Medical advancements in geriatrics present-day issues and opportunities.

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Abstract

Greater use of emergency medical services is linked to the growing percentage of elderly persons. The proportion of elderly patients returning unexpectedly after being discharged from the emergency department is a serious issue in this situation (ED). We sought to determine if discharge from the ED followed by referral to a specialised Geriatric Revaluation Clinic (GRC) is related to fewer early unplanned returns. Residents in General Internal Medicine (GIM) should be equipped to handle this patient population. We describe the present and projected geriatric education trends in GIM residency programmes in this paper.

Introduction

The attitudes, knowledge, and abilities necessary to deliver outstanding geriatric care will need to be imparted to GIM residents through specialized training. Geriatrics training in GIM has been the subject of reports, but they are either out-of-date or they only covered one area of geriatric education. By presenting the findings of an extensive review of current initiatives and trends in geriatric education for GIM residencies, this paper fills this gap [1].

We found 2503 records, reviewed the entire texts of 393 of those for eligibility, and included 367 of those in the theme analysis. Curriculum, topics, teaching strategies, learning environments, medical students' abilities and attitudes were the six main issues that came to light. Vertical integration of geriatric medicine into the curriculum has been urged; new curricula focused on minimal geriatrics competencies, geriatric psychiatry, and comprehensive geriatric assessment. Delirium, pharmacotherapies, healthy ageing and health promotion, and telemedicine were among the areas that were new or emerging [2].

Interprofessional education, senior mentor programmes, intergenerational engagement, journaling and reflective writing by students, simulation, clinical placements, and online learning were highlighted as effective teaching strategies. Among the new instructional environments were nursing homes. Three qualities were emphasized as being crucial for connecting with older adults: communication skills, empathy, and professionalism. Adults 65 and over made up 39% of ambulatory visits in general internists' offices in 1999. 4 Less than 10,000 of the 120,000 general internists and family doctors in the United States who are now in practise have obtained a Certification Of Additional Qualifications (CAQ) in geriatric medicine, nevertheless. The care needs of elderly patients will require the services of all general internists, both those with and without geriatric accreditation [3].

The survey instrument was created with collaboration from geriatrics-trained members of the Society of General Internal Medicine (SGIM). Five directors of internal medicine residency programmes pretested it. General programme information required geriatric medicine experiences for primary care track residents, required geriatric medicine experiences for categorical/combined programme residents, other geriatric medicine experiences, and one open-ended question about best practices made up the eight sections of the self-administered survey. Geriatric experience was described as "a curriculum specifically structured to teach geriatric care principles and not merely an environment in which certain older folks are observed" in the instructions given to the residency directors [4].

Lack of faculty was the main problem in implementing a geriatrics programme that was most frequently mentioned. According to our research, the biggest barrier limiting programme directors from increasing geriatrics training is now a packed curriculum rather than a shortage of staff. Given the depth of internal medicine training and the rise in RRC requirements, this concern is not surprising. Program directors continue to play a crucial role in determining how much geriatric medicine instruction GIM residents receive. Longitudinal geriatric medicine experiences do appear to be underutilised in GIM training programmes, nevertheless [5].

Conclusion

We advise that current research discussed in this publication be incorporated into undergraduate medical courses in geriatric medicine. Different educational environments and methodologies should also be taken into consideration, in addition to newly emerging topics and advancements in already existing themes. The use of vertical integration throughout the undergraduate course might be a helpful addition to the knowledge gained in a specific undergraduate

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Geriatric Medicine course. Interprofessional education can enhance teamwork abilities and comprehension of other professions' roles. With an emphasis on communication and empathy, it should be possible to communicate with older patients more effectively. Medical students should have the abilities required to treat elderly patients successfully if predicted levels of geriatric competencies are embedded

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