty training. Each objective requires specific knowledge and skills. Assessment will be based on the demonstration that a trainee has achieved competence in these objectives. The syllabus further on in this curriculum is designed to summarize the necessary level of performance required for each competency.
The following are the principal learning objectives which will provide the trainee with the expertise to practice as a specialist in geriatric medicine:

- Perform a comprehensive geriatric assessment (CGA) of an older person, including but not limited to, mood and cognition, gait, nutrition, functionality and fitness for surgery.
- Diagnose and manage acute illness in older patients with chronic diseases and disability.
- Provide multidisciplinary rehabilitation to an older patient.

- Plan discharge from hospital and the continuity of care of frail older patients. This contains also the coordination of the different services for the care of multimorbid older patients in community settings.
- Assess a patient's eligibility for admission to long term care and assess the care needed for those in long term care (continuing care).
- Assess and manage older patients presenting with common geriatric problems (syndromes).
- Demonstrate competence in the following Special Topic areas:
    - Palliative care
    - Orthogeriatric medicine and rehabilitation
    - Old Age Psychiatry
    - Pharmacology
    - Stroke care, when that is the national requirement
- To be competent in basic research methodology, ethical principles of research, comprehensive scrutiny of medical literature and preferably to have personal experience of involvement in basic science, clinical (health services) research.
- To be competent in basic quality improvement work.

Overview:

Expertise in some areas will develop throughout training, while others may require specific full time or sessional attachments to achieve the appropriate level of knowledge and skills. At the completion of training by a process of consolidation throughout the years of the training program acquiring a variety of experience, the trainee should have acquired the necessary knowledge, skills and attitude to function as a European specialist in geriatric medicine. He/she should:

- be able to establish a diagnosis and differential diagnosis diagnostic formulation for older patients presenting with typical and atypical clinical symptoms by appropriate use of history, clinical examination and investigations.
- have the knowledge, skills, and competence to develop a management plan for each patient, including treatment, rehabilitation, health promotion, disease prevention, education of patient and caregiver, and chronic disease management.
- have the appropriate attitude, communication skills and patient-centred approach to be able to effectively and efficiently manage the multidisciplinary team and also patients, their relatives and caregivers.
- be able to work with health care specialist of all settings to promote the optimal management of older patients, to ensure patient safety and the continuity of care throughout all relevant settings.

Core Knowledge Objectives

The following list is intended to underpin the principle learning objectives above. They should act as a guide for areas specific to geriatric medicine in which trainees should gain experience during the course of their training:

1. Basic Science and Biology of Ageing

Trainees should be able to explain:

- The process of normal ageing in humans
- The effect of ageing on the different organ systems and homeostasis
- The effect of ageing on functional ability
- Changes in pharmacokinetics and pharmacodynamics in older people
- The concept of frailty
- The basic elements of the psychology of ageing
- The social theories of ageing
- Demographic trends in the country of training and global perspectives
- Ageism and strategies to counteract this

2. Comprehensive geriatric assessment

Trainees should understand the principles of CGA and be able to apply it when appropriate in different settings, e.g. acute care, during rehabilitation, preoperative assessment and in the emergency department. They should be able to use different measures, e.g. assessment scales, used to assess functional status and outcome of rehabilitation and their limitations: objective evaluation of ADL and IADL status, level of activity limitation and participation restriction, cognitive status, and mood. Trainees should be able to work in a multidisiciplinary team to achieve this and understand the requirements, roles and expertise of the different members of the team.

3. Multimorbidity and Common Geriatric Problems (Syndromes)

Trainees should be able to describe the types of pathologies and especially multimorbidity encountered particularly in older people and the effect this has on the presentation (e.g. specific or non-specific) and management of illness in old age. They should be able to assess and manage these problems and have the knowledge to use and interpret the results of the CGA.
This is of particular importance in the following areas where non-specific presentation may occur:

- Falls and syncope
- Reduced mobility and physical inactivity
- Incontinence - urinary and faecal
- Cognitive impairment, dementia, delirium and behavioural changes
- Weight loss, malnutrition and dysphagia
- Dehydration
- Fatigue
- Polypharmacy

4. Presentations of Other Illnesses in Older Persons

Older people can present with a wide array of symptoms. Trainees should be able to define the risk factors, causes, pathophysiology, clinical features, laboratory findings, investigations results, treatments, prognosis and preventative measures for common problems and presentations in old age.

The suggested list below is by no means exhaustive in the range of problems, symptoms and pathologies in different domains that trainees should encounter during their training, and be able to demonstrate competence in managing :

- Cardiovascular e.g. chest pain, arrhythmias, hypertension, orthostatic hypotension, valvular heart disease, heart failure
- Cerebrovascular e.g. stroke and transient ischaemic attack (TIA)
- Respiratory e.g. dyspnoea, haemoptysis, infection
- Gastrointestinal e.g. dysphagia, vomiting, altered bowel habit, jaundice
- Endocrine e.g. hypo- and hyper-glycaemia, thyroid and parathyroid dysfunction, hypothermia
- Renal e.g. fluid and electrolyte imbalance, renal failure, infection, lower urinary tract symptoms
- Neurological e.g. seizures, tremor, altered conscious level, movement disorders, speech disturbance
- Sensory loss e.g. impaired vision and hearing, neuropathy
- Cognitive disorders
- Psychiatric e.g. depression, delirium, anxiety, sleep disturbance
- Dermatological e.g. pruritus, rashes, leg ulcers and pressure sores, skin infections
- Musculoskeletal e.g. joint pain and stiffness, degenerative joint disease, osteoporosis
- Non-specific e.g. dizziness, fatigue, anaemia, fever or inflammatory syndrome, suspected abuse
- Weight loss and malnutrition

5. Drug Therapy

Trainees should be able to explain the indications and contraindications, mechanism of action, effectiveness, potential adverse effects, potential drug interactions and alternatives for medications commonly used in older patients. They should also be able to recognize symptoms that could be explained by adverse drug reactions and risk factors for increased risk of adverse drug effects.

A working knowledge of the basic principles of drug-drug interactions, drug-food interactions, effects of disease states on drug pharmacokinetics is important. Trainees should acquire knowledge on polypharmacy, potentially inappropriate medications (PIMs), and under- or overuse of the most common drugs in older patients.

The following list (not intended to be exhaustive) contains drugs frequently prescribed to older patients and that should be revised:

- Gastrointestinal: ulcer healing drugs and laxatives

- Cardiovascular: inotropes, diuretics, antiarrhythmic drugs, antihypertensive drugs, drugs for heart failure and angina, antiplatelet agents, lipid lowering agents, anticoagulants
- Respiratory: bronchodilators,
- CNS: hypnotics and anxiolytics, antipsychotics, antidepressants, antidementia drugs, antiepileptics, antiparkinsonian drugs
- Infections: antibiotics
- Endocrine: insulin and oral hypoglycemics, drugs for thyroid disease, steroids, drugs for osteoporosis
- Urinary Tract: drugs for incontinence
- NSAIDs
- Narcotics
- Nutrition: vitamin and mineral supplements, nutritional supplements, enteral and parenteral nutrition
- Vaccines
- Infusion management

6. Rehabilitation in Older Persons

Trainees should be able to explain the:

- Principles of rehabilitation in older people and importance of comprehensive geriatric assessment (CGA)
- Knowledge of the range of interventions such as physical therapy, occupational therapy, aids, appliances and adaptations, and a knowledge of specialist rehabilitation services available
- Specific requirements for stroke, cardiovascular and orthopedic rehabilitation
- An appreciation of the biopsychosocial models of management of functional limitation due to ageing and disease
- Knowledge of the methods for the prevention and management of complications of acute illness such as pressure sores, venous thromboembolism, contractures, constipation, functional impairment, sarcopenia and aspiration pneumonia

7. Planning Transfers of Care and Continuing Care Outside Hospital

Trainees should be able to explain the:

- Determinants of successful transfer of care outside hospital which meet patient and caregiver perspectives and needs
- Suitability for different levels of care within the community
- Role of the multidisciplinary team with regard to planning
- Liaison with primary care and social services to facilitate successful transfer of care from hospital
- Systems of provision for social care, day care, respite care and caregiver support
- Legislation surrounding long and intermediate term care

8. Ethical and Legal Issues

Trainees should be able to explain:

Relevant and country specific medico-legal issues such as :

- Assessment of competence and capacity and the «best interests priciple » where lacking
- Classical ethical principles of autonomy, beneficence, non-maleficence and justice
- Appointment of Power of Attorney
- Guardianship
- Advance Decisions and advance care planning
- Procedure for sectioning, assessment and treatment under the Mental Health Act of the country of training
- If applicable legislation concerning patients rights, palliative care, assisted dying
- The current legal framework for management of adults with mental incapacity in the country of training
- End of life decision making process, e.g. life-prolonging treatments, resuscitation following cardio-respiratory arrest, Do Not Resuscitate orders
- Informed consent process for treatment, procedures and participation in scientific research

9. Management

Trainees should be able to explain the:

- Structure and the financing of the health care in the country of training
- The framework and dynamics of interagency and partnership between health and social care working in their country
- Roles of national and international institutions that promote Quality Improvement
- Clinical governance and its relevance in geriatric medicine
- Principles of the accreditation process in the country of training
- Administrative duties relevant to a consultant geriatrician; including the work of committees, service development and relevant employee law
- Methods of dealing with complaints

10. Health Promotion

Trainees should be able to explain the:

- Benefits of a healthy lifestyle in older age, including adequate nutrition and hydration, exercise, smoking cessation and moderating alcohol intake
- Specific techniques for disease prevention and for the reduction of geriatric syndromes in older persons

Syllabus

1. Theoretical knowledge

Theoretical knowledge required for a 'European Geriatrician' is based on a consensus article by Roller-Wirnsberger R. et al. European Postgraduate curriculum in geriatric medicine developed using international modified Delphi technique[4].

Knowledge in patient care

1. Biology of ageing
2. Acute and Chronic Disease in Old Age, their clinical presentation including atypical presentation and their effect on organ function and functionality
3. Falls
4. Dizziness and Vertigo
5. Syncope
6. Gait disorders
7. Parkinson's Disease and Syndromes
8. Other Movement disorders
9. Stroke
10. Dysphagia
11. Malnutrition and fluid imbalance
12. Osteoporosis and bone health
13. Sarcopenia
14. Frailty
15. Continence (urinary and faecal)
16. Pain (acute and chronic)
17. Cognitive impairment and dementia
18. Delirium
19. Sleep disorders
20. Depression
21. Other psychiatric disorders in old age
22. Tissue Viability including pressure ulcers
23. Ethical issues and confidentiality including ageism and elder abuse
24. Legal framework for work with older people (country specific)

[4] Age Ageing. 2019 Mar 1 ; 48(2):291-299

25. Social and Health inequalities
26. Health promotion and healthy ageing
27. Pharmacological issues associated with ageing and in geriatric care
28. Iatrogenic and care delivered disorders
29. Sexuality in older adults
30. Comprehensive Geriatric Assessment
31. Content and principles of geriatric rehabilitation and its multi-professional aspects
32. Multidisciplinary and interdisciplinary approach in the management of geriatric patients (eg. orthogeriatrics, oncogeriatrics, perioperative care, cardiology, nephrology, emergency medicine and others)
33. Role of family and other care givers
34. Management of patients in long-term care including residential and nursing care homes
35. Palliative and Hospice Care in older patients
36. Gerotechnology and eHealth – appropriate housing, ambient assisted living, interventions to support an autonomous life

Additional skills and attitudes required for geriatricians

1. Educational and teaching skills
2. Interpersonal and communication skills
3. Development of geriatric services (country specific)
4. Quality and patient safety improvement
5. Interprofessional team management
6. Advocacy of patients' requirements and wishes
7. Leadership competencies
8. Life-long learning and continuous professional development
9. Integration of holistic skills and attitudes for an individualized person-centred care

2. Practical and clinical skills

Trainees should demonstrate competence in these skills prior to being appointed as a specialist in geriatric medicine:

- Physical examination
- Functional status assessment
- Cognitive status assessment
- Communication
- Patient centred care

- Team work
- System based practice

3. Competences

By the time an individual is appointed as a specialist he/she would be expected to have the following competences:

- Knowledge and understanding of the relevant medical sciences, public health sciences, pathophysiology and principles of management and care of patients with any of the core knowledge objectives (see page 6)
- Ability to indicate and interpret diagnostic testing: laboratory test, diagnostic imaging techniques, test performance characteristics.
- An understanding of the modes of action and potential adverse effects of therapies and experience in advising patients about the risks and benefits of such therapies.
- Ability to analyze and utilize research finding in geriatric medicine so that his/her clinical practice is, as far as possible, based upon evidence.
- Be able to provide evidence that he/she is maintaining his/her general medical as well as knowledge in geriatric medicine at a sufficient level to ensure a high standard of clinical practice.
- Understand that patients with certain diseases may need more specialized care, for which other specialists (internist, neurologist, cardiologist, psychiatrist etc) should be consulted to achieve optimal diagnostic and treatment outcomes.
- An understanding of the healthcare system(s) within the country of training.
- Be prepared for his/her role as future clinical leader.
- Be able to be an effective member and a leader of a multidisciplinary team.

The trainee's progress will be followed using the principle of EPA: entrusted professional activities[5]. The trainee will keep a Logbook with the level of each EPA to monitor the progress, and to determine whether the trainee meets the criteria to be a geriatrician. The levels are from novice to expert as stated below.

Levels of competence:

1. Has observed
2. Can do with assistance
3. Can do whole procedure but may need assistance
4. Competent to do without assistance
5. Entrustable Professional Activities

[5] ten Cate O. Entrustability of professional activities and competency-based training. Med Educ 2005; 39: 1176–1177.

6. Can teach others how to do the procedure

This ETR recognizes that the details of some of the competencies will be determined by the country where the training took place, and may differ in details. In this ETR we follow the guidelines of the American Geriatrics Society and Association of directors of geriatric programs.[6]

Geriatricians entering into unsupervised practice, in and across all care settings, are able to:

1. Provide patient centered care that optimizes function and/or well-being
2. Prioritize and manage the care of older patients by integrating the patient's goals and values, comorbidities and prognosis into the practice of evidence-based medicine
3. Assist patients and families in clarifying goals of care and making care decisions
4. Prevent, diagnose and manage geriatric syndromes and other medical problems frequently attaining older patients
5. Provide comprehensive medication review to maximize benefit and minimize number of medications and adverse events
6. Provide palliative and end-of-life care for older adults
7. Coordinate healthcare and healthcare transitions for older adults with multimorbidity and multiple providers
8. Provide geriatric consultation and co-management
9. Skillfully facilitate a family meeting
10. Collaborate and work effectively as a leader or member of an interprofessional health care team
11. Teach the principles of geriatric care and aging-related health care issues to professionals, patients, families, health care providers and others in te community
12. Collaborate and work effectively in quality improvement and other systems-based initiatives to assure patient safety and outcome for older adults

To complete the training, the trainee should for all these 12 EPAs at least have reached competence level 4, and 8 EPAs level 5.

2. Organisation of training

[6] Leipzig RM, Sauvigné K, Granville LJ et al. What is a geriatrician?American geriatrics Society and Association of Directors of Geriatric Academic Programs End-of-Training Entrustable Professional Activities for Geriatric Medicine. J Am Geriatr Soc 2014; 62:924-9

a. Schedule of training

A duration of minimum 5 years, with at a sufficient training in core geriatric medicine to fulfill the competencies is recommended. In the first 2 years of training basic internal medicine skills and competencies should be acquired. In some countries where training for other specialties is 4 years, a minimum period of 4 years can be considered, whilst aspiring to increase this to 5 years in the future. But the minimum levels of EPAs as mentioned earlier has to be achieved, regardless of training duration. The training period in geriatric medicine will be in keeping with EU requirements and is in any case sufficient to ensure that a trainee has met all the required educational and training needs. Specific arrangements for the overall training for any individual trainee would be decided locally and be influenced by relevant national requirements.

At applying for a post in another EU country, the trainee should be able to show the curriculum he actually followed with details about the required nature and extent of clinical experiences, the methods by which a trainee is supported in his/her development and how judgments are made about the progress as regards the development of knowledge and understanding, the progression of his/her clinical work and his/her development as a professional.
It is recommended that geriatric medicine training is spent in units approved as training institutions by their national responsible authority.

b. Curriculum of training

The curriculum is outcome focused but with sufficient flexibility to allow personal development distinguished by the needs of the individual, the centre in which he/she is training and the country where this takes place.
Training should include teaching skills for generic competences and geriatric medicine specific competences.
Thus, the curriculum is based on the following principles.

A European specialist in geriatric medicine will:

- be a pluripotent specialist and a multisystem disease expert
- be competent in history taking, physical examination, management and continuing care of patients with both acute and chronic medical conditions, taking into account the physical and cognitive capacity of the patient
- communicate effectively with patients, their families and with professional collaborators
- know when to collaborate with other specialists to provide the best patient-centered care for older people
- be able to practice evidence-based care
- be able to practice cost-effective care
- understand the nature of and degree of risk taken in his/her clinical practice
- maintain the quality of his/her practice by being aware of personal developments
- undertake multidisciplinary team (MDT) work
- provide clinical leadership

- demonstrate a lifelong commitment to reflective learning
- promote the health and well-being of individual patients, communities, and populations
- have an understanding of specialty-based Public Health
- be able to teach and support trainees
- be committed to the health and well-being of individuals and society through profession-led regulation and high standards of personal behaviour and clinical practice

Geriatricians who wish to seek employment in a country different from the country of training should have a portfolio of evidence which of the above goals he/she has achieved.

c. Assessment and evaluation

Different countries will have different approaches to assess and evaluate these outcomes but the evidence that they have been achieved should be increasingly of a homogeneous nature that facilitates the learning and experiences of trainees, the engagement of clinical supervisors and ease of recognition of progress and achievements across EU member countries. In addition, such an approach will help provide confidence to the public and to individual countries that the training has been of an appropriate standard and that the performance of doctors is likewise of a satisfactory standard. This ETR recognizes that the details of some of the assessment methods will be determined by different countries but the aim is to make them homogeneous.

Logbook /Training Portfolio

Each trainee must keep an authorized Logbook that meets the standards of the UEMS logbook for documentation of professional experience. It will contain reports from the trainer giving an account of the trainee's proficiency in assessing research evidence, and active participation in the work of the unit, his/her publications, scientific and research works, including relevant theses.
The trainee will have to demonstrate that he/she has managed a wide range of cases. Logbook entries must be monitored by regular inspection and signed off by the appropriate trainer; assessment forms for each training period completed and signed by trainers for that period should also be included.
The Logbook should be ready to be presented to a receiving country/employer, upon request, as a proof of the knowledge/skills achieved during postgraduate education.

Moreover, the trainee should be encouraged to keep a Training Portfolio, which should include an up-to-date curriculum vitae (EUROPASS style) incorporating:

- details of previous training posts, dates, duration and trainers
- details of examinations passed
- details of EPAs achieved
- list of publications with copies of published first page or abstract
- list of research presentations at local, national and international meetings
- list of courses attended

Periodic progress assessment

Training institutions should provide a system of appraisal – at entry into every part of the program, at an intermediate point and at the end. A structured goal setting for each training period according to the curriculum at its evaluation is recommended.
The purpose of assessment is to ensure continuing progress in the trainee's knowledge and skills as well as professional conduct and ethics.
Trainees have to meet the agreed standards and requirements of the planned program.
To this end, it is recommended that the trainee documents the following structured assessments:

- mini- Clinical Evaluation Exercise (observed clinical skills)
- Directly observed procedural skills (e.g. lumbar puncture)
- Case-Based Discussions
- Multi Source Feedback (from colleagues, nurses and other professionals) (360° Assessment)
- Patient feedback from in- and outpatients
- Teaching Observation
- Entrusted Professional Activities

The minimal numbers of each of those items should be determined nationally.

Assessment must be performed on an annual basis or at the end of each rotation period by the appropriate trainer, using an evaluation sheet. Clinical experience will be assessed by a review of the patients seen by a trainee and for whom the trainee has had a personal responsibility as regards care. The Logbook is used as supporting documentation. The result of the evaluation must be discussed with each trainee. Failure to meet the agreed targets must be brought to the attention of the training director.
It is the responsibility of the training director to identify any failure in a trainee's progress, to conduct and to provide appropriate advice, and to take remedial action. To this end, it is advised that trainees meet with their training director or his/her substitute on a regular basis, at least every 6 months, to discuss their work . Such discussion will take the format of an appraisal with the trainee providing information about how he/she is progressing, accompanied by documented evidence of clinical engagement and achievement of learning and training outcomes. Moreover, the assessor should take particular care of ascertaining the trainees' professional behaviour through the collection of multisource feedback, from trainers , other professionals , patients and caregivers.
In the event of a trainee not progressing as required, there are three stages of action:

- targeted training: closer monitoring and supervision to address particular needs
- intensified supervision and, if necessary, repetition of the appropriate part of the program
- withdrawal of the trainee from the program. This last measure should be reserved to persons that are not willing or not able to comply with the first two stages.

End of training assessment

At the end of geriatric medicine training the Training Director certifies the attainment of adequate competency level for each training outcome.
The achievement of learning/training outcomes must be assessed at least on an annual basis by the Director of Training together with the faculty. Adequate permanent records of the evaluation must be maintained. Such records must be available in the trainee file and must be accessible to the trainee and other authorized personnel. The assessment must be objective and document progressive trainee performance improvement appropriate to their educational level. In particular, the final year assessment must verify that the trainee has demonstrated sufficient competence to enter the specialty workforce without direct supervision.

d. Support of trainees

A trainer on location will supervise a trainee's clinical work. The trainer will be responsible for providing the trainee with regular feedback as regards his/her their performance and guidance in matters related to the clinical care that they are delivering.
Additionally it is recommended to link every trainee to a *mentor/supervisor*, who will follow the trainee during the whole period of training for monitoring progress with help of a continuing portfolio and adjusting it if necessary.
All training programs in geriatric medicine will be led in an institution (or in a group or network of allied institutions) by a Program Director.
While actively cultivating traditional teaching such as regular grand rounds and weekly structured teaching sessions, training institutions should be proactive in introducing new training methods according to the modern principles of adult learning.
A program of formal bleep-free regular teaching sessions (where the trainees will not be interrupted) to cohorts of trainees could include

- Case presentations
- Lectures and small group teaching
- Grand Rounds
- Clinical skills demonstrations and teaching
- Critical appraisal and evidence-based medicine and journal clubs
- Research and audit projects
- Joint specialty meetings

e. Governance

The governance of an individual's training program will be the responsibility of the Training Director and the institution(s) in which the training program is being delivered. A trainer will be responsible to the Training Director for delivering the required training in his/her area of practice.

II. TRAINING REQUIREMENTS FOR TRAINERS

1. Process for recognition as trainer

a. Requested qualification and experience

A trainer would be a registered medical practitioner and be registered as a specialist in geriatric medicine within his/her own country. He/she will have satisfied any relevant national requirements as regards accreditation/appraisal/training to be a trainer. A Program Director would be someone who has been or still is a trainer and who has considerable knowledge and experience in training doctors, in some countries this person is also the professor in geriatric medicine. Trainers and Program Directors must be in active clinical practice and engaged in training in the training centre or network.
The director of training should have been practicing geriatric medicine for at least 5 years after specialist accreditation, have a sound practical knowledge of the whole field of geriatric medicine and must be recognized by the national monitoring authority. The medical staff acting as mentors/supervisors should be actively practicing geriatric medicine and devoted to residency training.

Recognition across the EU as regards competence to be a trainer despite practitioners coming from different countries and having different routes and extents of training is covered by Directive 2005/36/ EC (Paragraph C2/20).

b. Core competencies for trainers

A trainer will be:

- Familiar with all aspects of the overall geriatric medicine curriculum as it relates to practice within his/her country.
- Experienced in teaching and in supporting learners.
- Skilled in identifying the learning needs of the trainees and in guiding the trainees to achieve their educational and clinical goals.
- Able to recognize trainees whose professional behaviors are unsatisfactory and initiate supportive measures as needed.
- Trained in the principles and practice of medical education and follow regular updating in educational and team leader skills.

2. Quality management for trainers

Trainers and Program Directors should have their job description agreed with their employer which will allow them sufficient time for support of trainees and in the case of Program Directors, sufficient

time for their work with trainers. The number of trainees would determine the amount of time that would be allocated to their support.
Trainers will collaborate with trainees, the Program Director and their Institution to ensure that the delivery of training is optimal. They should meet at least twice a year with each trainee to openly discuss all aspects of training including the evaluation and approval of his/her log book and portfolios.
The educational work of trainers and Program Directors should be appraised annually within their Department/Institution.
Educational support of trainers and Program Directors will be provided by their Department and Institution and through the Section and Board of geriatric medicine of UEMS in collaboration with national society .

III. TRAINING REQUIREMENTS FOR TRAINING INSTITUTIONS

(if not covered by EU Directive on Professional Qualifications)

1.Process for recognition as training centre

The education of trainees in geriatric medicine to practice independently is experiential, and necessarily occurs within the context of each health care delivery system. Training must be realized in dedicated centers where qualified personnel and adequate resources are available. Geriatric medicine training may take place in a single institution or in a network of institutions working together to provide training in the full spectrum of clinical conditions and skills detailed in the curriculum. The network should preferably include a hospital or institution providing academic activity in geriatric medicine. Each participating institution in a network must be individually recognized at national level as a provider of a defined section of the curriculum.

a. Requirement on staff and clinical activities

To be recognized as a geriatric medicine training unit on European level, an institution/department must:

- Be recognized as a training facility in geriatric medicine by the responsible national authority in its country.
- Have a program director that fulfils the requested qualification and experience, see II.1.a.
- Contain the facilities to perform diagnostic assessments, functional investigation and measurement, and treatments relevant to the discipline.
- Maintain a network of contacts among clinical colleagues and professionals allied to medicine in hospital settings and services assisting the discharge of patients into the community.
- Show training activity:
    - in clinical domains through organizing case presentations, staff meetings, workshops, symposia or congresses,
    - in research work by trainee participation in the research activities of the unit

It would be unacceptable for a trainee to have only one trainer during their entire training period. It would be more usual for a trainee to have a number of named trainers with whom they work on a day-to-day basis. Each trainer would cover different aspects of a trainee's clinical training but this individual will not be the only person who will provide educational support to a trainee.

It is essential that as part of their training, trainees will be responsible for caring for patients on both an emergency and routine basis. This may need the involvement of multiple training sites and settings as appropriate for clinical and organizational skills. The trainee should be involved in the management of new patients, the follow up of outpatients and inpatient care.

Over the course of the training period the trainee must have progressively increasing personal responsibility for the care of patients.

The staff of a training centre will engage collaboratively in regular reviews of the centre's clinical activity and performance. There will be regular multidisciplinary meetings to determine optimal care for patients and such meetings will involve both medical and other healthcare staff. There will be clinical engagement outside of the centre with other clinical groups such as orthopaedic, neurology, psychiatry, rheumatology, internal medicine, anaesthesiology and others.
Within a geriatric medicine training centre there should be a wide range of clinical services available so that a trainee will be able to see and contribute to the care of all common sources of disability. In addition, the patient numbers and specialist numbers should be sufficient so that trainees will be able to be instructed and then supervised in the clinical procedures required of a specialist.
The balance between in-patient and out-patient numbers is constantly changing and varies across European countries depending on different care pathways adopted. Thus, no specific in- or outpatient numbers are stated as being necessary to be seen by a trainee during their training.

There is no specific trainee/trainer ratio that is required but it would be unusual for there to be less than three specialists in a training center or clinical network and for a trainer to have more than four trainees attached to him/her at any one time. If a trainee moves between several centers for his/her training it is recommended that, whenever possible, although the trainers may change, the Program Director should remain the same.
It is not a requirement that a training center is also an academic centre for geriatric medicine but it is desirable that a training centre would have strong academic links and contribute to research in the field.

b. Requirement on equipment, accommodation

A training centre would need to have sufficient equipment and support to enable the clinical practice that would be expected of a training centre and thus provide the necessary educational opportunities for trainees.
Trainees would have suitable accommodation for their work.
Computing and Information Technology and library resources must be available. All trainees must engage in clinical audit and have the opportunity to engage in research.

2. Quality Management within Training institutions

a. Accreditation

Training centres must be recognized as a training facility in geriatric medicine by the responsible national authority. It is expected that training centres undergo regular audit within their country with

respect to their clinical, scientific and educational activity; therefore the audit would include data relating to the progress of trainees and their acquisition of specialist accreditation.

b. Clinical governance

Training centres should undertake internal audits of their performance as part of the requirements for continuing national recognition/accreditation. Any national evaluation of a training center's performance is expected to include the demonstration that it is:

- Providing care for patients with a wide range of geriatric conditions
- Providing educational and training support for trainees and others
- Part of a healthcare system that provides immediate access to relevant laboratory and other investigations as well as providing when necessary immediate access to other clinical specialties that may be required by their patients.

Training centers should keep records of the progress of their trainees, including any matters relating to Fitness to Practice or other aspects that might affect a trainee's registration with the relevant national body. The Program Director has specific responsibilities in this regard.

c. Workforce planning

Among the task of the UEMS is to support national authorities with guidelines on the planning of medical workforce in any definite specialty. Each country should train only enough specialists in geriatric medicine to meet its own requirements of specialist workforce. Trainees' recruitment in the training centers should be subordinated to the results of this planning; in any case the number of trainees present at any time in a training institution cannot exceed its clinical capacity to expose the trainees to the minimal number of procedures detailed in this document.

d. Regular report

The training institution must have an internal system of quality assurance including features such as mortality and morbidity and structured incident-reporting procedures. Furthermore, various hospital activities in the field of quality control such as infection control and drugs and therapeutic committees should exist. Visitation of training centers by the National Monitoring Authority shall be conducted in a structured manner.

e. External auditing

External auditing is not mandatory except the national authority requests it. In the future, European accreditation by UEMS bodies may be recommended.

f. Transparency of training programs

It would be expected that a training centre would publish details of the training provision available with details of the clinical service it provides and the specialist and other staff. Such information

would include the training program, the nature of the clinical experiences with which a trainee would be engaged and the support and interaction with the trainer and Director of training. There would be a named individual whom a prospective trainee might contact and discuss the program.