

The Training of Geriatric Fellows in Rehabilitation: AGS Educational Guideline

AGS Education Committee

Chronic diseases, which impose significant health burdens on older persons, may also produce physical disability. The "Guidelines for Fellowship Training in Geriatric Medicine" by the Accreditation Council for Graduate Medical Education include training in rehabilitation medicine for geriatrics fellows. The goals of geriatric rehabilitation are to limit the extent of disability, prevent functional and social decline, and delay or prevent loss of independence and institutionalization (see Appendix 1).

Disease and the aging process may affect successful rehabilitation of geriatric patients. Older persons may have impaired strength and ability to learn new techniques. Goals sometimes must be modified and rehabilitation procedures selected with careful consideration of patients' functional and disease status. Geriatric programs are encouraged to develop training experiences so that fellows will achieve the following clinical competencies by graduation from the program.

GOAL

Geriatric fellows will be competent and confident in their abilities to care for older patients during a program of rehabilitation, to maintain continuity of care, and to produce optimum outcomes of rehabilitation.

CLINICAL COMPETENCIES

1. The fellow will be able to evaluate patients with physical impairments and disability through use of musculoskeletal and neurologic examinations and instruments that measure activities of daily living and instrumental activities of daily living. The fellow will be able to assess the extent of disability and the patient's remaining functional capacity. The fellow will be able to assess the extent of deterioration by comparison with previous capacity,

via historical information obtained from the patient and family.

2. The fellow will understand terminology, including impairment, disability, and handicap, used in rehabilitation to describe a patient's functional status.
3. The fellow will be able to evaluate the patient's medical status, psychosocial setting, cognitive function, affect, and communication skills and to determine the effects of these on rehabilitation potential and discharge outcome.
4. The fellow will understand the expertise and roles of each member of the rehabilitation team: physiatrist, physical therapist, occupational therapist, speech-language pathologist, recreational therapist, social worker, dietitian, and nurse. The fellow will understand the expertise and roles of other professionals often involved in rehabilitation of the patient: kinesiologist, psychologist, chaplain, dentist, podiatrist, audiologist, pharmacist, and music or art therapist. The fellow will be able to consult appropriately with other team members and interact suitably in interdisciplinary team conferences. The fellow will understand the importance of an interdisciplinary team approach in rehabilitation of older persons.
5. The fellow will be able to assess the patient's values, beliefs, and preferences and use this information to adjust rehabilitation goals.
6. The fellow will be able to develop, review, and revise each patient's rehabilitation goals, including discharge planning, in consultation with other team members, the patient, and the family.
7. The fellow will be able to prescribe therapeutic modalities such as exercise and physical agents (e.g., heat, cold) and understand their indications and contraindications.
8. The fellow will know the common indications for frequently used assistive technology, such as canes, walkers, wheelchairs, adaptive devices, and bracing and splinting techniques.
9. The fellow will be able to assess patients, set rehabilitation goals, and refer patients for consultation in multiple settings (acute care, subacute care, nursing home, inpatient rehabilitation, home, ambulatory care/clinic, and day care) in the management of conditions found in older adults, including:

This American Geriatrics Society (AGS) Position Paper was developed by the Education Committee and approved by the American Geriatrics Society Board of Directors in 1993. It was revised in May 2001 by the AGS Education Committee and the Rehabilitation Special Interest Group. The AGS thanks Niharika N. Suchak, MBBS, MHS, and Gail Sullivan, MD, for their work on this position statement.

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Appendix 1

Impairment, disability, and handicap are defined as follows.

Impairment: Any loss or abnormality of psychological, physiological, or anatomical structure or function; impairment represents the problem at the tissue and organ level (e.g., weakness, limited range of motion, pain, confusion, paralysis, or amputation).

Disability: Any restriction or lack of the ability to perform an activity in the manner or within the range considered normal for a human being resulting from an impairment; disability represents the problem at the whole-person level (e.g., inability to walk or dress independently).

Handicap: A disadvantage, resulting from an impairment or a disability, for an individual that limits or prevents the fulfillment of a role that is normal (depending on age, gender, and social and cultural factors) for that individual; handicap represents the problem at a societal level (e.g., inability to live alone, or difficulties with social integration or economic self-sufficiency).

- a. disabilities caused or aggravated by immobilization, inactivity, deconditioning, restricted activities, or malnutrition
- b. ischemic heart disease, chronic lung disease, or postoperative recovery requiring cardiopulmonary rehabilitation
- c. stroke, both right- and left-sided lesions, and traumatic brain injuries
- d. other chronic neurological disorders such as Parkinson's disease, multiple sclerosis, and amyotrophic lateral sclerosis
- e. myelopathy, radiculopathy, spinal stenosis, and spinal cord injury
- f. fracture of the hip, arm, or vertebra
- g. replacement of the knee or hip
- h. lower extremity amputation, stump care, and use of prosthetic devices
- i. arthritis with impaired mobility of the back, knees, hips, shoulders, or other joints
- j. Paget's disease
- k. osteoporosis
- l. cervical spondylosis
- m. speech and swallowing problems
- n. chronic pain syndrome, including phantom limb pain
- o. aging with a previous disability

TEACHING METHODS AND FACILITIES

A physician qualified to provide instruction in rehabilitation should be associated with each geriatrics fellowship program. Fellows may be taught rehabilitation principles and practice during a block rotation or a longitudinal part-time experience and may serve as primary care physician or consultant. Experience with a variety of clinical settings and teaching methods is optimal. Responsibilities for the care of inpatients in acute care hospitals and long-term care institutions and for community-dwelling older persons in outpatient settings will provide exposure to the full range of rehabilitative care. Home visits to disabled older patients can provide valuable insight into their function.

Lectures, case conferences, readings, and teaching sessions with therapists to demonstrate techniques may supplement clinical experiences to ensure comprehensive coverage of the curriculum.