A Review of Entry Level Education in Gerontology

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This study investigated the current state of gerontological instruction in entry level occupational therapy curricula. Four educational needs relating to content inclusion and emphasis, clinical experience, and instructional time were identified through a needs assessment.

Education and practice in the health care professions have not kept pace with major medical, technological, and scientific developments in gerontology. As Tietelman, Parham, and Payton (1982, p. 26) maintain, the health professions must increase their commitment, both educationally and clinically, to the management of chronic disorders among the elderly.

Many occupational therapists are presently providing services to the elderly without the benefit of current gerontological information. Although efforts have been made to provide continuing education courses at the national, state, and local levels, they have not reached a sufficient number of practitioners to remedy this problem (Rogers, 1980).

Maguire (1980) recognized the need for providing continuing education courses in gerontology for clinical practitioners. She also advocated a more aggressive effort to modify entry level occupational therapy curricula to reflect a greater emphasis on the needs and care of the elderly. Although the curricula are already overcrowded, room for gerontological content must be made if occupational therapy hopes to meet the challenge of providing quality health care for the elderly.

The purpose of this research project was to ascertain the extent to which current occupational therapy curricula are preparing entry level students for geriatric practice and to draw implications from the data regarding future directions in gerontological programming.

Method

A curriculum development methodology was used to contrast current curricular instruction with an ideal instructional program, facilitating identification and verification of educational needs. The process involved three steps: establishment of an “ideal” model of instruction, description of the existing “actual” model of instruction, and comparison of the two models. The final step identified educational needs.

The ideal model is an outline of the knowledge, skills, and attitudes necessary for a specific student population to attain a specific educational goal. The ideal model of gerontological instruction in this study was developed by means of an extensive literature review and consisted of four components:

1. Inclusion of 22 topics identified by the Association of Gerontology in Higher Education as “essential” to all practitioners in the biomedical professions (e.g., physicians) and the biocultural professions (e.g., psychologists).
2. Provision of major emphasis on gerontological preparation within the context of the total occupational therapy curriculum.
3. Requirement of a clinical experience in geriatrics, involving both the well and ill elderly.
4. Assignment of a minimum of 80 clock hours (4-5 semester hours) to the development of competencies in gerontological health care (Strasburg, 1984, p. 68).

The actual model of gerontological instruction was determined by means of a closed-question survey mailed to all entry level occupational therapy programs in the United States that were accredited as of July 1, 1983. The questionnaire elicited information on general curriculum characteristics, on curriculum content, on the presence or absence of the four ideal model components, and on situational obstacles to expanding gerontological content.

The descriptive statistics were summarized to determine the compliance of the surveyed occupational therapy programs with each of the four ideal model criteria (i.e., topic inclusion, curricular emphasis, required clinical experience, and clock hours devoted to gerontological instruction). The data regarding each criterion were compiled to form the actual model of instruction.

Once established, the two models were compared to identify educational needs. The absence of ideal model components or the presence of ideal model components to a lesser degree (e.g., inclusion of 14 of the 22 ideal model topics) indicated educational deficits in gerontological programming.

Results

General Curricular Characteristics

A total of 45 of a possible 53 preprofessional occupational therapy programs (bachelor’s or master’s entry level) returned the questionnaire, a response rate of 85%. A mean of six full-time and three part-time faculty were employed per program surveyed. Most of the programs sampled offered clinical experiences in the specialty areas of geriatrics (93%), pediatrics (93%), physical disabilities (91%), and psychosocial disorders (91%); they used general hospitals (98%), rehabilitation centers (98%), psychiatric centers (98%), and Veteran’s Administration facilities (91%) to provide clinical learning experiences for their students.

Gerontological Curriculum Variables

A total of 392 full-time and part-time faculty were employed by the programs participating in the study. From this pool, 56 faculty were identified as having "special" preparation in the area of gerontology. Three or more continuing education courses in gerontology was the most frequently seen type of preparation (48%), followed by 3 or more years of geriatric practice (18%), and academic degrees in gerontology (15%). A substantial number of the curricula had access to at least one of the following gerontological resources: centers for the study of aging (62%), senior centers (93%), and extradepartmental academic concentrations in gerontology (62%). Clinical experiences in gerontology were required by 62% of the sample, with more than half using nursing homes (84%) and home health agencies (51%) to provide the experience. Although nearly all of the programs affiliated with general hospitals and rehabilitation centers, only 13% of the general hospitals and 18% of the rehabilitation centers were used to provide a gerontological orientation to health care. The three obstacles to increased gerontological programming selected most frequently by the respondents were competition for space in a crowded curriculum (78%), shortage or lack of trained clinical faculty (33%), and insufficient funding (31%). Nearly 10% of the sample identified insufficient faculty interest as a barrier to increased gerontological instruction.

Actual Instructional Model

Of the 45 curricula represented in the study, 47% met at least one of the four ideal model criteria for gerontological instruction, 53% failed to meet any of the ideal model criteria, and none of the curricula met all four of the ideal model criteria.

The mean number of ideal model topics included in entry level occupational therapy curricula was 14. Nine percent of the respondent programs included all 22 of the topics delineated by the ideal model (criterion 1), while 7% included none.

The degree of curricular emphasis placed on the specialty area of geriatrics in entry level curricula was determined through a Likert-type scale. The average emphasis was found to be 3.3. In contrast, pediatric preparation received a mean curricular emphasis value of 4.4. No emphasis was placed on gerontological preparation in 6.6% of the curricula, while major emphasis (criterion 2) was provided by 9% of the sample.

Although only about a third of the programs in the study (29%) required a fieldwork placement in geriatrics for all their students (criterion 3), nearly two thirds (62%) provided some type of clinical experience in this area, and 93% identified gerontology as an available clinical option.

The number of clock hours devoted to gerontology (criterion 4) in entry level education was determined by averaging the number of clock hours assigned to gerontological topics per program. Evaluation of the data in this manner revealed an average of 25 clock hours of gerontological programming in the actual model.

The current level of gerontological preparation in entry level occupational therapy education (actual model) may be characterized as doing the following:

- Addressing an average of 14 topics;
- Providing moderate curricular emphasis;
• Containing some type of gerontological clinical experience; and
• Consuming 25 hours of professional curricular time.

Model Comparisons: Identification of Educational Needs

Table 1 presents the mean number of clock hours devoted to gerontological topics in entry level education. The findings indicate that topics that are biomedical or psychological in orientation (e.g., mental health and illness) are more frequently included in entry level education than are topics with a socioeconomic focus (e.g., legislation concerning the elderly).

The actual and ideal models differ significantly in the degree of curricular emphasis assigned to the development of gerontological competence. Although the study documented that a number of ideal model topics are included in entry level education, the extent to which the instructional focus was truly gerontological could not be evaluated. The limited emphasis placed on gerontological preparation in current curricula and the generic nature of several of the topics (e.g., personality development) suggest that the gerontological focus intended by the ideal model is not represented in the actual model.

Required clinical experience was the actual model component that most closely approximated the ideal standard. Although only a minority of the programs in the study required fieldwork placements in geriatrics for all their students, a majority provided some type of clinical experience in geriatrics and/or offered fieldwork placements in geriatrics as a specialty option. Most of these experiences were provided in long-term care or home health agencies, however, deviating from the ideal model requirement of interaction with both the well and the ill elderly. Settings that provide clinical encounters with the well elderly, such as senior centers, were underused.

Respondent estimates of the time devoted to gerontological preparation in the actual model averaged 25 clock hours, as compared to the 80 hours required by the ideal model. This was the most striking discrepancy between the two instructional models.

The educational needs identified in the project, through comparison of the actual and ideal models, may be summarized as follows:

• Inclusion of the socioeconomic aspects of aging;
• Intensification of the gerontological focus of current content;
• Provision of required clinical experiences with the well elderly; and
• Expansion of curricular time to develop gerontological competencies.

Table 1
Mean Hours of Gerontology Topics

<table>
<thead>
<tr>
<th>Topic</th>
<th>Mean Clock Hours</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mental health and illness</td>
<td>13.75</td>
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<tr>
<td>Personality development and/or theory</td>
<td>7.8</td>
</tr>
<tr>
<td>Pathology, disease processes, and aging</td>
<td>8.45</td>
</tr>
<tr>
<td>Stress or loss, response to it</td>
<td>7.24</td>
</tr>
<tr>
<td>Psychology of aging</td>
<td>7.16</td>
</tr>
<tr>
<td>Health and aging</td>
<td>6.97</td>
</tr>
<tr>
<td>Cognitive changes and aging</td>
<td>6.71</td>
</tr>
<tr>
<td>Health care and services for the aged</td>
<td>6.67</td>
</tr>
<tr>
<td>Sensory changes in aging</td>
<td>6.67</td>
</tr>
<tr>
<td>Chronic and/or multiple conditions in aging</td>
<td>6.50</td>
</tr>
<tr>
<td>Behavioral changes and aging</td>
<td>6.22</td>
</tr>
<tr>
<td>Biology of aging</td>
<td>6.05</td>
</tr>
<tr>
<td>Marital and family relationships and aging</td>
<td>5.61</td>
</tr>
<tr>
<td>Attitudes toward aging and aged</td>
<td>5.39</td>
</tr>
<tr>
<td>Environment and aging</td>
<td>4.87</td>
</tr>
<tr>
<td>Exercise physiology, physical fitness, and aging</td>
<td>4.74</td>
</tr>
<tr>
<td>Economics of aging</td>
<td>4.05</td>
</tr>
<tr>
<td>Demography of aging</td>
<td>3.89</td>
</tr>
<tr>
<td>Public policy for aged</td>
<td>3.68</td>
</tr>
<tr>
<td>Legislation concerning aged</td>
<td>3.59</td>
</tr>
<tr>
<td>Pharmacology and aging</td>
<td>3.0</td>
</tr>
<tr>
<td>Nutrition and aging</td>
<td>2.5</td>
</tr>
</tbody>
</table>

Discussion

"Faculty members with special preparation in aging are in very short supply, ranging from five to twenty-five percent of the number required in different fields" (DHHS, 1984, p. 1). The programs represented in this study identified 56 full-time and part-time faculty (14%) with special training in aging. The impact of this faculty shortage on the inclusion of gerontology in the curricula, curricular emphasis, and the provision of clinical orientations to gerontological health care appeared to be an adverse one in this study, preventing realization of the ideal model. In order to meet current and future curricular needs in aging, an increase in the number of faculty with gerontological expertise is critical.

The study identified a wealth of gerontological resources, such as centers for the study of aging, senior centers, and degree programs in gerontology, that seemed to be largely untapped. These resources could be used to expand gerontological programming. Three potential areas for increased resource use were identified by the study: socioeconomic topic development, increased curricular attention to gerontological issues, and expansion of gerontological clinical experiences.

This study documents that occupational therapy students receive a biased perspective of geriatric health care during clinical orientations to gerontological practice. Chronically ill elderly, the majority of whom are institutionalized, are used almost exclusively to introduce the entry level student to gerontic occupational therapy. A nursing study of gerontological curriculum design concluded that "when students are exposed to geriatrics through ... only one perspective, then perception of the social environment of the elderly will be narrowed" (Bigge, 1971, p.
Although entry level programs appear to be increasingly concerned with providing supervised clinical experiences in geriatrics, the current trend in clinical training may actually be promoting student stereotypes regarding the elderly. The study also revealed that a significant amount of clinical education occurs in service sites with large geriatric populations (e.g., general hospitals) but without gerontological objectives. These settings could provide a gerontological focus to health care if they were to be further developed and used as geriatric clinical settings. Such a change in perspective would not only increase the number of sites available for geriatric affiliation, but would provide students with the opportunity to interact with a broader spectrum of elderly people.

Respondents identified three major obstacles to gerontological programming: an overly crowded curriculum, lack of trained clinical faculty, and insufficient funding. Each of these could pose a significant barrier to increasing gerontological instruction. It is essential that these barriers not be perceived as insurmountable, however. Presently, 11% of practicing occupational therapists serve a relatively small proportion of the elderly (DHHS, 1984, p. 42), and yet, "The elderly are expected to account for over a third of all personal health care expenditures in the year 2000" (Rice & Feldman, 1983, p. 386). With this increase in health care use comes an increased demand for qualified occupational therapists to serve the elderly. A recent NIA report (1984) estimated that a fourfold increase in the number of occupational therapists with geriatric training will be necessary to meet this demand.

"The quality of services available to the older adult depends directly upon the quality of personnel who provide them" (White House Conference, 1981). In an editorial comment regarding professional school curricula, Levenson (1981) cited faculty prejudice as a major deterrent to the implementation and survival of gerontological programming. In the present study, 10% of the sample identified insufficient faculty interest as a barrier to increased gerontological instruction, seeming to substantiate Levenson’s contention.

Marginal emphasis on socioeconomic topics in entry level curricula may result in little or no awareness of the elderly’s health care needs. Without an understanding of the effect of public policy and legislation on social and health care programs for the aged, occupational therapists cannot be proactive in planning for the needs of the elderly and thus will abdicate to others their responsibility for the development of occupational therapy services for the older adult.

Conclusions

Historically, service needs have justified the greater focus given to pediatric preparation, but the demographic structure of our society has changed. With this change has come the need for more clinicians with special preparation in gerontology to meet current and future health care demands. It is the responsibility of entry level occupational therapy curricula to meet this challenge.

Although over half of the programs in the study provided some gerontological instruction, it was not sufficient to meet any of the four ideal model criteria. If occupational therapy is to competently meet the needs of the expanding elderly population, compliance with the ideal standard is obligatory.

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References


