National training curriculum

for the specialist training of elderly care physicians in the Netherlands

2015

Commissioned by the Central Board for Elderly Care Medicine Specialty Training in the Netherlands (SOON).

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This training curriculum was developed under the direction of the Training Modernization Project group:
Eric van der Geer, Radboud University Medical Center Nijmegen
Ilse Kleine Schaars, University Medical Center Nijmegen
Michelle Kromhout, Leiden University Medical Center (from April 2014)
Arian Lindenbergh, SOON (project leader)
Rachel Mak, VU University Medical Center Amsterdam
Elize Oosterling, independent educator
Martin Smalbrugge, VU University Medical Center Amsterdam (Chair)
Michiel van der Wel, Leiden University Medical Center
Paul Went, Leiden University Medical Center (until April 2014).

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Preface

This national training curriculum for residents in elderly care medicine in the Netherlands (2015) succeeds the national training curriculum published in 2007 (adapted in 2011). It was developed by the Elderly Care Medicine Training Modernization Project group.

Vision

Group members of the Elderly Care Medicine Training Modernization Project began by writing a vision paper entitled "Training of elderly care physicians. Vision and strategy document. May 2013"[1]. This vision paper formed the frame of reference for the new training curriculum. The vision paper was based on the results of the evaluation of the current training program, on the new requirements for medical practice (published in 2011 by Verenso and SOON) and on Verenso's revised professional profile.[2] The document describes new developments, such as the growing collaboration between elderly care physicians and GPs, the removal of barriers between primary care and nursing homes, the growth and development of geriatric rehabilitation and the desire from government to improve medical care for the elderly.

Critical professional situations

A major change to the previous version of the curriculum in terms of education is the addition of "critical professional situations" (CPSs). The CPSs give the training program its shape and color, as it were, and also determine its content. Since the professional activities that an elderly care physician carries out in a CPS are tested, the underlying competencies are also tested. The competency-based character of the training program is therefore unaffected[3]. The organization of the program around CPSs means that we have had to leave behind the themes of the previous training curricula. In other words, the "old" themes are embodied in the CPSs. The CPSs also ensure that the training program closely follows the most recent scientific developments as well as societal views on the profession of elderly care physicians.

Other changes are as follows:

- the three-year training program is now differentiated into a foundation phase (Year 1) and an advanced phase (Years 2 and 3);
- the number of formal teaching days varies from a minimum of 100 to a maximum of 130 days;
- the program now includes compulsory patient consultations in a primary care setting during the psychogeriatric and somatic medicine training periods of the advanced phase;
- the program includes a training period in geriatric rehabilitation;
- the guidelines regarding the minimum number of patients are more stringent;
- tests on knowledge are given once or twice a year;
- the program in the advanced phase now includes modular instruction.

I would like to take this opportunity to thank all those who have contributed to this national training curriculum. Particular thanks go to the members of the sounding board group for being willing – each in their own role and with their own expertise – to share their thoughts on the content of this curriculum.

Eric van der Geer, chairman of the SOON board of directors
Utrecht, January 2015.

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[1] *Opleiden tot specialist ouderengeneeskunde. Visie en uitgangspunten mei 2013* (SOON 2013)

[2] Elderly care physicians in the Netherlands, professional profile and competencies (Verenso, 2015)

[3] These competencies can be subdivided according to the CanMEDS framework into seven areas of competence. These groups are described in the document entitled "Elderly care physicians in the Netherlands, professional profile and competencies" (Verenso, 2015). Please also refer to the appendices.

Chapter 1 From framework decision to training curriculum

This national training curriculum outlines the main aspects of the three-year specialist training program for elderly care physicians in the Netherlands. This training program is based on the regulations laid down by the Dutch Central Board for the Recognition and Registration of Medical Specialists (CGS). This chapter describes the various documents involved and how they are interrelated.

Framework decision

The Dutch Board for General Practice and Nursing Home Medicine (CHVG, the legal predecessor of the CGS) has compiled a so-called framework decision on the training programs. As the name indicates, this decision establishes the framework for the training programs for general physicians, elderly care physicians and physicians for persons with intellectual disabilities. The specific requirements for the specialist training program for elderly care physicians are stipulated in the framework decision on elderly care medicine. This framework decision, as well as the other decisions, can be found (in Dutch) on the website of the Royal Dutch Medical Association (KNMG) at www.knmg.nl under *Opleiding en Registratie* (Training and Registration).

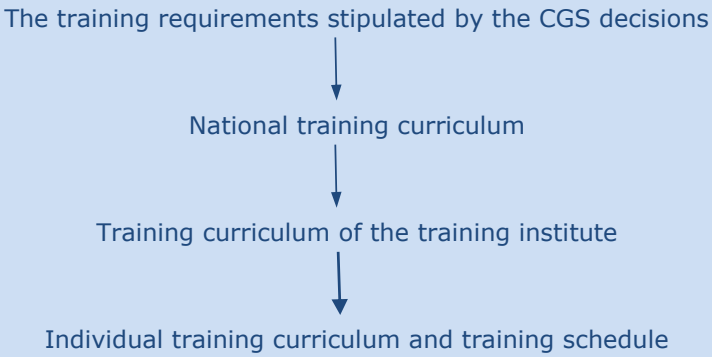
National training curriculum

The framework decision stipulates that a national training curriculum be developed jointly by the directors of the training institutes. The national training curriculum for specialist training in elderly care medicine establishes the framework for the organization and delivery of the program.

Training curriculum

Each individual institute then uses the national training curriculum to develop its own training curriculum. This curriculum describes the structure and content of the teaching and learning processes. The national training curriculum also establishes a framework for the individual training curricula, the training schedules and the work-training plans.

From training requirements to individual training curriculum



Individual training curriculum and training schedule

The training schedule gives the trainee an overview of the start and end dates of her[4] training program as well as the order and the locations of the different program components. Each individual training curriculum is linked to the training schedule. It is an elaboration of the training curriculum at an individual level, which describes how the trainee can acquire the specified

[4] Since 70 percent of the specialists in elderly care medicine are female, we refer to the trainee as "her" or "she".

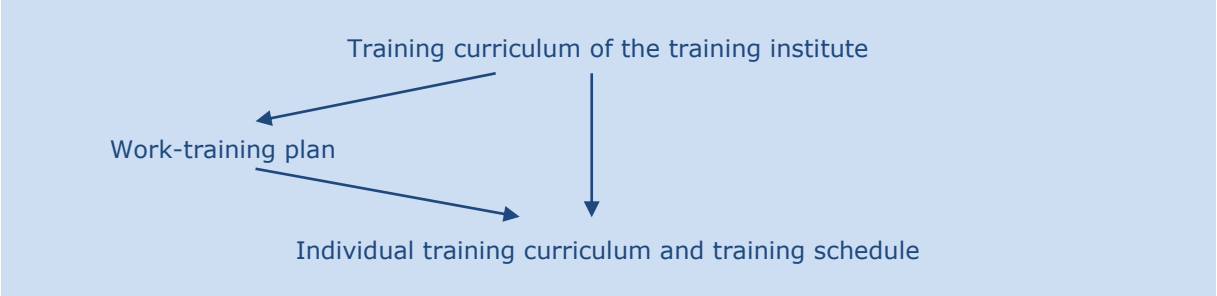
competencies. When developing her individual training curriculum, the trainee must not only remain within the limits set by the institute's training curriculum, but also take into account the options and limitations of her work placement locations. Within these limits, the trainee can draw up a curriculum that most closely matches her learning goals and interests in specific aspects of the profession.

Accelerated training

If at the start of the training program a trainee is able to provide documentation demonstrating that she has already acquired sufficient expertise in specific competencies, the director may decide to shorten the duration of the training program. This variation is included in the training schedule and training curriculum subject to conditions. During the first three months of the training program, the trainee's main learning goals are outlined in more detail. Based on these learning goals, the trainee, together with her tutor and her trainer, can then adjust her training schedule and curriculum. The individual training curriculum describes how attention is focused on the development and assessment of professional activities and to CPSs.

Work-training plan

The work-training plan describes the content and organization of the practical components of the training program at the trainer's place of work and at the training facility, and also at the work placement supervisor's place of work and at the work placement facility, all taking the training curriculum into account. The work-training plan also provides a framework for the trainee's own individual training curriculum. The work-training plan is drawn up by the trainer and is then approved by the program director.



Flexibility

In this national training curriculum we have tried to limit the number of stipulations to a minimum, i.e. no more than are necessary to provide sufficient guarantees for a comprehensive training program. Together, the individual training curriculum and the work-training plan offer scope for proper organization of the work-based component of the program, thereby taking advantage of the local situation. This ultimately enables us to deal as flexibly as possible with the trainee's learning needs. The competency-based nature of the training program requires freedom of choice for the trainee wherever possible.

Chapter 2 Profile of the elderly care physician

Who are elderly care physicians? What is their domain of work, what are the developments in their area of specialization and how do they practice? These are the main aspects that make up their professional profile, which we will describe in this chapter. This general profile is based on the report entitled "Elderly care physicians in the Netherlands, professional profile and competencies" (Verenso 2015) and the vision paper "Training of elderly care physicians. Vision and strategy document. May 2013".

Target group

Elderly care medicine is specialized in the care of frail patients and the chronically ill – principally the elderly – in relation to the care network (i.e. the entirety of patient, their family and care providers). These are patients for whom various factors in the somatic, psychological, communicative or societal domains have led to a precarious situation in terms of their functional autonomy and their ability to live independently. In other patients, this equilibrium has already been disturbed, resulting in a downward spiral of ever-increasing functional decline.

The characteristics of this target group are multiple problems, comorbidity, multimorbidity, and the co-occurrence of multipathology with specific manifestations of old age. The basic principles of the specialization of elderly care medicine are also applicable to the care of younger patients with comparable complex symptomology. In the area of elderly care medicine, specific expertise has been developed in the care of various groups of patients with conditions such as Huntington's disease or Korsakoff's syndrome.

Objectives

The objective of elderly care medicine is to provide medical care for those with complex geriatric problems with an emphasis on enhancing the functional autonomy and quality of life of the patient. The elderly care physician provides this care wherever the patient is situated.

Integral approach

A characteristic of elderly care physicians is their broad, integral approach. The elderly care physician looks at the patient in their entirety by taking into account his or her condition, care network, medical history, personality and his or her social and material environment. It is not only the disease or diseases of the patient that determine where the elderly care physician directs their

The "ideal" elderly care physician[5]

The experienced elderly care physician is a competent physician whose approach to care is both problem-oriented and goal-oriented; who acts as much as possible on the basis of evidence; and who takes the patient's preferences into account at all times.

Personal characteristics that score highly:

- the ability to analyze and solve problems;
- good communication skills;
- the ability to take initiative;
- self-confidence;
- leadership skills for bringing together and guiding professionals;
- entrepreneurship in the organization of work and acquiring relevant information and funding;
- the ability to put things into perspective and the resilience to cope with setbacks and limitations;
- the skills to pass on knowledge.

[5] Source: *Opleiden tot Specialist Ouderengeneeskunde. Visie en uitgangspunten mei 2013* (SOON, 2013).

focus. Equally important are the consequences of disease for the functional autonomy and the quality of life of the patient, in relation to his or her care network.

What does this mean in practice? The elderly care physician uses medical diagnostic procedures and the psychological, social and personality characteristics of the patient to map out the care required by the patient (care diagnostics). The elderly care physician also makes an estimate of how a patient's care requirements will develop (care prognostics) and draws up a plan for achieving care objectives and monitoring the patient (care management). In the interests of the patient, the elderly care physician works closely with healthcare professionals from other disciplines. Elderly care physicians are responsible for their own medical management and are responsible for drawing the attention of the management to the quality of care that is being delivered.

Roles

The elderly care physician is able to assume three roles:
- Primary treating physician: she in charge of the treatment process;
- Co-treating physician: she contributes to prevention, therapy and guidance and offers supportive care during the treatment process;
- Advisory expert: she offers advice to or about a patient.

The role that an elderly care physician takes on will depend on a number of things, including how care is allocated in practice, the patient's preference and the opportunities available for mutual agreements between care providers.

Trainee in elderly care medicine

In order to be able to function well in their future working environment and to fulfil the profile of the elderly care physician, a trainee in elderly care medicine should possess certain qualities. Who is the ideal trainee in elderly care medicine?

The "ideal" trainee in elderly care medicine[6]

The trainee in elderly care medicine must be a robust, qualified physician who is both scientifically-minded and societally-oriented. She must believe that her actions can contribute to the independent functioning and the quality of life of the members of the target group, and must be able to act empathetically and decisively. She should be a strongly logical thinker and be sensitive to relationships in order to be able to prioritize correctly.

Personal characteristics of trainees in elderly care medicine that score highly:
- is intrinsically motivated for a career in elderly care medicine;
- has the ability to analyze and solve problems;
- has good communication skills;
- is enterprising;
- possesses self-confidence.

[6] Source: *Opleiden tot Specialist Ouderengeneeskunde. Visie en uitgangspunten mei 2013* (SOON, 2013).

Chapter 3 Principles of the training program

The specialist training program for elderly care physicians is guided by five principles:

1. Professional practice
2. Competency-based learning and training
3. Critical professional situations
4. Strong learning environment
5. Personal responsibility of the trainee for the learning process

In this chapter we give a brief explanation of each of these starting points.

1. Professional practice

A distinctive feature of the training program is that working and learning are inextricably linked. The professional profile published by Verenso serves as a framework for both training goals and learning goals. To achieve these goals, the trainee must spend about 80% of her training time working in professional practice. Professional practice is therefore considered to be the point of departure for both learning and training. The teaching activities that take place on institute training days should follow learning experiences in professional practice as closely as possible. In other words: the teaching and learning processes are driven by professional practice.

2. Competency-based learning and training

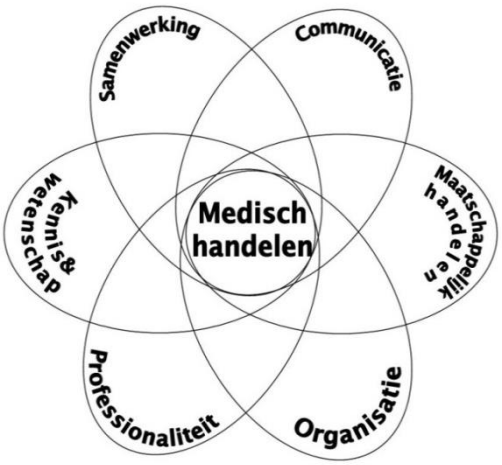
The training program gives the trainee the opportunity to acquire the competencies needed to become an elderly care physician. Verenso gives the following definition of a competency:

A competency is the capability to properly perform a professional activity in a specific, authentic context by the combined application of the correct knowledge, insights and skills and with the correct attitude.[7]

Competencies develop and grow through a combination of participation in professional practice and reflection on such participation. Reflection then leads to lessons learned (which may differ between trainees) and the formulation of corresponding learning and training needs. These needs are partly or entirely addressed by a second round of participation and reflection as well as by the acquisition of new knowledge and skills that enrich the practical skillset. The trainee must be able to demonstrate that she has attained the competencies to a predetermined level. The trainee's development in terms of competencies is therefore also a key element of her assessment. More on this topic can be found in Chapter 6 (Testing and assessment protocol).

The competencies are subdivided into seven areas of competence. The core area of competence is "medical expertise", to which all the other areas of competence are linked.

Medisch handelen	Medical expertise
Samenwerking	Collaboration
Communicatie	Communication
Maatschappelijk handelen	Health advocacy
Organisatie	Management
Professionaliteit	Professionalism
Kennis & wetenschap	Role as scholar



[7] Elderly care physicians in the Netherlands, professional profile and competencies (Verenso, 2015).

3. Critical professional situations

What it is that a trainee learns, as well as where and when she learns it, has been clarified in the form of so-called critical professional situations (CPSs). These are situations (real or simulated) that typify the profession of an elderly care physician. During the training periods and work placements, learns the most effective approaches to various CPSs. This allows her to develop the competencies needed to act effectively in these and in similar situations.

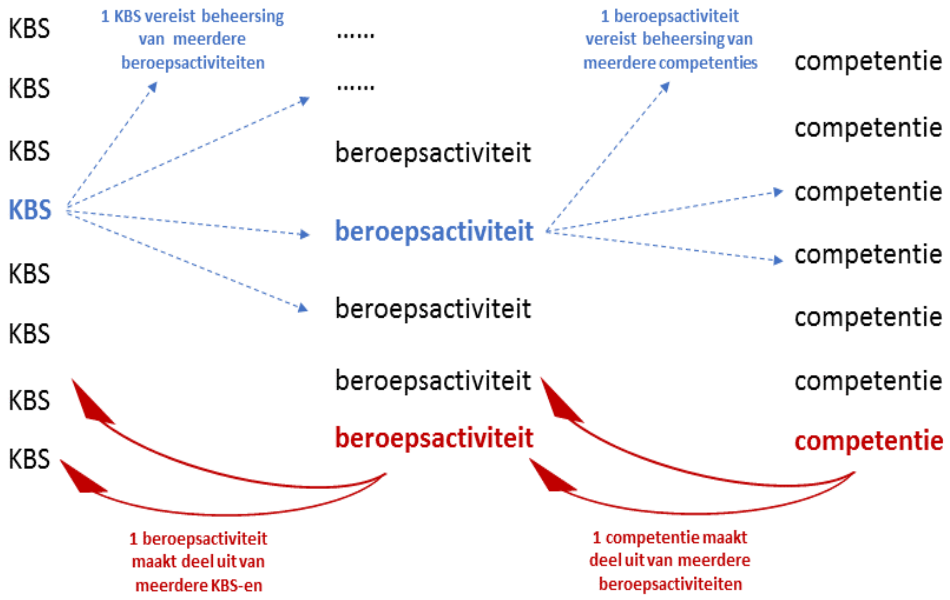
From another perspective, it is about looking at what the specialist actually does in such situations. And by situations we mean professional activities: activities that are frequently seen and that belong to the core of profession. For example:

- carrying out a geriatric assessment;
- drawing up and implementing a treatment plan;
- practicing emergency elderly care medicine;
- advance care planning;
- evaluating the ability to give informed consent;
- dealing with compulsory treatment and use of restraints;
- communicating with the patient/support system;
- collaborating with other care professionals;
- leading and collaborating in multidisciplinary teams;
- working with management;
- efficiently and effectively organizing personal care practice;
- participating in integrated care/treatment as an elderly care physician;
- participating in and contributing to quality monitoring of care and treatment;
- contributing to the further development of elderly care and elderly care medicine;
- functioning as an ambassador for the profession and for the elderly in society.

What matters is that in a certain practical situation the elderly care physician will engage in professional activities in the correct combination and in the correct order, taking into account the specific aspects of a particular situation. This requires sufficient expertise in the underlying competencies.

Relationships between CPSs, professional activities and competencies

KBS	CPS
beroepsactiviteit	professional activity
competentie	competency
1 KBS vereist beheersing van meerdere beroepsactiviteiten	1 CPS requires expertise in several professional activities
1 beroepsactiviteit vereist beheersing van meerdere competenties	1 professional activity requires expertise in several competencies
1 beroepsactiviteit maakt deel uit van meerder KBS-en	1 professional activity is a part of several CPSs
1 competentie maakt deel uit van meerdere beroepsactiviteiten	1 competency is a part of several professional activities



See Appendices 1 and 2 for the following:

- more details on the relationships between competencies, professional activities and CPSs;
- an overview of the CPSs according to training period and work placement.

4. Strong learning environment

The training institute and the training facility are responsible for creating an effective learning climate that allows the trainee to achieve the required competencies. An effective learning climate presupposes the presence of a strong learning environment. This is a learning environment that balances different forms of learning, such as supply and demand-based learning. It should also offer sufficient variation in working methods, such as tutorials, self-directed learning and practicing skills in simulated situations.

For individually tailored teaching, various forms of e-learning can be used. Social media can also be used for knowledge-sharing and for collaborative distance learning. The strong learning environment of the training program for elderly care physicians is a result of the combination of practical learning, formal tuition, learning from peers, clinical supervision, progress interviews, testing and assessment.

5. Personal responsibility of the trainee for the learning process

Each trainee embarking on the training program for elderly care physicians will have her own personal learning experiences. She will link such prior knowledge to any new information and experiences, thereby forming her own ensemble of knowledge and insights. Knowledge is often very personal and this also applies to the learning needs of the trainee. In the training program we take account of this by working together with the trainee to develop a tailored learning pathway. This means that the trainee's way of working and learning must be active, reflective and responsible. In other words, the trainee is personally responsible for her learning process.

Chapter 4 Training in practice

The practical training comprises three periods of training and three work placements spread over the total training period of three years. Once the trainee has completed all training periods and work placements and the accompanying formal tuition, she is then regarded as having had enough practice in various CPSs and in the associated professional activities to be able to work as a skilled specialist in all three roles, i.e. primary physician, co-treating physician and advisory expert.

Training periods

During the training periods, the trainee works with elderly care physicians. From a pedagogical perspective it is preferable that training be built up from simple to complex. However, in reality the work does not always fit in with learning requirements, and often the most complex problems present themselves first. Since the training program has to take its lead from the learning opportunities presented in practice, the assumption is that the trainer will take the complexities of the activities into account and adjust the nature and extent of supervision accordingly. In order to progressively develop into an independently functioning elderly care physician, the trainee begins with simple, commonly-occurring problems. During the training period this gradually shifts towards more complex symptomology. The trainee is progressively entrusted with more tasks. The associated responsibilities of the trainer and the trainee are described in the work-training plan. The trainer carries final responsibility for the patient care provided by the trainee.

From a business point of view, the trainee contributes to the productivity of the training facility and her contribution will increase as her training progresses. However, work-related commitments that are necessary to get the work done may not interfere with organized learning activities such as tutorials and the carrying out of practical assignments that form part of the formal tuition.

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Training period	**Somatic medicine (SOM)**
Duration	6–12 months
Content	Medical care for: - chronically ill and handicapped people (elderly or otherwise) who are resident in facilities (Years 1 and 3) including acute care and palliative care of these patients. - chronically ill and handicapped people (elderly or otherwise) who are not resident in facilities (Year 3). The trainee learns to deal with those CPSs encountered in the course of her professional activities that are relevant to this period (see Appendix 1).
Training facility	At a minimum, the following professionals should be available at the facility where the trainee follows the somatic training period: nurse, physiotherapist, occupational therapist, speech therapist, nutritionist, registered health psychologist/general psychologist and supervising pharmacist. The presence of the following is also desirable: activity leader, spiritual counsellor and social worker.
Number of patients	On the basis of a full-time appointment, the trainee is responsible for the medical care of between 50 and 100 patients. These are indicative rather than absolute numbers and are also dependent on the phase of training.
Further comments	See box on “Primary care”.

Training period	**Psychogeriatric medicine (PG)**
Duration	6–12 months
Content	Medical care for: - psychogeriatric and gerontopsychiatric patients who are resident in facilities (Years 1 and 3), including acute care and palliative care of these patients; - psychogeriatric and gerontopsychiatric patients who are not resident in facilities (Year 3). The trainee learns to deal with those CPSs encountered in the course of her professional activities that are relevant to this period (see Appendix 1).
Training facility	At a minimum, the following professionals should be available at the institution where the trainee follows the psychogeriatric training period: nurse, physiotherapist, occupational therapist, speech therapist, nutritionist, registered health psychologist/general psychologist and supervising pharmacist. The presence of the following is also desirable: activity leader, spiritual counsellor and social worker.
Number of patients	On the basis of a full-time appointment the trainee has responsibility for the medical care of between 65 and 130 patients. These are indicative rather than absolute numbers and are also dependent on the phase of training.
Further comments	See box on "Primary care".

Primary care

There is no separate primary care training period. The trainee develops the appropriate competencies in this area principally during the somatic and psychogeriatric medicine training periods and during the ambulant work placement. During the somatic and psychogeriatric training periods, the trainee must carry out a minimum of ten primary care consultations in the home setting of the frail elderly with somatic and/or psychogeriatric conditions. In order to competently take on the role of co-treating physician or primary care physician in primary care, it is recommended that the trainee also opts for one or more of the following:

- participation in the primary care consultation team of a nursing home (e.g. Mobile Geriatric Team; Dementia, Research and Case Management (DOC) team; ambulant team);
- giving advice to family doctors on cases (inter-physician consultation);
- participation in multidisciplinary team (MDT) meetings on frail elderly in care homes of family doctor practices;
- optional work placement in family practice.

Training period	**Geriatric rehabilitation care (REH)**
Duration	3–6 months
Content	Integrated multidisciplinary care aimed at expected recovery of function and participation in the frail elderly following an acute condition or functional decline. The trainee learns to deal with those CPSs encountered in the course of her professional activities that are relevant to this period (see Appendix 1).
Training facility	At a minimum, the following professionals should be available: a geriatric rehabilitation specialist and/or rehabilitation specialist for consultation, nurse, physiotherapist, occupational therapist, speech therapist, nutritionist, health psychologist/general psychologist and supervising pharmacist. The presence of the following is also desirable: activity leader, spiritual counsellor and social worker.

Number of patients	On the basis of a full-time appointment, the trainee has responsibility for the medical care of between 20 and 40 patients. These are indicative rather than absolute numbers and are also dependent on the phase of training.

Work placements

The difference between a training period and a work placement is that during a work placement the trainee works in a part of the healthcare sector where an elderly care physician does not normally work (the hospital placement), or where the work is not necessarily done by an elderly care physician (the ambulant work placement – where both an elderly care physician and a psychiatrist/geriatric psychiatrist may work – and the optional placement). The trainee can learn certain professional competencies better or faster during such a work placement. During these work placements, the trainee is also expected to contribute to productivity.

Criteria for work placements:

- The content and objectives of the work placements should be compatible with the competencies required of the elderly care physician.
- Based on the trainee's personal choices and interests, she should have the opportunity to broaden existing knowledge and gain more in-depth knowledge related to competencies.

Work placement	**Ambulant (AMB)**
Duration	6–12 months
Content	The care of ambulant psychogeriatric and/or gerontopsychiatric patients and their families. Care comprises diagnosis (including early diagnosis), guidance, process guidance and treatment. The trainee learns to deal with those CPSs encountered in the course of her professional activities that are relevant to this period (see Appendix 1).
Training facility	At a minimum, the following professionals should be available at the facility where the trainee follows the ambulant work placement: social-psychiatric nurse, registered health psychologist/general psychologist, an elderly care physician or a psychiatrist/geriatric psychiatrist.
Number of patients	A guideline for a training period of 6 months: the trainee should treat or co-treat 50 new patients and 50 existing patients. The numbers mentioned here are indicative rather than absolute.

Work placement	**Hospital (HOS)**
Duration	3–6 months
Content	An opportunity for the trainee to gain experience in the secondary care of the elderly and the frail elderly and has the opportunity explore the medical side of various CPSs.
Training facility	This placement is on a clinical geriatric ward or on an internal medicine or neurology ward.
Number of patients	The number of patients is dependent on the specific details of this placement.

Work placement	**Optional (OPT)**
Duration	3–6 months
Content	This work placement is carried out at a site that has been approved by the head of the training institute. The objective of this optional work placement is to give the trainee the opportunity to explore her competencies in a particular area of the profession in greater depth. The optional work placement should preferably take place during the final phase of the training program.

	Examples of optional work placements include the following: a hospice or rehabilitation center, or scientific research in a geriatric department resulting in a scientific article.
Training facility	This depends on the specific details of the optional placement.
Number of patients	This also depends on the specific details of this placement.

Acute care

Acute care covers working under pressure of time, the requirement to carry out triage and crisis intervention. In order to learn about providing acute care, during each of the three training periods the trainee should work a minimum of one weekend day every six weeks plus a minimum of one evening or one night shift every three weeks. The trainee may also work evening, night and weekend shifts during hospital and ambulant care work placements. This is dependent on the arrangements made with the site of work placement and the learning requirements and objectives of the trainee.

Flexibility and part-time work in the training schedule

A trainee can work flexibly during the training schedule under certain conditions. Year 1 is the foundation year during which it is preferable not to plan optional work placements. The program in Year 2 includes the hospital work placement and ambulant care placement, with the option of planning the optional work placement or the training period in geriatric rehabilitation care. Year 3 is centered around further in-depth study and broadening of knowledge.

Example 1 of a training schedule

Year 1	Year 2			Year 3	
PG	HOS	AMB	REH	PG	OPT
SOM				SOM	

Example 2 of a training schedule

Year 1	Year 2			Year 3	
PG	AMB	HOS	REH	OPT	PG
SOM					SOM

The training program for elderly care physicians can also be followed on a part-time basis. Doing the practical training part time involves working at least half of a full-time appointment, spread over a minimum of three days, and the modules are lengthened accordingly. These modifications are reported in the individual training schedule. Sometimes the training facilities are only able to offer certain modules of the training program on a full-time basis.

The trainer

The trainer is an experienced elderly care physician who is affiliated with a medical practice that is a recognized training facility. The trainer is a member of a group of elderly care physicians that should ideally be generally recognized as a training group, with the trainer carrying final responsibility for training.

The trainer is responsible for:

- fulfilling those conditions required for the development of the trainee;
- redirecting the attitude and working practice of the trainee where necessary;
- guiding the trainee in acquiring the competencies of an elderly care physician.

The tasks of the trainer include the following:

- regular observation of the trainee in practice;
- weekly tutorials with the trainee;
- periodic consultation with the tutor about the trainee's progress;
- carrying out educational and selective assessments, which the trainer uses to advise the head of the training course about the trainee's progress (see Chapter 6, Testing and Assessment Protocol).

The tasks are specified in the work-training plan provided by the training facility. The trainer must follow (or have followed) the didactic training offered by the training institute and further specialist training for trainers. The didactic training is based on the competence profile of trainers that has been drawn up by the Dutch Board for General Practice and Nursing Home Medicine (CHVG)[8].

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The "ideal" trainer

The ideal trainer is an elderly care physician who has a wide experience of practice, who has hands-on professional knowledge, who is skilled in passing on this knowledge, and who works in a training-oriented practical setting. The trainer should be intrinsically motivated to invest time in the professional development of a trainee.

The trainer should consciously act as a role model and inspire the trainee to push her boundaries and to explore her talents. A trainer should also coach the trainee by stimulating reflection and self-determination and introducing her to appropriate networks as well as stimulating her interest in the scientific aspects of the profession.[9]

The supervisor

During the three work placements, the trainee will be guided by a supervisor from a medical specialization that is not elderly care medicine. The supervisor should preferably be affiliated with a professional treatment group, ideally one that is generally recognized as a training group. The supervisor should have overall responsibility, and both the supervisor and the training group should preferably fulfil the criteria laid down in the document entitled "The competencies of the trainer and those of members of the training group".[10] The supervisor supports and supervises the trainee in carrying out her individual training plan at the work placement facility, takes time to give tutorials and feedback and, among other things, to assess whether the trainee's work placement objectives have been achieved.

The training facility[11]

Professional practice is the starting point for learning and training. For this reason it is logical that the quality of the organizations where a trainee receives her training is critically examined. What are the minimum requirements? These are described in the box below.

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The training facility

The training facility should have an enthusiastic group of trainers, a good learning climate and enough variation in the group of patients to provide the trainee with a broad experience of the professional activities necessary to become an elderly care physician. The training facility should actively participate in the integrated care of the elderly in areas such as dementia, CVA etc.[12] The organization of practice should be efficient and the training facility must work with electronic patient records.

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[8] *Competentieprofiel van de opleider CHVG. Werkgroep Modernisering CHVG (KNMG),* April 2008.
[9] Source: *Opleiden tot Specialist Ouderengeneeskunde. Visie en uitgangspunten mei 2013* (SOON, 2013).
[10] *Competentieprofiel van de opleider en leden van de opleidingsgroep, Project Modernisering medische vervolgopleidingen,* KNMG 2012.
[11] Training facility refers both to the work placement facility and the facility where the trainee follows her training period.
[12] Source: *Opleiden tot Specialist Ouderengeneeskunde. Visie en uitgangspunten mei 2013* (SOON, 2013).

Chapter 5 Formal tuition

Formal tuition ties in with the practical part of the training program and is aimed at acquiring, practicing and assessing the knowledge and skills that the trainee needs to develop her competencies. The training program must offer a minimum of 100 and a maximum of 130 days of formal tuition. It is important that the formal program should be sufficiently flexible to respond to a trainee's individual learning goals.

Objectives of formal tuition:

1. to reflect on one's own professional behavior;
2. to broaden and deepen knowledge and skills that prepare for and are aligned with practical training.

Organization of learning activities that make up formal tuition

The learning activities are coordinated and organized as follows:

- by the institute; and/or
- by a national collaboration between the institutes; and/or
- by the trainee herself in the context of her individual training curriculum.

Principles upon which formal tuition are based

1. Where possible, the formal tuition is attuned to the professional activities of the CPSs that correspond with the relevant stage of the training program.
2. There is also room for themes than extend across multiple CPSs, such as ethics, law and teaching.
3. The focus is on applying basic knowledge, basic skills and guidelines.
4. The level of knowledge satisfies the requirements described in the Verenso guidelines and in the guidelines of other disciplines relevant to the profession. This includes collaboration with related medical specialties.
5. Trainees are presumed to have the medical knowledge required by the core curriculum. It is a trainee's own responsibility to keep her basic knowledge up-to-date and at her fingertips.
6. The three-year program consists of a foundation phase (Year 1) and an advanced phase (Years 2 and 3).
7. During formal tuition, case-based learning and interventions aimed at reflection are important teaching methods.
8. During the foundation phase, the emphasis is on working methodically, on communication and on somatic (SOM) and psychogeriatric (PG) topics.
9. During the advanced phase, the topics from the foundation phase are also addressed. In addition, modular instruction is given to enable trainees to gain the knowledge and skills required to practice the profession of an elderly care physician. As part of this instruction, the trainee reflects on case studies put forward by herself or by others. These sessions are led by teachers – sometimes guest teachers – who have expertise in the discipline of a particular module. Compulsory periods are linked to fixed modules, e.g. geriatric rehabilitation, ambulant psychogeriatric care, palliative care, medical management/healthcare organization. Topics for optional modules include in-depth study of somatic and psychogeriatric medicine, general management and entrepreneurship. When developing and teaching the modules, the institutes work together in order to make optimal use of nationally available expertise.
10. There is a variation in teaching methods and interventions, which are in keeping with the learning and guidance needs of trainees at each stage of the training program.
11. Different forms of e-learning are utilized to ensure that educational resources are flexible and customized. The objective of this is to enhance learning efficiency.
12. The number of meetings that take place (in tutorial groups) is relatively higher during the foundation phase than during the advanced phase.
13. Besides her own tutorial group, the trainee will also participate in groups that vary in composition in size, based on her individual training and learning needs.

Institute training days

Each institute organizes its own training days, which cover topics such as the following:

- the integral approach of an elderly care physician, illustrated by case studies for example;
- current developments, such as reports in the press about the quality of care for the elderly, the publication of new guidelines or other publications related to the profession;
- any situations experienced by the trainee that were particularly interesting or that made a strong impression.

The trainee also follows, at a minimum, the following compulsory components:

- modules in the field of psychogeriatric medicine, chronic diseases, rehabilitation, acute and palliative care;
- clinical supervision;
- workshops and modules on themes than extend across multiple CPSs (ethics, law, teaching, research, primary care consultation skills);
- case-based teaching;
- tutor meetings to discuss progress of the learning process;
- tests on knowledge;
- delivering critical reviews and giving presentations on change management and research;
- attending review and audit meetings and presentations;
- conducting scientific research (dissertation, CAT).

Personal study

In addition to the formal tuition and practical learning and working, the trainee is expected to spend an average of six hours a week on personal study (on top of the 38-hour work week).

Attending conferences

The trainee is expected to actively follow developments in the profession, for example by attending conferences, such as the Verenso conference.

E-learning and online applications

The considered use of e-learning and other online applications can contribute to a more tailored approach, make training days more efficient and get specialists more involved in tuition (e.g. via a webcam). Over the next few years, tests and experiments will be done to clarify what exactly the possibilities are and what results they will have. For the time being we are using the internet for the preparation of case study discussions. This improves the efficiency of discussions.

Chapter 6 Testing and assessment protocol

The testing and assessment protocol outlines the rules for testing and assessing trainees in elderly care medicine.

Vision and accountability

Regular assessment stimulates trainees to learn; testing and providing feedback gives them an idea of their strengths and limitations.
The aims of the protocol are as follows:

- to ensure that trainee assessment is clear, transparent and consistent;
- to offer legal certainty to trainees;
- to give guidance to trainers and teachers; the protocol is a checklist and planning instrument for setting dates for assessment activities in the digital portfolio;
- to make the testing and assessment system accessible and understandable for trainees and other users.

The protocol follows the testing and assessment stipulations and terminology named in the applicable regulations (these can be found in Dutch at www.knmg.nl/ore). All training institutes in elderly care medicine in the Netherlands are bound to the text of this protocol, because it is a part of the national training curriculum approved by the Dutch Central Board for the Recognition and Registration of Medical Specialists (CGS). This guarantees that testing and assessment always takes place in the same manner, regardless of where the trainee follows the training program. Each training institute uses the protocol to develop its own assessment plan.

Outline of assessment system

Continuous assessment

The trainee is assessed in different ways throughout the training program. She also receives regular feedback on her competencies from the trainers/supervisors and from the teachers at the training institute. The results of this assessment demonstrate the degree to which the trainee has achieved her learning objectives. She also uses the results of assessment to draw up a plan to improve her way of working.

Educational assessment

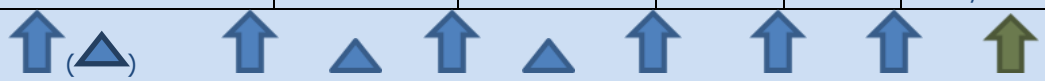
Each trainee has several educational assessments. During an educational assessment, the trainer/supervisor or the teacher at the training institute gets together with the trainee to take stock of the trainee's development of competencies at that particular moment. Is the development of competencies on schedule? What points require attention? Has the trainee completed the relevant tests? This can be checked against the list of competencies of the elderly care physician that belong to that particular phase of the training program. To make sure the trainee remains on track, the educational assessment may result in extra measures being taken, such as the scheduling of extra assessments (see rules on educational assessment on page 21).

Selective assessment

The selective assessment also looks at the trainee's development of competencies. The trainee takes stock together with the trainer/supervisor or the teacher at the training institute. Is the development of competencies on schedule? What points require attention? The main difference with the educational assessment is that the selective assessment is used by the program director to determine whether the trainee can continue with the training program (subject to additional conditions, if necessary) or whether she should discontinue her training. Selective assessments take place at fixed times (see rules on selective assessment on page 21).

Example of an assessment schedule

Year 1	Year 2		Year 3		
SOM/PG	HOS	AMB	OPT	REH	SOM/PG



Explanation of symbols

Educational assessment: Selective assessment: Selective final assessment:

Part-timers and interruptions

If the training program is followed on a part-time basis or is interrupted, this can have consequences for assessment. Provisions for this eventuality are described in the assessment plan.

Procedures

Assessment schedule

At the start of the training program, the training institute provides the trainee with an overview that includes when assessment takes place, the assessment methods used and how the results are used. The training institute must announce any changes to this in good time and using several means of communication. The institute may also add additional assessments to the schedule, making use of appropriate assessment methods.

Extra selective assessment

The protocol allows for time to schedule an extra interim selective assessment if so desired by the trainer/supervisor or the teacher or as part of an extra coaching pathway.

Compulsory participation

The trainee is obliged to co-operate with all forms of testing and assessment described in the protocol.

Leaving the training program early

The director of the training institute is authorized to terminate the training agreement with the trainee if there is strong justification for this, for example if the trainee is considered "untrainable". There is always "strong justification" if continuing the training program is not safe in that it poses a risk to public health.

Extended training

The training program can be extended by a maximum period of six months. For trainees attending the program part time, this maximum period is extended proportionately. At least three months prior to the intended end date of the training program, the program director prepares a proposal to extend the training program and submits this to the Registration Committee Medical Specialists (RGS) for approval. In this proposal, the director also indicates the changes made to the training schedule and the individual training curriculum.

Disputes

In the case of disputes, the dispute regulations apply as described in the KNMG's regulations on medical specialties and profiles (*Regeling specialismen en profielen geneeskunst*). The most recent version of these regulations can be found in Dutch at www.knmg.nl/ore.

Rules for continuous assessment

1. Assessment of the trainee's competencies takes place throughout the training program. The norms take account of both the required attainment level and the relevant phase of the training program.
2. Assessments are carried out in accordance with the assessment plan.
3. Each assessment is recorded on an assessment form in the trainee's digital portfolio. The assessor and the trainee discuss and sign the assessment form.
4. In addition to the compulsory assessment methods, other non-compulsory assessment methods can be used. All assessment methods that the trainee can use for her assessment plan are described in the digital portfolio.

Rules for educational assessment

1. Halfway through the hospital placement and the ambulant psychogeriatric placement, the teacher and the trainer/supervisor carry out an educational assessment of the trainee's development of competencies. Additional educational assessments can be carried out at the request of the workplace-based trainer, teacher or trainee, e.g. in Year 1 between the first and second selective assessments.
2. The results of an educational assessment can lead to adjustments in the individual training curriculum. This assessment may also lead to an extra selective assessment and, if needed, to the initiation of an extra coaching pathway.
3. Each educational assessment is recorded on the assessment form in the trainee's digital portfolio. Trainee and assessors (trainer/supervisor or teacher) discuss and sign the assessment form.

Rules for selective assessment

1. Selective assessments take place at fixed times:
   - in the fourth month of the training program
   - at the end of Year 1
   - upon conclusion of the hospital placement
   - upon conclusion of the ambulant placement
   - upon conclusion of the training period in geriatric rehabilitation care
   - upon conclusion of the optional work placement
   - at least three months before the end of the training program.
2. The selective assessment is recorded on the assessment form in the digital portfolio. The assessor (trainer/supervisor or teacher) and trainee discuss and sign the assessment. This assessment also includes a recommendation to the program director concerning the trainee's suitability for continuing and completing the training program.
3. Before making a decision, the director checks to see whether the appraisal given by the trainer/supervisor is the same as that given by the teacher. Such a decision is one of the following:
a. Satisfactory: the trainee may continue the training program in accordance with the individual training curriculum;
b. Doubtful: the trainee can continue the training program subject to certain conditions. If necessary, the director extends the duration of the training program. Adjustments are made to the training schedule and the individual training curriculum.
c. Unsatisfactory: the trainee may not continue the training program; the director ends participation in the training program.
4. In cases where the trainee's suitability is in doubt, the director informs the trainee in writing of the conditions that the trainee must meet, the period of time within which these conditions must be met, and the way in which they will be assessed. This extra coaching pathway is concluded with a selective assessment.
5. If the trainee is unsuitable and considered incapable of continuing the training program, the director makes the decision to end participation in the training program. The director informs the trainee and the RGS of his or her decision in writing and terminates the training agreement.
6. In cases where the director's decision is to adjust, extend or end participation in the training program, he or she must inform the trainee about the dispute regulations.

Rules for final assessment

1. The final selective assessment takes place no later than three months prior to the intended end date of the training program. This assessment provides an answer to the question of whether, after having followed the training program, the trainee is fit for and capable of independently and properly carrying out the medical specialty of elderly care medicine.
2. The selective assessment is recorded on the assessment form in the digital portfolio. The assessor (trainer/supervisor or teacher) and trainee discuss and sign the assessment. This assessment also includes a recommendation to the program director concerning the trainee's suitability for and capability of completing the training program and, subsequently, independently and properly carrying out the medical specialty of elderly care medicine.
3. Before making a decision, the director checks to see whether the appraisal given by the trainer/supervisor is the same as that given by the teacher. Such a decision is one of the following:
a. Satisfactory: the trainee may complete the training program according to the individual training curriculum, on the condition that she passes the remaining tests before the intended end date of the training program and fulfils the compulsory training requirements;
b. Doubtful: the director extends the duration of the training program subject to conditions. Adjustments are made to the training schedule and the individual training curriculum.
c. Unsatisfactory the trainee may not complete the training program; the director ends participation in the training program and the trainee leaves the program early.
4. For full-time trainees, the maximum extension period is six months. The program director puts forward a proposal and informs the trainee of this in writing. He or she also submits the proposal to the RGS for approval.
5. In cases where the director does not consider the trainee capable of independently and properly carrying out the medical specialism of elderly care medicine, he or she can decide to end the training program early. The director informs the trainee and the RGS in writing of this decision.
6. In cases where the director's decision is to extend participation in the training program or end participation early, he or she must inform the trainee about the dispute regulations.

Rules for extra coaching pathway

1. An extra coaching pathway is an adapted individual training pathway that allows the trainee to continue the training program subject to certain conditions. The extra coaching pathway is concluded with a selective assessment.
2. When the extra coaching pathway is implemented, an individual coaching plan is drawn up to complement the individual training curriculum. This additional coaching plan lists the objectives of the extra pathway, the conditions under which it takes place, the time period and the way in which the trainee's development will be assessed.
3. The teacher records the extra coaching pathway on a form in the digital portfolio. Teacher, trainer/supervisor and trainee sign the document digitally.
4. An extra coaching pathway usually lasts for three months.
5. An extra coaching pathway can result in an extension of the training program. If this is the case, the director makes sure that the RGS has been informed at least three months prior to the intended end date of the training program.

Appendix 1 Critical professional situations / training period or work placement

	Critical professional situation (CPS)	Training period or work placement
1.	The patient/elderly patient and polypharmacy	PG/Som 1st year PG/Som 3rd year (including primary care consultations)
2.	The patient/elderly patient with abdominal symptoms	PG/Som 1st year
3.	The patient/elderly patient with weight loss	PG/Som 1st year
4.	The patient/elderly patient with skin disease/skin problems	PG/Som 1st year
5.	The patient/elderly patient with a wound	PG/Som 1st year
6.	The patient/elderly patient with (chronic) pain	PG/Som 1st year
7.	The patient/elderly patient with incontinence (urine and/or feces)	PG/Som 1st year
8.	The patient/elderly patient who has fallen	PG/Som 1st year
9.	The patient/elderly patient with breathlessness	PG/Som 1st year
10.	The confused patient/elderly patient	PG/Som 1st year
11.	The patient/elderly patient with reduced level of consciousness	PG/Som 1st year
12.	The patient/elderly patient with loss of neurological function	PG/Som 1st year
13.	The patient/elderly patient with fever	PG/Som 1st year
14.	The patient/elderly patient in the terminal phase	PG/Som 1st year PG/Som 3rd year (including primary care consultations)
15.	The patient/elderly patient with problematic behavior	PG/Som 1st year Ambulant work placement, 2nd year PG/Som 3rd year (including primary care consultations)
16.	The family/representative experienced as problematic	Ambulant work placement, 2nd year Geriatric rehabilitation care, 3rd year PG/Som 3rd year (including primary care consultations)
17.	The patient/elderly patient with memory problems	Ambulant work placement, 2nd year
18.	The patient/elderly patient with depression	Ambulant work placement, 2nd year
19.	The patient/elderly patient with anxiety	Ambulant work placement, 2nd year
20.	The overworked informal carer	Ambulant work placement, 2nd year Geriatric rehabilitation care, 3rd year
21.	The patient/elderly patient with problems of loneliness	Ambulant work placement, 2nd year
22.	The distrustful/suspicious patient/elderly patient	Ambulant work placement, 2nd year
23.	The patient/elderly patient with an addiction	Ambulant work placement, 2nd year
24.	Rehabilitation of the patient/elderly patient with a neurological condition	Geriatric rehabilitation care, 3rd year
25.	The patient/elderly patient in rehabilitation after an orthopedic operation	Geriatric rehabilitation care, 3rd year
26.	The patient/elderly patient in a diminished general condition	Geriatric rehabilitation care, 3rd year
27.	The patient/elderly patient who no longer wishes to live	Ambulant work placement, 2nd year PG/Som 3rd year (including primary care consultations)
28.	Active participation in a quality committee	PG/Som 1st year

Appendix 2 Critical professional situations / professional activities / testing

	Critical professional situation (CPS)	Professional activities	Tests
1.	The patient/elderly patient and polypharmacy	Carrying out a geriatric assessment Drawing up and implementing a treatment plan Advance care planning Communicating with patient/support system Collaborating with other care professionals Efficiently and effectively organizing own care practices	short practice assessment (SPA), treatment plan, discharge letter, audio-video recording (AV) of interview with patient's representative, 360° feedback
2.	The patient/elderly patient with abdominal symptoms	Carrying out a geriatric assessment Drawing up and implementing a treatment plan Practicing emergency elderly care medicine Advance care planning Evaluating the ability to give informed consent Communicating with patient/support system Collaborating with other care professionals Demonstrating ability to lead and collaborate in multidisciplinary teams Efficiently and effectively organizing own care practices	SPA, treatment plan, discharge letter, AV patient's representative, 360° feedback, audio-video recording of multidisciplinary team meeting (AV-MDT)
3.	The patient/elderly patient with weight loss	Carrying out a geriatric assessment Drawing up and implementing a treatment plan Advance care planning Evaluating the ability to give informed consent Communicating with patient/support system Collaborating with other care professionals Demonstrating ability to lead and collaborate in multidisciplinary teams Efficiently and effectively organizing own care practices	SPA, treatment plan, discharge letter, AV patient's representative, 360° feedback, AV-MDT, ethical consultations
4.	The patient/elderly patient with skin disease/skin problems	Carrying out a geriatric assessment Drawing up and implementing a treatment plan Communicating with patient/support system Collaborating with other care professionals Efficiently and effectively organizing own care practices	SPA, treatment plan, discharge letter, AV patient's representative, 360° feedback

5.	The patient/elderly patient with a wound	Carrying out a geriatric assessment Drawing up and implementing a treatment plan Practicing emergency elderly care medicine Advance care planning Communicating with patient/support system Collaborating with other care professionals Demonstrating ability to lead and collaborate in multidisciplinary teams Efficiently and effectively organizing own care practices	SPA, treatment plan, discharge letter, referral letter, AV patient's representative, 360° feedback, AV-MDT
6.	The patient/elderly patient with (chronic) pain	Carrying out a geriatric assessment Drawing up and implementing a treatment plan Practicing emergency elderly care medicine Communicating with patient/support system Collaborating with other care professionals Demonstrating ability to lead and collaborate in multidisciplinary teams Efficiently and effectively organizing own care practices	SPA, treatment plan, discharge letter, referral letter, AV patient's representative, 360° feedback, AV-MDT, ethical consultations
7.	The patient/elderly patient with incontinence (urine and/or feces)	Carrying out a geriatric assessment Drawing up and implementing a treatment plan Advance care planning Evaluating the ability to give informed consent Communicating with patient/support system Collaborating with other care professionals Demonstrating ability to lead and collaborate in multidisciplinary teams Efficiently and effectively organizing own care practices	SPA, treatment plan, discharge letter, AV patient's representative, 360° feedback, AV-MDT
8.	The patient/elderly patient who has fallen	Carrying out a geriatric assessment Drawing up and implementing a treatment plan Practicing emergency elderly care medicine Coping with obligatory care and restrictions of personal freedom Communicating with patient/support system Collaborating with other care professionals Demonstrating ability to lead and collaborate in multidisciplinary teams Efficiently and effectively organizing own care practices	SPA, treatment plan, discharge letter, referral letter, AV patient's representative, 360° feedback, AV-MDT
9.	The patient/elderly patient with breathlessness	Carrying out a geriatric assessment Drawing up and implementing a treatment plan Practicing emergency elderly care medicine Advance care planning Communicating with patient/support system Collaborating with other care professionals Efficiently and effectively organizing own care practices	SPA, treatment plan, discharge letter, referral letter, AV patient's representative, 360° feedback

10.	The confused patient/elderly patient	Carrying out a geriatric assessment Drawing up and implementing a treatment plan Practicing emergency elderly care medicine Advance care planning Evaluating the ability to give informed consent Coping with obligatory care and restrictions of personal freedom Communicating with patient/support system Collaborating with other care professionals Demonstrating ability to lead and collaborate in multidisciplinary teams Efficiently and effectively organizing own care practices	SPA, treatment plan, discharge letter, referral letter, AV patient's representative, 360° feedback, AV-MDT
11.	The patient/elderly patient with reduced level of consciousness	Carrying out a geriatric assessment Drawing up and implementing a treatment plan Practicing emergency elderly care medicine Advance care planning Coping with obligatory care and restrictions of personal freedom Communicating with patient/support system Collaborating with other care professionals Demonstrating ability to lead and collaborate in multidisciplinary teams Efficiently and effectively organizing own care practices	SPA, treatment plan, discharge letter, referral letter, AV patient's representative, 360° feedback, AV-MDT
12.	The patient/elderly patient with loss of neurological function	Carrying out a geriatric assessment Drawing up and implementing a treatment plan Practicing emergency elderly care medicine Advance care planning Evaluating the ability to give informed consent Coping with obligatory care and restrictions of personal freedom Communicating with patient/support system Collaborating with other care professionals Demonstrating ability to lead and collaborate in multidisciplinary teams Efficiently and effectively organizing own care practices	SPA, treatment plan, discharge letter, referral letter, AV patient's representative, 360° feedback, AV-MDT
13.	The patient/elderly patient with fever	Carrying out a geriatric assessment Drawing up and implementing a treatment plan Practicing emergency elderly care medicine Communicating with patient/support system Collaborating with other care professionals Efficiently and effectively organizing own care practices	SPA, treatment plan, discharge letter, referral letter, AV with patient's representative, 360° feedback

14.	The patient/elderly patient in the terminal phase	Carrying out a geriatric assessment Drawing up and implementing a treatment plan Advance care planning Evaluating the ability to give informed consent Communicating with patient/support system Collaborating with other care professionals Demonstrating ability to lead and collaborate in multidisciplinary teams Efficiently and effectively organizing own care practices	SPA, treatment plan, discharge letter, AV patient's representative, 360° feedback, AV-MDT
15.	The patient/elderly patient with problematic behavior	Carrying out a geriatric assessment Drawing up and implementing a treatment plan Practicing emergency elderly care medicine Advance care planning Evaluating the ability to give informed consent Coping with obligatory care and restrictions of personal freedom Communicating with patient/support system Collaborating with other care professionals Demonstrating ability to lead and collaborate in multidisciplinary teams Efficiently and effectively organizing own care practices	SPA, treatment plan, discharge letter, referral letter, AV patient's representative, 360° feedback, AV-MDT, ethical consultations
16.	The family/representative experienced as problematic	Drawing up and implementing a treatment plan Advance care planning Communicating with patient/support system Collaborating with other care professionals Demonstrating ability to lead and collaborate in multidisciplinary teams Efficiently and effectively organizing own care practices	treatment plan, discharge letter, AV patient's representative, 360° feedback, AV-MDT, ethical consultations
17.	The patient/elderly patient with memory problems	Carrying out a geriatric assessment Drawing up and implementing a treatment plan Advance care planning Evaluating the ability to give informed consent Coping with obligatory care and restrictions of personal freedom Communicating with patient/support system Collaborating with other care professionals Demonstrating ability to lead and collaborate in multidisciplinary teams Efficiently and effectively organizing own care practices	SPA, treatment plan, discharge letter, AV patient's representative, 360° feedback, AV-MDT

18.	The patient/elderly patient with depression	Carrying out a geriatric assessment Drawing up and implementing a treatment plan Evaluating the ability to give informed consent Coping with obligatory care and restrictions of personal freedom Communicating with patient/support system Collaborating with other care professionals Demonstrating ability to lead and collaborate in multidisciplinary teams Efficiently and effectively organizing own care practices	SPA, treatment plan, discharge letter, AV patient's representative, 360° feedback, AV-MDT
19.	The patient/elderly patient with anxiety	Carrying out a geriatric assessment Drawing up and implementing a treatment plan Communicating with patient/support system Collaborating with other care professionals Demonstrating ability to lead and collaborate in multidisciplinary teams Efficiently and effectively organizing own care practices	SPA, treatment plan, discharge letter, AV patient's representative, 360° feedback, AV-MDT
20.	The overworked informal carer	Drawing up and implementing a treatment plan Advance care planning Communicating with patient/support system Collaborating with other care professionals Demonstrating ability to lead and collaborate in multidisciplinary teams Efficiently and effectively organizing own care practices	treatment plan, discharge letter, AV patient's representative, 360° feedback, AV-MDT, ethical consultations
21.	The patient/elderly patient with problems of loneliness	Carrying out a geriatric assessment Drawing up and implementing a treatment plan Advance care planning Evaluating the ability to give informed consent Communicating with patient/support system Collaborating with other care professionals Demonstrating ability to lead and collaborate in multidisciplinary teams Efficiently and effectively organizing own care practices	SPA, treatment plan, discharge letter, AV patient's representative, 360° feedback, AV-MDT
22.	The distrustful/suspicious patient/elderly patient	Carrying out a geriatric assessment Drawing up and implementing a treatment plan Advance care planning Evaluating the ability to give informed consent Communicating with patient/support system Collaborating with other care professionals Demonstrating ability to lead and collaborate in multidisciplinary teams Efficiently and effectively organizing own care practices	SPA, treatment plan, discharge letter, AV patient's representative, 360° feedback, AV-MDT

23.	The patient/elderly patient with an addiction	Carrying out a geriatric assessment Drawing up and implementing a treatment plan Evaluating the ability to give informed consent Communicating with patient/support system Collaborating with other care professionals Demonstrating ability to lead and collaborate in multidisciplinary teams Efficiently and effectively organizing own care practices	SPA, treatment plan, discharge letter, AV patient's representative, 360° feedback, AV-MDT, ethical consultations
24.	Rehabilitation of the patient/elderly patient with a neurological condition	Carrying out a geriatric assessment Drawing up and implementing a treatment plan Advance care planning Evaluating the ability to give informed consent Communicating with patient/support system Collaborating with other care professionals Demonstrating ability to lead and collaborate in multidisciplinary teams Working with management Efficiently and effectively organizing own care practices Participating in integrated care/treatment as an elderly care physician	SPA, treatment plan, discharge letter, AV patient's representative, 360° feedback, AV-MDT, ethical consultations
25.	The patient/elderly patient in rehabilitation after an orthopedic operation	Carrying out a geriatric assessment Drawing up and implementing a treatment plan Advance care planning Evaluating the ability to give informed consent Communicating with patient/support system Collaborating with other care professionals Demonstrating ability to lead and collaborate in multidisciplinary teams Working with management Efficiently and effectively organizing own care practices Participating in integrated care/treatment as an elderly care physician	SPA, treatment plan, discharge letter, AV patient's representative, 360° feedback, AV-MDT
26.	The patient/elderly patient in a diminished general condition	Carrying out a geriatric assessment Drawing up and implementing a treatment plan Advance care planning Evaluating the ability to give informed consent Communication with patient/support system Collaborating with other care professionals Demonstrating ability to lead and collaborate in multidisciplinary teams Efficiently and effectively organizing own care practices Participating in integrated care/treatment as an elderly care physician	SPA, treatment plan, discharge letter, AV patient's representative, 360° feedback, AV-MDT

27.	The patient/elderly patient who no longer wishes to live	Carrying out a geriatric assessment Drawing up and implementing a treatment plan Advance care planning Evaluating the ability to give informed consent Communication with patient/support system Collaborating with other care professionals Demonstrating ability to lead and collaborate in multidisciplinary teams Efficiently and effectively organizing own care practices	SPA, treatment plan, discharge letter, AV patient's representative, 360° feedback, AV-MDT, ethical consultations
28.	Active participation in a quality commission	Collaborating with other care professionals Working with management Efficiently and effectively organizing own care practices Participating in and contributing to quality monitoring of care/treatment.	360° feedback

Appendix 3 Glossary

Assessment	An appraisal of the state of affairs in terms of a trainee's development of competencies.
Assessment dossier	Documents demonstrating the trainee's development; decisions on selection are made based on this dossier.
Assessment plan	Elaboration of the testing and assessment protocol that provides an overview of the testing and assessment methods.
CHVG Framework Decision	The framework decision compiled by the CHVG that stipulates the general requirements for the training programs for general physicians, elderly care physicians and physicians for persons with intellectual disabilities; as well as the requirements for the recognition of trainers, training facilities or training institutes in these specialties; and the registration and re-registration of doctors in these specialties.
Competency	The competence to properly perform a professional activity in a specific, authentic context by having and combining knowledge, insight, skills, attitude, and personal traits and characteristics.
Critical professional situations (CPS)	Professional situation that is representative of the field of work of the elderly care physician[13].
Director	Head of the specialist training program for elderly care physicians (unless otherwise indicated).
Dispute regulations	The procedure regarding disputes that relate to the structure, content and duration of the training program or to inclusion in the training register, as stipulated in the KNMG's regulations on medical specialties and profiles (*Regeling specialismen en profielen geneeskunst*).
Educational assessment	An assessment of a trainee's development of competencies that may be used to streamline the training program, e.g. by adjusting the ITC.
Exemption	The exemption from the obligation to follow a part of the training program resulting in a shorter training period.

[13] In the context of this national training curriculum, the description applies specifically to elderly care physicians.

Extra coaching pathway (ECP)	An individually adapted training pathway that allows the trainee to continue her training subject to certain conditions and that is concluded with a selective assessment.
Facility	An organizational unit, having one or more locations, where a field of medicine as specified by the CGS is practiced, or where one or more individual health care professions are carried out.
Final assessment	An assessment of whether the trainee, upon completion of the training program, is considered fit for and capable of independently and properly carrying out the medical specialty for which she has been trained.
Formal tuition	Structured tuition in the form of a course, to complement practical learning.
Individual training curriculum (ITC)	Description of the training curriculum for an individual, indicating the way in which competencies can be acquired.
Institute	An organization that has links to a university and that coordinates the entire training program and provides the associated formal tuition.
National training curriculum	Curriculum that defines the framework of the organization and implementation of the training program.
Personal study	Activities that are necessary for successful completion of the training program and but that do not form a part of either the practical training or the formal tuition.
Portfolio	A collection of documents compiled by the trainee that systematically records the progress that she had made during the training program.
Practical training	The practical development of competencies required for the training program.
Professional activity	Activity that is one of the core tasks of the profession of an elderly care physician[14].
Progress interview	A structured interview between the trainer/supervisor or teacher and the trainee to reflect on the training program and on the trainee's development in particular.

[14] In the context of this national training curriculum, the description applies to the specific target group of elderly care physicians.

Selective assessment	An assessment given by the director indicating whether he/she considers the trainee fit for and capable of continuing the training program, based on assessments provided by the supervisor and teacher.
Supervisor	The person providing the work placement at a work placement facility as part of the specialist training program and who has been approved by the RGS for the practical training of trainees.
Teacher	A member of staff at the training institute who is involved in the teaching and assessment of trainees.
Testing	Determining if and to what extent learning goals have been achieved.
Trainee	A medical doctor training to be a specialist, in this case an elderly care physician. The Dutch term for this is *aios*, an abbreviation of an *arts in opleiding tot specialist,* the equivalent of a resident in the US or a specialty registrar in the UK.
Trainer	An elderly care physician who has been approved by the RGS for the training program and who is responsible for either the entire training program or a part of it.
Training facility	A facility in the Netherlands (or location thereof) that has been approved by the RGS and where practical training takes place.
Training institute	An institute in the Netherlands that has been approved by the RGS for providing the training program for elderly care physicians.
Training program	The specialist training program for elderly care physicians.
Training schedule	An overview of the start and end dates, and the sequence and the locations of the trainee's training and parts thereof, in accordance with the training curriculum.
Tutor	Each trainee is assigned one of the teachers as their personal tutor for the duration of the training course.
Work placement	The part of the training program that takes place outside the specialty of elderly care medicine.

Work placement facility	A facility, or department thereof, having one or more locations that has been approved by the RGS and where a work placement for a specialty can be carried out.
Work-training plan	Plan that describes the structure and content of the work-based and theoretical parts of the program at the trainer's place of work, the training facility or the work placement facility, taking the training curriculum into consideration.

Appendix 4 The competencies of elderly care physicians

In 2012, Verenso compiled a professional profile and list of competencies of elderly care physicians. This professional profile is a specification of the general competencies of a medical specialist as presented in 2003 by one of the predecessors of the CGS, the Dutch Central Board for Medical Specialisms (CCMS)[15]. The professional profile has been translated into English (Verenso, 2015) and lists seven areas of competence, as specified below.

Competencies of elderly care physicians

Medical expertise

"Medical expertise" is the core area of the profession. The other competencies cannot be seen separately from this core area. The descriptions given below combine the steps diagnosis/treatment/prevention and the steps of a cyclical care process. In addition a distinction is made between direct patient care (1), and the carrying out of consultations (2).

Elderly care physicians are able to:

1 Use diagnostic and therapeutic skills for the purpose of providing functional, effective and patient-centered care within an integral, multidisciplinary, problem-oriented, and cyclical care process.

1.1 Make well-supported decisions on diagnostic and therapeutic interventions based on information and preferences and patient consent, scientific evidence and clinical judgment.

1.1.1 Make diagnoses and prognoses on psychogeriatric and gerontopsychiatric disease entities and intercurrent illnesses, which are focused not only on making diagnoses but also on the identification of associated disorders, polypharmacy, limitations and handicaps and the care requirements and wishes of the patient. Diagnoses can be made at various stages of the symptomology, i.e. acute, chronic and terminal.
More specifically, they can effectively carry out the following:

- history taking – from the patient or from someone familiar with the history;
- general physical examination;
- specific further examinations (orienting neurological examinations and neuropsychological tests/examinations);
- psychiatric and psychogeriatric examinations;
- assessment of a patient's capacity;
- recognition of the necessity to adjust the patient's legal status, prevention of the use of restraints and compulsory treatment, and if unavoidable to indicate that restraints should be used;
- requests for laboratory tests, technical and specialist investigations; assessment and finalization of appropriate individual care on the basis of disease-centered diagnostics and projected consequences of disease;
- estimation of how the need for care will develop (the prognosis);
- analysis and interpretation the findings of investigations (problem clarification, analysis and definition, differential diagnostics, system analysis).

[15] The CHVG also uses this model for its regulations concerning the training programs that at the time fell within the scope of this board.

1.1.2 Carry out (or delegate) treatment for chronic illnesses in accordance with the medical treatment plan. This treatment is aimed at cure and at maintenance treatment and includes:
- starting and coordinating pharmacotherapy;
- requesting paramedical and psychosocial treatment or interventions;
- indicating specific interventions by nurses or care assistants;
- carrying out or delegating reserved procedures;
- applying system interventions and other psychotherapeutic techniques;
- carrying out crisis intervention (strategies for intervening in acute situations);
- referring to or consulting with external specialists.

1.1.3 Implement individualized preventive strategies:
- the prevention of illness and loss of function;
- the prevention of deterioration in illness and loss of function.

1.1.4 Draw up a medical treatment plan.

1.1.5 Competently carry out all medical-technical procedures that are essential in professional practice.

1.1.6 Evaluate and adjust goals of treatment in consultation with the patient and other care providers in a multidisciplinary discussion, and to coordinate this.

2 Undertake effective consultations

2.1 in patient care,
2.2 in education,
2.3 in legal matters (obtaining court orders for e.g. compulsory hospitalization)

Communication

The enabling competencies associated with "Communication" cover all communication and collaboration with the patient and their support system. Point 3 comprises the entirety of the relationship with the patient/support system. Point 4 describes the gathering of information. Point 5 concerns the conveying of information.

3 Build effective treatment relationships with patient and their support system

3.1 correctly engage with the diversity of ethnic and cultural backgrounds of patients;
3.2 correctly engage with patients who have disorders of cognition and communication;
3.3 create an environment that is characterized by understanding, trust, empathy and confidentiality.

4 Effectively gather relevant patient information

4.1 gather relevant information from the patient and their support system and from other healthcare professionals;
4.2 show interest in the ideas, worries and expectations of the patient concerning the origins, the nature and the treatment of his or her disease or problems;
4.3 assess the value of the influence of factors such as age, gender, ethnocultural background, level of education, social network and emotion.

5 Discuss relevant information with patient and family

5.1 obtain consent for the medical treatment plan;
5.2 give information and advice to the patient in a respectful and sensitive manner and promote understanding, discussion and active patient participation in decisions about his or her treatment;
5.3 listen effectively to a patient and their family and friends to ensure optimal and consistent patient care for the patient and their family;
5.4 verify that the patient and family have understood what has been said;
5.5 keep clear and accurate medical records.

Collaboration

The enabling competencies associated with "Collaboration" cover the collaboration with all those care providers who, along with the elderly care physician, are involved with care for the patient. Point 6 concerns collaboration with the individual patient and those around them, while point 7 deals with matters beyond the bounds of patient care. This includes matters such as committee work, research and education.

6 Carry out effective discussions
- with the multidisciplinary team about the care and treatment plan;
- with colleagues from primary and secondary care about the medical situation of the patient;
- with care providers from other institutions concerning medical and general care for the patient (therapeutic environment etc.).

6.1 recognize the limits of their own professional expertise during such discussions;
6.2 acknowledge the role and expertise of other parties involved;
6.3 involve the patient and their families in decision-making;
6.4 explicitly integrate the opinions of the patient and care providers into the medical treatment plan;
6.5 coordinate the multidisciplinary team.

7 Contribute to effective interdisciplinary collaboration and shared care along the medical axis

7.1 shape modifications and changes in the supply of care, recognize the expertise of other team members, respect the opinions and roles of individual team members, contribute towards healthy team development and conflict resolution, use own expertise to support the team.

Role as scholar

The enabling competencies associated with "Medical expertise", such as diagnosing and treating, require a great deal of readily available knowledge. The enabling competencies associated with "Role as scholar" are aimed at the process of acquiring and managing knowledge. Point 8 is aimed at critically evaluating the professional literature. Point 9 refers to participation in projects aimed at increasing knowledge and quality assurance. Point 10 refers to personal development and point 11 to the sharing of personal knowledge with others.

8 Critically evaluate medical information concerning their own professional activities in the interests of personal clinical assessment and decision-making skills

8.1 formulate questions in such a way that, in principle, they can be answered using the professional literature;
8.2 efficiently search for research data;
8.3 assess the quality of research data;
8.4 keep up-to-date with the evidence base for quality norms.

9 Advance the broadening and development of scientific professional knowledge by taking part in joint research projects, quality assurance or the development of guidelines for professional practice

9.1 conduct an independent literature study;
9.2 participate in collective research projects;
9.3 participate in quality assurance;
9.4 participate in developing guidelines and treatment protocols.

10 Develop and maintain a personal program for continuing professional training and development

10.1 set personal learning objectives;
10.2 choose suitable learning methods;
10.3 critically evaluate results for use in personal professional practice.

11 Advance the expertise of students, residents, junior doctors, nurse specialists, nurse practitioners, physician assistants, medical colleagues, patients and others involved in the health services, by means of teaching, education and publication

11.1 help others formulate their learning goals;
11.2 advise others on professional development;
11.3 provide constructive feedback;
11.4 apply the principles of adult teaching and learning in interaction with others.
11.5 guide and supervise those persons who carry out tasks under their responsibility.

Health advocacy

The enabling competencies associated with "Health advocacy" cover the work of an elderly care physician in society and the ways in which the elderly care physician can act as an advocate on behalf of the patient. Point 12 focuses on the individual doctor-patient relationship and on any larger groups. Point 13 covers larger groups such as infection prevention.

12 Know and recognize those determinants of patient health in order to promote the health of patients and that of the further community

12.1 adapt patient care and disseminate information in order to promote health and to increase insight into management policy;
12.2 stimulate coping skills;
12.3 stimulate active participation in medical decision-making.

13 Identify and respond to questions where an advocate for patients, professions or the community is required

13.1 identify groups at risk;
13.2 recognize policy measures that affect health;

13.3 apply methods to influence the development of health care and social policy.

Management

The enabling competencies associated with "Management" cover the organization of personal practice and the setting of priorities (point 14) as well as working within an organization (point 15).

14 Manage their work in such a way as to create a balance between professional activities, the requirement for further development and their private lives

14.1 practice effective time management;
14.2 evaluate their own practice in order to recognize realistic expectations.

15 Work effectively and efficiently as an independent practitioner or within a health care organization

15.1 ensure good working practice;
15.2 function within the wider management systems of organizations or group practice, such as multidisciplinary teams and committees and quality committees;
15.3 use the resources available for patient care responsibly;
15.4 use information technology to provide optimal patient care, training and other activities.

Professionalism

The enabling competencies associated with "Professionalism" cover the standards of quality that are required in order to practice as an elderly care physician. This competency is therefore linked to all other competencies. It also includes dealing responsibly with legal and ethical questions related to this enabling competence.

16 Deliver high-quality care in an honest, open and compassionate manner

16.1 reflect on their own actions as elderly care physicians;
16.2 promote transparency concerning methods of medical practice by carrying out inspections, discussing case histories etc.
16.3 recognize their own responsibilities for their actions as elderly care physicians;
16.4 recognize personal and professional boundaries;
16.5 accept the consequences of mistakes they make in their own practice;
16.6 call others to account in the case of incidents and near-incidents.

17 Practice medicine in accordance with the accepted ethical and legal norms of the profession

17.1 operate within a legal framework such as the Medical Treatment Contracts Act (WGBO), the Psychiatric Hospitals Compulsory Admission Act (BPOZ), the Individual Health Care Professions Act (BIG) etc.
17.2 conduct themselves professionally;
17.3 respond effectively to ethical dilemmas;
17.4 manage discussions on ethical problems.

Appendix 5 Composition of sounding board group and task groups

Members of the sounding board group

Dieter Boswijk
Wilma Deerenberg
Nienke Nieuwenhuizen
Richard Faaij
Paul Geelen
Aafke de Groot
Linda Hartman
Cees Hertogh
Lucie van Iersel
Rob Kok
Martin Kooij
Sanne Kouwenhoven
Jan Lavrijsen
Willemijn Scholvinck
Pauline Lorier
Angelique Nepal
Nynke Scherpbier
Siebe Swart
Geert van der Velden
Dick Verburg
Anne de Wit

Members of the task group on Critical Professional Situations & Assessment

Martin Smalbrugge (Chair)
Marian Keijzer
Margot Klijberg
Rachel Mak
Peronneke Slaets
Judith Wagter

Members of the task group on Practice & Organization

Paul Went (Chair until April 2014)
Michelle Kromhout (Chair from April 2014)
Wim van den Dool
Belinda Hopmans
Beatrijs de Leede
Marc Stalpers
Michiel van der Wel
Edith Wendt

Members of the task group on Formal Tuition

Eric van der Geer (Chair)
Jos van Berkel
Marcia Kersten
Elize Oosterling
Ilse Kleine Schaars
Johan Verloop