



# Elderly care physicians in the Netherlands

Professional profile and competencies



# **Elderly care physicians in the Netherlands, professional profile and competencies**

## Colofon

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## Working group members:

- Mrs M. Bezemer, MD, elderly care physician at Zuwe Zorgcentrum Woerden
- Mr C.M.P.M. Hertogh, MD, Professor of Elderly Care Medicine, Department of Nursing Home Medicine, EMGO Institute for Health and Care Research, VU University Medical Center
- Mr R.T.C.M. Koopmans, MD, Professor of Elderly Care Medicine, specializing in long-term care, UMC St. Radboud, Nijmegen
- Mrs G.M.A. Piek, MD, elderly care physician at Rivas Zorggroep, Gorinchem
- Mr C.J.G. Theeuwes, MD, elderly care physician
- Mr D. Verburg, MD, social geriatrician and elderly care physician
- Mr F.J. Roos, LL.M., executive director of Verenso, Utrecht
- Mr R.B.J. Knuiman, LL.M., legal policy officer Verenso, Utrecht
- Mrs M.L.M.Th. Bogaerts, MSS, policy officer Verenso, Utrecht

With thanks to Verenso's quality control committee

- Mrs M. Bezemer, MD, elderly care physician
- Mrs R.M. Dijkman, MD, elderly care physician
- Mrs A.J.J.M. Keijzer-van Laarhoven, MD, elderly care physician
- Mrs J.M.J. Mulders, MD, elderly care physician
- Mrs T.C.M. Nieuwlands, MD, elderly care physician
- Mrs C. Ramaker, MD, elderly care physician
- Mr S.J. Roufs, MD, social geriatrician
- Mrs L.L.E. Stuyfzand, MD, elderly care physician
- Mr R. Verfaillie, MD, elderly care physician and specialized primary care physician

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# Preface

Life expectancy in the Netherlands is currently higher than expected back in 2008. Between 2012 and 2040, the number of people aged 65 and over is set to increase from 2.4 to 4.6 million. This figure represents 143,000 more elderly people than the figure given in the previous prognosis by Statistics Netherlands. Over the next 50 years, life expectancy for men is expected to increase from 78.8 to 84.5 years, and for women from 82.7 to 87.4 years. In 2040 the maximum population of the Netherlands will total 17.8 million people, about 360,000 higher than was expected in 2008.

This means that maximum life expectancy is a flexible concept that in the future may well be stretched far further. As a result, rather than seeing a decrease in the number of years that we live with chronic disease – as James Fries had hoped – we are more likely to see an increase. And there is research to back this up: despite an increase in life expectancy in general (although in this respect the Dutch still lag some way behind the Japanese for example), we are seeing a decrease in healthy life expectancy.

There is no natural “norm” for determining what we consider to be normal or healthy; all we have is our historic experience. And why would we set this as our standard when considering old age? This is the reason why Rudi Westerdorp suggests referring to age-related deficiencies as disease. This strategy was conceived by the National Institute of Aging in the United States. In the 1980s, while the institute was unable to obtain funding for research into senility, it was able to do so for research into Alzheimer’s disease – after a rhetoric renaming of the same phenomenon. Giving a phenomenon a name and establishing a diagnosis are gaining in popularity: for example, someone who has trouble walking is now said to have sarcopenia. Creating a diagnosis often makes it easier to draw up a prognosis and treatment program or to take preventive measures in order to limit the expected effects of the disease.

In the complex environment of health, we endeavor to use a network approach to take steps towards high-quality medical care for the elderly. Through continuing cooperation, we strive for effective and efficient working practice. This means implementing a collective and consistent program that is based on the best knowledge available, and that is represented by all appropriate parties, including family doctors, medical specialists and elderly care physicians as well as other related treating professionals. Uniform management is a prerequisite in this.

Franz Roos  
Executive director of Verenso

# **Part A**

The context and the profession

# Introduction

## 1.1 Rationale

Elderly care medicine is a relatively young specialism that is finding its way in a changing society. This means that both the profile and professional activities of elderly care physicians<sup>1</sup> are still evolving. On the one hand, human life expectancy has increased, and on the other, a greater emphasis is being put upon the quality of life experienced by the patient. Quality of life is linked to the degree of autonomy and independence experienced by the patient. In a care-dependent patient, autonomy entails that the patient has a right to self-determination, is given respect for personal space, retains control over their personal life, and is involved in agreements about their complex medical care. For the patient, quality of life goes hand in hand with respect, attention and safety.

Currently, elderly individuals with very complex medical needs – those who have one or more chronic disease (multipathology)<sup>2</sup> and/or use multiple medications (polypharmacy) – stay living in their own homes for longer. The patient's experience of quality of life can be improved by setting up a well-functioning network that includes the family doctor, the elderly care physician and other healthcare professionals. In this respect, when complications or escalations occur, the expertise of elderly care physicians is of great value, in that they help to minimize the consequences of decline and/or complications. This complex medical care must be implemented on time and independent of location.

### History

- In 1989, the two-year training program in nursing home medicine started.
- In 1990, nursing home medicine was recognized as an official medical discipline in the Netherlands.
- In 1992, a Dutch policy document appeared describing the job description and professional activities of the nursing home physician (Functieomschrijving en takenpakket van de verpleeghuisarts). This document has guided the development of quality policy, of training program curricula and of the de-institutionalization of nursing home medicine.
- In 2003, this document was revised (Nota Takenpakket verpleeghuisarts/sociaal geriater).
- In 2006, the Dutch Association for Nursing Home Physicians (NVVA) fused with the Dutch Association for Social Geriatrics (NVSG).
- In 2007, two-year training program was extended by 12 months.
- In 2009, the name "nursing home physician" was changed to "elderly care physician". This is the name used both by formerly registered nursing home physicians and by physicians who have successfully completed the training program to become an elderly care physician, and who are registered with the Ministry of Health, Welfare and Sport as an individual healthcare professional (on the so-called BIG register).

Over the past few years the discipline has developed greatly both in terms of content and in terms of the scope of the discipline. This was a reason for the Verenso board of directors to want to update the professional profile, in close consultation with their members.

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1 While the rest of this document only refers to elderly care physicians, the term also includes registered social geriatricians.

2 While this document uses the term multimorbidity, it should be noted that a singular chronic illness can be so complex that it also requires the involvement of an elderly care physician.



The Dutch policy document entitled "The 'general geriatrician' at home in elderly care – Policy plan of the NVVA (renamed Verenso in 2009) 2008-2012" [De 'algemeen geriater' thuis in de ouderenzorg – Beleidsplan van de NVVA 2008-2012'] states the following:

"the heart of Verenso's mission is to support the medical geriatric expertise for the frail elderly and the chronically ill who have or are expected to have complex issues. This frailty is caused by the presence of several illnesses at the same time (multipathology). The aim of elderly care medicine is to provide medical care to those with complex geriatric healthcare issues with an emphasis on enhancing the functional autonomy and quality of life of the patient. This complex medical care is provided independently of the patient's location."

It is this statement and the forecast sketched in a position paper from the Royal Dutch Medical Association (KNMG) entitled "Strong medical care for frail elderly" [Sterke medische zorg voor kwetsbare ouderen] that are guiding the development of elderly care medicine and the positioning of the profession for the coming years.

## 1.2 Developments in health

### Trends and developments

The Dutch are in good health. Health and society are very much interrelated, with prosperity and life expectancy influencing each other. The twentieth century saw economic growth in Europe that was accompanied by a decrease in mortality. In the 1970s, Thomas McKeown pointed to the fact that these developments are most likely causally related. Robert Fogel, winner of the 1993 Nobel Memorial Prize in Economic Sciences, has demonstrated conclusively that – for the most part – economic growth results in better nutrition and health. It would therefore appear that the phenomenon is an interaction involving various societal developments.

Background (socio-economic status) and level of education are to a large extent what determine a person's opportunities in Dutch society. In this respect, it is not only about having money, means and power, but also about having access to information, about cultural and social participation and about health. Many chronic diseases are related to an unhealthy lifestyle. Some segments of the Dutch population – particularly groups with very little education and/or with a low social economic status – engage in several types of unhealthy behavior at the same time. This effect is seen in all age categories. However, changing lifestyle is no easy prospect.

Health and disease are not static concepts. What we consider to be "health" depends strongly on the social context. Society has certain expectations about what constitutes "normal functioning" – the so-called human capital. At the same time, it is the people themselves who have high expectations of their functioning. This means that minor discomforts are more likely to be considered an illness for which something can be done. These developments have led to a process of re-definition of what we consider to be normal and abnormal.

Increasingly, the discussion is about how disabilities affect a person's sense of health and their social participation. The degree of participation in society depends on the patient's degree of autonomy and independence. Participation in society – adapted to a person's disabilities – is an important part of perceived quality of life. A consequence of this is that there is a shift in perspective from only considering the diseases, illnesses and their risk factors towards also supporting disabilities and preventing complications and deterioration in those who are ill. Participation in society remains important to people, also after the elderly become dependent on care, medical or otherwise. This dependence on care means that the person's participation in society becomes more dependent on their contacts with family and friends.

### 1.3 The elderly in society

Those older persons who live in their own social environment are focused on quality of life. For example, they may wonder "what is important?", "what do I care about?" and "what makes life worth living?" Older persons themselves refer to health, their spouse/partner, children and grandchildren and other family members as being "important in their life". Loss of health and relationships and the fear of this loss affect their quality of life. Older persons express the wish to live independently for as long as possible. The broader interpretation of frailty therefore overlaps with the notions of "quality-of-life" and "successful aging". Indeed, the concept of frailty distinguishes itself more acutely from the concepts "comorbidity", "multimorbidity" and "physical disabilities" by taking not only organic and physical problems into account but also the way older persons themselves experience psychological and social frailty.

According to a population model drawn up by the Netherlands Institute for Social Research (SCP), the number of frail persons aged 65 years and older in the Netherlands is expected to rise from 2010 to 2030 by between 700,000 and more than a million. This amounts to an increase of more than 300,000 frail older persons in the coming 20 years. The percentage of frail over-65s will fall over the same period from 27% to 25%. According to SCP forecasts, the profile of the frail elderly population will also change over the next two decades. From around 2025 onwards, there will be an increase in the percentage of people aged over 85 who are living alone, though this is a relatively small group. Similarly, the percentage of people with mild disabilities, also a relatively small group, will increase.

#### Frailty is not a state but a process

There is a small group of older persons without comorbidity/multimorbidity or severe long-term disabilities. This group of older persons live independently, are relatively young and their frailty lies primarily in the psychological and social domains. In this respect they too belong to the frail elderly. Research has shown that a quarter of elderly people above the age of 65 are psychologically frail. Many of the people in this group report symptoms of depression or anxiety. Clinical practice has shown that older persons generally do not seek help for psychological problems. Extra attention on the part of professionals for the psychological health of frail older persons is therefore called for. An additional problem is that older persons do not always report their psychological problems clearly. They often describe only the physical symptoms that accompany depression or anxiety, such as pain or tiredness. Or they say that they can no longer get enthusiastic about anything. This is often treated by doctors as a somatic complaint, so that depression or anxiety is not recognized. Recognizing and treating symptoms of depression and anxiety in frail older persons could improve their quality of life considerably.

In addition, depression and anxiety are too often still regarded as simply a part of aging. There is also the perception that it is not possible to treat older persons adequately, whereas there are in fact several evidence-based treatments for older persons, such as problem-solving therapy and the life review method. These are often short-term treatments that could be very easily provided in the primary care system, and thus close to older persons' home setting.

Loneliness in older persons is a major problem and is relatively common among those who are psychologically frail. Both local social policy and the Social Support Act (WMO) are important in preventing social isolation and loneliness. However, owing to the comorbidity of other psychological complaints such as depression, there is also a task for care professionals from primary and secondary healthcare systems. Treatment of depression ought to go hand-in-hand with measures to help lift people from their social isolation and eliminate feelings of loneliness.

Around 30% of frail older persons report problems with memory. These problems may be associated with age or with poor physical and mental health. The memory problems sometimes disappear when the psychological problems are eliminated. While dementia is still not readily treatable, the associated behavioral and psychological problems are. Early diagnosis is important for the patient and those around them. Early recognition of beginning dementia allows psychosocial intervention to begin early, and this can have a positive effect on the course of the disease (Gauthier et al. 2006).

A recent position paper from the Royal Dutch Medical Association (KNMG) also recommends a proactive approach by family doctors, among other things through screening for frailty, performing a multi-domain analysis<sup>3</sup> and setting up professional program support services (KNMG 2010). Elderly care physicians are playing an increasingly complementary role in family practice and in hospitals in ensuring that the older person receives the right medical care at the right time – care that is both integrated and systematic.

## 1.4 Consequences

The future scenarios for care of the elderly need to be put into context. The current elderly population (the baby-boom generation) grew up in a time very different to that of their parents. Will their care needs therefore not also develop very differently and will this perhaps have consequences for the services available to them? Home ownership is more widespread in the baby-boom generation. They also enjoy greater wealth and will be able to organize and receive suitable care in their home setting for a longer period. In a professional sense, the medical care needs will not change. What will change is the location and manner in which medical care is provided. This is due not only to demographic and epidemiological changes but also because the future group of older people will have different preferences. Residential elderly care will remain available for highly dependent patients for whom the disease process is unmanageable in the home setting, such as those who have advanced dementia syndrome, those recovering from major stroke and those with advanced Parkinson's disease, advanced COPD or severe multiple sclerosis.

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3 *Multi-domain analysis refers to considering different aspects of life according to the so-called SAMPC model. The Dutch abbreviations SAMPC (Somatic, ADL, Social, Psychological, Communicative) and SFMPC (Somatic, Functional, Social, Psychological, Communicative) are often used interchangeably and have the same meaning.*

Healthy aging is not expected to greatly slow down the demand for medical care. While James Fries expected the so-called compression of morbidity to reduce medical costs, James Lubitz has now demonstrated that it makes little difference whether or not someone is healthy or not so healthy. Healthy people require less care, but they live for longer and during that longer life their total medical costs increase like anyone else. Unhealthy people have higher medical costs but for a shorter period: they die earlier. In a report for the Dutch National Institute for Public Health and the Environment in 2011, J.J. Polder wrote the following: "Two more years in good health. The two years of life that were recently gained are largely spent in good health and without physical limitations. Nevertheless more and more people have one or more diseases at the same time and the number of people with a chronic disease will continue to increase. This has, however, not resulted in more physical limitations or a lower level of perceived health. The increase in the number of diseases is partly due to their early detection and partly due to improved survival. This produces a paradoxical trend: more disease and better health at the same time." Looking ahead to an increasing number of older people in the last years of life, it is important to enhance the development and implementation of medical interventions. Such interventions should not only contribute to improving health and reducing the disease burden, but also keep increases in medical costs down to an acceptable level. The question of what is considered "acceptable" forms a societal and political dilemma, for which economic assessments can provide necessary support (Polder, 2008).

In conclusion, it would appear that the effects of an aging population on costs of care are mainly related to the relationship between demographic and epidemiological developments, but are also affected by developments in medical technology and in policy. And it is here that the policy discussions about the aging population should be focused. The knowledge that the aging population itself is not the problem provides a balanced starting point for informed debate.

# The profession of elderly care physicians

## 2.1 Target group

### Frail elderly

Frailty in older persons is a process of an accumulation of physical, psychological and/or social deficits in functioning which increase the chances of frailty regarding autonomy and control over life. This process can lead to a downward spiral of increasing loss of function. Elderly care physicians have expertise in the care of the frail elderly who have the following characteristics:

- There are multiple issues,  
Comorbidity: in addition to the main diagnosis, there are several subdiagnoses related to a chronic illness, such as depression in dementia.  
Multimorbidity: there are several illnesses/diseases present at the same time, such as Parkinson's disease and diabetes mellitus.
- Multipathology (comorbidity and multimorbidity) is seen together with specific signs of aging such as osteoarthritis and osteoporosis.
- The presentation and course of the diseases are atypical, often characterized by a reduction in independence (control/functional autonomy).
- The aim of treatment is not so much to relieve or cure the disease, but to restore functionality and independence and/or enable the best possible quality of life.

### Frail adults<sup>4</sup> with specific chronic diseases

Elderly care physicians may also be involved in the care of younger patients with similar complex medical care problems. Such target groups may have very specific illnesses such as neurodegenerative diseases (multiple sclerosis, amyotrophic lateral sclerosis), Korsakoff's syndrome, or be patients in a long-term vegetative state, patients with acquired brain injury (ABI), or young people with terminal illnesses etc.

## 2.2 Aims of elderly care medicine<sup>5</sup>

Elderly care medicine is not the only medical specialism that is focused on the target groups described above. Family practice, clinical geriatrics, elderly care internal medicine and geriatric psychiatry should also be mentioned in this context. The target groups of elderly care physicians can be found mainly within the "complex geriatric care pathway". The expertise of elderly care physicians is called on in cases where complex medical issues are involved. Increasingly, this complex medical care will be provided independently of the patient's location.

The principle of elderly care medicine is based on the relationship between patient and context, i.e. between the patient and the system of healthcare and treatment. Typically, the activities of elderly care physicians include providing comprehensive proactive integrated medical care that is multi-disciplinary and aimed at multiple domains (SAMPC). This is aimed at managing the current problem, with a focus – within the scope of medical care – on respect for the patients and their wishes. The approach is both system based and problem based. Since patients are independent persons who have their own ideas and beliefs

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<sup>4</sup> Persons under the age of 65 years.

<sup>5</sup> Wherever elderly care medicine is mentioned, this also refers to frail adults with specific chronic diseases.

about what is important in their lives, they should therefore be given the opportunity to decide which treatment and care fits best with their beliefs and way of life.

If a patient's functional autonomy decreases, elderly care physicians should be extra alert to coordinate the treatment and care in accordance with the patient's wishes.<sup>6</sup> From the perspective of the patient, there is often not only a desire to take their own decisions, but also a desire to be helped and supported; so not just a wish to keep control over their life and body, but also the hope and the need to be able to place the responsibility for their care in someone else's hands. It is the task of elderly care physicians to safeguard the patient's right to self-determination to the best of their ability. This right to self-determination is about the degree to which patients can retain control over the coordination of the objectives of medical care and control over the personal care they are being given.

The aim of elderly care medicine is to provide medical care for those with complex geriatric healthcare issues with an emphasis on enhancing the functional autonomy and quality of life of the patient. This complex medical care should be provided independently of the patient's location.

## 2.3 The profession

Elderly care physicians have practical knowledge of age-related diseases and complex comorbidity and multimorbidity. Where possible, the activities of elderly care physicians should preferably be based on scientific research. Their work should be evidence-based and otherwise based on best practice. In particular they should have developed knowledge about the final phases of chronic disease processes. In their treatment plans they should anticipate and take into account the progression of diseases and the effect of such progression on the functioning and on the quality-of-life of patients and their caregivers. To this end, elderly care physicians can initiate the deployment and management of other disciplines within a multidisciplinary collaboration. This allows them to provide proactive and comprehensive care. They are also skilled in leading discussions about the limits of medical treatment options in the context of the quality-of-life experienced. The result of this may be to avoid or limit distressing tests and treatments. According to legislation, the primary treating physician is responsible for coordinating the multidisciplinary team.

The elderly care physician's domain of work is caring for elderly patients and young adults who require continuous systematic, long-term multidisciplinary care (CSLM care) that involves complex issues. As the primary treating physician, elderly care physicians are responsible for treating patients with these complex issues. To ensure that medical care is properly tailored to the complex medical care needs of the patient, elderly care physicians make use of shared decision-making. In this form of decision-making, the basis of all decision-making is the patient; i.e. the patient's experiences, needs, norms, values and preferences. Elderly care physicians employ these principles when making the choices involved in forming both a cohesive and coherent treatment plan as well as further medical management. This method of working safeguards quality of life for the patient. Elderly care physicians can also have important complementary functions as treating professionals, consultants or co-treating physicians for both frail older persons and the chronically ill.

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<sup>6</sup> *If the patient is unable to communicate or to make independent decisions then coordination of treatment and care takes place with both patient and representative (family member or mentor).*

### The working environment of elderly care physicians

Elderly care physicians carry out their activities wherever their expertise is required. Elderly care physicians work in nursing homes as treating professionals, in the home setting within a group practice of family doctors, within a collaboration of specialists in elderly care medicine, and/or as co-treating physicians or consultants for family doctors or medical specialists. Increasingly, elderly care physicians are developing their own specific field of interest, making them experts in a specific area. Such areas include dementia, multiple sclerosis, Parkinson's disease and complex medical care for patients with specific requirements such as long-term ventilation. In the case of social geriatricians, their main field of expertise is psychogeriatric medicine. They carry out their activities in an integrated setting, coordinating between nursing homes and mental health institutions (for older psychiatric patients), between mental health institutions and the home setting (for older persons with psychiatric problems) and as a consultant (for nursing homes specialized in older persons with chronic psychiatric disorders).

The elderly care physician will implement secondary<sup>7</sup> and tertiary<sup>8</sup> preventive measures to ensure that risks to health are prevented. Such measures are important – they are aimed at preventing risks to health for as long as possible and maintaining the maximum degree of autonomy for the patient. This requires close collaboration with family doctors, hospital specialists and other caregivers in the areas of cure and care, both in primary and secondary care. The promotion of autonomy can be achieved not only through prevention, treatment (both preventive and therapeutic) and counselling, but also by means of giving an indication for supportive care.

### Primary treating physician

As a primary treating physician, elderly care physicians are responsible for the medical diagnosis, needs assessment, treatment, setting up and implementation of the medical treatment plan and for 24-hour care. They also coordinate the multidisciplinary team. This coordinating role is independent of the elderly care physician's work situation. If an elderly care physician works in a nursing home or hospital, then the multidisciplinary team will be made up of the paramedical and perimedical services at that institute. If an elderly care physician works in primary care, then the multidisciplinary team will be formed in collaboration with paramedical and perimedical practices and home care services.

### Co-treating physician

If an elderly care physician is a co-treating physician, then the coordinating role in setting up a treatment plan lies with the primary treating physician. In this case, it is necessary that clear agreements are made about the division of tasks. If required, as co-treating physician the elderly care physician can also write the treatment plan. The treatment plan describes how the tasks are divided between the doctors, who takes the lead and who coordinates the care provision. Elderly care physicians are responsible for the medical aspects that they themselves have initiated. For treatment provided by other doctors (family doctors, specialists), elderly care physicians play a coordinating role but are not responsible for this treatment. Who is to carry out this coordinating role must be agreed on beforehand.

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7 *Secondary prevention: strategies aimed at increasing the chances of a cure, or minimizing the chances of complications, by focusing on early detection of a disease.*

8 *Tertiary prevention: strategies aimed at minimizing the chances of recurrence of a disease or reducing the chances of exacerbation of a chronic disease.*



### Consultant

As consultants, elderly care physicians are responsible for the content of consultations that they carry out. Such consultations may take the form of a telephone call to offer advice to the family doctor or treating specialist regarding a patient, or of face-to-face contact with a patient, with or without an additional assessment. Elderly care physicians give answers to the questions asked and keep notes of the results of the consultation. They register in the treatment plan any care that they initiate and make sure that the proposed treatment is known to the primary treating physician. They also make sure that the patient knows which recommendations will be passed on to the treating physician.

## 2.4 Legal framework

Healthcare services in the Netherlands must meet the requirements of good health care according to professional standards and as laid down by law. Such laws include the Medical Treatment Contracts Act (WGBO), the Care Institutions (Quality) Act, the Exceptional Medical Expenses Act, the Individual Health Care Professions Act (BIG), the Psychiatric Hospitals (Compulsory Admissions) Act (BOPZ), the Patients' Right of Complaint Act (WKCZ), and the Personal Data Protection Act (WBP). The Dutch Psychiatric Hospitals (Compulsory Admissions) Act (BOPZ) stipulates the assessment of a patient's capacity, the necessity to adapt a patient's legal status, and the necessity to adapt the use of measures restricting personal freedom. National legislation and case law give the doctor the responsibility for the content and standard of medical care. The doctor determines which treatment is desired, and whether this corresponds with the wishes of the patient or the patient's representative, from whom informed consent is required. Elderly care physicians are responsible for their own medical management and are also responsible for passing on to institutional management any concerns regarding the quality of care provided by nurses and care assistants.

## 2.5 Responsibilities beyond the bounds of patient care

### Gatekeeper function

Elderly care physicians can enlist the aid of other disciplines, which means they can call on paramedical care providers as well as other medical specialists, nurses and caregivers. As a result, elderly care physicians have a gatekeeper function controlling access to medical specialists in secondary care.

### At the micro-level: supporting, observing, signaling and reporting

Elderly care physicians give instructions to all caregivers involved in the patient's individual care plan, both when asked and on their own initiative. Naturally all this is done while maintaining the individual professional responsibility of all disciplines involved and based on the collaboration that is needed to achieve the desired objective. Elderly care physicians give support and guidance to persons carrying out medical interventions on their behalf (task delegation), including nurse specialists, nurse practitioners, physician assistants and junior doctors.



### At the meso-level: creating suitable conditions and providing advice

It is becoming increasingly important for elderly care physicians to establish the framework within which they will provide their medical care in the coming year within the organization<sup>9</sup> where they work. They do so by advising the management team of the organization about the medical management (providing medical treatment to the target groups) and the services and organizational factors involved. They contribute to the prognosis for the coming year with regard to both quantity (number of patients to be treated) and quality (the standards treatments must meet; what and who will be needed for this and when they will be needed, and what preconditions are necessary). This information is recorded and discussed with the management team of the organization. Together they come to decisions about how they want the medical care to develop. Placing the responsibilities for medical care under dual management results in a transparent and high-quality medical framework for the coming year.

Together, elderly care physicians help to guide the development of organizational policy, i.e. healthcare-related quality policy. Such policies include care for bedsores, implementing measures for control of infectious diseases, oral health, behavioral problems, influenza injections, ensuring continuing physical examinations for psychiatric patients, policy on polypharmacy, overview of current medication list, metabolic syndrome in long-term use of psychoactive substances etc.

The advisory role of elderly care physicians lies in signaling or passing on concerns about the quality of care being provided by the treatment team. Elderly care physicians will collaborate with others to safeguard and stimulate quality. Elderly care physicians also function as observers and pass on to the management team any concerns about the quality of care provided by the nursing staff and carers, both when asked and on their own initiative.

### At the macro level: representative of elderly care physicians

The activities of elderly care physicians take place in different locations throughout the region. This gives them the opportunity to optimize existing networks as well as to optimize coordination and collaboration between care needs and care services at the regional level. This applies in particular to the networks set up by the Dutch National Care for the Elderly Program, but also to networks set up for palliative and end-of-life care and for chronically ill patients requiring complex medical care. Elderly care physicians contribute to innovative projects. In terms of quality, elderly care physicians are subject experts who can offer advice about the care services available in a particular region.

Within the various inter-agency collaborations with which they are involved, elderly care physicians act as representatives both of the organizations where they work and of their own profession. Self-employed elderly care physicians act as representatives of their profession and of the organizations with which they have contracts.

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<sup>9</sup> Organization can refer to a nursing home/hospital but also to a group practice of family doctors to which the elderly care physician is attached, or to a group of elderly care physicians working together.



# Part B

The competencies of the  
elderly care physician

# Competencies and expertise

## 3.1 General competencies of a medical specialist

### CanMEDS

The general competencies that are applicable to all medical specialists comprise seven key groups<sup>10</sup> :

- Medical expertise
- Communication
- Collaboration
- Role as scholar
- Health advocacy
- Management
- Professionalism

Verenso has used these groups to describe the competencies of an elderly care physician. The groups are defined further in Appendix 1. This chapter highlights those subjects that are very specifically associated with elderly care physicians.

## 3.2 Objectives of describing competencies

The describing of competencies has the following objectives:

- To provide the individual elderly care physician with guidance in day-to-day practice and a vision of their professional duties in the future.
- To contribute to the standing and the accessibility of the profession of elderly care physician at both national and regional level. This is also pertinent to other practicing medical professionals and the paramedical, psychosocial, nursing and caring disciplines that operate within the network of the elderly care physician.
- To function as an aid to the development of a program for scientific research, to the development of guidelines and as a practical resource in daily practice.
- To direct and guide training by defining final attainment levels and a framework curriculum, and to define the training requirements based on these which are required by the Board for General Practice and Nursing Home Medicine and Medical Care for the Mentally Disabled (CHVG). To develop syllabuses based on these training requirements. This determines the requirements for re-registration and serves as a frame of reference for further training and continuing education for re-registration.
- To provide guidance in the adaptation of the professional profile/competencies of the elderly care physician.
- To function as an aid to the career development of the elderly care physician.
- To be a means of giving concrete form to the profession and making it transparent in order to attract the students of the future.

## 3.3 Definition of the practice of elderly care physicians

Elderly care physicians approach their patients in a proactive manner. The elderly care physician should possess a high level of analytical skill and be able to make effective risk analyses that lead to a treatment plan proposal. While practicing their profession as physicians in the carrying out of medical treatment, elderly care physicians should integrate their medical-geriatric expertise with expertise in the fields of diagnosis, prognosis and coordination and/or management. The central tenet of this approach is not only to treat disease but, more importantly, to relate the consequences of disease in terms of functional autonomy and the patient's quality of life to the health care system.

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<sup>10</sup> Based on CanMEDS 2005 from the Royal College of Physicians and Surgeons of Canada.

This means that when drawing up a care plan the physician not only takes medical diagnostic procedures into account, but also psychological and social factors as well as the patient's personality. In addition, the physician should make an assessment of how the patient's care requirements will develop (make a prognosis) and draw up an appropriate medical treatment plan. The physician monitors the patient and evaluates treatment in collaboration with a multidisciplinary team that he/she is the coordinator. In doing this the physician makes use of the so-called SAMPC model (Somatic, ADL, Social, Psychological, Communicative)<sup>11</sup> and works with SMART aims (Specific, Measurable, Acceptable, Realistic and Time-bound) in the treatment plan. Researching, evaluating, collaborating with and implementing innovative care initiatives are integral to the core business.

The elderly care physician has an important role to play in exemplifying the way in which the patient is approached by others. Elderly care physicians should have the knowledge and skills to clearly explain differing methods of approach to the care team, and to initiate and support such appropriate methods of approach on behalf of the patient.

### **3.4 Aspects of elderly care medicine**

#### **Palliative medicine**

Palliative medicine involves pain relief, symptom relief, comfort, psychological and spiritual care, and support for the family and network of carers during the dying process.

#### **Chronic illnesses**

The main chronic illnesses are dementia, Parkinson's disease, status following CVA, heart failure, COPD, diabetes mellitus, hypertension, rheumatoid arthritis, multiple sclerosis, osteoarthritis, osteoporosis, recurrent delirium (Lewy body dementia), sensory disorders, mobility disorders and incontinence.

#### **Geriatric psychiatry**

As the population ages, the incidence of cognitive disorders and thus the requirement for help is increasing. The group of people with psychiatric disorders is also ageing. This is the reason that the flow of psychiatric patients being admitted to nursing homes has been steadily increasing for many years. This is compounded by the fact that in the Netherlands, the capacity of the geriatric-psychiatric health services to admit patients to hospital and for residential care has been steadily reduced and in the near future is to be completely transferred to the nursing and caring sectors.

#### **Acute medicine**

Acute medical conditions include delirium, acute heart failure, CVA, acute abdomen, lung emboli, pneumonia, ascending urinary tract infections, manifest psychosis and suicidality. Dealing with these acute illnesses in combination with frailty and multipathology is part of the expertise of the elderly care physician.

#### **Geriatric rehabilitation medicine**

Geriatric rehabilitation takes a number of forms including orthopedic rehabilitation, integrated care for CVA, COPD rehabilitation and outpatient rehabilitation.

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11 Or the SFMPC model = Somatic, Functional, Social, Psychological, Communicative.

### Extramural medical care

Extramural medical care includes treating a patient jointly with other health professionals at home or in a care facility, acting as a consultant in multidisciplinary discussions at home or in a care facility, evaluating the medications of care facility residents, participating in a mobile geriatric team and carrying out consultations at the request of family doctors.

### Medical ethical considerations

The elderly care physician is required to make important decisions. This involves not only making the decision to treat or not-to-treat in end-of-life situations, but also making decisions concerning patients who, as a result of cognitive deterioration, are temporarily or permanently unable to make conscious decisions (legally incapable). These include the following decisions: to treat or not to treat, to admit or not to admit to hospital, to tube feed or not to tube feed. Central to this is not the point of life, but the point of the medical treatment balanced against quality of life.

### Multidisciplinary approach

A multidisciplinary approach involves a number of disciplines – each with their own field of expertise – liaising together to produce a body of knowledge and care that is centered on the patient. This form of collaboration can be effected in various ways; one commonly found method of practice is working in accordance with multidisciplinary guidelines and care protocols. Working in accordance with a multidisciplinary guideline means that the care supplied by various care providers is coordinated in such a way that it is tailored to the care requirements of the patient.

A term often used as a corollary of the term “multidisciplinary” is “interdisciplinary”. This concept, meaning literally “between the disciplines”, refers to the idea of looking and thinking beyond the boundaries of a single professional field and combining activities with other fields. In practice it is difficult to establish where multidisciplinary action stops and interdisciplinary action starts.

In practice, this method of working is often stimulated by multidisciplinary discussion (see Hertogh, 1999). A multidisciplinary approach can involve working with care assistants, nurses, psychologists, physiotherapists, occupational therapists, speech therapists, dieticians, music therapists etc. The collective care actions and aims are noted down in the patient’s care and living plan.

## 3.5 Competencies and skills, attitude and knowledge

The skills, attitudes and knowledge that are required to fulfil a role in general are called “professional attitude”. Professional attitude covers many aspects from empathy to knowledge of the law. In order for physicians to fulfil their various roles and take responsibility for patient-related activities, complex medical care, diagnostics and coordination/management tasks, they require specific skills, attitude and knowledge (SAK). These vary from medical-technical skills and knowledge of disease entities and polypharmacy to heading up a multidisciplinary team. The skills required for non-patient-related activities (e.g. managing a practice, knowledge of the network of care providers, education, training, research and quality management) can vary from the development of implementation of care arrangements to being able to work with audiovisual aids. For optional activities (general management, training and scientific research) a diverse range of skills are necessary, e.g. project management skills and the ability to write a review article.

### 3.6 Task delegation

Task delegation is actuated by a number of factors:

- Responsible task delegation improves the continuity of the provision of care.
- The delegation of tasks increases the job satisfaction of the specialist nurse, nurse practitioner, physician assistant and the elderly care physician.
- Time is freed up for the elderly care physician to focus more on core business.

Task delegation enables elderly care physicians to re-evaluate the way they approach their job and to carry out their work while maintaining a high degree of responsibility and quality. Task-shifting and task delegation offer good opportunities to make the profession of elderly care physician an intrinsically more attractive prospect. Additionally, the deployment of nurse specialists, nurse practitioners, physician assistants and junior doctors considerably reduces the workload of the physician. Specialist medical management continues to be the responsibility of the elderly care physician.

Potentially, it is the shifting of the medical tasks of the elderly care physician to the nurse specialist or nurse practitioner that gains the most time. The tasks that are delegated are those procedures traditionally carried out by a doctor. The delegation of subsidiary tasks to practice nurses, geriatric nurses, or, in the case of mental health care, social psychiatric nurses, follows on from this. If task management passes to a non-medical individual, the elderly care physician continues to be responsible for medical practice and management. Currently, around half the nursing homes in the Netherlands are developing initiatives for the shifting and/or delegation of tasks of the elderly care physician to other disciplines. Verenso supports these initiatives.

# Patient-related focus points

## 4.1 Introduction

This chapter describes the patient-related focus points of the elderly care physician. These focus points are the treatment of and the medical approach to the frail elderly and chronically ill. The medical approach comprises those tasks that are limited to physicians as well as the administrative duties arising from these tasks which can be defined as medical, e.g. diagnostics, prognostics, coordination and management. In elderly care medicine a triangular model is typically used (triad), in which the physician often uses an indirect line of communication with the patients<sup>12</sup>, i.e. via the care system of friends, family and care providers. When carrying out patient-related tasks, the elderly care physician works closely with other disciplines. This is a multidisciplinary, problem-focused and cyclical care delivery process.

## 4.2 Most commonly occurring diseases

In the presence of one or more chronic diseases (comorbidity), concomitant conditions (multimorbidity), direct consequences of disease (disorders, limitations, handicaps), indirect consequences of disease (quality of life, interactions, life orientation), the requirement for care becomes more complex and the integrated approach mentioned above becomes necessary (compare Hertogh, 1999, and see description of complex care requirements in Appendix). The approach is primarily problem-oriented and not disease-oriented with the aim of improving functional autonomy and quality of life. The problems targeted by this approach are very individually determined and vary over the course of the provision of care.

By far the largest majority of the actual patient population of the elderly care physician can be described as having one or more of the conditions listed below (shortened list from Netherlands National Nursing Home Care register (LZV)).

- Dementia syndrome
- Cerebrovascular disorders (and their consequences)
- Post-orthopedic operation
- Diabetes mellitus
- Parkinson's disease
- Osteoporosis
- Heart failure
- COPD
- Depression and anxiety disorders
- Multiple sclerosis
- Rheumatoid arthritis
- Osteoarthritis
- Pressure sores
- Delirium
- Incontinence
- Mobility disorders
- Sensory disorders

The aims and functions of medical treatment include the following: stabilization, rehabilitation, chronic somatic and/or psychogeriatric care, palliative terminal care, diagnostics (including guidance and advice), and crisis intervention.

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<sup>12</sup> In cases where the patient is legally incapable and/or unable to communicate with the elderly care physician.



### 4.3 General medical focus points

The general medical patient-related focus points are the carrying out of general and specialist medical diagnostic procedures, treatment and counselling.

- Diagnostics: making diagnoses and prognoses for somatic, psychogeriatric and gerontopsychiatric disease entities and intercurrent illnesses. The focus is not only on making a diagnosis, but also on the identification of associated disorders, limitations and handicaps.
- Treatment tasks: pharmacological and non-pharmacological treatments
- Prevention: preventing disease and loss of function and limiting the consequences; both indicated and care-related prevention.
- Counselling and guidance: taking the lead in discussions or facilitating discussions with the patient and/or their family and offering support in this.
- Medical-technical activities: medical care includes being able to carry out medical-technical procedures among others.
- Developing orienting guidelines on medical management and implementing these in the professional group for the benefit of the institution or group practice.
- Taking the wishes of the patient into account when making a needs assessment.
- Provision of information to patients and their families and obtaining their consent to treatment (informed consent).
- Providing other disciplines with support, advice and guidance.
- Examining the deceased, organizing post-mortems and taking care of administrative settlement.
- Taking care of administration, correspondence and record-keeping.

### 4.4 Specific focus points

Medical practice comprises physician-specific tasks and of a number of attendant medical tasks in the field of administration: diagnostics, care, and coordination/management. The elderly care physician may carry out these tasks in the role of treating physician, co-treating physician or as a consultant.

#### Diagnostics

On the grounds of medical examination and analysis of medical data, the elderly care physician identifies those disease entities that play a role in the condition of the patient. This is done using medical and psycho-social diagnosis in combination with the perceived problems (and residual capacities) of the patient. Multipathology is classified in order of the principle diagnosis and comorbid conditions. This order may change (permanently or temporarily) in the acute phase of one of the comorbid conditions and/or if another condition presents itself.

#### Prognostics

Prognostics refers to the prediction or expectation of the occurrence of an event or its course, as in a disease for example. A prognosis and those considerations involved in making it, with or without an active treatment plan, is a medical-ethical consideration. The risks of treatment weighed against its advantages, and the resilience of the patient to be able to tolerate treatment both have to be considered when determining treatment policy. These considerations are often expressed in terms of aims and means and expressed in the triad of:

1. adequacy (is the intervention a suitable one?)
2. subsidiary (are there any other, less radical alternatives?)
3. proportional (engendering abnormally high costs, depriving someone of their freedom, or not asking someone for their consent are regarded as being disproportional).

Assessing which disease entities and problems are most prominent and what the total sum of the consequences of these will be for the patient is extremely complex in people with comorbidity and multimorbidity. The elderly care physician carries out an in-depth and comprehensive geriatric assessment based on comorbidity and multimorbidity. Geriatric assessment is characterized by multidisciplinary examinations and investigations. An assessment may include somatic, functional, social, psychiatric/psychological, communication and relationship questions.<sup>13</sup> The problems that have been investigated are then translated into objectives that can be assessed. In formulating these objectives, the wishes and capacities of the patient and the resources of the care system (i.e. total sum of patient, loved ones and caregivers) are the determining factors. The routes taken to achieve these objectives, whether via multidisciplinary interventions from professionals or via informal care, are described as actions. Interventions are largely focused on limiting the consequences of disease, on determining care needs and offering supportive care, and on maintaining functional capacities.

### Coordination/management

An integrated approach to the patient gives the elderly care physician a comprehensive overview of the principal diagnosis, the degree of comorbidity and multimorbidity, polypharmacy and the health care professionals involved. This enables the physician to facilitate coordination and management so that treating professionals and other health care professionals can coordinate the necessary treatment and arrangements. Setting priorities and making mutual agreements makes the plan clear to the patient. Together with the multidisciplinary team and the patient, the elderly care physician oversees and evaluates treatment objectives, monitors and modifies the treatment plan as required, and communicates with the treating professionals and care providers in order to maintain an unambiguous management plan.

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<sup>13</sup> This list is often referred to as SAMPC or SFMPC. Both terms have the same meaning.

# Non-patient-related focus points

## 5.1 Introduction

This chapter deals with those activities of the elderly care physician that are not directly patient-linked. These activities (some standard, some optional) are also part of the job description of every elderly care physician.

## 5.2 The elderly care physician in the network of care providers

In order for all parties to work together seamlessly in various roles in various settings (quality multi-agency care), objective-focused collaboration (i.e. network formation) is an absolute must. The elderly care physician fulfills this role on behalf of the care institution, group practice or the professional group. He/she contributes to the realization of diverse networks (shared care) in the region, including care of the elderly, palliative terminal care, CVA care, AIDS-related health care, care networks for people with dementia etc.

The issues concerned mainly go beyond the bounds of direct patient care and include:

- Facilitating collaboration, including collaboration between medical professionals.
- Implementing modifications and changes in care supply.
- Facilitating/stimulating the process of change.
- Contributing to public relations for the profession.
- Participating in activities of the elderly care physicians' professional organization.
- Initiating and carrying out innovations.

## 5.3 Education, training and research

- Keeping up with the developments in the professional field, acquiring new skills and disseminating knowledge, skills, and attitude to fellow physicians and others.
- Building on the scientific basis of the profession.
- Promoting public relations in the role of ambassador for the profession.

### Practice

- Participating in education for purposes of training and continuing education.
- Contributing to the development of expertise by means of mutual testing, intervision and supervision for elderly care physicians. Taking part in inspections.
- Organizing and taking part in continuing professional education on subjects and themes particularly relevant to those working in the field of elderly care, e.g. nurse practitioners, nurse specialists, physician assistants, nurses and families.
- Keeping up with the professional literature.
- Critically evaluating the professional literature and its quality.
- Implementing the latest findings from scientific research into personal medical practice and actions. Applying evidence-based medicine.
- Delegating tasks to nurse practitioners, physician assistants and junior doctors and supporting and coaching these groups in their implementation.

## 5.4 Management and quality management

This involves creating an organizational infrastructure that enables elderly care physicians to carry out their operational tasks in the area of elderly care medicine effectively and to promote a good quality of care.

- Drawing up guidelines and procedures.
- Maintaining and improving the quality of all aspects of medical practice.
- Identifying problem areas in care that are related to personal professional responsibilities, and undertaking appropriate actions to draw the attention of management to these problem areas.
- Monitoring drug safety.
- Contributing to line and project management and the quality of care in care facilities.
- Contributing to the definition and carrying out of transparent and responsible ethical policies.
- Supervising standards of hygiene and implementing measures to prevent infectious diseases.
- Signing declarations of competence for the delegation of reserved procedures to practical nurses, registered nurses, nurse practitioners, nurse specialists and physician assistants.
- Committing to practice in premises that are large enough and well-equipped to enable the elderly care physician to practice optimally.
- Organizing adequate locum cover in the event of unavailability.
- Determining and monitoring the indication criteria of patients presenting for treatment.
- Contributing to and developing procedures for the accepting and transfer of patients.
- Monitoring the planning of the size of the patient population/caseload.

### General management

The management activities carried out by elderly care physicians are dependent on the work environment in which the profession is carried out, and the position that they occupy in a group of physicians. If a group of elderly care physicians is attached to a facility such as a nursing home or hospital, they are required to produce an annual plan and accompanying budget for the management. By means of consultation and agreement with management (dual management) they maintain the quantity and quality of provision of services. If the elderly care physician works with a family doctor practice or runs their own group practice then management activities lie more in the areas of acquisition and of negotiation with health insurers concerning matters of quality and production in primary and secondary care.

## 5.5 Optional activities

The activities that have been described up to now are carried out by all elderly care physicians. There are additional activities which are indispensable to good medical practice and the development of the profession, but which do not necessarily all have to be carried out by every elderly care physician (optional activities). Many elderly care physicians carry out a number of these activities during the course of their career. Optional activities can be defined as activities in the fields of management, education, and scientific research.

### Education

- The education and/or mentoring of elderly care physicians in training, and family doctors in training.
- The education of students in the medical and nursing professions, care workers and treatment support staff.
- Education in further training and activities related to continuing professional development (e.g. mutual testing, intervision and supervision) for elderly care physicians, family doctors, nurse practitioners, specialist nurses, physician assistants and so on.

### Scientific research

- Critical appraisal of the professional literature and its quality.
- Carrying out or participating in scientific research.
- Publishing articles or research results.

### Other optional activities

- Fulfilling the role of medical advisor.
- Functioning as a SCEN physician (Support and Consultation in Euthanasia in the Netherlands).
- Participating in disciplinary tribunals.
- Participating in complaints committees.
- Representing the care organization or professional group.
- Carrying out activities within the professional body.
- Compiling quality policies such as guidelines, treatment protocols and practical resources material.
- Representing the interests of the profession.
- Carrying out duties as a "BOPZ" physician in accordance with the Psychiatric Hospitals Compulsory Admission Act: taking responsibility for developing policy-level conditions targeted at preventing the use of measures that restrict personal freedom and supervising these measures.
- Functioning as a point of contact and carrying out those duties required by the laws on infectious diseases.
- Functioning effectively as a consultant medical specialist for external agencies such as the Dutch Health Care Inspectorate, the administrators of the Exceptional Medical Expenses Act (AWBZ), and health insurers.
- To take primary medical responsibility within the team.

# Recommendations for the future

## 6.1 Transmural and extramural care

Current developments in society and health care require elderly care physicians to reorientate the way in which they practice their profession. As the elderly population grows, so does the number of frail elderly and chronically ill people who are staying in their own homes for longer. In order to be able to deliver good medical care to this group of patients, elderly care physicians need to make their knowledge and expertise available outside care facilities. As well as knowledge of somatic, psychogeriatric and gerontopsychiatric illnesses, excellent communication and collaborative skills are necessary for this. The elderly care physician is not only required to develop a confident and innovative approach to the situation but also to have specific knowledge of the parties playing a role in primary health care.

## 6.2 Changes in nursing homes

In the Netherlands, we are now seeing a transformation to specialized nursing home care. By concentrating particular target groups in specialist facilities, expert medical and nursing care focused on the needs of these particular groups can be provided. This is bringing about a qualitative improvement in medical and nursing care. It is essential that elderly care physicians should follow those further training courses that are available to them. In this way, as well as being a general physician, it is also possible to become an expert in one particular area of the profession. These specialized primary care physicians should implement the knowledge thus gained into daily practice and also use it to support colleagues in the practice of elderly care. They also have an advisory and supportive role to play in advising care facilities about the conditions under which this special care can be delivered.

## 6.3 Further specialized training

### Further specialized training in primary health care

After following this course, the elderly care physician will have expertise and skills in the following areas:

- Strategic profiling, communication and collaboration.
- Stimulating the formation of networks of elderly care physicians and also inter-agency networks including family doctors.
- Effectively carrying out a telephone or face-to-face consultation with a family doctor.
- Preparing for, carrying out and giving feedback on multidisciplinary discussions concerning patients of the family doctor.
- Developing a structured plan for co-treatment and administration in primary care.
- Communicating with family doctors and other disciplines electronically.
- Developing and implementing structured projects for the improvement of medical care for the frail elderly and chronically ill in primary care.
- Deepening medical knowledge and scientific support of medical practice.
- Promoting and expanding the expertise of health care workers and treating professionals in primary care.
- Expanding the opportunities for the elderly care physician in extramural practice.

### Further specialized training in psychogeriatric medicine

After following this course, the elderly care physician will have expertise and skills in the area of psychogeriatric medicine at a specialist level. He/she will be able to act as a consultant in psychogeriatric care to other care providers, to provide education in the field of psychogeriatric medicine, to critically evaluate the scientific literature and integrate insights thus gained into personal practice.

### Further specialized training in geriatric rehabilitation

After following this course, the elderly care physician will have expertise and skills in the area of geriatric rehabilitation at a specialist level. He/she will be able to act as a consultant in geriatric rehabilitation to other care providers, to provide education in the field of geriatric rehabilitation, to critically evaluate the scientific literature and integrate insights thus gained into personal practice.

### Further specialized training in palliative care

After following this course, the elderly care physician will have expertise and skills in the area of palliative care at a specialist level. He/she will be able to act as a consultant in palliative care to other care providers and to provide education in the field of palliative care. He/she will be familiar with methods of quality evaluation and know how to apply them. He/she will be able to critically evaluate the scientific literature and integrate insights thus gained into personal practice.

## 6.4 Technical developments

### Electronic patient records

An elderly care physician not only works in a nursing home setting but also treats patients in other care facilities and in the home setting. The physician must be responsible at all times and under all circumstances for the reliability of the data that he/she registers. In shared care situations it is important that all the professions involved in care have access to the data. In this situation, the patient's privacy must be safeguarded.

The changing organizational circumstances in which the elderly care physician works – and the differing forms of collaboration with other physicians and care providers – do not in themselves place any other intrinsic demands on reporting. However, the form that the reporting takes is a different matter. Now more than ever, elderly care physicians must ask themselves if their reporting is comprehensible and accessible to other care providers and to what extent privacy has been maintained. Another, more minor, point that should be addressed is the interlinking of the data registered by the elderly care physician and those data registered by a care facility and/or other disciplines.

The requirement to register data electronically is growing. Elderly care physicians are increasingly working in different locations and in patients' homes. Electronic links to the systems of care facilities, family doctor practices and pharmacies are called for. Guidelines issued by the Royal Dutch Medical Association (KNMG) on the exchange of data and the code of conduct for electronic data exchange in the health services must be adhered to.

Standardization is necessary for the exchange of data. Standardization promotes compatibility between individual dossiers both within a single facility and between multiple facilities and care providers. The linking of data can prevent situations in which identical data have to be entered more than once. It also promotes the clear and unambiguous registration of medication data, diagnostic data and test results.

In order to provide good, comprehensive care to the elderly with complex problems who are known to require many different care providers, it is absolutely necessary that exchange of data is fast and reliable. Electronic patient records and an electronic prescribing system are crucial to providing good 24-hour, 7-day-a-week care. Elderly care physicians have an independent requirement to register their own findings in a manner that permits other practicing professionals and care facilities to use these findings, where this is appropriate and permitted. The contribution made by elderly care physicians to a care plan is greatly simplified if they are able to access their own data quickly and easily. This makes specific demands of electronic patient records.

### Domotics

The use of domotic technology (home automation) offers the following:

- Prevention/limitation of domestic accidents.
- Increased level and feeling of safety through use of burglar and fire alarms and personal alarms.
- Ability to monitor unusual situations.
- Support to care providers.
- Better temperature control, therefore energy savings.

#### *In practice*

Someone finding their way to the toilet in the dark can be helped by lights between bedroom and bathroom that switch on automatically. Someone who suddenly needs help can sound an alarm. This can be activated by pressing a button and even by calling out loudly. A care provider (internal or external) can be called on a DECT telephone (Digital Enhanced Cordless Technology), and a telephone call between patient and carer can take place. There is a bed mat that monitors movement and sends out a signal when someone gets into or out of bed, and it is possible for room lighting or an electric hotplate to be switched from day to night mode. The attention of a care provider can be drawn to someone who has not moved for a given period. A motion detector passes this information to the care provider who is situated elsewhere. In this way, in the event of a calamity the alarm can be raised at an early stage.

Domotics offer technical options to increase patient safety and limit the use of measures restricting personal freedom. The elderly care physician can therefore include the aid of domotics when drawing up a care plan.



# Reference list (in Dutch)

- T. Bakker, H. Diesfeldt Psychiatische stoornissen bij kwetsbare ouderen 2010
- Bovens M. Wille A. Diploma democracy. Utrecht/Leiden; Utrecht University/Leiden University 2009.
- BTSG, Alzheimer Nederland: Wonen met dementie, 2006 Bunnik 2006.
- Capaciteitsorgaan, Capaciteitsplan 2010 deelrapport 5; specialist ouderengeneeskunde Utrecht, december 2010.
- Capaciteitsorgaan, Taakverschuiving bij de medische zorg vanuit verpleeghuizen I. Bloemendaal, T. Bisseling, L.J. van Eck Utrecht 2010.
- CBS gegevens 2010.
- CHVG-besluiten
  - Titelaanduiding. No. 2-1998.
  - Eisen voor de opleiding. No. 3-2000.
  - Eisen en voorwaarden voor de erkenning van opleiders, opleidings-inrichtingen en opleidingsinstituten (opgenomen in No. 3-2000).
  - Eisen en voorwaarden inzake de herregistratie. No. 9-1999.
  - Arts in opleiding tot huisarts/verpleeghuisarts/arts voor verstandelijk gehandicapten en tot onderzoeker (AIOTO). No. 9-2000.
- J.J.E. van Everdingen, D.H.H. Dreesens, Bohn Stafleu van Loghum Houten 2011, Glossarium kwaliteit van zorg.
- R. Fogel, Economic Growth, Population Theory and Physiology: The Bearings of Long-Term Processes on the Making of Economic Policy, 1994.
- Fries J. Koop C, Beadle C, Cooper P, England M, Greaves R, Sokolov JJ, Wright D. Reducing health care costs by reducing the need and demand for medical services. N Engl J Med, 1993;329:321-5.
- Hertogh, C.M.P.M., Functionele geriatrie. Probleemgerichte zorg voor chronisch zieke ouderen. Maarssen: Elsevier/De Tijdstroom 1999.
- KNMG, Algemene competenties van de specialist 2005.
- De landelijke werkgroep Raamcurriculum 2007.
- De landelijke werkgroep Raamcurriculum en goedgekeurd door HVCR, Raamcurriculum Verpleeghuisarts opleiding Amsterdam.
- Lubitz J, Cai L, Kramarow E, Lentzner H, Geenberg LG, Gorina Y, Wartzman L, Gibson D. Health life expectancy, and health care spending among the elderly – three decades of health care use by the elderly, 1965-1998. N Engl J Med, 2003;349(11):1048-55.
- Lucht, F. van der; Polder, J.J. Towards better health, The Dutch Public Health Status and Forecasts Report 2011.
- LUMC opleiding tot kaderspecialist ouderengeneeskunde in de 1e lijn 19-07-2011 Leiden.
- McKeown T. The role of medicine. Dream, Mirage or Nemesis? London; The Nuffield Provincial Hospital Trust 1976.
- Navarro V. What we mean by social determinants of health. Int. Journal of Health Services 2009; 39;(3):423-41.

- NVVA, Beroepsprofiel verpleeghuisarts. Utrecht: NVVA 2000.
- NVVA, Nota Takenpakket verpleeghuisarts/sociaal geriater, Utrecht: NVVA 2003.
- Polder JJ 2008, Levensloop en zorgkosten. Solidariteit en de zorgkosten van vergrijzing, RIVM Rapport 270082001.
- Robben, P.B.M., Kwartet voor ouderen. Ontstaan en ontwikkeling van de medische beroepen in de ouderenzorg. Houten: Bohn Stafleu Van Loghum 2002.
- Prof. dr. Paul Schnabel, directeur Sociaal en Cultureel Planbureau Kwetsbare ouderen, Den Haag 2011.
- Verenso, Helderheid over verantwoordelijkheid, verantwoordelijkheid voor medische zorg in relatie tot verantwoorde zorg, Utrecht 2009.
- VWS, Tijd en toekomst Deelrapport van de VTV 2010. Van gezond naar beter Den Haag: VWS 2010.
- VWS, Van gezond naar beter, Kernrapport Volksgezondheid toekomst verkenning 2010 Den Haag: VWS 2010.
- Weeder, W.E. en G.P. Melkert, Managementparticipatie door verpleeghuisarts/sociaal geriater; handreiking als bijdrage aan de discussie. Utrecht: NVVA en NVVZ 1998.
- Prof. Westendorp R, Buitenspel? De kunst van het oud worden, Wormer 2007.
- R. Wiewel Verenso 2005 , De competenties van de Verpleeghuisarts 2005.
- Inge Wijkamp, Janet Klaster, Paul van Wilgen, Groningen 2008, Multidisciplinaire samenwerking: een kans tot kwaliteitsverbetering voor de vrijgevestigde logopedist. Ontwikkeling en implementatie binnen de eerste lijn.

# Part C

## Appendices

# The competencies of elderly care physicians

Elderly care physicians have expertise in the care of the frail elderly who have the following characteristics:

- There are multiple issues,
  - Comorbidity: in addition to the main diagnosis, there are several subdiagnoses related to a chronic illness, such as depression in dementia.
  - Multimorbidity: there are several illnesses/diseases present at the same time, such as Parkinson's disease and diabetes mellitus.
- Multipathology (comorbidity and multimorbidity) is seen together with specific signs of aging such as osteoarthritis and osteoporosis.
- The presentation and course of the diseases are atypical, often characterized by a reduction in independence (control/functional autonomy).
- The aim of treatment is not so much to relieve or cure the disease, but to restore functionality and independence and/or enable the best possible quality of life.

## Frail adults with specific chronic diseases

Elderly care physicians may also be involved in the care of younger patients with similar complex medical care problems. Such target groups may have very specific illnesses such as neurodegenerative diseases (multiple sclerosis, amyotrophic lateral sclerosis), Korsakoff's syndrome, or be patients in a long-term vegetative state, patients with acquired brain injury (ABI), or young people with terminal illnesses etc.

## Aims of elderly care medicine<sup>14</sup>

The aim of the specialism of elderly care medicine is to provide medical care for complex elderly care problems whereby the improvement of the functional autonomy and quality of life of the patient are important. This complex medical care should be provided independently of the patient's location.

## Working environment

Elderly care physicians carry out their activities wherever their expertise is required. Elderly care physicians work in nursing homes as treating professionals, in the home setting as a co-treating physician or as a consultant to the family doctor, and in hospitals as co-treating physician or as a consultant to the treating specialist. There are elderly care physicians who practice independently and who offer their services to nursing homes, family doctor practices and hospitals. Elderly care physicians carry out their activities wherever their expertise is required.

Increasingly, elderly care physicians are developing their own specific fields of interest, making them experts in a specific area. Such areas include dementia, multiple sclerosis, Parkinson's disease and complex medical care for patients with specific requirements such as long-term ventilation. The main field of expertise of social geriatricians is psychogeriatric medicine. They carry out their activities in an integrated setting, coordinating between nursing homes and mental health institutions (for older psychiatric patients), between mental health institutions and the home setting (for older persons with psychiatric problems) and as a consultant (for nursing homes specialized in older persons with chronic psychiatric disorders).

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<sup>14</sup> Wherever elderly care medicine is mentioned, this also refers to frail adults with specific chronic diseases.

### Primary treating physician

As primary treating physician, elderly care physicians are responsible for the medical diagnosis, needs assessment, treatment, setting up and implementation of the medical treatment plan and for 24-hour care. They also coordinate the multidisciplinary team. This coordinating role is independent of the elderly care physician's work situation. If an elderly care physician works in a nursing home or hospital, then the multidisciplinary team will be made up of the paramedical and perimedical care providers working at that institute. If an elderly care physician works in primary care, then the multidisciplinary team will be formed in collaboration with paramedical and perimedical practices and home care services.

### Areas of work

Medical practice is concentrated in the following areas: geriatric rehabilitation, chronic somatic and/or psychogeriatric care, chronic psychiatric care, palliative terminal care, crisis intervention, diagnostics, prognostics, coordination/management and advisory.

Overview of areas of competence:

- Medical expertise
- Communication
- Collaboration
- Role as scholar
- Health advocacy
- Management
- Professionalism

These seven areas of competence give rise to 17 groups of competencies as defined below.

### 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<sup>15</sup>, 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.

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<sup>15</sup> In the case of legal incapacity, the consent of the patient's legal representative.

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).

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 <sup>16</sup> 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)

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<sup>16</sup> In the case of legal incapacity, in consultation with the patient's legal representative.

## 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
  - 6.1 with:
    - the multidisciplinary team about the care and treatment plan;
    - colleagues from primary and secondary care about the medical situation of the patient;
    - care providers from other institutions concerning medical and general care for the patient (therapeutic environment etc.).
  - 6.2 recognize the limits of their own professional expertise during such discussions;
  - 6.3 acknowledge the role and expertise of other parties involved;
  - 6.4 involve the patient and their families in decision-making;
  - 6.5 explicitly integrate the opinions of the patient and care providers into the medical treatment plan;
  - 6.6 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.

# Terminology

## Basic health care

This covers all those facilities in the areas of housing, care and social well-being that institutions/government make available to their patients and which are not specifically linked to the individual potentials or limitations of the patient. This includes residential institutions, mental health institutions, home care services and the conditions of the Medical Research (Human Subjects) Act (WMO). The degree to which an individual patient can lay claim to these facilities is determined by a decision on needs assessment.

## Professional profile

A description of the target groups for whom elderly care physicians are medically responsible and of the core competencies that are necessary for this.

## Complex care needs

Elderly patients present with complaints and symptoms. These are often of an aspecific nature whereby loss of function predominates and where there is no distinct unambiguous line that can be traced back to a single pathological principal diagnosis. Comorbidities are present. This can have a synergistic effect on the nature and the severity of the patient's problems and limitations making it difficult to identify these clearly. Additionally, the relationship between disease and the consequences of disease is strongly influenced by factors such as personality, mood, acceptance and processing, social support and cultural values. There is, in fact, a downward spiral in which loss of function due to negative feedback leads to further deterioration in functional limitations and possibly even to new chronic illnesses (Hertogh 1999, pp. 27-28). The effect of this downward spiral is to make medical care more and more complex as the disease process progresses.

## Comorbidity

The co-occurrence of one or more additional disorders related to a disease or chronic condition, e.g. depression with dementia.

## Multimorbidity

There are several illnesses/diseases present at the same time, such as Parkinson's disease and diabetes mellitus.

## Multipathology

The patient has both comorbidity and multimorbidity.

## CSLM CARE

Continuing systematic long-term multidisciplinary care.

## Frailty

Frailty in older persons is the process of an accumulation of physical, psychological and/or social deficits in functioning which increase the chances of frailty regarding autonomy and control over life. This process can lead to a downward spiral of increasing loss of function. Elderly care physicians have expertise with regard to frail older persons who have the following characteristics:

- There are multiple issues. Comorbidity: The co-occurrence of one or more additional disorders related to a disease or chronic condition, e.g. depression with dementia. Multimorbidity: there are several illnesses/diseases present at the same time, such as Parkinson's disease and diabetes mellitus.
- Multipathology (comorbidity and multimorbidity) involves specific diseases of old age such as osteoarthritis, osteoporosis and similar.
- The presentation and course of these diseases may be atypical, often characterized by a reduction in independence (control/functional autonomy)
- The aim of treatment is not so much to relieve or cure the disease, but to restore functionality and independence and/or enable the best possible quality of life.

### Frail adults with specific chronic diseases

Elderly care physicians may also be involved in the care of younger patients with similar complex medical care problems. Such target groups may have very specific illnesses such as neurodegenerative diseases (multiple sclerosis, amyotrophic lateral sclerosis), Korsakoff's syndrome, or be patients in a long-term vegetative state, patients with acquired brain injury (ABI), or young people with terminal illnesses etc.

### Optional areas of specialization

These areas of interest fall outside the scope of the core activities of the elderly care physician. Nevertheless, optional areas of interest are essential to the practice and further professional development of the elderly care physician. In order to operate in these areas of interest, extra skills and/or training courses are necessary.

### Geriatric rehabilitation

This is treatment aimed at recovering the functional independence of the body, independence in the home and in carrying out other desired activities.

### Task

The cohesive entirety of all those activities with which elderly care physicians achieve their objectives. These objectives may be directly linked with treatment, or may be linked with improving the conditions in which patients are treated.

### Competencies and areas of specialization

The sum total of the competencies that must be satisfied in order to realize the specifications laid down in the professional profile, and which are required of every elderly care physician. These competencies and areas of specialization are partially patient-linked and partially non-patient-linked.

### Medical treatment plan

The medical treatment plan encompasses the results of diagnostic and medical history-related investigations, problem interventions, goals of treatment, current multidisciplinary treatment, problem-oriented interventions, potential preventative measures (including taking responsibility for these), observations, information/instructions for nurses and care assistants, making agreements with the patient or their lawful representative, evaluating the effect of treatment and making any adjustments necessary. It is self-evident that the elderly care physician draws up the medical treatment plan in consultation with the patient, and that on transfer of this data any sensitive information concerned with privacy should be treated in confidence. The elderly care physician is responsible for drawing up the medical treatment plan.

### Care and living plan

In the eyes of the law, the care and living plan can comprise the sum of various documents: the medical treatment plan + care plan + list of medications + overview of measures restricting freedom. It may be one integrated document, which may or may not be stored electronically. The care and living plan is not an agreement and it does not need to be signed by the elderly care physician. The elderly care physician is not responsible for the care and living plan. However, as is the case with other care providers, the elderly care physician is responsible for ensuring that the content is not at odds with the existing medical management plan and the general state of health of the patient.

### Diagnosics

The assessment and diagnosis of disease, degree of comorbidity and the consequences of this for the patient. Comorbidities are ranked depending on the principal diagnosis and multimorbid conditions (depending on which disease is currently most prominent). The principal diagnosis may change if the patient's state of health changes.

### Prognosics

Based on the diagnosis of the disease, comorbidity and ranking derived from a geriatric assessment, the expected consequences are evaluated and a prognosis for the required treatment/care needs is made.

### Coordination/management

Activities targeted at guiding and coordinating the care and treatment provided by various disciplines and carers.

### Care system

The sum total of all involved in providing individual care for a patient, including formal, semi-formal and informal care providers.







verenSo

Mercatorlaan 1200  
3528 BL Utrecht

Postbus 20069  
3502 LB Utrecht

T 030 28 23 481  
F 030 28 23 494

info@verenso.nl  
www.verenso.nl