
EDITORIALS

GERIATRIC TRAINING FOR NON-SPECIALIST

With the change in demography, there is increasing number of elderly population. A lot of them can survive with reasonable functional level until a catastrophic event happen and die suddenly. A number may suffer from repeated insults with stepwise or progressive deterioration in functional level before the terminal event occurs. Depending on the complexity of the situation, they may be looked after by specialist Geriatrician, Family Physician with some training in Geriatric Medicine or non-specialist. Training pathways for specialist Geriatrician accreditation follows standard guidelines / criteria since the establishment of the Hong Kong Academy of Medicine in 1993. Alternatively a clinician may want to gain knowledge and skills in Geriatric Medicine yet practise as Family Physician or non-specialist. In the States, a practitioner may take a two years course and be accredited for the training. In UK, one can take the Diploma in Geriatric Medicine examination organised by the Royal Colleges and be recognised in the training. In Hong Kong, there was little opportunity for non-specialist to acquire more knowledge and skills in managing elderly. Breakthrough happened in 2000 when the Hong Kong Geriatrics Society, in collaboration with the University of Hong Kong, organised the Postgraduate Diploma Course in Geriatrics Medicine. The course lasts for 9 months with guided learning and practical exposures taught by specialist Geriatrician. At the end of nine months, trainees will be required to sit the Postgraduate Diploma in Geriatric Medicine with renowned overseas Geriatricians as overseas examiners. The diploma is a quotable qualification under the Hong Kong Medical Council. Detail of the course can be obtained at <http://www.hku.hk/cerfm/geriatrics>.

What does this mean to the service? In Hong Kong, there are about 32,000 elders living in residential places of different level run by either NGOs. There are even more numbers living in private residential homes. Majority of them has chronic diseases. At times they may also suffer from minor ailments that complicate pre-existing chronic diseases, e.g. urinary tract infection complicating diabetes mellitus. Some may suffer from debilitating

pain secondary to osteoporotic vertebral fractures. Others may have internal malignancy with cachexia. Though the conditions may not be difficult to treat, one has to be aware of the potential complexity in this group of elderly. The complexity may arise from atypical presentation, underlying risk factors that are not recognised / corrected, comorbidity conditions, and potential iatrogenesis from drug-drug interaction during treatment. One has to assess the potential reversibility of the conditions so that the patient will not be over-treated or under-treated. One may also need to review the overall management plan and objectives of treatment in this group of patients. Many a time, a non-specialist without adequate training may feel incompetent in handling the situation and the patient be referred to hospital care. Some sort of postgraduate training is required for a clinician to pick up the skill and philosophy so that they learn how to care for an elderly appropriately. With the acquired training from the postgraduate diploma course, the clinician will be much competent in identifying the problems, recognising the complexity and organising appropriate management plan towards better patient care. They know what can be treated so that conditions can be reversed rather than just label as "ageing process". They know what may be unrealistic and alternative management plan organised. They may also initiate hospitalisation more appropriately and timely. From the hospital services side, this group of trained clinician will be good community partners for shared care. They have the basic knowledge and skills. They share the philosophy. They know what is achievable and what is not. Referral to hospital services will be more appropriate. For the disabled elderly, they will have better and more coordinated care. They will be cared by clinician and other healthcare workers who know them well. For the healthcare system, it helps to restore the care at the community rather than hospital based. The training helps to set the foundation on re-shaping the future model for care of disabled elderly.

This is the vision to be realised. With a yearly intake of about 30 clinicians into the course, the output may not be high enough to satisfy the

demand. The course has only started. As time goes by, we hope to cumulate enough non-specialists who are equipped with knowledge and skills in elderly care. The course is just the beginning,

practice will be the process, and coordinated elderly care will be the outcome to achieve.

Christopher Lum.