Educating Entry-Level Occupational Therapy Students in Gerontology

Ronald G. Stone, Krista B. Mertens

Key Words: aged • curriculum design • education

Demographic projections indicate that the proportion of elders in the United States will rise significantly at least through the middle of the 21st century, accompanied by a dramatic increase in the number of chronically disabled elders (National Center for Health Statistics, 1989; U.S. Bureau of the Census, 1982). Although elders with chronic disabilities have needs similar to persons of any age with chronic disabilities, they also have age-specific needs that require consideration. The purpose of this paper was to identify key gerontologic elements relevant to occupational therapy and to discuss gerontologic education in entry-level occupational therapy programs.

Literature Review

For at least the next 60 years, the population over 85 years of age is expected to grow at a faster rate than any other age group (U.S. Bureau of the Census, 1982). Elders differ from their younger cohorts in several ways. Although most elders report that their health is good to excellent, older age groups are characterized by increasing rates of chronic disability (National Center for Health Statistics, 1989). The results of the National Health Interview Survey (LaPlante, 1988) revealed that nearly 3 out of 4 persons over 85 years of age experience a limitation in one or more activities, compared with 1 out of 20 persons under 18 years of age. Elders are more likely to have physical, hearing, visual, and cognitive impairments that limit their ability to communicate and participate in specific activities. Furthermore, roles, interests, and habits evolve over the life span. Occupational therapists who work with elders must be aware of these and other age-specific needs that affect occupational performance.

The Gerontic Occupational Therapist: Generalist or Specialist?

The purpose of entry-level education in occupational therapy is to ensure that therapists entering the profession can function as generalists (American Medical Association [AMA] & American Occupational Therapy Association [AOTA], 1983). Dunn and Rask (1989) urged that specialty content be excluded from entry-level curricula. They proposed instead that specialty knowledge and skills be obtained after therapists enter the profession with the use of mechanisms such as graduate or continuing education, fellowships, mentoring, or research activities. If specialist content is to be precluded from entry-level education, a distinction between what constitutes general practice and what constitutes specialty practice is necessary.

Is providing occupational therapy services to elders the work of a generalist or a specialist? Dunn and Rask (1989) categorized gerontic practice as a specialty. Ten years ago, the chair of AOTA's Gerontology Special Inter-
Section characterized the skills required of a gerontic occupational therapist as those of a generalist (Rogers, 1981). Five years ago, the developers of the Role of Occupational Therapy with the Elderly (ROTE) curriculum also supported the view that gerontic practice is the work of a generalist, not a specialist (Davis & Kirkland, 1986). Practice patterns appear to support the notion that gerontic occupational therapy is the work of generalists. In recent surveys, although only one out of seven occupational therapists reported that the age range of their patients was exclusively the 65-and-over age group (Staff, 1987), one out of three reported that they worked with elders (Peterson, Bergstone, & Douglass, 1988), and three out of five reported working in hospitals and other settings where elders are frequently served (Staff, 1987). Because elders currently account for almost half of all days of care provided in hospitals in the United States (American Association of Retired Persons and Administration on Aging, 1990), most fieldwork students and beginning therapists who work in hospitals must assess and intervene with elders.

The Association for Gerontology in Higher Education advocates the incorporation of gerontologic content in entry-level professional programs. The results of a personnel resources study conducted by Peterson et al. (1988) under the sponsorship of the Association for Gerontology in Higher Education indicated that a high proportion of occupational therapists work with elders. For this reason, the study stated that occupational therapy personnel should receive formal gerontologic education as part of the entry-level academic program.

Curriculum Content: Who Decides What Is Essential?

Although the evidence suggests that gerontic practice is within the domain of entry-level generalists, the question of how much and what gerontologic content to include in entry-level curricula remains. The formal document that provides for the accreditation of occupational therapy educational programs, Essentials and Guidelines of an Accredited Educational Program for the Occupational Therapist (AMA & AOTA, 1983), does not prescribe the quantity or nature of gerontologic content to be included in entry-level curricula. Regarding age-related curricular content, the Essentials merely states that academic programs should include the study of human development and occupation throughout the life cycle and that Level II fieldwork should include experience with patients of various ages.

Whether the Essentials should be more prescriptive about what content is included in entry-level curricula is an issue with historic roots (Colman, 1986, 1990). Wittman (1990), reporting on the January 1990 Directions for the Future Symposium, noted that a prescriptive sentiment existed among some symposium participants who strongly recommended that the core knowledge of occupational therapy be described and defined at all levels of the educational hierarchy. Grant (1986) cautioned against such a prescriptive approach to curriculum planning, suggesting that it might contribute to narrow technical preparation rather than professional development. The long history of academic freedom and institutional autonomy in this country has bred reluctance on the part of colleges and universities to accept outside control of their curricula by professional organizations. Curriculum designers and educators seek to develop a curriculum that integrates the expectations of accrediting organizations with the institution’s mission. This process can result in a unique curriculum that is enhanced by its ability to capitalize on the unique attributes of the university. If the Essentials becomes too descriptive and prescriptive, the diversity of programs could be stifled and individual program strengths lost.

The relative weighting of curricular elements such as knowledge, theory, values, attitudes, and skills in entry-level education has been debated by educators and practitioners for many years. In her Eleanor Clarke Slagle Lecture, Rogers (1983) described the balance that entry-level education must achieve in these curricular elements to produce therapists who are scientists, ethicists, and artists. West (1990) stated that the teaching of principles rather than techniques and of knowledge rather than skills is needed to produce practitioners who are capable of creative problem identification and problem solving. Yerxa and Sharrott (1986) called for the return of occupational therapy to its liberal education roots to ensure that occupational therapists have the grounding to think critically, to exert moral and ethical leadership, and to act in the public interest and not merely out of self-interest.

Each of these respected leaders and educators, although not speaking only to gerontic education, identified the need for therapists to design interventions around the patient’s values. Hassellkus and Kiernat (1989) expressed the concern that therapists who have not been adequately educated in gerontologic concepts have difficulty recognizing the special developmental, health, and occupational needs of their older patients. These authors stated that education must focus on attitudes about elders so that therapy is not diminished by negative stereotypes or ageism. To address concerns such as these, educational programs must stimulate the students’ learning, thinking, and examination of personally held assumptions and attitudes about elders.

Specific Gerontologic Content

The most ambitious approach to identification and compilation of gerontologic content relevant to occupational therapy was conducted by AOTA’s Division of Continuing Education in the mid-1980s. A variety of studies and projects were undertaken involving hundreds of gerontic practitioners and educators as part of the ROTE project.
Two significant outcomes of this project were the publication of ROTE (Davis & Kirkland, 1986) and the continuing education workshops on this topic, conducted throughout the United States since 1986. The developers of this competency-based curriculum noted that although it was designed for the advanced education needs of occupational therapy personnel, it can also be applied selectively to entry-level education. The competencies developed for the ROTE project are shown in Appendix A. More than 100 performance objective statements support these competencies (Davis & Kirkland, 1986).

Because the Essentials do not prescribe the quantity or nature of gerontologic content in entry-level occupational therapy education and because recent relevant survey data are not present in the literature, little is known about what gerontologic elements are currently taught in U.S. programs. The ROTE curriculum has probably influenced the coverage of gerontic content in entry-level programs since 1986. The extent to which these materials have been integrated into entry-level programs, however, is unknown.

Previous Gerontologic Education Surveys

Many surveys of occupational therapy curricula have been conducted; some of these have been reported in the literature and are succinctly reviewed by Nelson, Cash, and Bauer (1990). Although physical therapy programs were surveyed in 1988 regarding gerontologic content, the most recent survey of gerontologic content in occupational therapy programs was conducted before the publication of the ROTE curriculum.

Strasburg and Gingher (1986) surveyed entry-level occupational therapy programs sometime before 1986. Their study compared occupational therapy education in gerontology with what they described as an ideal model of gerontologic instruction. Although their report is seriously weakened by its failure to state the rationale used to determine the model criteria and its limited discussion of model design, parts of the report are nevertheless informative. Fourteen percent of full-time and part-time faculty who taught in responding programs were characterized as having special preparation in gerontology on the basis of their amount of experience in advanced education or geriatric practice. Concerning fieldwork experiences, Strasburg and Gingher reported that 29% of schools required a fieldwork placement in geriatrics and 62% provided some type of clinical experience in geriatrics. The authors reported that the responding schools devoted an average of 25 hr to age-related topics and addressed an average of 14 of 22 (64%) of the age-related topics delineated by the researchers' ideal model.

In 1988, the American Physical Therapy Association's (APTA's) Department of Accreditation surveyed entry-level physical therapy programs with regard to their gerontology content (APTA, 1990; Solon & Kilpatrick, 1989).

Sixty-eight percent of entry-level programs responded, and 84% of the respondents reported that gerontologic material was conveyed in at least one required course. One third of the programs offered one or more elective courses that conveyed material related to aging. From a list of 20 gerontologic topics, each program was asked to identify topics that were included in its curriculum. Partial results of this portion of the study are shown in Table 1.

Survey of Entry-Level Educational Programs, November 1990

We surveyed all 101 entry-level occupational therapy programs admitting students in fall 1990 (92 accredited, 9 developing) to collect up-to-date information about the status of gerontologic content. The names and addresses of programs were obtained from the listing of accredited and developing entry-level programs in the United States, updated on November 1, 1990, by AOTA's Education Division.

A two-page survey was constructed to gather selected data on current gerontologic content in occupational therapy entry-level programs with the use of previous survey reports of occupational therapy and physical therapy programs as models (APTA, 1990; Solon & Kilpatrick, 1989; Strasburg & Gingher, 1986). The survey was designed so that it could be completed by either the program director or a gerontic faculty member in less than 10 min. The survey contained questions regarding the following curricular elements: (a) gerontologic admission prerequisites, (b) required and elective gerontologic courses offered within the occupational therapy program, (c) textbooks used for gerontologic readings, (d) Level I and Level II gerontic fieldwork requirements, and (e) change in the amount of gerontologic content in the past 5 years. In addition, the survey listed 30 gerontologic topics and asked respondents to note whether each topic was currently included in the curriculum and whether each topic should be included in entry-level curricula. Fourteen of these topics were extracted from a 1988 survey of physical therapy entry-level programs (APTA, 1990; Solon & Kilpatrick, 1989) (see Table 1). The remaining sixteen topics were derived from the competencies of gerontic practitioners, which were developed for the ROTE curriculum (Davis & Kirkland, 1986).

Results

Seventy-two (71%) of the 101 programs surveyed responded, representing 51 baccalaureate degree, 16 master's degree, and 5 certificate programs. Forty-seven percent of the responding programs required a prerequisite gerontic course work outside of the occupational therapy program. Most of these courses were taught by psychology or human development faculty. Other departments in
Table 1
Gerontologic Topics Required in Entry-Level Occupational Therapy (OT) and Physical Therapy (PT) Programs in the United States

<table>
<thead>
<tr>
<th>Topic</th>
<th>PT(^a)</th>
<th>OT(^b)</th>
<th>% of OT Programs saying Topic Should be Required at Entry Level(^c)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Biological and psychosocial theories of aging</td>
<td>43</td>
<td>97</td>
<td>100</td>
</tr>
<tr>
<td>Age-related anatomical, physiological, and cognitive changes</td>
<td>67</td>
<td>96</td>
<td>100</td>
</tr>
<tr>
<td>Medical complications common to elders</td>
<td>74</td>
<td>93</td>
<td>97</td>
</tr>
<tr>
<td>Death and grieving issues</td>
<td>--</td>
<td>95</td>
<td>92</td>
</tr>
<tr>
<td>Primary and secondary dementia</td>
<td>--</td>
<td>92</td>
<td>94</td>
</tr>
<tr>
<td>Methods and environmental modifications for elders</td>
<td>--</td>
<td>88</td>
<td>97</td>
</tr>
<tr>
<td>Reimbursement for OT services under Medicare</td>
<td>--</td>
<td>88</td>
<td>96</td>
</tr>
<tr>
<td>Demographics of elders</td>
<td>38</td>
<td>83</td>
<td>93</td>
</tr>
<tr>
<td>Elder social support systems and family</td>
<td>--</td>
<td>78</td>
<td>92</td>
</tr>
<tr>
<td>Broad health policy and health provision system issues</td>
<td>--</td>
<td>78</td>
<td>86</td>
</tr>
<tr>
<td>Attitudes of health care providers toward elders</td>
<td>59</td>
<td>76</td>
<td>92</td>
</tr>
<tr>
<td>Program evaluation and quality assurance</td>
<td>--</td>
<td>75</td>
<td>83</td>
</tr>
<tr>
<td>Ethical considerations in caring for elders</td>
<td>55</td>
<td>74</td>
<td>96</td>
</tr>
<tr>
<td>Disease prevention and health promotion for elders</td>
<td>31</td>
<td>74</td>
<td>92</td>
</tr>
<tr>
<td>Community health care resources for elders</td>
<td>53</td>
<td>72</td>
<td>88</td>
</tr>
<tr>
<td>Treatment of institutionalized frail elders</td>
<td>40</td>
<td>72</td>
<td>82</td>
</tr>
<tr>
<td>Unemployment and social programs such as Social Security</td>
<td>--</td>
<td>71</td>
<td>81</td>
</tr>
<tr>
<td>Pharmacology and drug interaction in elders</td>
<td>47</td>
<td>69</td>
<td>90</td>
</tr>
<tr>
<td>Elder caregiver issues</td>
<td>--</td>
<td>68</td>
<td>89</td>
</tr>
<tr>
<td>Assessment specific to elders</td>
<td>60</td>
<td>67</td>
<td>89</td>
</tr>
<tr>
<td>Elder abuse</td>
<td>--</td>
<td>64</td>
<td>81</td>
</tr>
<tr>
<td>Treatment of homebound frail elders</td>
<td>11</td>
<td>58</td>
<td>75</td>
</tr>
<tr>
<td>Nutrition for elders</td>
<td>19</td>
<td>56</td>
<td>68</td>
</tr>
<tr>
<td>Autonomy and choice of activities in institutions</td>
<td>--</td>
<td>50</td>
<td>68</td>
</tr>
<tr>
<td>Motivation and compliance with treatment suggestions</td>
<td>--</td>
<td>53</td>
<td>69</td>
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<tr>
<td>Patient education techniques specific to elders</td>
<td>--</td>
<td>51</td>
<td>75</td>
</tr>
<tr>
<td>Legal considerations in care of elders</td>
<td>21</td>
<td>46</td>
<td>74</td>
</tr>
<tr>
<td>Advocacy for changes to improve patient access to services</td>
<td>--</td>
<td>44</td>
<td>75</td>
</tr>
<tr>
<td>Consultation to activity programming</td>
<td>--</td>
<td>43</td>
<td>67</td>
</tr>
<tr>
<td>Case management</td>
<td>--</td>
<td>53</td>
<td>64</td>
</tr>
</tbody>
</table>

\(^{a}\) (Solon \& Kilpatrick, 1989). \(^{b}\) Based on the responses of 72 (71\%) of 101 entry-level professional OT programs surveyed in November 1990.

which prerequisites were offered were sociology, education, gerontology, and anthropology.

Most programs (89\%) reported having a required gerontic course or module within the occupational therapy program. Four percent of the programs indicated that their developing programs were not yet fully operational and that although required gerontologic courses or modules were designed, they had not yet been offered. Six percent of the programs required neither gerontologic prerequisites nor a gerontologic course or module within the program but offered electives with a gerontologic emphasis. One percent of the programs did not offer a required gerontologic course or module within the occupational therapy program but required a gerontologic prerequisite. For programs that required gerontologic course work within the occupational therapy curriculum, the average academic credit load granted for such course work was 2.61 semester credits (approximately 40 hr). All of the required courses or modules within the occupational therapy programs were taught, at least in part, by occupational therapists.

Twenty-eight publications were identified by the respondents; the primary textbooks used for required gerontic course work included *The Role of Occupational Therapy With the Elderly (ROTE)* (Davis \& Kirkland, 1986), used by 31\% of the respondents; *Elder Care in Occupational Therapy* (Lewis, 1989), used by 22\% of the respondents; and *Aging: The Health Care Challenge* (2nd ed.) (Lewis, 1990), used by 20\% of the respondents. Lesser-used published materials included readings from selected chapters of *A Model of Human Occupation* (Kielhofner, 1985), a variety of life span human development textbooks, and clinical gerontology journals, such as *Generations, Physical and Occupational Therapy in Geriatrics, Journal of Gerontology: Gerontologist, and Topics in Geriatric Rehabilitation*.

Elective gerontic course work was offered by 31\% of the occupational therapy programs. The average load of elective course work available in programs that offered it was 4.25 semester credits (approximately 69 hr). The programs that offered elective course work reported that between 1\% and 33\% of occupational therapy graduates have taken such courses. Half of all programs that did not offer elective gerontic courses had no plans to add such course work, whereas 8\% reported plans to add such an elective within 4 years.

Forty-seven percent of the programs required all students to complete a Level I fieldwork experience with elders, compared with 15\% that required a Level II fieldwork placement with elders. Although 82\% of the respondents claimed that requiring gerontic fieldwork was desirable, only 51\% believed that such a requirement was feasible. Many respondents commented that work with elders was an integral, although not exclusive, part of many of their fieldwork experiences.

The respondents were asked to identify the degree and direction of perceived change in the amount of gerontology-related content required in their occupational therapy program over the past 5 years. Three percent of the respondents perceived some decrease; 14\% reported
no change; 64% perceived some increase; and 19% responded that their program had experienced a large increase in required gerontologic content.

Table 1 shows the extent to which the responding programs covered 30 selected gerontologic topics as well as the extent to which the respondents stated that those topics should be required in entry-level programs. Also included in this table is a column summarizing results from APTA’s 1988 survey of physical therapy programs (APTA, 1990; Solon & Kilpatrick, 1989) for the 14 topics that were identical in the two studies.

One developing program required only six gerontologic topics from the list, the fewest of any program, but it plans to add both required and elective gerontologic course work in the near future. Four programs (7%) required only 10 topics from the list in their required curricula, but all of these programs offered elective gerontologic studies to students either as part of the program or within the institution. Forty-one programs (57%) included at least three fourths of the topics in their required course work, and 7 programs (10%) reported that they covered all 30 topics. The most widely included topic, biological and psychosocial theories of aging, was taught in 70 programs (97%), whereas the least widely covered topic, case management, was taught in 24 programs (33%). Biological and psychosocial theories of aging and age-related anatomical, physiological, and cognitive changes were identified by all programs as being essential to entry-level education, whereas case management was identified by 46 programs (64%) as being essential to entry-level education. Twenty-six percent of the programs indicated that all 30 gerontologic topics should be covered in entry-level occupational therapy curricula.

When data on topics were stratified according to the nature of the topic, topics with physical or psychological components were most frequently required by programs and most frequently selected as being essential for entry-level programs, followed in rank order by content related to social and community issues, public policy issues, values, and treatment issues. The topics that were required by the fewest number of programs and considered less essential for entry-level education were: (a) nutrition for elders, (b) autonomy and choice of activities in institutions, (c) motivation and compliance with treatment suggestions, and (d) advocacy for changes to improve patients’ access to services.

Discussion

Survey Limitations

The survey was designed to collect data that could be easily and quickly provided by either a program director or a gerontologic content teacher. The survey did not gather detailed information about elements such as time allotted to specific gerontologic topics; teaching methods; focus on theory, attitudes, and skills; availability and expertise of faculty; or other curricular and administrative factors that could be of use in curriculum planning.

Although the 71% response rate is relatively good for a voluntary mailed survey, it is possible that the self-selection of respondents skewed the results. The programs that did not respond to the survey may have provided very different answers to the questions posed. Thus, although the results reported here are an accurate reflection of gerontologic education in three fourths of the entry-level programs in the United States, they should not be viewed as representative of all U.S. programs.

Gerontologic Elements That Require Special Attention in Entry-Level Education

Table 1 shows a list of gerontologic elements that were identified in the literature as being relevant to entry-level educational programs. Some survey respondents suggested additional topics, including (a) living wills, right-to-die issues, and death with dignity; (b) delineation of roles and functions of therapists and assistants in geriatric settings; (c) communication skills and adaptations necessary to visual and hearing impairments; (d) intergenerational issues; and (e) leisure issues, including retirement and preretirement planning. Several other gerontologic issues were raised that deserve additional comment.

Because life expectancy for women is greater than for men, the number and proportion of widows among elders is increasing rapidly (Hassellkus & Kiernat, 1989). The average annual income for widows is considerably below the average income for men of the same age. Further, because the rate of disability increases with age, a higher proportion of elderly women are disabled as compared with elderly men. Thus, older women are most affected when access to acute, preventive, and long-term services is restricted. Several survey respondents urged that this sociological phenomenon and its implications for occupational therapy and our society be discussed in required entry-level education so that occupational therapists may be better prepared to advocate for public policy that is sensitive to the quality of health and occupational performance of elders in general and of older women in particular.

Several respondents commented that other public policy issues are also important to include in entry-level gerontologic modules. Although public policy issues are not exclusive to elders, Medicare’s coverage of virtually all elders in the United States makes public policy an essential topic for therapists working with this population. Also, Elke’s (1990) analysis of new directions in health policy is that a person’s ability to function in everyday life is highly valued by policymakers at the present time. Given occupational therapy’s tradition of assessment and treatment of occupational performance disorders, it is now critical that occupational therapists learn about poli-
cy issues to understand how the system works and to become involved in shaping health policy.

Other respondents commented that the reimbursement issues that should be emphasized in entry-level education are those that provide opportunities for students to learn professional ethics and values. The rationale for including such issues in entry-level education is that these issues often first arise for a therapist when he or she enters independent practice or is no longer able to obtain supervision from a disinterested third party. One example of such an issue is the therapist's responsibility to avoid conflict of interest in business practices, as raised by the AOTA White Paper on referral for profit (AOTA, 1990b) and elaborated on by Crabtree (1991).

Another issue that provides the opportunity for students to learn values and professional ethics involves the provider's responsibility to follow up when Medicare denies reimbursement for services (Allen, Foto, Moon-Sperling, & Wilson, 1989; Anderson, 1988, 1989; Crabtree, 1989; Foto, 1988a, 1988b; Foto, Allen, Sperling, & Wilson, 1989). If the denial is appropriate, follow-up serves as a learning opportunity for the provider. If the denial is erroneous, the provider's appeal serves as a learning opportunity for the intermediary. If the provider does not follow up when a claim for reimbursement is denied, learning opportunities are lost. An extension of this issue is the dilemma that arises when institutions or other providers refuse service to Medicare beneficiaries because reimbursement for similar services has been denied in the past. When the previous denials have been the result of errors by either the intermediary or the provider, subsequent patients are wrongfully denied services to which they are entitled by law. Occupational therapists who refuse to provide services in such a case are in violation of the profession's code of ethics. Entry-level education should be used to expose students to dilemmas such as these.

Some respondents commented on the need for entry-level education to include content on and exposure to well elders as well as chronically disabled elders. Such a perspective has appeared in previous articles (Hasselkus & Kiernat, 1989; Strasburg & Gingher, 1986). The respondents were concerned that gerontologic education that limits its focus to dysfunction reinforces for entry-level students the stereotype that elders are frail, disabled, and sedentary, thereby ignoring the majority of the elderly population who are well and active.

Finally, many respondents commented on gerontologic fieldwork. Although 4 out of 5 respondents answered that gerontic fieldwork should be required in entry-level education, only half of all respondents believed that such a requirement was feasible. Several respondents, however, sided with Strasburg and Gingher (1986) and Hasselkus and Kiernat (1989) in their belief that general hospitals and rehabilitation settings can serve effectively as gerontic fieldwork settings if physical dysfunction objectives as well as the age-specific needs of elderly patients are emphasized so as to provide a focus on the person, not merely on the condition.

The Status of Gerontologic Education in Entry-Level Occupational Therapy Programs

The results of this survey indicate that gerontologic content is required in U.S. occupational therapy entry-level educational programs and that the amount of such content has increased in most programs over the past 5 years. Whereas about half of the respondents required students to study gerontology offered in academic disciplines (e.g., psychology, human development, sociology), 9 out of 10 programs have a required gerontic module or course within the occupational therapy curriculum that is taught by an occupational therapist. Three fourths of the respondents used for their required gerontic module or course a textbook written at least in part by occupational therapists. Some programs reported using selected articles written by a variety of health care professionals, including occupational therapists.

Generally, topics related to physical and psychological factors were most likely to be required in entry-level programs, and topics related to specific treatment settings or that were of a political or legal nature were least likely to be covered. Interestingly, autonomy and motivation, topics that we consider to be of particular importance for occupational therapy, were required topics for only about half of the responding programs.

Although the survey failed to ask respondents to what extent their gerontologic curricula incorporated the competencies for gerontic practice (see Appendix A) contained in the ROTE curriculum, about one third of the programs used ROTE (Davis & Kirkland, 1986), which is the source where those competencies are published. These gerontic practice competencies, which were developed with the help of more than 800 occupational therapy educators and practitioners, might be used by entry-level programs as a program evaluation tool or as a model for gerontologic content curriculum design.

Gerontologic Education Beyond the Entry Level

For practicing occupational therapy personnel who completed entry-level education at a time when less gerontologic content was offered or for the therapist who wishes to develop gerontic specialty knowledge and skills, many opportunities exist to obtain gerontologic education. Continuing education programs abound, sponsored by associations such as AOTA, the American Society on Aging, the Gerontological Society of America, and the National Council on the Aging. More than 25 geriatric education centers, which are associated with major universities, are located throughout the country. These centers, supported in part by the Bureau of Health Professions of the
U.S. Department of Health and Human Services, offer a variety of reasonably priced educational and training programs and maintain resource clearinghouses from which various geriatric materials can be purchased or borrowed.

Formal educational programs in gerontology are available throughout the country. Eight programs leading to a postprofessional master's degree in occupational therapy with a concentration in gerontology are identified in "Graduate Programs for Occupational Therapists" (AOTA, 1990a). Academic programs leading to a clinical certificate, a master's degree, or a doctorate in gerontology or in other disciplines, such as sociology, psychology, and human development with a concentration in gerontology, are listed in the National Directory of Educational Programs in Gerontology (Association for Gerontology in Higher Education, 1987). (See Appendix B for more information on continuing and advanced educational opportunities.)

Conclusion

Entry-level educational programs are not required to include gerontologic content in their curricula. Because gerontic occupational therapy practice is considered by some to be a specialty, the question arises whether gerontologic content should be reserved for post-entry-level education. The increasing number of elders in our society, however, translates into an increasing proportion of hospital patients who are elderly and who are being treated by entry-level occupational therapists. Because elders have age-specific needs that these entry-level occupational therapists must consider, it follows that some gerontologic content should be included in entry-level occupational therapy curricula. All of the responding entry-level programs in this study required that the students study some gerontologic content, and 82% of the responding programs perceived that the amount of required gerontologic content in their curricula has increased over the past 5 years.

Appendix A

Competencies for Gerontic Occupational Therapy Practice

1. Understand aging and development as normal life processes and perceive the importance of interdisciplinary study and practice.
2. Demonstrate knowledge of the basic biological and psychosocial theories of aging.
3. Identify the major demographic and health statistics of the older population and recognize the unique professional value of gerontic occupational therapy to the elderly consumer.
4. Recognize the anatomical, psychological, and cognitive changes of advancing age and differentiate these changes from disease or pathological processes.
5. Understand the importance of nutrition and proper drug use to the occupational performance of older adults.
6. Identify major physical and psychopathological conditions secondary to the aging process.
7. Understand the roles and the functions of occupational therapy personnel in gerontic practice in institutional and community settings, including acute care hospitals, geriatric evaluation units, rehabilitation units, long-term-care programs, hospices, home health agencies, day programs, and retirement planning programs.
8. Apply principles of assessment, treatment planning, reevaluation, and continuity of care to gerontic practice.
9. Understand chronic illness as an adaptive task for older adults in developing coping skills.
10. Understand the rationale for and develop effective gerontic occupational therapy programs in activity programming, prevention, care of the terminally ill, activities of daily living, therapeutic adaptations, and cognitive and psychosocial treatment.
11. Understand and be prepared to function in the interdisciplinary team and case management models of service coordination.
12. Understand the importance of and develop skills in educating patients and working with the family as a unit.
13. Understand the consultancy process as it applies to gerontic practice.
14. Understand the health service provision system for and by older adults and be prepared to function in community networking for older clients.
15. Identify and understand major health care legislation and reimbursement mechanisms and their ramifications in gerontic practice.
16. Understand strategies for quality assurance and accountability and recognize their importance, especially in demonstrating the value of gerontic occupational therapy to fiscal agents and other professionals.
17. Understand ethical issues in the treatment of the elderly.

Appendix B

Resources for Post-Entry-Level Specialty Education in Gerontology

In addition to the ongoing continuing education opportunities available through the American Occupational Therapy Association, the following resources can be of assistance to practitioners seeking to further their gerontologic knowledge:

Association for Gerontology in Higher Education 600 Maryland Avenue, SW West Wing 204 Washington, DC 20024 202-484-7505 Gerontological Society of America 1275 K Street, NW Suite 350 Washington, DC 20005-4006 202-842-1275 The American Society on Aging 853 Market Street, Suite 512 San Francisco, CA 94103 415-543-2617 To locate the nearest Geriatric Education Center: GEC Coordinator, Bureau of Health Professions 5600 Fishers Lane, Parklawn Building, Room 8-103 Rockville, MD 20857 301-443-6887

The American Journal of Occupational Therapy

649
Acknowledgment

We heartily thank the many academic program directors and gerontic educators who took the time to complete their surveys.

References


