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ABSTRACT

This conference report consists of the texts of nine papers presented at a conference on the need for nursing education programs to respond to the needs of the elderly for specialized nursing care. Included in the volume are the following reports: "The Aging Society and Nursing Education: A National Perspective," by Daniel J. O'Neal, III; "Research in Gerontology and Implications for Nursing Education," by Celeste A. Dye; "The Aging Society and Nursing Education: Critical Issues from the Practice Arena," by Linda D. Robinson; "Curriculum Considerations in Baccalaureate and Higher Degree Programs," by H. Terri Brower; "Gerontological Nursing: Curriculum Considerations in Associate Degree Programs," by Mary Jean Etten; "Faculty Members' Involvement in a Gerontological Nursing Program: Duke University School of Nursing," by Ruby L. Wilson; "Faculty Involvement in a Gerontological Nursing Program at Emory University, Atlanta," by Elizabeth A. Mabry; "Gerontological Nursing Education," by Lois N. Knowles; and "Future Directions in Gerontological Nursing," by Charlene Connolly Quinn. (MN)

THE AGING SOCIETY: A CHALLENGE FOR NURSING EDUCATION

Papers Presented at the Fall 1981 Meeting

of the

Southern Council on Collegiate Education for Nursing

SOUTHERN REGIONAL EDUCATION BOARD
1340 Spring Street, N.W.
Atlanta, Georgia 30309

1983

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FOREWORD

The growing number of elderly persons in our population poses new challenges to health care providers. Nursing, like other health professions, has not yet adequately prepared its members to recognize and attend to the special problems of the aged.

In papers presented at the 1981 meeting of the Southern Council on Collegiate Education for Nursing, speakers pointed to the urgent need for nursing education programs to give attention to care of the elderly, comparable to the attention traditionally given to care of the very young. The papers, reproduced in this publication, aim at increasing awareness of the problems and helping nurse educators find practical ways to improve faculty and students' attitudes, knowledge, and skills regarding care of the aged.

Audrey F. Spector
Executive Director, Southern
Council on Collegiate Education
for Nursing

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THE AGING SOCIETY AND NURSING EDUCATION: A NATIONAL PERSPECTIVE

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The federal government has responded to the needs and opportunities for service to the aged population with a complex and diverse array of programs and entitlements. One source documents more than 164 major programs with strong aging emphasis within 23 federal agencies.[1] It appears that these programs may be less than well-conceptualized in Congress, inadequately carried through to enactment, and less than well-developed at implementation. Given frequent reorganizations of federal agencies, the resulting mix of programs adds to the confusion experienced by a student of aging who is trying to track a program from the need which generated it to the outcome measures by which its effectiveness is evaluated.

For aging, good ties exist with the educational and research community. Needs which form the motivation for research, service development, or training can emerge from any level of policymaking. Increasingly within the last several years, initiatives have arisen from the consumer sector where a number of effective advocacy groups for the aging have established close liaison with policymakers at all levels of government. Though there seems to be a reasonably tight line of communication through the network of aging policymaking, it should be noted that the health delivery system does not interact effectively with this policymaking arena. Health and social services, or even physical health services and mental health services, are poorly integrated for any consumer group in our country. This assertion is certainly true for aged consumers.[2,3,4]

The following tables relate to the last Congress as of early 1979. Table 1 represents House committees and subcommittees

with jurisdiction over areas related to the aged; Table 2 the respective Senate committees and subcommittees; and Table 3 presents a broad overview of several categories of services and the federal agencies which administer them. Here again, the complexity of interests in aging, the surveillance mechanisms for large budgets, and overlap of categories is apparent.

Current federal policies do not stem from a master national policy on aging. The aging advocacy network especially is striving for an overall policy rather than the perceived existing patchwork of services and programs which some feel do not address root causes of the major problems of aging. The current aggregate of policies toward aging have resulted in spending one-fourth of the annual federal budget ($132 billion out of $531 billion, FY 1980) for programs for the aged, who comprise only 11 percent of the nation's population.

The sheer increase in the numbers of aged, and the changing demographics of the aged population--many more aged are very old--will lead to triple federal expenditures over the next several years if the existing structure does not change. Without a strong national policy on aging, some feel the direction for such change will not be present.

A significant mark of progress toward the establishment of national policy on aging was achieved with the passage of the Older Americans Act (OAA) of 1965, as amended and reauthorized to the present. The OAA has generated much federal and state legislation, with federal expenditures reaching $1 billion for the OAA in FY 1980 alone. To study issues of aging in our nation, the White House Conferences on Aging were convened in 1961, 1971, and again in the fall of 1981. A Federal Council on Aging was established in 1974 to evaluate federal programs and to advise the President. A National Institute on Aging was established in 1974 to coordinate research on aging within the National Institutes of Health.

To some, the federal/state partnership established under the Older American Act is a precursor of the "New Federalism"; which

Table 1

HOUSE COMMITTEES AND SUBCOMMITTEES WITH JURISDICTION OVER AREAS RELATED TO THE ELDERLY

COMMITTEE	SUBCOMMITTEE	PROGRAM AREA
SELECT COMMITTEE ON AGING Conducts studies and investigations on problems of the elderly; primarily a fact-finding body; advises Committees listed below which have responsibility to act on bills benefiting the elderly	FULL COMMITTEE STAFF	Responsible for oversight investigations, special studies and hearings by full Committee, and staff administration
	SUBCOMMITTEE ON RETIREMENT INCOME AND EMPLOYMENT	Income maintenance and employment
	SUBCOMMITTEE ON HEALTH AND LONG-TERM CARE	Health Care Program
	SUBCOMMITTEE ON HOUSING AND CONSUMER INTEREST	Housing and consumer interests
	SUBCOMMITTEE ON HUMAN SERVICES	Social services for the elderly
COMMITTEE ON AGRICULTURE	SUBCOMMITTEE ON DOMESTIC MARKETING, CONSUMER RELATIONS, AND NUTRITION	Food Stamp Program and certain other nutrition-related programs
COMMITTEE ON BANKING, FINANCE AND URBAN AFFAIRS	SUBCOMMITTEE ON HOUSING AND COMMUNITY DEVELOPMENT	Housing programs which serve the elderly

Table 1 continued

COMMITTEE	SUBCOMMITTEE	PROGRAM AREA
COMMITTEE ON EDUCATION AND LABOR	SUBCOMMITTEE ON SELECT EDUCATION	Education programs
	SUBCOMMITTEE ON ECONOMIC OPPORTUNITY	Programs under the Older Americans Act
	SUBCOMMITTEE ON EMPLOYMENT OPPORTUNITIES[1]	Employment programs for the elderly administered by U.S. Dept. of Labor
	SUBCOMMITTEE ON MANPOWER, COMPENSATION, AND HEALTH SAFETY	Older American Volunteer program administered by ACTION
	SUBCOMMITTEE ON ELEMENTARY, SECONDARY, AND VOCATIONAL EDUCATION	Age discrimination in employment
		Senior opportunities and services administered by the Community Services Administration
		Private pension plans[2]
COMMITTEE ON THE JUDICIARY	SUBCOMMITTEE ON CRIME	Law Enforcement Assistance Administration (Crime Prevention)
COMMITTEE ON INTERSTATE AND FOREIGN COMMERCE	SUBCOMMITTEE ON HEALTH AND ENVIRONMENT	Grants to states for medical assistance programs (Medicaid)
		National Institute on Aging
		Nursing home and intermediate care facilities authorized under the National Housing Act of 1959, Section 232
	SUBCOMMITTEE ON TRANSPORTATION AND COMMERCE	Railroad Retirement Act

[1] Jursidiction over subject matters listed not permanently assigned to specific subcommittee.

[2] Bills on pension plans are referred either to Committee on Education and Labor, or Committee on Ways and Means, depending upon content of bill.

Table 1 continued

COMMITTEE	SUBCOMMITTEE	PROGRAM AREA
COMMITTEE ON POST OFFICE AND CIVIL SERVICE	SUBCOMMITTEE ON COMPENSATION AND EMPLOYEE BENEFITS	Civil Service Retirement Act
COMMITTEE ON PUBLIC WORKS AND TRANSPORTATION	SUBCOMMITTEE ON SURFACE TRANSPORTATION	Services for the elderly authorized under the Urban Mass Transportation Act
COMMITTEE ON VETERAN AFFAIRS	SUBCOMMITTEE ON COMPENSATION AND EMPLOYEE BENEFITS	Veterans pension programs
	SUBCOMMITTEE ON MEDICAL FACILITIES AND BENEFITS	Health Care Program
COMMITTEE ON WAYS AND MEANS		Full Committee has jurisdiction over taxation and private pension plans
	SUBCOMMITTEE ON SOCIAL SECURITY	Old-age, Survivors and Disability Insurance Program (Social Security)
	SUBCOMMITTEE ON HEALTH	Health insurance for the aged and disabled (Medicare)
	SUBCOMMITTEE ON PUBLIC ASSISTANCE	Supplemental Security Income (SSI); Social services for low-income individuals authorized under Title XX of the Social Security Act

The information in Table 1 was taken from a table in "Federal Responsibility to the Elderly," Congressional Research Service, 95th Congress, second session, January 2, 1979. House Select Committee on Aging, Publication 95-167.

Table 2

SENATE COMMITTEES AND SUBCOMMITTEES WITH JURISDICTION OVER AREAS RELATED TO THE ELDERLY

COMMITTEE	SUBCOMMITTEE	PROGRAM AREA
SPECIAL COMMITTEE ON AGING Conducts studies and investigations on problems of the elderly; primarily a fact-finding body; advises committees listed below which have responsibility to act on bills benefiting the elderly		Has oversight and investigative responsibilities on all matters relating to the elderly
COMMITTEE ON AGRICULTURE, NUTRITION AND FORESTRY	SUBCOMMITTEE ON NUTRITION	Food Stamp Program and other certain nutrition-related programs
COMMITTEE ON BANKING, HOUSING, AND URBAN AFFAIRS	SUBCOMMITTEE ON HOUSING AND URBAN AFFAIRS	Housing programs which serve the elderly Nursing home and intermediate care facilities authorized under the National Housing Act of 1959, Section 232 Services for elderly under the Urban Mass Transportation Act.
COMMITTEE ON FINANCE		Old Age, Survivors and Disability Insurance Program (Social Security) Grants to states for Medical assistance (Medicaid) Health insurance for the aged and disabled (Medicare) Private pension plans Social services for low-income individuals authorized under Title XX of the Social Security Act Supplemental Security Income Program (SSI) Taxation

Table 2 continued

COMMITTEE	SUBCOMMITTEE	PROGRAM AREA
COMMITTEE ON FINANCE (Continued)	(Subcommittees primarily have oversight functions)	
	SUBCOMMITTEE ON HEALTH	Health Care Program
	SUBCOMMITTEE ON PRIVATE PENSION PLANS	Private pension plans
	SUBCOMMITTEE ON SOCIAL SECURITY FINANCING	Old-age, Survivors and Disability Insurance (Social Security)
	SUBCOMMITTEE ON SUPPLEMENTAL SECURITY INCOME	Supplemental Security Income (SSI)
COMMITTEE ON HUMAN RESOURCES	SUBCOMMITTEE ON AGING	Programs under the Older Americans Act
	SUBCOMMITTEE ON HEALTH AND SCIENTIFIC RESEARCH	Health Care Program
	SUBCOMMITTEE ON EMPLOYMENT, POVERTY AND MIGRATORY LABOR	Senior opportunities and services administered by the Community Services Administration Older Americans volunteer program administered by ACTION
	SUBCOMMITTEE ON LABOR	Private pension plans Railroad Retirement Act Manpower programs Age discrimination in employment
	SUBCOMMITTEE ON EDUCATION, ARTS, AND THE HUMANITIES	Education Programs
COMMITTEE ON GOVERNMENT AFFAIRS	SUBCOMMITTEE ON CIVIL SERVICE AND GENERAL SERVICES	Civil Service Retirement Act

Table 2 continued

COMMITTEE	SUBCOMMITTEE	PROGRAM AREA
COMMITTEE ON THE JUDICIARY	SUBCOMMITTEE ON CRIMINAL LAWS AND PROCEDURES	Law Enforcement Assistance Administration (Crime Prevention)
COMMITTEE ON VETERANS AFFAIRS	SUBCOMMITTEE ON COMPENSATION AND PENSIONS	Veterans pension programs
	SUBCOMMITTEE ON HEALTH AND READJUSTMENT	Health Care Program

The information in Table 2 was taken from a table in "Federal Responsibility to the Elderly," Congressional Research Service, 95th Congress, second session, January 2, 1979. House Select Committee on Aging, Publication 95-167.

Table 3

FEDERAL PROGRAMS BENEFITING THE ELDERLY,

BY CATEGORY AND BY AGENCY

Note: The following is a list of programs and the departments under which they fall:

EXECUTIVE DEPARTMENTS

Agriculture

- Farmers Home Administration
- Food and Nutrition Service

Health, Education, and Welfare

- Public Health Service:
  - Health Services Administration
  - National Institute on Aging
  - National Institute of Mental Health
- Administration on Aging
- Health Care Financing Administration
- Office of Education
- Administration for Public Services
- Social Security Administration

Housing and Urban Development

- Office of Insured and Direct Loan Programs
- Office of Assisted Housing
- Community Planning and Development

Justice

- Law Enforcement Assistance Administration

Labor

- Employment Standards Administration
- Employment and Training Administration

Department of Transportation

- Urban Mass Transportation Administration

Treasury

- Office of Revenue Sharing

Table 3 continued

INDEPENDENT AGENCIES

ACTION

Community Services Administration

Legal Services Corporation

Railroad Retirement Board

Small Business Administration

Office of Personnel Management

Veterans Administration

PROGRAM	RESPONSIBLE AGENCY OR PROGRAM
EMPLOYMENT AND VOLUNTEER:	
Age Discrimination in Employment	Employment Standards Administration
Community Based Employment and Training	Employment and Training Administration
Community Service Employment for Older Americans	Employment and Training Administration
Employment Programs for Special Groups	Employment and Training Administration
Foster Grandparent Program	ACTION
Retired Senior Volunteer Program (RSVP)	ACTION
Senior Companion Program	ACTION
Service Corps of Retired Executives (SCORE)	Small Business Administration
Volunteers in Service to America (VISTA)	ACTION
HEALTH CARE:	
Health Resources Development Construction and Modernization of Facilities (Hill-Burton Program)	Health Services Administration
Community Mental Health Centers	National Institute of Mental Health
Construction of Nursing Homes and Intermediate Care Facilities	Office of Insured and Direct Loan Program
Grants to States for Medical Assistance Programs (Medicaid)	Health Care Financing Administration
Program of Health Insurance for the Aged and Disabled (Medicare)	Health Care Financing Administration
Veterans Domiciliary Care Program	Veterans Administration
Veterans Nursing Home Care Program	Veterans Administration

Table 3 continued

HOUSING:	
Housing for the Elderly (Sec. 202)	Office of Insured and Direct Loan Programs, and Office of Assisted Housing
Low and Moderate Income Housing (Sec. 8)	Office of Insured and Direct Loan Programs, and Office of Assisted Housing
Mortgage Insurance on Rental Housing For the Elderly (Sec. 231)	Office of Insured and Direct Loan Programs, and Office of Assisted Housing
Rural Rental Housing Loans (Sec. 515)	Farmers Home Administration
Community Development	Community Planning and Development
Low Rent Public Housing	Office of Insured and Direct Loan Programs, and Office of Assisted Housing
Rural Home Repair Program (Sec. 504)	Farmers Home Administration
Rural Rental Assistance (Sec. 521)	Farmers Home Administration
INCOME MAINTENANCE:	
Civil Service Retirement	Office of Personnel Management
Food Stamp Program	Food and Nutrition Service
Old-age, Survivors and Disability Insurance Program (Social Security)	Social Security Administration
Railroad Retirement Program	Railroad Retirement Board
Supplemental Security Income Program	Social Security Administration
Veterans Pension Program	Veterans Administration
SOCIAL SERVICE PROGRAMS:	
Crime Prevention (LEAA)	Law Enforcement Assistance Administration
Education Opportunities for Older People	Office of Education
Legal Services Corporation	Legal Services Corporation
Multi-Purpose Senior Center Facilities	Administration on Aging
Nutrition Programs	Administration on Aging
Revenue Sharing	Office of Revenue Sharing

Table 3 continued

SOCIAL SERVICE PROGRAMS (continued)	
Senior Opportunities and Services	Community Services Administration
Social Services for Low Income Persons and Public Assistance Recipients (Title XX)	Administration for Public Services
State and Community Social Service Programs (Title III)	Administration on Aging
TRAINING AND RESEARCH PROGRAMS:	
Model Projects	Administration on Aging
Multi-Disciplinary Centers of Gerontology	Administration on Aging
Personnel Training (Title IV--Older Americans Act)	Administration on Aging
Research and Demonstration Program (Title IV--Older Americans Act)	Administration on Aging
Research on Aging Process and Health Problems	National Institute on Aging
TRANSPORTATION:	
Capital Assistance Grants for Use by Public Agencies	Urban Mass Transportation Administration
Capital Assistance Grants for Use by Private Non-Profit Groups	Urban Mass Transportation Administration
Reduced Fares	Urban Mass Transportation Administration
Capital and Operating Assistance Grants	Urban Mass Transportation Administration

The information in Table 4 was taken from a table in "Federal Responsibility to the Elderly," Congressional Research Service, 95th Congress, second session, January 2, 1979. House Select Committee on Aging, Publication 95-167.

is the federal organizational basis for the Reagan administration. The OAA gave increased authority to state and local governments, and decentralized administration to a great extent. Again, in this federal/state partnership for aging services, health is minimally included, mostly through Title XX of the Social Security Act which is coordinated at a state level for aged persons. Although since 1973 states have been mandated to develop comprehensive and coordinated systems of social services for aged persons, the inclusion of health within a system of service delivery was felt to be an unreachable task. Further reorganizations of the Older Americans Act added emphasis to long-term care, to serving the chronically ill and disabled older person, and to improving employment of older workers. Since some would feel that long-term care is a poor stepchild of the health care arena, and rehabilitation of the disabled is a field largely assumed by the educational disciplines rather than by health disciplines, it can be argued that health service delivery to aged persons continues to be underexamined, uncoordinated, and unsatisfactory.

A SURVEY OF AGENCIES

Several agencies were surveyed to determine issues affecting aging service delivery for the future, including health service delivery. The universe polled included: National Council of Aging, Federal Council on Aging, American Public Welfare Association, National Governors' Association, National Voluntary Organizations for Independent Living for the Aged, National Institute for Senior Centers, National Association of State Units on Aging, and a number of other agencies. The writings and position papers of these agencies were reviewed in order to identify issues which are relevant for nursing.

A second aim was to identify those parts of the education and research community which are developing new models of service delivery. A third aim was to catalogue federal programs and services for the nation's aged.

Issues Identification

Throughout the publications of the quasi-private and private agencies which facilitate service management, a recurring theme appeared, which appears also in health literature about aged persons. The problems of service delivery are complex; the needs of the aged are complex and are not adequately served by institution-based services. Surveyed agencies repeatedly identified that community-based problems need community-based solutions. Since health services are institution-based, the sample of agencies feels that the narrow, rather authoritarian structure of most health care does not fit the often informal structures which characterize communities, where 95 percent of aged persons reside.

Another issue is the simplistic response of government to a need. Historically, the response has been categorical funding. Services are provided to people with disease entities or diagnostic categories, rather than provided on the basis of the more difficult-to-define functional capacities. For health services, categorical funding is manifested by a medical bias in service delivery where, for example, wheel-chairs and other medical equipment are available for persons with end-stage renal disease, but not, perhaps, for an aged person who is without specific disease and is just frail. Bureaucratic categories are not always consistent with health and social needs of the aged.

Another issue has implications for health service, which traditionally has a narrow power structure with the physician as the final arbiter and the final authority point, and having all responsibility. The problems of the aged are complex and require input of many disciplines. Hence, interdisciplinary practice is the most effective and efficient manner to collaborate in the design of a plan to assist older people to attain and maintain health. In social service settings, key leadership can switch among a variety of disciplines at any given time.

Within health settings, on the other hand, all disciplines are adjunct to medicine which retains authority and power. Since free interdisciplinary practice is difficult to achieve in medical settings, some would feel that plans which come from health settings are intrinsically inadequate for the complex problems of the aged.

The position papers of some of the agencies surveyed indicate that requirements which are designed by the service providers become constraints to the consumers of services. Cooperative options for drugs for aged persons are imposed by providers, but add to an already large out-of-pocket medical expense for older adults. Program guidelines are not always consistent with consumer need.

The meaningful coordination of services to the aging is seldom achieved. This failure is probably because of the complexity of service delivery which makes coordination difficult at the very least. Because each program has its own funding stream, as well as its own set of eligibility requirements, it is nearly impossible for an older person to identify what programs might be available at any given point. Since health and social conditions are dynamic and change over time, progress under one program is followed sometimes by ineligibility for future service from that program. Services necessary to maintain health may be less available than those services which allow a person to attain health.

Writings from most of the agencies surveyed identify repeatedly the necessity for aged persons to have accessibility to a wide array of services to match carefully defined needs. In few areas of the country are such arrays available. Services are usually spotty, leaving out one or another segment of the aged population, and poorly coordinated, so that flow is made very difficult from one level of care to another, or from one category of need to another. The issues identified by the agencies surveyed have significance for nursing, which some

feel stands ready and able to assume a larger coordinative role in the design of health and social service delivery systems.

The federal government has continued to respond to the issues which the surveyed agencies identified. Certain of the National Health Priorities of Section 1502, released as proposed rules on November 25, 1980, echo issues from the previous section:

> (7) The development of health service institutions of the capacity to provide various level of care...on a geographically integrated basis.
>
> (14) The elimination of inappropriate placement in institutions....

The draft National Health Planning Goals also address some of these issues:

> Goal III B.1. ...providers of health services should be organized...(to) assure that various types and levels of services are linked together to form comprehensive and efficient systems of care....
>
> Goal III B.4. Every resident...should have available the widest possible range of options for health care services....
>
> Goal III C.2. There should be close coordination among the various health, social, rehabilitative and other human services which those with chronic or prolonged disabilities often require....[5]

Given these broad frameworks and an existing network of locally administered programs which serve the public, the federal approach seems to have been a reasonable one, though much is yet to be done at federal, state, and local levels. In sum, there are a number of factors which serve as barriers

to developing a continuum of care for older persons. These include:

Federal funding, program and reimbursement biases against non-medical and non-institutional care;

Fragmented approaches to providing for long-term care needs through a variety of federal programs and funding sources;

A system which currently focuses on the provider rather than on the needs of the older people, both for adequate needs assessment and evaluation of effectiveness;

Difficulties in administering programs with multiple funding sources and conflicting rules and regulations;

Few mechanisms for coordination of program development at state and local levels.

New Models of Care Delivery and Other Research

Given that services for the aged are under-organized and under-coordinated, and given that this state of affairs has been recognized for some time, the federal response has been the development of several initiatives. Research and development, demonstration projects, and gerontology centers are among the developments in recent years. There are 22 Long-Term Care Gerontology Centers in the nation and eight long-term care channeling demonstration grants.

Seven of the eight current demonstration projects funded by the Administration on Aging jointly with the Health Services Administration utilize nurses in the demonstrations. Many research and development grant awards are made annually for improvement and demonstration, as well as separate model demonstration project funds. The Health Care Financing Administration also funds research and demonstration grants through waivers of reimbursement criteria. Health manpower who provide skilled services to the aged are prepared by programs within the Bureau of Health Professions, Health Resources Administration, which includes the Division of Nursing. Relevant Division of Nursing projects are listed in Appendix A.

The private sector has prepared issue papers or has funded research to some extent. All of the agencies surveyed have published position papers or issue papers, occasionally used for obtaining funding from various sources. Particularly through its influence in Congress, the private sector has channeled its energies toward several pieces of legislation now before Congress. S.851, by Senator Packwood, is titled Noninstitutional Acute and Long-Term Care Services for The Elderly and Disabled Act, and would create a new Title XXI of the Social Security Act. This proposal would attempt to coordinate under one title community-based long-term care services being provided under Medicare, Medicaid, and Title XX of the Social Security Act. It is not known how many of the research and development projects have nursing input into their design, nor how many of the private sector organizations include nursing as resource professionals. As a result of the 1978 amendments to the Older Americans Act, more data will be collected on the need for long-term care personnel. Currently, national nursing inventories provide rough data on nursing home staffing, but not on other categories of long-term care. Already signed into law is P.L. 96-499, the 1979 Medicare amendments, which eliminate the three-day prior hospitalization for nursing home care under Part A of Medicare. Among the other barriers to health care eliminated by the new law are the $60 deductible under Part B and the 100 home visit limit under Parts A and B. There is now equal financial eligibility for institutional and community-based care, and an increased federal match for home health versus institutional services.

The publication of Healthy People: The Surgeon General's Report on Health Promotion and Disease Prevention established goals and subgoals which relate to older adults and which are relevant for nursing. The overall goal for healthy older adults is to improve health and quality of life, to reduce

annual number of days of restricted activity by 20 percent, or to fewer than 30 days per year for people 65 and older. A subgoal is to increase the number of older adults who can function independently; another is to reduce premature death from influenza and pneumonia.

The above evidence suggests that the nation's concept of health is changing more toward a dynamic view and away from a disease-oriented view. Agreement on this concept of health, or some concept of health, is a necessary step before the scope and detail of human needs can be established. This concept of health, however it finally emerges from the current period of critical change, will form the visual grid through which we will perceive needs, and sample the universe of data so as to interpret issues that health policy development must address. From the agreement on a concept of health and the establishment of a perceptual orientation to needs, the aspects of measurement, outcome criteria, organizational structure of delivery system, cost, and financing may follow.

RESPONSE OF NURSING

Given the evidence that our nation's concept of health is changing, nursing has the knowledge base and the track record which enables it to generate much of what the aged public needs. Client-oriented needs assessment techniques are being developed by the profession, which always has had a client-oriented base. Nurses are often highly motivated and in good strategic position to foster and enhance informal support networks of family members and neighborhoods and to link all levels of a support system.

Along with other professionals, nurses have made some progress in the development of a procedure to assess service needs of an older person in relation to functional limitations and other social factors. Nurses have designed and participated in individual case management as one strategy to match needs with resource availability. Nurses are well able to design additional services,

as well as bridging services, to make more complete the array of services which may be needed by older people at various points in time.

Some nurses have argued for development of policies on those services which might be universally provided to all older persons, and have worked to establish common definitions for services and minimum standards for each service. The nursing literature has reported on a variety of training programs to assist the service agencies and other providers to develop skills for working across programs and service systems in their perception of older people and in their practice.

Table 4 presents a schematic of decision making in health care, outlining the factors which lead to decisions which might affect any given population group. This schemata can also be used to identify tasks and opportunities for nursing to continue to develop and explore in order to make decisions that fit national needs as well as the specific needs of the older population. These tasks and opportunities may form the framework for the planning of nursing research, education, and practice as it affects older people. The national response to aging people has been identified and the areas where decisions are apt to be most needed have been pointed out. It remains for nursing to identify approaches, strategies, and to allocate resources for the application of nursing knowledge to these decision areas.

Table 4

DECISION MAKING IN HEALTH CARE

INFLUENCING FACTORS	FOCI OF DECISION-MAKING EFFORTS	TASKS FOR NURSING
Values	Community's perception of health needs	Clarify for profession Develop instrumentation, especially for assessment
Client demographics:		
Population's health status	Health needs, including preventive needs	Clarify for profession
Historical demand for services	Health priorities and goals [1 & 2]	Interpret for consumer Identify what is responsive to nursing Interpret for nursing
Present system of health delivery	Health objectives[3]	Interpret for consumer Identify what is responsive to nursing
Illness-dominated technology	Health methods, including training programs	Apply nursing knowledge Interpret to consumer and profession Establish measures of effectiveness and nursing services
	Impact measures (morbidity, mortality, quality of services)	Instrumentation for quality of life and quality of care Identify impact of nursing Operationalize impact measures into standards of practice

[1]National Guidelines for Health Planning, 3/28/78

[2]Forward Plan for Health 1977-1981, DHEW, 8/75

[3]Promoting Health, Preventing Disease, DHHS, Fall 1980

APPENDIX A

U.S. GERONTOLOGY NURSING PROGRAMS

The nation's pool of gerontology nursing programs are of two major types: those preparing specialists in gerontology nursing or those preparing gerontology nurse practitioners. Either type of program may be free-standing or may be a discrete track in a larger educational offering. Programs funded through the Division of Nursing Advanced Nurse Training Program prepare gerontology nursing clinical specialists at the master's level only. Programs funded through the Division of Nursing Nurse Practitioner Program prepare at the master's level primarily, but also at the certificate level. Of the nation's remaining 15 gerontology nursing programs which are not funded through the Division of Nursing, all but two are for the preparation of gerontology nurse clinical specialists.

NOT CURRENTLY FUNDED BY DN	DN-FUNDED, ADVANCED NURSE TRAINING PROGRAM[1] FY80	DN-FUNDED, NURSE PRACTITIONER PROGRAM FY 80
GRADUATE	GRADUATE	GRADUATE
Adelphi University Garden City, New York	University of California at San Francisco San Francisco, California $238,961	Boston University (GNP) Boston, Massachusetts $136,026
University of Arizona Tucson, Arizona	Case Western Reserve University Cleveland, Ohio $146,649	California State University (GNP)[2] Long Beach, California $162,331
University of California Los Angeles, California	University of Delaware Newark, Delaware $40,575	Columbia University (GNP) New York, New York $109,346
University of Cincinnati Cincinnati, Ohio	Duke University Durham, North Carolina $59,322	University of Kansas (GNP) Kansas City, Kansas $31,814
University of Connecticut Storrs, Connecticut	George Mason University Fairfax, Virginia $53,997	University of Lowell (GNP) Lowell, Massachusetts $144,846

[1]Funding for programs with multiple tracks is adjusted to reflect only estimated gerontology nursing track-specific funds.

[2]FY 1979 Funds.

GNP = gerontologic/geriatric nurse practitioner

NOT CURRENTLY FUNDED BY DN

GRADUATE

Emory University
Atlanta, Georgia

Northern Illinois University
DeKalb, Illinois

Pennsylvania State University
University Park, Pennsylvania

University of Puerto Rico
San Juan, Puerto Rico

Rush University
Chicago, Illinois

St. Louis University
St. Louis, Missouri

University of Texas
Houston, Texas

Vanderbilt University
Nashville, Tennessee

CERTIFICATE

University of Colorado (GNP)
Boulder, Colorado

George Washington University
Washington, D.C. (GNP)

DN-FUNDED, ADVANCED NURSE TRAINING PROGRAM FY 80

GRADUATE

Georgetown University
Washington, D.C.
$105,685

Indiana University
Bloomington, Indiana
$34,100

University of Kentucky
Lexington, Kentucky
$33,247

University of Maryland
Baltimore Maryland
$32,053

University of Michigan
Ann Arbor, Michigan
$106,843

Montana State University
Bozeman, Montana
$17,803

Murray State University
Murray, Kentucky
$94,079

University of Oregon
Eugene, Oregon
$177,126

University of Pennsylvania
Philadelphia, Pennsylvania
$59,407

University of Rochester
Rochester, New York
$85,032

DN-FUNDED, NURSE PRACTITIONER PROGRAM FY 80

GRADUATE

University of Miami (GNP)
Coral Gables, Florida
$61,483

Seton Hall University (GNP)
South Orange, New Jersey
$111,232

University of Utah (GNP)
Salt Lake City, Utah
$123,638

University of Wisconsin (GNP)
Madison, Wisconsin
$126,076

CERTIFICATE

University of Pittsburg (GNP)
Pittsburg, Pennsylvania
$84,621

New York Hospital/Cornell Medical (GNP)
New York, New York
$119,577

SUNY - Upstate (GNP)
Syracuse, New York
$60,165

NOT CURRENTLY FUNDED BY DN	DN-FUNDED, ADVANCED NURSE TRAINING PROGRAM FY 80	DN-FUNDED, NURSE PRACTITIONER PROGRAM FY 80
	GRADUATE	
	San Jose State University (GNP) San Jose, California $100,198	
	SUNY - Binghamton Binghamton, New York $139,532	
	Syracuse University Syracuse, New York $30,409	
	University of Wisconsin Milwaukee, Wisconsin $37,146	

TOTALS: Advanced Nurse Training Program: $1,592,164 - 19 programs
Nurse Practitioner Program: $1,271,155 - 12 programs
U.S. Total - 46 programs

SOURCES: NLN Pub. No. 15-1312, Master's Education in Nursing: Route to Opportunity in Contemporary Nursing, 1980-1981.

A Directory of Expanded Role Programs for Registered Nurses - 1980, Hyattsville, Maryland, DN, HRA, DHHS

Division of Nursing, HRA, DHHS

ADDENDUM: FY 1981 7/31/81		
	Michigan State University Lansing Michigan $88,170	Metropolitan State College (GNP) Denver, Colorado $41,499
	University of Kansas Kansas City, Kansas $164,325	SUNY - Buffalo (GNP) Buffalo, New York $149,149
		Hunter-Bellevue, CUNY (GNP) New York, New York $228,576

DIVISION OF NURSING SPECIAL PROJECTS GRANTS IN GERONTOLOGY NURSING, FY 1980[1]

A. CURRICULUM REVISION GRANTS WITH A GERONTOLOGICAL/GERIATRICS FOCUS
FY 80 FUNDS OF $490,990

Augustana College, Sioux Falls, SD
Niagara University, Niagara, NY
University of Tennessee, Memphis, TN
University of Maryland, Baltimore, MD
Emory University, Atlanta, GA
Carroll College, Helena, MT
University of Miami, Miami, FL

B. CONTINUING EDUCATION GRANTS WHICH INCLUDE GERONTOLOGICAL NURSING CONTENT
FY 80 FUNDS OF $680,793

University of Vermont, Burlington, VT
Old Dominion University, Norfolk, VA
University of Rochester, Rochester, NY
Research Foundation (Stony Brook), State University of New York, Albany, NY
Arizona State University, Tempe, AZ
Hospital General de Castaner, Inc., Castaner, Puerto Rico
Michael J. Owens Technical College, Toledo, OH
University of Pittsburgh, Pittsburgh, PA

C. INSERVICE EDUCATION WITH A GERONTOLOGICAL/GERIATRIC FOCUS TO UPGRADE SKILLS OF LICENSED PRACTICAL NURSES, NURSING ASSISTANTS, AND OTHER PARAPROFESSIONAL PERSONNEL
FY 80 FUNDS OF $251,970

Westbrook College, Portland, ME
Donnelly College, Kansas City, KS
Miami Jewish Home and Hospital for the Aged, Miami, FL
St. John's Medical Center, Tulsa, OK

[1]U.S. Senate, Report 97-62, Part 2. A Report of the Special Committee on Aging. Washington, D.C.: U.S.G.P.O., May 13, 1981, pages 243-244.

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[1]Irma Schecter, *1980 Chartbook of Federal Programs in Aging*, Washington, D.C.: Care Reports, Inc., 1980.

[2]Robert H. Binstock, "A Policy Agenda on Aging for the Eighties," *National Journal Issues Book*, Washington, D.C.: Government Research Corporation, 1979.

[3]American Public Welfare Association, "Public and Private Roles in the Provision of Human Services," *Report on APWA Policies*, November, 1978.

[4]Richard J. Bringewatt, "Human Services Management in the Aging Network: A Cooperative Approach to Systems Development," Silver Spring, Maryland: The Assistance Group for Human Resources Development, 1979.

[5]U.S. Government Printing Office, "National Guidelines for Health Planning, 42 CFR Part 121," *Federal Register*, Vol. 45, No. 229, Tuesday, November 25, 1980, pp. 78552-78586.

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RESEARCH IN GERONTOLOGY AND IMPLICATIONS FOR NURSING EDUCATION

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The University of Texas at Austin
School of Nursing

I am very pleased to have this opportunity to speak to the problems and prospects involved in gerontological nursing research and education. I would like to begin with a synopsis of the early studies and reviews of research activity that provide us with a basis for comparison.

BACKGROUND

One of the first reviews of selected gerontological literature was conducted by Basson (1967), who examined some 438 publications for the decade from 1955 to 1965. Of these, 372 articles were not directly related to research; thus 12 percent of the total could be classified as research. This review was followed by Gunter and Miller's (1977) analysis of studies over a 25-year time span, from 1952 through 1976, which included 17 studies of general nursing care of the aged and 29 studies of a psychosocial nature. The pyschosocial studies were categorized by the authors into three principal areas--those that dealt with psychosocial characteristics and needs of aged patients; those that dealt with the attitudes of nurses toward aged patients; and those that dealt with psychosocial nursing interventions. The survey approach was a widely used research method at this time, as might be expected during the early stages of a developing specialty. In reviewing these studies the authors raised some disconcerting questions and issues on methodological problems that were very much in evidence. They cited the lack of evidence of sound survey design; an absence of critical review of theory; inadequate, nonrandom, nonrepresentational samples; an absence of base-line measurements; little discussion of intervening or confounding variables; little attention to the threat of bias in recording

and coding; and inadequate and inappropriate statistical analysis.

The concerns raised by these authors were echoed in Brimmer's (1979) review. Brimmer applied the categorical classifications used in the International Nursing Index in her cross-sectional review of studies for the years 1966, 1971, and 1976. She found clear evidence of an emerging specialization in gerontological nursing, but also found that most of the 1,091 articles reviewed were not research-oriented. Over 40 percent of the articles focused on institutional care, with little attention to either innovative care approaches or to extra-institutional, community-based approaches. She voiced an additional concern over an apparent acquiesence to the "traditional system," as evidenced by strategies devoted to coping within "the system" rather than to any approaches toward modification or change of the system itself.

The concerns and orientation of the reviewers and an analysis of the reviews themselves reveal some obvious methodological and philosophical differences. Basson's review provides us with the earliest base-line data of a quantitative nature; Gunter and Miller's review gives us an updated estimate of professional activity and the emphasis directed to psychosocial and attitudinal concerns during that time; and Brimmer's review reminds us again of the imbalance between professional literary activity and professional scientific activity.

Because operational definitions and sampling frames are often highly dissimilar in the review process, I decided in this investigation to seek a "major variable" focus, as identified by the authors and by computer search programs. And, since gerontological nursing research may well be published in non-nursing journals both here and abroad, absolute numbers that reflect the total professional output are difficult to derive. To offset this and to attain the closest numerical estimates, two Medlars on-line searches of the literature were initiated. Key words and phrases

central to the concept "gerontological nursing research" were fed into the program to identify all publications in domestic nursing and gerontological journals for the years 1977 through July 1981. A second Medlars search was undertaken to remove extraneous, non-relevant citations and to explore the central "key" terms even further. This resulted in the identification of the final sample, each with a major variable, that constituted the principal focus for the investigation. The third step in this process involved a direct review of journals for studies of a research nature that, lacking a thorough abstract, might have gone undetected by the search. The total number of gerontological nursing articles reviewed for the four-and-a-half-year period was 528. Of these, 44, or approximately 8 percent, were research oriented.

PATTERNS AND TRENDS

Less is learned from these figures if we consider them in isolation than if we compare them quantitatively and qualitatively across time.

Quantitative. If Basson's figure of 438 articles for the decade 1955 to 1965 is held constant, the present output of 528 articles for a four-and-a-half-year period represents a significant increase in publication activity. While the research portion is small indeed, if the present 8 percent of the total output is maintained, the decade total may well exceed Basson's 12 percent.

In addition, fluctuations in the volume of publication and research activity are obvious in the nearly doubled output for the years 1978 and 1979, compared with either preceding or succeeding years. Such fluctuations are difficult to explain but it is possible that recent increases in publication lag time may account for some of the fluctuation.

Journals. Research activity is clearly no longer limited by publication in any single nursing journal. Whereas earlier gerontological nursing research efforts were published almost exclusively in Nursing Research, we now find that at least nine

nursing and three non-nursing journals publish research by nurses on aging.

The bulk of the information-education-opinion pieces are housed in two nursing journals--The Journal of Gerontological Nursing and Geriatric Nursing.

The research output exhibits an almost erratic quality--occasionally a journal will devote an entire issue largely to research studies, and yet, the next several issues of the same journal will have virtually no research articles. The greatest consistency appeared in the Journal of Gerontological Nursing, with an average ratio per issue of one research article to 5 or 6 opinion pieces.

Designs, Methodology, Statistics. In all instances, there appear to be a directly proportional relationship between the quality and appropriateness of design, the sophistication of methodology and statistical analysis, and the professional research seniority of the principal author-investigator. Master's-prepared nurses are conducting and publishing small-scale research studies usually of a clinical, pre-experimental, empirically based nature. But, as would be expected, the vast majority of larger scope studies are conducted by doctorally prepared nurses who frequently use experimental and quasi-experimental design. What are conspicuously absent are large-scale studies employing field or qualitative methods. Most of the studies conducted are anchored in either direct care or educational institutions.

Applications of chi-square, t-tests, and simple one-way anovas, which largely defined the statistical state of the art in earlier studies, are still used for preliminary runs; but the greater complexity of contemporary designs that test multiple variables across multiple trials necessitate the current use of repeated measures--analysis of variance and multivarient analysis in addition to widely used discriminant, regression, and co-variant analysis. Clearly, greater cognizance and research sophistication

are exhibited by senior researchers in design, methodology, and statistical analysis.

Qualitative. Qualitative differences are found in the nature of researchable foci. Earlier studies appeared to focus on the tripartite model that encompassed psychosocial patient needs, attitudes of nurses, and psychosocial nursing interventions. Present studies reveal a variance that has broadened considerably. The term "psychosocial" was retained by this study but was delimited by adaptation and adjustment disorders in aging. Studies of a predominantly psychosocial nature accounted for only 22 percent of the total. Studies of nurses' attitudes, which had been a major focus five years ago, now account for only 6 percent of the total; major attention is presently being directed to issues involved in the professional practice of gerontological nursing. A breakdown of the findings for both research and non-research articles, by percentages, is as follows:

Gerontological Nursing	31 percent
Psychosocial Factors	22 percent
Education and Specialization	13 percent
Ecology and Health	8 percent
Attitudes and Aging	6 percent
Geropsychological Factors	5 percent
Ethnicity and Cross-cultural Factors	3 percent
Thanatology	3 percent
Bioethical, Political, and Legal Factors	3 percent
Bio-behavioral Therapies	1.5 percent
Recreant and Supportive Therapies	1.5 percent
Chronic Illness	1 percent
Research Reviews	1 percent
Socio-economic Factors and Drugs	1 percent
Total	100 percent

Though the 8 percent figure representing research-directed published articles is distressingly small, and the research studies were principally focused on psychosocial, attitudinal, geropsychological, cultural, and bio-behavioral issues for investigation, the spectrum is obviously broader. The degree and variety reflects a growing awareness, a heightened cognizance,

of the patient's eco-system; of cross-cultural and ethnic issues that have an impact on health; of the political, legal, and bio-ethical vulnerability of the elderly; and of a need for increased collaboration with professionals in other disciplines. Three of the articles reviewed reflected the value of interdisciplinary collaboration between nursing and social work, nursing and psychology, and nursing and dentistry.

A long-standing criticism of nursing research has been that too little attention is directed to studies that demonstrate the application of research findings from earlier investigations. The criticism was supported by the absence of any study that assessed the application of nursing theory or of any replication studies, but I did find an encouraging increase in the quality of investigation that applied previous findings from studies in nursing and other disciplines to the critically salient needs of aged patients. The study supporting this was not contained in the review process, but I think reflects a positive trend in nursing research. Omission of drug dose is the single most important pharmacologic problem among the elderly today. Kim and Grier (1981) in their excellent investigation applied findings from nursing, pharmacy, psychology, and education to their teaching and medicating responsibilities as nurses. Geropsychological findings for learning, cognition, and reaction time were used to determine that paced medication instruction could indeed yield significant learning gain scores--and ultimately reduce the number of self-medication errors among the elderly.

To those of us involved in social-psychological studies of attitudes, Brower's (1981) findings are of considerable significance to the field of attitude research. The literature is replete with attitudinal findings for individuals and the influence of groups on attitude change, but this study shows us that the influence of the social organization is a strong determiner of attitudes as well.

There is still a great deal to be done to improve the amount and nature of research activity in nursing but it would be myopic and perverse to either discount or dismiss the obvious accomplishments which have been made.

GERONTOLOGY NURSING EDUCATION

What are the implications of these findings for gerontological nursing education? Gortner (1980) in addressing contemporary research activity described it as an understandable preoccupation with the modes of scientific inquiry that has affected the rigor of research but not its capacity or output, i.e., preoccupation with design and methodology. The issue here is that nursing science is a science built upon a knowledge base. This base is composed of fundamental understandings of human biology and human behavior under conditions of stress, illness, and health. Research, in contrast, is the process of inquiry by which investigative increments add to existing knowledge. To make that contribution, to undertake the process of inquiry, one must have at least an awareness of something being wrong--some discomfort over an identifiable problem--and an awareness of where and how help can be sought. The process of inquiry can be initiated through a detective-like curiosity, moral indignation, or some intellectually puzzling phenomenon. The impetus for initiating the process, as opposed to ignoring the awareness, lies in a fundamental sense of oneself as a potential scientist, as a potential researcher. At heart is a pivotal attitude--the research attitude--and, like most attitudes, it is intellectual; it is emotional; it is pragmatic; and it is volitional. If the essential ingredients--the values of science, the values of inquiry, the values of asking good dumb questions, the values of identifying good ideas--are incubated during the educational process, there is a greater likelihood that some, not all, will act if they are given support.

I raise this issue in this manner because for many years I have been distressed by students at the baccalaureate, master's, or even doctoral levels who have not been incubated with the

research attitude. They have tended to be easily intimidated and even more easily deterred by the "rigors of research," i.e., linguistic and computational hobgoblins. More of my teaching time has gone into creation and maintenance of a positive, non-punitive atmosphere in which dumb questions and exciting ideas can flourish, than in either principles of design, methodology, or statistics.

The implications here are very great for gerontological nursing education. At this time there are very few role models for graduates choosing to work with aged patients; and, as Brower (1981) has shown in her study, in the absence of viable role models, the attitudes of the organization are adopted. This may well explain the high degree of attitudinal negativity among nurses working with the aged found in so many of the earlier studies.

Role specialization in gerontological nursing must include rudiments of the research attitude if the capacity and output are to be increased. Support networks must be created to guide, to advise, to instruct, and to encourage neophyte scientists and nurse researchers, to enter into the process of inquiry. Just as the elderly themselves are "networking" out of necessity--and quite successfully--so should educational institutions establish a "network of research" support for nurses in practice, for students, and for faculty. A "network research team," composed of a senior faculty member who is a seasoned and successful researcher, a junior faculty member, doctoral, master's, and baccalaureate students, and nurses in practice, can do more to foster, by example, the actual process of inquiry in action than any number of isolated, didactic courses.

In addition to the powerful learnings derived from autotelic or experiential involvement as well as the sorely needed modeling effect from such team efforts, we have the secondary gains--understanding the principles of scientific work by working with

them. The principles of

confirmation - of earlier research findings through selected replications;

communality - by generating and sharing ideas within and between "network research teams";

competition and colleagueship - by requisite collaborative scholarship necessary to answer the questions, once raised;

continuity - by the formulation of objectives for short- and long-term research studies that, in the aggregate, lead to the refinement and modification of ideas.

Together such principles add immeasureably to our funded knowledge. The impetus for such team efforts is likely available to us today within our university-based research centers, where the locus for direction and accountability could be based.

In summary, the evidence to date suggests that the link between gerontological nursing education, practice, and research is an inexorable one. Qualitative improvements in variable salience and sensitivity, design and methodological sophistication, and statistical analysis appear to be in ascendance. But, without continued support, endorsement, and direction from higher education, those promising adumbrations--those sketches on the horizon that are rife with possibility--may well fade.

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THE AGING SOCIETY AND NURSING EDUCATION: CRITICAL ISSUES FROM THE PRACTICE ARENA

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Medical Center

The rapid growth of the elderly population in this country has become a major health issue. The population 75 years of age and over is increasing much more rapidly than that between the ages of 65 and 75. The elderly have about twice as many hospital admissions, and these last almost twice as long as those of younger persons. However, more than 90 percent of the elderly are able to live in the community. We tend to lose sight of this fact when we examine in-patient populations. Approximately 45 percent of patients occupying acute care medical-surgical ward beds in most hospitals are over the age of 65. Approximately 95 percent of the nation's long-term beds are occupied by the elderly.

The geriatric population is basically independent and not ill. Older persons have multiple chronic problems which are neither debilitating nor disabling. The elderly are both fragile and resourceful. They present many more risk factors, yet are operating with a vast repertoire of finely honed coping skills which have been refined over years of living. One word characterizes the elderly--MORE--many more assessment factors to be considered in establishing a nursing diagnosis. Frequently operating at the limits of their resources, the elderly present highly complex interactions among physical-emotional-environmental spheres. Provision of health care must take into account these complex interactions.

Health care--especially medicine--is currently characterized by increasing technology and the prolongation of life--life that might have ceased to exist a decade ago. We now see an increase

in chronicity and survival, but with great risk to quality of life. We have assured quantity with little regard for quality.

Nursing is taking a greater role in provision of primary care for the elderly and the chronically ill. Nursing also is in the midst of a staffing crisis--not enough professional nurses are prepared to provide the clinical expertise and leadership needed. The problems of staffing create additional problems in setting priorities for care. More about that later. In the practice arena, we face a situation of increasing numbers of geriatric clients, increasing technology, problems with too few professional nurses--all of which place the elderly at greater risk.

My perspective on nursing education for an aging society is derived from my position as administrator of clinical, education, and research programs in geriatrics and gerontological nursing as a preceptor for undergraduate and graduate students in a highly specialized area. I am the associate chief in a Geriatric Research, Education, and Clinical Center (GRECC) at the Veterans Administration Center in Little Rock--one of eight in the country and the model for the majority of such programs. We are a multi-interdisciplinary team effort with our own mini nursing service doing primary nursing, and are probably better funded than most due to our multifocal mission. Our nurses are involved in all aspects of the program: clincial--Geriatric Evaluation Unit, Rehabilitation Unit, Consultation Service, Geriatric Ambulatory Clinic; education--inservice for our own staff and for the entire nursing service, regional and national educational consultations and specific programs (workshops), appointments to faculty at the local university medical center; research--ongoing interdisciplinary clinical studies, validation of protocols, investigation of specific gerontological nursing problems.

Our nursing staff are all self selected, not assigned into GRECC. The personnel department screens all nurse applicants and I interview all those who are interested in geriatrics. Here is an interesting bit of irony--my areas are the only ones

designated geriatrics but the whole facility (roughly 1,600 beds) is at least 50 percent geriatric each day.

New graduates tend to be interested primarily in acute care settings, the more dramatic intensive care areas where physicians are highly visible. They prefer to work with children and young adults, child-bearing and child-rearing families, or middle-aged clients. They are less interested in adolescents and rarely in the elderly. New graduates also prefer community settings--home visiting, clinics, or office work--where they can enjoy a more collegial relationship with the physicians.

It is a rare new graduate who elects to work in long-term care or with geriatric clients. Those who do so usually report having had good relationships with grandparents, a great aunt or uncle, or elderly family friends. (In reality, not many new graduates have grandparents who are "geriatrics." Witness the 21-year-old who has 56-year-old grandparents!) Neophyte nurses who have had bad experiences while obtaining health care for a favorite older relative frequently take up the challenge of gerontological nursing. Occasionally, a new graduate is professionally mature enough to realize the career potential in geriatrics or personally mature enough to be able to adapt to working with the elderly.

We usually see the R.N. seeking a geriatric setting after several years of practice. The seasoned nurse has frequently "burned out" in an acute care area, and with maturity has become aware of the intellectual and professional challenge in working with the elderly. The seasoned nurse is more likely to come to us with a strong commitment to the elderly.

The new graduates have many strengths. They are both self-confident and doubtful of their skills and abilities. They are highly knowledgeable about basic psychosocial needs of clients and families--including family dynamics and sexuality. They are skilled in the use of nursing process and write comprehensive care plans. They are comfortable with several modes of nursing care delivery--primary, team, case, functional--and

have a definite preference for primary nursing. They are skilled in nursing techniques, the procedures. They are very thorough, which makes them rather slow and presents problems in priority-setting. However, it is unrealistic for any nursing service to expect the new graduate to work with the same speed of accomplishment, rapid priority reorganization, and safety as the seasoned nurse. We in nursing service frequently make it impossible for the new graduate to perform by maintaining impossible working conditions. The new graduate is an assertive patient advocate, is committed to holistic and comprehensive care with a great deal of continuity, and is also committed to education of the patient and family to facilitate maximum compliance. The new R.N. expects to work in a close collegial relationship with physicians. She expects to be respected and to be considerate in all working relationships, especially with R.N. peers. She has a good knowledge base, and is skilled in physical assessment--except for the fact that it is not specifically gerontic.

As students, today's new graduates have had little to no specific content in geriatrics or gerontological nursing. They have learned about family dynamics, growth and development, and basic medical-surgical, psychiatric, and community health content. They have the distinct impression that nothing happens after age 45 but limbo and loss. They frequently have had negative experiences with older people as patients or as family members. They unconsciously subscribe to the dominant cultural notion of ageism and carry a negative stereotype of the elderly. We use the attitude assessment tools by Palmore and by Oberleder to document the extent of negative attitude and change over time in our own staff. The new graduate has a perception of devaluation of those who work with the elderly. Geriatric care is viewed as routine, unrewarding, unchallenging, dirty work. The few truly negative experiences have been generalized to the whole elderly population. Unfortunately, this has been unwittingly supported by faculty.

Let me briefly characterize the new graduate nurses I see and work with.

1. AD: "There has to be a better way." This nurse is content-oriented and closely questions all resource people, including the patient and family.
2. BS: "I can problem-solve and utilize all kinds of resources, so I don't need to know specifics." This nurse is process-oriented and is less apt to use patient and family as resources.
3. Master's: This graduate is painfully aware of her or his own limits of knowledge and skills. This nurse is research-oriented and growing in ability to evaluate, apply, and generate research; and is clinically highly knowledgeable and skillful.

As I consider my experiences in the practice arena and presume to give advice to nursing educators concerned with the aging society, a number of critical issues emerge. These can be subsumed under the rubrics of attitude, knowledge, and skill.

One cannot change the attitude of another, but one can set the stage so that change can take place. Positive initial learning experiences with the elderly are critical for developing positive attitudes. Faculty prepared in gerontological nursing who can be role models, and also good role models among the nursing staff in the clinical settings, do much to foster positive attitudes toward the elderly. Normal aging taught early in the curriculum is a must. Content emphasis must be on the well, ambulatory, self-actualizing elderly, not just on the sick, frail, and depressed. The elderly make superb teachers in the classroom and clinical areas; they are the experts on aging and coping. Empathy and sympathy can be fostered. Multi-interdisciplinary team training in health care for the elderly has also proved useful in promoting positive attitudes toward the elderly.

In the area of knowledge, the key is communication. Communication is the sine qua non of assessment, intervention, teaching, evaluation, and research with elderly persons. The quality of treatment outcome depends upon the quality of the initial assessment. The quality of that initial assessment depends upon

the quality of communication. Assessment encompasses physical, functional, cognitive, emotional, environmental, and resource dimensions.

Constant attention must be given to the normal changes that occur in aging and to the differences in cultural background and values. Much of nursing deals with pattern recognition. Hence, the nurse's knowledge base in aging concepts must make possible the recognition of the many subtle changes that herald major health-related changes in the elderly. The maintenance of prosthetic environments to support aging clients at home or in institutional settings is important and relates strongly to communications. We all get our cues about what behaviors are expected and are acceptable from the environment. The elderly may experience many sensory changes that mandate provision of specific environmental cues such as color coding--blue for bathroom doors and yellow for dining room doors. The accoutrements of aging must be part of the curriculum so that they will not be ignored in the process of priority-setting for care. By attention to accoutrements of aging, I mean--eye glasses, hearing aids, dentures, mobility devices, shoes, and clothing--that they be in working order, that they be in place, that they are appropriately used at all times, that they not be neglected in favor of attention to younger patients.

Last but not least, are some of the skills critical to working with the elderly. Specific attention must be given to the skill of pattern recognition--I cannot emphasize this too much. Observations utilizing all senses and gearing down one's pace to match the pace of the elderly are essential. Pacing is also part of communicating. Nurses need to develop skill in adapting to elderly clients; the elderly should not be required to do all the adapting. Getting well and staying well requires much energy. Having to fight an arbitrary and demanding system that creates unnecessary stress can prevent healing. Body mechanics, lifting and moving, and range of motion exercises are basic skills which seem to be

missing from today's nursing curricula. I urge that they be taught thoroughly to prevent injury to nurses and patients. New nurses need to learn priority-setting--not just in theory but to become skilled in its practice. This is especially critical in settings where the elderly must compete with younger clients for the attention of over-extended R.N.s. Skill is needed in pacing an oldster through the day, alternating activity and rest periods. Skill and comfort in deliberative touching is important. The neophyte nurse also needs beginning skills in letting go--in dealing with death, not only her own but also that of others.

If we are truly to ground our nursing curricula in the present and future realities of practice, we will have to accept the gerontological nursing imperative. This imperative mandates attention throughout all programs as opposed to relegation to specialty status.

In closing, let me refer you to a marvelous editorial, "Notes on a Guide to Gerontic Practice" by Laurie Gunter, in the August 1981 Journal of Gerontological Nursing. I wholeheartedly endorse the need for the guide and suggest that it could be a very useful adjunct in curriculum planning.

CURRICULUM CONSIDERATIONS IN BACCALAUREATE AND HIGHER DEGREE PROGRAMS

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The topic of gerontological nursing is important to all of us who teach. Although the newspapers and television assail us weekly and sometimes more often about the many problems the elderly have, we still debate "Should we focus our energies and attention on it?" "Is it necessary to teach gerontological nursing?" "What is different about the older client?" I venture to add that if we were discussing ethical issues, nursing theories, maternal and child health, or a myriad of other topics we would say how and where they should be placed in the curriculum.

Robert Butler coined the term "ageism" to operationalize societal views of aging, and we in nursing, as a part of society, do not escape these views. How many of us can say we are unconcerned with advancing age in ourselves, with the possibility of loss of cognitive functioning, with loss of physical prowess, with the occurrence of one or more chronic illnesses? Many of us will tell ourselves we don't even think of these things, and perhaps one method of dealing with these possibilities is to deny that such will happen to us. As death and dying, and before that, psychiatric or mental illnesses were dealt with by denial in the curriculum--we preferred not to confront them--so do we now persist in not confronting the realities of gerontological nursing. One nursing educator told me "We don't need more clinical experience with aged people, we need pediatrics and obstetrics. Let the nursing home industry get their house in order." The reality is, perhaps, that we are unrealistically attempting to focus too much of our clinical experience in these areas--in the face of dwindling births and numbers of ill children. The reality is that we are an aging nation, and the

sunbelt is a most attractive area to thousands of elders in-migrating to our states to spend their retirement days with us. We may not like that reality but it is a reality.

ATTITUDES, PERCEPTIONS, AND KNOWLEDGE

Formerly I believed attitudes were the primary reason for nursing educators' failure to do more in gerontological nursing. Indeed, one significant study (Kayser and Minningerode, 1975), which was replicated, has shown that the degree of stereotyping teachers have of the aged is significantly linked to influencing their respective students' attitudes. But I have enlarged my thinking to believe that it is the nursing faculty's perception of gerontological nursing that limits development. Just as society relegates a roleless, low status position to the elderly, so is the content and theory associated with aging assigned to a low status in our curriculum. Our perceptions of the lack of substantive content, the lack of need, the lack of importance--as we all vie for our own specialty content to be foremost--are persistent and insidious.

Working on this premise, that if nursing educators could be shown that they lacked knowledge in the field and therefore could not teach what they did not know, we developed a comprehensive, cognitive test in gerontological nursing at the University of Miami in the fall of 1980. We pre-tested our instrument on the entire group of graduate students and found that not one of these registered nurses knew what an Areawide Agency on Aging was. This lack of basic knowledge results in nurses being frustrated when working with older clients. These R.N.s did not even know where to find out about community resources for older persons. We tested our entire faculty, including our dean. Only one person refused to take the test and that person remains the most obstructive to any curricular progress in gerontological nursing. We pulled out the higher scores of the two geriatric nurse practitioner faculty, who in the past had taught the Geriatric Nurse Practitioner program. We left in the score of another self identified gerontological nursing faculty member. Lo and behold, all of the faculty

scored at about 50 percent, just slightly above our senior level students.

In an attempt to devalue the evidence we were gathering, one esteemed nursing academician said to us, "That proves nothing; I'll bet if you gave us a test in any major we'd score the same way." Well, I doubt that. Our testing of a technical school's faculty found that they scored below our senior level students; so our students were learning more than we had thought they were learning. Perhaps what was more revealing were the content areas found on item analyses that were missed by our faculty. Less than 50 percent of the faculty were able to identify normal aging changes in such areas as urinary or thermoregulatory function. Less than 50 percent knew the differences between reversible or acute organic brain syndrome and irreversible organic brain syndrome. Less than 50 percent knew about the assessment and intervention of hearing loss or interviewing and counseling the older adult on such items as loss, grief, and reducing feelings of helplessness. I was surprised to see that between 50 and 75 percent of the faculty did know about community resources for the aged because, as yet, they were not teaching it.

The CBS evening news of July 31, 1981 spotlighted nurses' attitudes in South Florida. They interviewed several diploma students whose idea of caring for older persons was that you work very hard and then they all go and die on you. The reporters found that none of the 150 graduating seniors from the current or prior Jackson Memorial School of Nursing's classes chose to work with older persons. Our recent University of Miami alumni survey found that only 41 percent of our graduates felt positive toward gerontological nursing, and of these only 4 percent felt very positive as contrasted with 15 percent who felt very negative. Since graduation only two of these nurses had taken any coursework or attended workshops involving the care of older persons, and the highest percentage (31 percent) of the respondents rated the older client as the least desirable of any age group with whom to work.

Is it any wonder that those of us who are attempting to teach the gerontological major in graduate education are faced with critical recruitment difficulties? Across the country I find the same story; all of us who are involved with graduate and undergraduate gerontological nursing education find an uphill battle of subtle resistance, negative socialization of students, and a dearth of graduate nurses wishing to work with or study the nursing care of older persons. What irony in light of the reality that this age group is the largest single user of nursing services!

Florida has the highest proportion of older persons among the 50 states. In some of our counties at least 40 percent of the populace is over the age of 65, and currently 15,000 older persons per month are migrating across our state borders. Primarily as a result of the nursing home industry's pressure in 1975, Florida became the first state to mandate the inclusion of geriatric/gerontological nursing content in all nursing programs.

A STUDY OF GERONTOLOGY IN NURSING EDUCATION

Through my role as the nurse member of the Long Term Care Task Force of the State Health Coordinating Council, in 1980 I surveyed the deans and directors of all the generic R.N. programs in Florida to investigate the strength of faculty preparedness and content inclusion in gerontological nursing. It was necessary to divide the results between technical and professional level education.* Several of the technical schools' deans and directors did not perceive gerontological nursing as a clinical nursing specialty on the graduate level, and when asked to identify their faculty's nursing preparation at the graduate level, they identified those who had preparation in gerontology. A gerontology degree is taught as a multidisciplinary discipline comprised of teachers who are predominately sociologists and psychologists. As such, there is no gerontological nursing theory taught and the

*Technical programs (associate degree and diploma programs) N = 24.
Professional programs (generic RN Baccalaureate programs) N = 9.

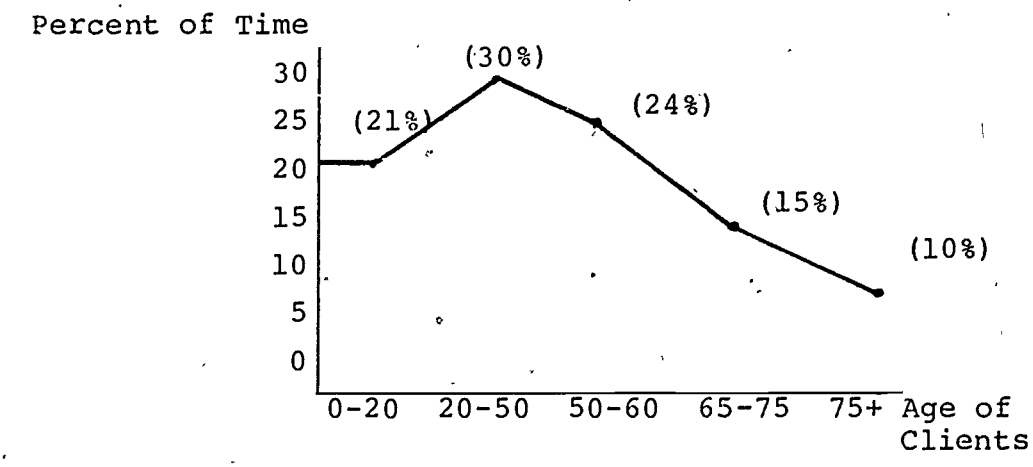
student may or may not apply this theory to nursing. None of the programs in the state had a faculty member prepared at the graduate level in gerontological nursing. However, we in the South can be proud that the first gerontological nursing program was started at Duke in 1972. As of 1980, there were already 41 graduate programs in the major in the United States, with seven located in the SREB states.

The study I performed again supports the lack of perception of need for preparation in gerontological nursing on the part of these leaders. Only one of the professional level deans stated that most of her faculty needed further preparation in gerontological nursing. One technical level leader, whose nursing faculty lacked any graduate preparation, thought all of her faculty had sufficient expertise in gerontological nursing. At the technical level those directors who tended to have well prepared faculty also perceived their faculty as not needing any further preparation.

There is a misperception on the part of the leaders if one were to match the percentage of aged clients they believe their students are caring for (Figures 1 and 2) with known statistics of morbidity, length of hospitalization, age of clients in health care facilities, and the percentage of time students are spending with aged clients. The greatest degree of morbidity with longer recuperative stays occur in persons over the age of 70 and this is also the fastest growing segment of persons in the United States. For example, at Mt. Sinai Medical Center on Miami Beach as of 1979, 73 percent of their total patient days were taken by patients 65 years of age or older; 44 percent were found to be over the age of 75. This figure would be higher if taken today. Hospitals in areas where the concentration of age is even greater would have a greater proportion of older patients. Other health delivery services that are categorically linked to medicare reimbursement, such as home health services, serve a predominately aging clientele. There is a miscalculation, unless faculty purposefully go out of their way to identify and preferentially assign (and thereby subtly socialize) students to caring and working with younger age clients.

Figure 1

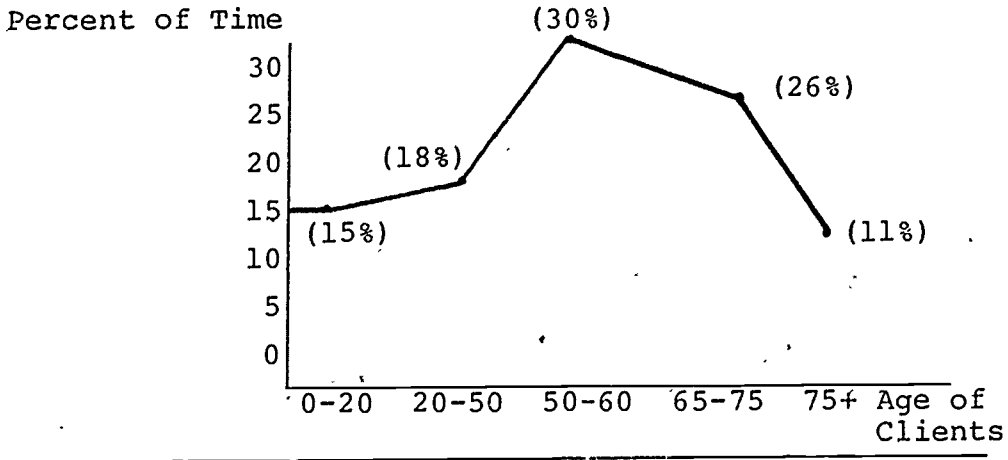
PERCEPTION OF TIME PROFESSIONAL STUDENTS SPEND WITH VARIOUS AGE CATEGORIES OF CLIENTS



Number of professional programs surveyed: 9
Number responding: 5 (56%)

Figure 2

PERCEPTION OF TIME TECHNICAL STUDENTS SPEND WITH VARIOUS AGE CATEGORIES OF CLIENTS



Number of technical programs surveyed: 24
Number responding: 17 (71%)

A number of leaders from both types of programs perferred faculty development in gerontological nursing to be obtained via a certificate in geriatric nursing. The only Geriatric Nurse Practitioner program in the state, at the University of Miami School of Nursing, was a highly technical program created to expand nurses' diagnostic and management skills and responsibility and included no research component in gerontological nursing. While there was some theory in gerontological nursing, this was small when compared to the emphasis on theory in geriatric medicine. The thrust, somewhat due to funding emphasis, was on primary health care and therefore the program had little to no focus on institutional care. This is less than the type of preparation a nursing faculty member should have. However, there was not a perceived need to have faculty members prepared in the gerontological nursing major at the graduate level. It is, therefore, doubtful that the leaders would seek out faculty prepared in gerontological nursing.

Tables 1 and 2 reflect gerontological nursing content in the programs. As can be seen, gerontological nursing consistently takes a back burner. Only one professional and two technical programs required a specific textbook in gerontological nursing, even though there were at least nine textbooks published in the specialty in 1980 alone. I was informed by one technical level dean that they teach through the modular approach and, as such, they do not require texts for all areas. I have to ask: Do the required readings as indicated through the modules alleviate the necessity of students purchasing a text in mental health or one in pediatrics?

STRENGTHENING GERONTOLOGICAL NURSING IN THE CURRICULUM

What should we do to begin to increase the theory component and better integrate gerontological nursing? First, we have to perceive that there is indeed a need to do more, and it is a given fact that not all nurse educators will perceive this. Even when it is perceived, not all will want to proceed in improving content or faculty's preparedness in the specialty.

Table 1

PROFESSIONAL GERONTOLOGICAL NURSING CONTENT

GERONTOLOGICAL NURSING CONTENT	YES*	NO*
Specific Modules	3 (60%)	2 (40%)
Group Modalities	4 (80%)	1 (20%)
Specific Text	1 (20%)	4 (80%)
Specific Bibliography	2 (40%)	2 (40%)
Student Clinical Experience in Nursing Home	5 (83%)	1 (17%)
Course in Human Development With Aging Content	3 (60%)	

Number of professional programs surveyed: 9
Number responding: 5 (56%).

*Not all respondents answered all questions.

Table 2

TECHNICAL GERONTOLOGICAL NURSING CONTENT

GERONTOLOGICAL NURSING CONTENT	YES*	NO*
Specific Modules	8 (50%)	8 (50%)
Group Modalities	9 (56%)	7 (44%)
Specific Text	2 (12%)	14 (88%)
Specific Bibliography	15 (94%)	1 (6%)
Student Clinical Experience in Nursing Home	15 (100%)	
Course in Human Development With Aging Content	9 (75%)	3 (25%)

Number of technical programs surveyed: 24
Number responding: 17 (71%).

*Not all respondents answered all questions.

I suggest that there are two essential elements in improving your curriculum. First and foremost is a leader who perceives the need and will spearhead the thrust. Second, you can consider yourself fortunate if you have one or more faculty members who are interested in learning more about gerontological nursing. You are even more fortunate if you have one who has been prepared at the graduate level in gerontological nursing. Since there are so few faculty members adequately prepared, and interest alone does not assure adequate preparation, many interested faculty members have difficulty in speaking up or knowing how to go about increasing theory in the specialty. Also, gerontological nursing is usually a secondary interest to their primary specialty.

A particular problem may be the opposition from other stronger or more numerous faculty from other specialties. Additionally, gerontological nursing faculty most often are not given adequate time to devote to the specialty, consequently it is an add-on to other teaching responsibilities. It will be up to the leader to guide and encourage interested faculty, to run interference with faculty who have a lack of knowledge or who may harbor ageistic attitudes. Do not expect faculty to acknowledge negative stereotyping. In September, the nursing consultant for our undergraduate gerontological project met with faculty from the first two curriculum levels to discuss how to combat ageism in themselves and nursing staff and how to identify and improve current integration of gerontological nursing content. Faculty from both levels denied that there has ever been any ageism found in either themselves or any clinical agency staff. The socializing of nurses teaches them to deny the existence of prejudice. Yet, on one level, the term "senile" was found in the syllabus outline, a derogatory, non-descriptive term. The nursing term "cognitive impairment" was suggested as a substitute. Our use of negative stereotypal terms of the aged are difficult to lay at rest. We were socialized to use them while we were students.

When considering curriculum for undergraduate baccalaureate education, you must begin by identifying what is currently in the curriculum that can be considered unique to gerontological nursing. You may be teaching some content under adult health that with a slightly altered emphasis could be considered older adult content. A lot of faculty will say, "Well, since it is already there, there is no need to do any more." What is needed is a greater degree of emphasis on the older adult so that students see that we value caring for that person.

The most important contemplation will be on asking yourselves, "What content/clinical experiences can be added or altered that will assist students to develop positive, caring attitudes toward older persons?" We have to help students become aware of, as well as develop positive feelings about, their own aging. I believe we can do this only if we ourselves have positive feelings about our own aging.

One problem is content organization; for example, death and dying content is usually associated with content on the older client. Aging in itself is a frightening concept, especially when, as nurses, we tend to channel our thoughts and perceptions into one of seeing aging as a decremental process, primarily because we are daily confronted with ill older persons. When we place two emotionally laden content topics together, where the student has difficulty in coping with feelings, we can easily end up with a negative association. Death can occur at any age.

When we analyzed the gerontological nursing content at the initiation of our project last year, we found that there was less taught because of overlap. Three levels were teaching normal aging processes but no one got around to teaching pathophysiological content. For example, we are only beginning to teach about acute and non-acute organic brain syndromes. Yet it is a disservice to the client and leads to less specificity in nursing interventions when a more definitive diagnosis than organic brain syndrome is not taught at the graduate level.

Although we were using home health agencies for one of the major clinical experiences in community health, community resources specific to the older adult were not being taught. Nurses who work in these agencies identify resources through a trial-and-error process coupled with a great deal of frustration which could have been alleviated, if not eliminated, had they learned resources while they were students.

I believe it is important to begin students with a more healthy, better adapted, older client group in the community in order to provide them with successful roles of older persons. When teaching mental health concepts, the aging populace is a ready group in which to integrate content. Not only can the full range of psychiatric mental disorders be seen in this group, but psychosocial principles are of utmost importance in interacting with long-term care residents. Unfortunately these are not stressed when we relegate the nursing home clinical to the fundamental or beginning levels of student experience. The nursing home is an excellent site to provide students with experience in remotivation, reality orientation, or reminiscence groups. Students can gain invaluable experience in leadership theory in a nursing home, where nurses have more autonomy for decision making than in acute care settings. Nowhere is there a more needed place for students to act as change catalysts. Why is it that these are such neglected clinical resources? We say, "Oh, we don't want our students to be exposed to such inferior nursing care," or "It's a great place to pick up technical skills." Technical skills can be picked up at any point in the student's educative process, but it takes more advanced skills to be able to function effectively in the nursing home setting. I believe a great deal more emphasis has to be given to upgrading the quality of care and providing leadership in long-term care at both the graduate and undergraduate levels. I would hope that funding initiatives, such as the recent one from the Robert Wood Johnson Foundation, will begin to show nursing faculty what we can do in these settings.

Teaching and counseling for older persons is an important topic for graduate education. Another curricular thread for a number of programs is the use of advocacy process in working on behalf of or in conjunction with a group of older persons. This process assists students in identifying with particular dilemmas and problems older persons face in our society and, if carefully selected, gives them some experience in the political arena. Performing a life review can help students to become aware of the rich historical material that the older person possesses and is willing to share with interested listeners. Graduate students need to be able to analyze theories and interpret nursing models as conceptual frameworks when working with older persons. A central thread to graduate programs is the research component, for it is through the generating of new gerontological nursing theory that the major will grow and strengthen.

I believe that a great deal can be done if we can convince and motivate faculty that they need to learn more in the specialty, that we must improve the socialization and knowledge base of our graduate and undergraduate students. We can begin by looking at the strengths of our individual schools and our particular region. I have found it very helpful to have an outside consultant work with faculty, no matter how much expertise there is at hand. Specific goals must be set for faculty to work on as they expand their knowledge in the field. I'm excited about the potential of what we can do to improve our curriculum and nursing programs in gerontological nursing in the South.

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GERONTOLOGICAL NURSING: CURRICULUM CONSIDERATIONS IN ASSOCIATE DEGREE PROGRAMS

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Most graduates of associate degree nursing programs devote a large portion, if not all, of their nursing careers to caring for older adults in acute care, long-term care, clinic, and home health care settings, where elderly represent the majority of clients. Present health manpower needs of this age group are well illustrated by the following statistics. Each year about 500,000 persons reach age 65, 20 percent of whom have serious disabilities. It is predicted that between now and the year 2000, the 65 to 74 age group will increase by almost 20 percent, or about 17.4 million persons; the 75 to 84 year-old group will double to 10.6 million; and those persons 85 and older will escalate by 80 percent to 3.8 million individuals--this represents a grand total of 28.8 million older adults.[1] Not only are these individuals more likely to experience multiple health problems, those over age 75, or about 14.4 million, are considered to be in a high-risk group, since they are three times more likely than younger persons to require a multiplicity of nursing, medical, and social services. To meet this demand, authorities estimate nearly one million additional nursing home beds will be needed in the next 20 years. This estimate does not reflect health care needs of elders in other settings.

The physical and psychosocial needs of older adults are the most complex of any age group. Such complex needs demand a thorough knowledge of age-related changes and unique responses to homeostatic disruptions, as they interface with established and changing social and psychological patterns of a lifetime.

Associate degree programs are responsible for educating about 41 percent of all registered nurses in this country.[2] Needless to say, our responsibility as educators is great when considering the pressing needs of our older population. Traditionally, in response to health care needs of a young nation, we have focused on and tested graduates in medical, surgical, and psychiatric nursing; nursing of children; and maternal-child nursing. Now, however, that nation is growing old, and health care needs are rapidly changing.

Data abound substantiating the numbers and status of older adults in our country. While their needs are many, I have chosen to concentrate on a few priority areas, namely: attitudes toward aging; faculty selection and preparation; curriculum development, and uniqueness of gerontological nursing content.

Gerontophobia, precipitated by society's glorification of youth and the denial of both aging and death, brought forth a generation of students, faculty, deans, and directors, whose attitudes and reactions toward aging are often far from positive. Can it be that, consciously or unconsciously, we tend to think that avoiding any confrontation with aging and death can stave off our own aging and demise? As surely as we are here together today, we are all experiencing aging and will in the future die. Furthermore, in our old age and dying process, as nursing educators, we will expect and demand the very best nursing care.

Among other factors, then, our own attitudes toward aging and our feelings of hopelessness and helplessness are reflected in nursing programs that perpetuate the cure model of nursing care rather than one that is directly related to health needs of older adults. The urgency of need for a different philosophical and practical model daily becomes more overwhelming in confronting care giver's negative attitudes, misinformation, and lack of understanding and caring for individuals in later stages of the life cycle.

Our own response in instruction for aging is reflected also in the students we graduate. Whilhite and Johnson report negative faculty attitudes directly relate to negative student attitudes.[3] Vogelberger describes the experience of instructors who find it difficult to adjust to this clinical area, complaining about depression and a sense of sameness.[4] Are these outcomes not probable if the instructor does not choose this specialty and is not prepared with an adequate knowledge base? Personally I can document the negative impact of faculty appointed to teach in areas for which they have no interest or educational preparation. The outcomes inevitably are dissatisfaction, boredom, fright, and even flight.

Some educators view gerontological nursing as a simple instructional area, devoid of complicated procedures, intricate machines, and acute client problems. In reality, it requires an extremely high level of knowledge, expertise, unbounding enthusiasm, and resourcefulness to make a positive, lasting impact on students. Furthermore, developing a course in gerontological nursing is considerably more than presenting only theory and concepts. It demands examining and challenging students' feelings and attitudes toward aging.

The philosophy of early associate degree nursing education held that graduates should be prepared as generalists and taught by faculty who were generalists. In our efforts not to emulate the medical model, nursing education has tried to adopt an integrated approach to curriculum development that calls for expert knowledge in many fields. As Opal Hipps so cogently writes, "I can see nothing to be gained by taking a skilled specialist and trying to turn him into a mediocre generalist."[5] Perhaps more than any other area, gerontological nursing cannot survive in an integrated curriculum taught by instructors who care or know little about older adults. Presenting bits and pieces of aging theory and practice throughout a nursing program by disinterested faculty significantly dilutes the content. A viable course in gerontological nursing, in my mind, demands that theory and content

be taught concomitantly by competent, well-educated gerontological nurse instructors who can act as resource persons and role models for other instructors. Such an approach is supported by the research of Robb and Malinzak and Brower.[6,7] Gunter and Estes, in their book Education for Gerontic Nursing, further support this premise.[8] It is easy to see why some nurse educators look upon gerontological nursing as borrowed from the major clinical concepts. However, these individuals fail to realize that research has uncovered a substantial body of knowledge unique to the aging process.

I want to speak to the point, now, of my own ideas related to the placement of a course in gerontological nursing. Students cannot be expected to function in a long-term, multifaceted health care setting during the first year of associate degree education. Assigning beginning students to a nursing home to learn basic nursing techniques greatly overwhelms students and often tends to enhance negative attitudes toward aging. Only students thoroughly grounded in the psychosocial and biological sciences, and nursing theory and practice can be expected to understand or intelligently assess and intervene in the complex health care needs of older adults. Without this background we are doing a grave disservice to the elderly, while turning away the student and eventually the graduate from ever serving in this area.

Thus far I have summarized major points relating to gerontological nursing education. Next, I will share with you a gerontological nursing course I developed and taught for the past five years in Florida's St. Petersburg Junior College, St. Petersburg campus nursing program.[9] The course is based on certain premises:

1. Since attitudes underlie behavior, this course is designed to promote positive student attitudes toward aging.

2. Since considerable emphasis is placed on earlier aspects of the life cycle, this course concentrates on middle age and older adult developmental levels.

3. To effectively intervene with ill middle-aged and older persons, it is necessary to understand healthy adaptation to normal aging by studying elders living productively in the community.
4. The thorough study of gerontological nursing involves consideration of healthy older persons, their response to illness and, finally, their death.
5. Holistic nursing care of elders requires knowledge and understanding of interrelated psychosocial and biological needs along with their implications for nursing intervention.
6. To effectively intervene, students need to utilize the nursing process in meeting total rehabilitative needs of middle-aged and older adults.
7. Since therapeutic communication enhances effective outcomes, students will learn how to effectively communicate with and teach older adults.
8. To promote overall health, students learn methods of health promotion, disease and accident prevention, plus the effective use of community resources.

The three-credit-hour course is developed around the broad nursing problem approach and the ANA Standards of Gerontological Nursing Practice. Since nurses often equate aging with illness, the theory class begins with a presentation of healthy old age. To reinforce these concepts, a panel of older persons speaks to the class, showing their personal philosophies of living, aging, and dying. Student responses to this panel are overwhelmingly positive. To further enhance this aspect, students interview a healthy older person in the community. Over a period of three weeks they assess developmental stages and complete nutritional and drug assessment studies. A psychosocial or physical problem is identified, a teaching plan developed and taught, and referrals are made to appropriate community resources if indicated. Students study the variety of community resources available, along with methods of initiating and advising of such services.

The many possible age-related changes in each body system, and unique responses of elders to disease along with therapeutic and rehabilitative methods of intervention, is presented next. Since pharmacotherapy and nutrition have a direct impact on the

health or illness of an individual, knowledge of elders' reaction to chemotherapy is considered thoroughly, along with important aspects of adequate nutrition.

In an effort to understand older adults' needs holistically, two units deal with the psychological and social aspects of aging. The psychological aspects of aging include mental health problems and the various interventions. First of all, students study the developmental tasks of middle and old age, in addition to personality, learning, intelligence, and therapeutic communication. Since sensory changes so crucially impact in elders' adaptation to living, I developed a module on informing and sensitizing students about sensory losses of aging. A filmstrip and lecture presents the age-related changes; a videotape shows an empathetic model of sensory deficits. Students then experience simulated sensory losses for each of the five senses. Following this experience they discuss specific ways of identifying sensory losses, therapeutic approaches, and methods of stimulating the senses. Considerable attention is given to common mental health problems experienced by older individuals, where both psychosocial and pharmacological therapies are addressed.

Understanding sociological aspects of aging is vital in planning comprehensive nursing intervention. Therefore, theories of aging, social theories, demography, myths, and stereotypes of aging, family, religion, economics, housing, retirement, leisure activities, transportation, ethnic and minority groups, and advocacy are included in this unit of study. Students also complete a learning module I developed on teaching older adults.

In an effort to consider all phases of the life cycle, the physical and psychosocial responses to dying and loss are studied. In-class exercises prompt students to examine their own feelings and reactions to aging and death. Furthermore, the unit includes elders' commonly experienced emotional reactions and coping mechanisms. Finally, we consider holistic nursing interventions and the hospice model of care for the dying.

The clinical portion of the course corresponds to the theory. In addition to the experience with non-institutionalized older adults, students rotate to a 240-bed Veterans Administration nursing home where they are assigned to residents. While there, students attend a multidisciplinary conference. They interact with and observe nurses, including a geriatric nurse practitioner, physical, occupational, and recreational therapists, dietitians, and social workers--all of whom are excellent role models. Attendance and participation in a variety of therapies and treatment modalities is encouraged. While in this clinical area, students complete a total health and nutrition assessment, from which they identify client problems and appropriate interventions. A priority problem is selected and a teaching plan developed and implemented. While there, students also select and carry out an appropriate psychosocial therapy. Pre- and post-conferences with staff are exciting and stimulating.

I assign each student to care for a dying, middle-aged, or older adult and family. Since this is a sensitive and important area of expertise, students prepare by reading and viewing selected readings and visual aids. Pre-conference sets the stage for a person-to-person encounter with the dying older adult and family. It is difficult to explain the tremendous import, awareness, and positive outcomes this has on students, while requiring constant attention and sensitivity on the instructor's part.

Last, as a part of the theory and clinical portions of the class, the students, along with the Multiservice Senior Center, sponsor a Health Fair. Students select topic-related and age-related changes and common physical and psychosocial problems of aging. Each group, in conjunction with various community resources, develops attractive booths, following a particular theme. Health screening, such as blood pressure and diabetic screening, and skin, mouth, and foot assessments are offered. Elders and children assist students in the booths where health teaching demonstrations and referrals are made available. About 1,000 older persons have attended this fair twice a year.

Developing and teaching a course in gerontological nursing is not easy. It takes much time to define and write the necessary content and learning strategies. Beyond this, it requires great enthusiasm and love for older adults and an eagerness to share this with students. I believe only instructors with these characteristics will make a notable difference.

During this presentation I have identified and discussed several areas of relevancy in regard to gerontological nursing at the associate degree level. Following this I showed a method by which such a course has been developed and is being taught.

Finally, in closing, I challenge each and every one of us to set aside our fears and look realistically and honestly at the overwhelming need. May this need prompt us in the Southeast to begin a new era of innovative gerontological nursing education. From the master's level educators, we need more programs to prepare gerontological instructors. From the baccalaureate and associate degree levels, we need a commitment to search for prepared, enthusiastic faculty and the freedom to develop model gerontological nursing courses. Last, from the Southern Regional Education Board, we need the leadership to help make all this possible. Now is the time for action.

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FACULTY MEMBERS' INVOLVEMENT IN A GERONTOLOGICAL NURSING PROGRAM: DUKE UNIVERSITY SCHOOL OF NURSING

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For over 25 years the School of Nursing at Duke has participated in the study and care of the aging. There was minimal involvement in 1955 when undergraduate students assisted with the physical examinations of the now-famous longitudinal study of the Center for Aging and Human Development. From that time there has been progressive involvement and in the mid-1960s Dr. Virginia Stone developed at Duke the first gerontological master's nursing program in this country. Dr. Stone has served as a state, regional, national, and international consultant in aging and has also participated in the two White House Conferences on Aging. She is now retired as a faculty member but continues to be an active consultant in aging.

A number of graduates of our gerontological master's program, as well as current faculty, have been and are influential 1) in policy making at the state and federal levels, 2) in the establishment of standards for gerontological nursing practice, 3) in the development of curricula with aging content, and 4) in the establishment of clinical services for the healthy aged, and the sick aged. As students have graduated and moved into these and other leadership positions in various settings, they continue to call upon the faculty as consultants to new and ongoing activities in aging. Thus, the colleague relationship established between graduate students and faculty has served to cement professional relationships and provide collaboration in clinical practice, research, and education. The graduate nursing courses in aging are open on a selective basis to medical, political science, clinical psychology, and

divinity students at Duke, depending on the focus and the particular interests of these non-nursing graduate students. In addition, graduate nursing students from the University of North Carolina at nearby Chapel Hill have been enrolled in these courses through our interinstitutional agreement. As the graduate program continued to grow, it soon became evident that, in order to develop the interest of nursing students early in their professional preparation, at least one elective course at the undergraduate level was essential. Because of our interest in developing positive attitudes toward the aging in the general population, a course entitled "Introduction to Gerontology" was developed and opened to all university students at the lower division level. This has been very successful and has provided an opportunity for nursing and non-nursing students to become acquainted with the field of aging as freshmen and sophomores, in addition to having opportunities to interact with a number of senior citizens on a continuum. A number of courses in aging are available to upper-class and graduate students in nursing, providing for either a concentration or specialization in aging.

In addition to teaching courses with specialized content relative to aging, the faculty also serve as clinical preceptors, sponsors of independent studies, and advisers for student research. The faculty consist not only of those whose foremost responsibilities are in teaching and research, but also those nurses in the clinical practice settings who qualify for clinical faculty appointments. Appointees as clinical faculty are nurses with a minimum of a master's degree in nursing and who meet other qualifications for beginning or advanced rank appointments as faculty members through the Board of Trustees. The contributions of the clinical faculty members are valued not only through their on-site clinical preceptoring and role modeling, but also through their provision of lectures, seminars, discussions, and various modalities of consultation. Dependent on their percentage of distribution of responsibilities in

clinical practice or teaching, a proportion of faculty members' salaries may be shared by the School of Nursing. However, this is not true in the majority of instances. Instead, there is a mutual understanding and agreement with the chief administrators of the clinical agencies and the School of Nursing as to the type and extent of personnel involvement. For example, one faculty member teaches an elective course each academic semester, participates in faculty committees and student advising, but the vast percentage of her time is in serving as the nurse clinician in the OARS-GET Clinic, a multidisciplinary clinic for a comprehensive approach to the care of the aged (OARS = Older Americans Resources and Services, and GET Clinic = Geriatric Evaluation and Treatment Clinic). However, during the time the faculty member is in the Clinic, she may also be assisting undergraduate and graduate students with clinical experiences. In this instance, it is difficult to separate what percentage of her time is involved in educational activities and what is purely clinical care. In addition, she is involved in research, continuing education, and assisting with other aging-related activities of the School of Nursing and other components of the Medical Center. During the summer, when this faculty member has decreased teaching responsibilities, she has additional time for clinical practice, as well as research and publication. There is a sharing of salary in this instance.

Another example is a clinical specialist in geriatric nursing at the Veterans Administration Medical Center-Durham who, having spent time as a graduate student in the OARS-GET Clinic, used it as a model for developing a similar multidisciplinary clinic in the VA facility. The vast majority of this clinical faculty member's time is spent in clinical practice; however, she also serves as a clinical preceptor to undergraduate and graduate nursing students, offers lectures in appropriate courses, serves on a Medical Center committee to implement a Long-Term Care Center, and assists with continuing education activities. In this instance, there is no remuneration provided by the

School of Nursing. (One of these nurses became interested in aging while an undergraduate at Duke and returned through special arrangement in her master's program elsewhere for a semester of study at Duke; the other nurse concentrated on aging while a graduate student at Duke.)

Because of mutual and complementary interests, a gerontological interest group of faculty and clinical specialists has been formed and students are invited to participate. This group meets every other week over a brown-bag lunch and serves as a forum for 1) sharing ideas, concerns, and publications relative to aging issues; 2) presentation and discussion of research protocols; and 3) constructive criticism of paper presentations to be delivered elsewhere to professional groups. It is a point of professional interaction for those involved in teaching, clinical, and research pursuits relative to the aging. Faculty and clinical specialists have received encouragement from each other to obtain ANA certification in geriatric nursing, and the collaborative efforts, dealing with the collective strength of individuals and the group as a whole, have fostered a cohesive group of faculty clinical practitioners, and students. It is members of this group that have provided strong support on behalf of nursing for the planning and implementation of a Long-Term Care Center at Duke through the AoA (Administration on Aging).

This AoA project mandates an interdisciplinary approach, and thus far nursing, medicine, physical therapy, and social work are the professional disciplines involved. The Chief of Nursing Services for the Veterans Administration Medical Center-Durham, who also holds a faculty appointment, and I serve on the Advisory Committee of this project. Faculty members representing each of the aforementioned health provider groups have been meeting during the last year to identify competencies in the care of aging that should be common to all disciplines, and those that should be specific to each. As you can imagine, this has been a difficult task. The group has had to deal with competencies not only within and among the involved disciplines, but also

competencies according to the beginning and advanced levels of learners in each, as well as on a continuing education basis. Traditionally, nursing has had a more structured curriculum than has medicine, and the logistics of implementing such a curricular program are still in the process of development. However, the faculty group is not only more informed about each other's roles and functions, but increased mutual respect for the contributions of each of the health provider groups has also emerged.

As an outgrowth of this curricular project, the Duke nursing faculty members proposed the exploration of a network program in aging for the baccalaureate and higher degree nursing programs in North Carolina. This was enthusiastically supported by the 12 deans of the involved schools, and representative faculty members from each school had an initial meeting in late spring of this year. The participants were unanimous in their agreement that an overall negative attitude toward aging on the part of the majority of their respective faculty groups was the major barrier to the inclusion of content on the care of the aging in their respective curricula. This, in addition to expressed territoriality for traditional clinical content, has been successful in keeping geriatrics out of their programs, in either an integrated or focused manner. In order to help resolve this situation, the Duke faculty group decided to plan a two-day conference with the assistance of external nursing consultants and selected Duke nursing faculty. This included faculty appointees from Sailors' Snug Harbor at Sea Level, North Carolina, and those located on the Duke campus. In fact, one of those participants was Charlene Connolly Quinn, who is one of several Duke alumnae participating in this regional program on aging. The enthusiasm of the presenters who are knowledgeable in aging, exposure to the OARS-GET Clinic as a clinical experience facility, displays of learning resources, and high interest of the attendees all contributed to a highly successful conference. One immediate outcome was that this

network of faculty members expressed a desire to organize and meet at least twice a year on a regular basis. Between these intervals they are aware they can utilize each other as well as the specific resources from Duke as they have need. Based on this statewide networking program, there is now a proposal to consider a three-state regional network program in aging. These three states are North Carolina, South Carolina, and Virginia, the same regional area in which schools with master's programs have organized the Virginia/Carolinas' Doctoral Consortium in Nursing. It is possible that, as a result of the interest expressed in this particular Southeastern regional meeting, other intra-regional interest groups may form, and this could lead to a Southeastern Regional Geriatric Nursing Conference on an annual basis. This format could enhance collaboration in curricular as well as research and practice endeavors related to aging. It would also be an approach to meeting the need for discussions formerly provided during the expensive national conferences, which will probably have declining attendance due to the decreased availability of travel funds. The Doctoral Consortium provides a structure for the sharing of faculty, curricular, and clinical resources, and for faculty and doctoral students to collaborate in areas of mutual interest, including research. Currently, a senior faculty member with an interest in aging holds a joint appointment with Duke University School of Nursing and the University of Virginia School of Nursing for such purposes.

I would like to mention another development that has recently occurred in the Duke Medical Center--the development of a Division of Geriatrics that includes both nursing and medicine. Because of the close proximity of Duke University Hospitals and the Veterans Administration Medical Center, this new organization includes personnel of both facilities. It is anticipated that with the close interaction of nurses and

physicians through this mechanism, an increased number of studies related to aging-involved nursing and medical parameters will materialize, as well as studies that are only nursing- or medical-focused. This Division has just been created within the last couple of months and development is still in the embryo stage. However, we are excited about a new Division being developed concurrently with the involvement of nursing and medicine. Already there has been mutual exploration and consideration of involvement in teaching nursing homes as well as community life centers. We have one faculty member involved on a continuing basis in providing continuing education to the staff of one nursing home, and her experience will be drawn upon as we consider similar involvement with a second nursing home. Clinical experiences for undergraduate and graduate students in nursing, medicine, physical therapy, and social work will occur in these long-term care facilities and in acute care hospitals in Durham and its environs.

Nursing faculty have also been engaged in continuing education for nurses through our Area Health Education Center (AHEC), a nine-county region in southeastern North Carolina; now physicians are also beginning to offer continuing education programs on aging for their colleagues through this AHEC. Another continuing education effort is being explored at the Veterans Administration Medical Center in Asheville, North Carolina, a distance of 250 miles, where Duke has a "Dean's Agreement" with that facility. Here, there is an extended care unit in addition to a large number of veterans of advancing age. Each semester a group of undergraduate Duke nursing students has clinical experiences with an ANA geriatric certified faculty member in residence. There are also a number of VA nurses with clinical faculty appointments at this facility. It is possible they may offer a course in geriatric nursing next semester for registered nurses in the vicinity of Asheville. Whether or not the prospective students are holders of a baccalaureate degree in nursing, these nurses would be enrolled on a special student

status for this course and receive baccalaureate academic credit from Duke. If certain factors do not permit the offering of the course for credit, there will then be a program offered on a continuing education basis.

The Center for Aging and Human Development at Duke is an interdisciplinary center within the university with faculty members having their initial appointments in the discipline of their preparation. Another nursing faculty member and I serve on the University Council on Aging, which is the advisory body for the Center. As part of its responsibilities, this group also suggests topics and speakers for the monthly presentations on aging that are open to the general public, and the academic community. Reports on pertinent research and informational presentations are included; the one last week was on "Nutrition and the Aging." Local and national speakers are invited. Workshops are also offered by the Center, and our faculty participate. We have several faculty members who have received appointments as fellows in the Center, and this provides them an opportunity for interaction with faculty members from different disciplines who have a mutual interest in aging. Because of the research emphasis of this Center, there are also post-doctoral students available to work with faculty members and assist in their research. Over the years these Center fellows and other faculty members have presented papers at national and international meetings of the Gerontological Society. Faculty research has been independent as well as collaborative with other nurses and other colleges in various disciplines.

Because aging is no respecter of persons when it comes to pathology, specific clinical groups, such as oncology, are now developing programs focused particularly on the aged. Such a conference was recently held in Washington, D.C., and three faculty members from the School of Nursing, in both oncology and aging, were the only nurses present at an otherwise all physician conference. This is not atypical for the situation,

but is why nurses with contacts in different organizations and groups need to be alert to the inclusion of nurses in appropriate conferences, especially as new clinical foci related to the aging are developed.

Another current activity of one faculty member is to serve as a Fellow appointed by the Gerontological Society to the Select Committee on Aging of the House of Representatives, chaired by Claude Pepper. This nursing faculty member works with Congressional staff on issues, reviews studies, and prepares statements regarding needed research and appropriations from Congress.

Faculty members enjoy their varied involvements in the study and care of the aged, and they feel particularly rewarded when either students or graduate nurses develop an interest in aging and then continue on to leadership positions in aging. Doctoral study for faculty has permitted several to develop dissertation topics on aging, and these have been faculty whose interests previously centered on chronic illness and community health, rather than aging specifically.

FACULTY INVOLVEMENT IN A GERONTOLOGICAL NURSING PROGRAM AT EMORY UNIVERSITY, ATLANTA

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INTRODUCTION

Involvement has several, and even contradictory, meanings: it can be positive, as in associated or engrossed; may be negative, as in entangled or complicated; and it can also be viewed from a subjective or an objective perspective. I will try to present how our faculty is associated with gerontology as objectively as possible.

While there is now an increase in the number of programs which include gerontological care as a clinical nursing specialty, this awakening interest has come after schooling for many current nurse educators. Robert Butler (1979) says that although nurses provide the major contact with elderly patients in varied settings and for a wide range of functions...baccalaureate nursing programs which include gerontological content are not in sufficient numbers: Patrick and Carnivali (1980) point out that few nurses graduate from schools in which nursing care of the elderly has been taught as an area requiring special knowledge and expertise, and they believe...this absence of attention to aging communicates a particular (and negative) message to students. Non-nurse gerontologists (Kart, Metress and Metress) write that the majority of nurses by default find their way into the care of older patients.

Our faculty members, like those of many other schools have gained knowledge of the aging process and of the special needs of older adults through varied and often self-designed efforts.

EVOLVING INVOLVEMENT AT N.H.W.

It is difficult to look objectively at gerontology in our programs without describing the evolution of our interest in nursing care of older adults. In the 1960s a special study of "Nursing Needs and Wants Among Economically Independent Persons Having Chronic Health Conditions" took some nurses of our faculty into the community surrounding the Emory campus to provide home-bound patient care and family and client teaching. The positive reception by the clients, their physicians, and the community in general led to other projects.

One subsequent special project, the Emory Community Nursing Service (ECNS) was incorporated in 1974 as a nursing service with an overriding purpose of quality health care for the community. Particularly, it made available to faculty members clinical resources in which to correlate nursing practice (primary assessment skills) with teaching and to improve their level of professional competency.

In this project home visits opened new challenges in simple to complex patient management and care, and the staffing of walk-in clinics demanded updating skills of assessment, interview, counseling, and knowledge of pharmacology, pathology, psychology, and sociology, to mention but a few areas. The project was designed to serve family groups without age distinction; nonetheless, the majority of home visits were to elderly clients. Also, a large proportion of clients for the clinics were older adults. Of the seven walk-in clinics held weekly, three were located in high-rise retirement residences, and one served the retired members and their neighbors in a particular church-sponsored preventive health program.

Effects on faculty and students were pleasing. Students enjoyed dynamic contact with well elderly persons and had an opportunity to observe their faculty as responsible care providers. Nurse educators, for whom public health was not a part of their normal armamentarium, found care of clinic clients and home-bound

elderly a challenging and stimulating experience. One view, which might be construed as too subjective, was expressed by one faculty member, who after initial resistance to leave the classroom structure and acute care clinical teaching, was literally propelled into a deeper and broader appreciation and focus of gerontological nursing as a clinical specialty. These experiences also had direct effects on the baccalaureate and graduate programs of the school of nursing.

CURRICULUM IMPLICATIONS

In response to client and administrative satisfaction in the health maintenance and information clinics of the retirement facilities, dual appointments were arranged whereby nurse practitioner faculty members could provide direct client service and still maintain curricular responsibilities for baccalaureate and graduate student experience. One project, whose purpose is to develop teaching sites in nontraditional settings, has offered student experience and faculty practice in a low income housing authority complex. Here, the DeKalb Council on Aging has a nutrition program, day care activities, etc. The community health teachers from our faculty staff the health department clinic in a gerontological milieu for practice and teaching. The baccalaureate curriculum is designed for students to apply and integrate content in each of the traditional nursing specialty practice settings, and requires the faculty responsible to keep updated on the various integrating concepts and content threads. Faculty-developed learning modules use selected patient care models to develop problem-solving skills and knowledge-expanding discussions. In each module at least one model has a gerontological focus of normal aging and of those pathologies which accompany aging. Clinical application is in long-term care, community health care, and general hospital and acute care practice areas.

Gerontological nursing is more distinctly defined, however, in the master's program. Our first gerontological nursing clinical specialists with practitioner skills will graduate at the end of

this year. Faculty involvement here is the responsibility for content, clinical practice, and research activities for this subspecialty of the Adult Health major.

The family/community health major places strong emphasis on gerontology. Faculty in the non-degree program, in responding to expressed needs of nurses across Georgia, are involved in workshops and seminars on the aging process, and assessment and management of health care for older adults.

FACULTY PERCEPTIONS OF GERONTOLOGICAL NURSING INVOLVEMENT

Earlier I mentioned that there is subjectivity in viewing faculty involvement. An informal survey of individual opinions of personal involvement in gerontological nursing showed that one-third of the group stated they had direct responsibility for gerontological content in at least one of the three programs. Two-thirds had no direct responsibility for this content, but most of this group saw a close relationship between their own clinical specialty and gerontological nursing. More than two-thirds felt they needed further study in the subject of gerontological nursing, about half of these indicated that they had participated in continuing education offerings in gerontology. It was no surprise that a majority of our faculty members indicate their primary contact with older adult clients is through student assignment in community health experiences, high-rise retirement clinics, and adult health sections of acute care and psychiatric/mental health hospitals.

Present faculty includes nurses skilled and certified in specialties pertinent to older adult care. We have some faculty who have had formal preparation in gerontological nursing and gerontology, but for the majority it is through self-propelled update and creative use of rich clinical resources that they are able to strengthen their own knowledge of gerontological care and thus present a positive view of older clients to students.

FACULTY EFFORTS IN BEING INVOLVED

Personal descriptions of faculty's self-directed study are as diverse and interesting as they are rewarding, and classification

is difficult. Creativity and commitment accompany these activities initiated to further clinical knowledge and skill. For example, many are involved in community service that is not directly job related.

Faculty members are engaged in several activities providing direct patient care. The Atlanta Housing Authority clinic was begun approximately four years ago by four undergraduate faculty members. This clinic is for the older clients, generally low-income retirees. In the clinic the nurses assess, manage care, provide health teaching, and consult with other health care providers. They make home visits upon request of the resident manager, or as indicated by their own perception of client needs. While record-keeping receives less attention than patient contact, the clinic is managed as a truly professional service. There are no fees for service by client or agency. The renumeration to the nurses is figured in personal and professional satisfaction of enhanced knowledge and skill in many aspects of gerontological nursing. There is no official link between the clinic and the school.

Several faculty members report rewarding experiences through their church-sponsored gerontological projects. One pediatric specialist is being prepared to be a Eucharistic minister to the elderly members of her church community. She will offer to them and their families consultation and counsel. I find it particularly gratifying that she, a pediatric specialist, is exemplifying the idea that it is important to have knowledge of people along the whole life continuum.

Several faculty members function in free hypertension clinics, again sponsored by the church or other such groups to meet the needs and desires of their members. For the most part the clients who come to these clinics provide the nurse with a good opportunity for observing older adults and assessing their status and needs.

There is also active involvement in positive health teaching. Retirement and pre-retirement seminars and community education

courses in aging concerns bring involvement with both the young-old and the old.

Sessions with groups of adult children of elderly parents dealing with expectations of aging and effects of the aging process on behavior offer interaction and group process which is conducive to problem solving and discussion of the concerns confronting multigenerational families. Our faculty implements this activity through the Emory Community Education Program and in church and club groups.

The nurse epidemiologists of our faculty offer infection control classes for long-term care personnel. Requests for such in-service programs are increasing.

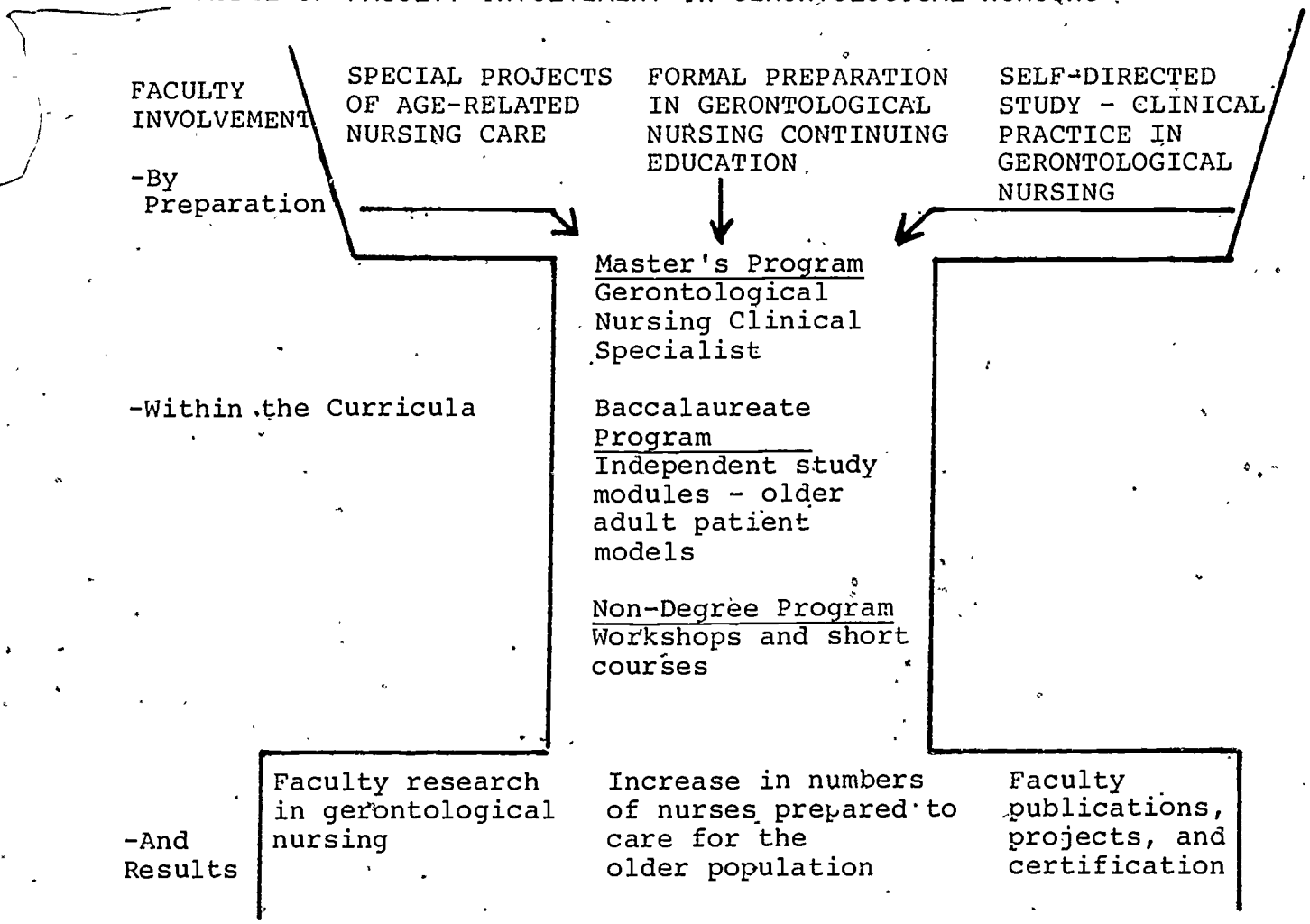
Consultation may be official or non-official. A member of the psychiatric/mental health faculty provides family therapy and consultation to nursing home staff in planning for gerontological projects.

At present several research studies are being conducted by faculty related to older population. Titles include "Social Learning Approaches to Modification of Fear and Avoidance Behavior Toward the Elderly," "A Survey Schedule to Assess Pain Coping Behavior in Adults," "Social Learning Approaches to Modification of Fear and Avoidance Behavior of Nerve Block as a Pain Control Mechanism," and "Development of List of High Risk Factors for the Hospitalized Older Adult." One faculty member is participating in her husband's research into "Consumer Skills and Behaviors of the Elderly."

Publications include a textbook of physical assessment, with a special section describing the older client; a chapter in a large nursing text on the aging process; and several articles and books are in process, such as a text on coping behavior. Personal involvement is certainly the most subjective and the most motivating. All of us are personally involved with aging through relatives, friends, and often ourselves. Involvement

as a "significant other" motivates learning by stimulating questions about care and demanding study of ways to answer these questions. Personal involvement sensitizes our commitment to helping the aging. The following diagram summarizes aspects of faculty involvement in gerontological nursing at Emory.

MODEL OF FACULTY INVOLVEMENT IN GERONTOLOGICAL NURSING



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GERONTOLOGICAL NURSING EDUCATION*

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INTRODUCTION

Gerontological nursing has lain almost dormant in academia, like a sleeping giant waiting its turn for nurses' attention. The burgeoning elderly population forecast by sociologists, and their corresponding health care needs, forecast by gerontological nursing pioneers, has arrived. Full credit is given to those faculty members and nurses in practice and other positions who, for the past 20 years, have kept lighted the lamp of enlightened gerontological nursing, hoping that its illumination would ignite complacent colleagues previously inattentive to the inevitable coming flood of elderly people needing nursing care.

Since 1966, when the American Nurses' Association declared gerontological nursing a specialty, faculties in schools of nursing have made sporadic attempts to prepare themselves and their students in this specialty. Concurrently, the aged population has exploded to the magnitude predicted by the demographers. This paper will review the present status in the nursing of the aged, with implications for planning based on statistically demonstrated need and within the context of nursing's responsibilities. Five issues to be examined include: educational needs of faculty; the number of nurses prepared in gerontological nursing; consumer needs of the aged as indicated by demographic studies of the health status of the aged; identification of factors facilitating or inhibiting the professional advahcement of gerontological nursing faculty members, including employment availability for such faculty by deans or directors of

*Dr. Knowles presented her paper at a meeting of continuing education directors held in conjunction with the meeting of the Southern Council on Collegiate Education for Nursing.

schools of nursing; and identifying guidelines for the knowledge upon which gerontological nursing is based.

THE DEMOGRAPHY OF THE AGED AND THEIR HEALTH STATUS

The United States is experiencing a growing urgency related to the health care of its aged. The over-65 population constitutes an increasing proportion of the country's population. Specifically, the over-65 population is now about 25 million, approximately 12 percent of the total population. It is predicted that by the year 2030, this age group will increase to 50 million people, over 18 percent of the total population. Moreover, the over-75 age group has increased even more rapidly than the 65 to 74 age group. While all the aged share some problems, the over-75 are most vulnerable to the physical, mental, and social assaults that lead to the need for nursing care. In 1975, the over-75 age group represented 37 percent of the over-65 population. The numbers of single women and minorities who are aged are also expected to increase proportionally (Brody, 1980). The situation is complicated by the fact that the elderly, being subject to the highest rates of illness and disability, consequently use health care services at the highest rate of any age group and place heavy demands on health care resources. In 1977, health care services for the aged constituted 29 percent of the total personal health care cost of the United States, totaling $142.6 billion (Shaeffer, 1980).

Although the majority of the aged are living active lives in their own households, 47 percent of them are limited in activity due to chronic conditions. These chronic conditions so increase with age that, by age 75, approximately 56 percent of the elderly have chronic health problems and may require institutionalized health care (Haber, 1978).

A recent National Advisory Council of Aging report summarizes factors that must be considered when planning health care delivery systems for the aged. In terms of general health care, the aged require more, especially long-term care. They

are less capable economically, physically, and socially of obtaining such care without assistance. Health care providers for the aged have been less motivated, less educated, and less financially rewarded than providers of health care for other age groups (Haber, 1978).

In terms of mental health care, the needs of the aged only recently have been considered as different from mental health needs of other age groups. Statistical analyses reveal that five percent of the aged population have severe psychiatric disorders, either organic or functional or both, and approximately 15 percent of the aged need mental health treatment. The incidence of suicide in the depressed aged is at least three times as high as in the young. Mistaken belief that the aged who are mentally ill may not be responsive to treatment interferes with provision of appropriate care.

Because the provision of long-term health care is complicated by the complex interaction among health factors and social factors, it must be provided within the context of family, community, and cultural life patterns. It is provided in a variety of settings, including institutions or communities. Consequently, an interdisciplinary and inter-agency approach is required for effective delivery of health care for the aged.

Moreover, the aged are at greater risk for institutionalization. Recent researchers place the percentage of aged persons in long-term institutions at greater than the oft-quoted four to five percent. Kastenbaum and Candy (1973) estimate that 23 percent of deaths among the over-65 population in Detroit occurred in long-term institutions. Palmore (1976) found that 26 percent of the over-65 population had been institutionalized in long-term facilities before death. Vicente et al. (1979) found that 38.9 percent of the persons in their sample had stayed in a convalescent hospital or nursing home at least once before death, and that among persons with one or more stays, about 40 percent had been institutionalized for periods of six months

or more. Risk of institutionalization has been correlated with living alone, being separated or never married, having few or no children, being female, having inadequate finances, having education of seven or fewer years, and being white. Palmore reported similar findings. Palmore also found that rates of institutionalization increased with age; among persons who were 85 or older, 67.7 percent had been institutionalized at least once.

The term "the vulnerable aged" is used to describe the very old who are alone, bedfast, housebound, and in need of either institutional care or long-term care. The number of "vulnerable aged" will increase substantially in proportion to the increase in the over-65 population over the next two decades and represent a population with increasing health care needs (Scott, 1979). In 1979, the Florida Statewide Health Coordinating Council recognized that the higher rate of chronic illnesses and disabilities requires advanced nursing knowledge and specialization related to this population.

More gerontological nurses are needed. One state, Florida, has a population of approximately 2.3 million people in its over-60 population, constituting 24 percent of the population. However, Florida has only 26 master's-prepared geriatric nurse specialists (American Nurses' Association, 1978). It should be noted that the percentage of aged population in Florida is much higher than in a number of Southern states.

PREPARATION OF FACULTY

One of the criteria for meeting accreditation requirements of the National League for Nursing requires that nursing programs align themselves with the needs of society (NLN, 1977).

The question of faculty has been addressed by several authors: Burnside (1976) cited several studies which indicate that undergraduate nursing programs are placing little if any emphasis on the care of the elderly. In 1980, she noted that "there are still

not enough prepared and qualified instructors to teach gerontological nursing courses at all the various levels of nursing.. and we lack role models." O'Driscoll, and Wister (1979) reported a study by Sullivan (1978), conducted by the Division of Gerontological Nursing Practice of the American Nurses' Association in 1975, which investigated the amount and placement of course content in basic education programs relating to the elderly and found that:

1. Approximately 14 percent of the schools offered courses concerned with gerontological nursing; nearly 85 percent did not.
2. Less than 5 percent of classroom time was devoted to gerontological nursing by 30 percent of the respondents, and 30 percent indicated that 5 to 14 percent of class hours were devoted to the subject.
3. About 97 percent indicated that aspects of gerontological nursing were integrated into courses taken by all students, usually fundamentals of nursing, medical-surgical, and psychiatric-mental health nursing. (Etten [1979] makes a special plea to have gerontological nursing a separate course.)
4. Almost 45 percent of the schools indicated that opportunities to care for the well older adult needed to be strengthened.
5. Nearly all of the 138 faculty members responding indicated that self-study was how they had gained their gerontological nursing knowledge, and they had the following years of experience in the formal teaching of gerontological nursing: nearly 42 percent--1 to 2 years; nearly 25 percent--3 to 5 years; nearly 13 percent--more than 5 years; and nearly 4 percent--none." (p. 653).

Sullivan adds that an inference can be drawn from these last figures regarding the length of time that educational programs have been offering courses in gerontological nursing.

The state of education of nurses in gerontological nursing was reported in a survey by Shields (Statement on the Education of Nurses in Gerontological Nursing before the U.S. Senate Special Committee on Aging, 1978). The study, sponsored by the American Nurses' Association, described the preparation of nurses in gerontological nursing as the respective levels of basic, graduate, and continuing education. Deficits at the basic preparational level were identified:

The majority of programs do not offer specialized courses in gerontological nursing. There is lack of content of all aspects of gerontological nursing except as incorporated in existing curricula.

The faculty had three years or less formal teaching experience in gerontological nursing.

Almost one-half of the faculty reported five years or less of clinical experience in gerontological nursing.

The most frequently reported category of clinical experience was that obtained in the hospital. The next most frequently reported category was the skilled nursing facility.

The sources cited by faculty where they gained specific education in the principles and concepts of gerontological nursing were predominantly self-study (94.2 percent) and continuing education (99.9 percent).

Positive aspects were identified as follows:

Within those programs offering specialized courses in gerontological nursing, two-thirds indicated that coursework is required in the curriculum. Of those programs where there are no specialized courses, 85 percent indicated that such programs are being planned for future implementation.

An overwhelming number, 96.7 percent, reported that aspects of gerontological nursing were incorporated into some of the coursework required of all students (pp. 10-11). (Shields advises that coursework alone on concepts about aging is insufficient; actual practice under the direction of prepared clinicians is essential.)

In graduate education, the survey revealed that of the 15 programs in gerontological nursing surveyed, three were in the adult health category with specialization in gerontological nursing.

Continuing education programs range from 8 to 12 months. Faculty preparation in gerontological nursing in graduate programs usually combined self-study and continuing education. No faculty members held a graduate degree in gerontology. Shields observes "the present short-term continuing education programs are a temporary, stopgap measure while there are insufficient numbers of gerontological nurse practitioners at the graduate level" (p. 12). She also urges that both baccalaureate and master's prepared nurses need to inform themselves on

current knowledge and skills through well-planned continuing education programs. Such programs should adhere to the Standards of Continuing Education established by the American Nurses' Association Council of Continuing Education. (Shields, Statement on the Education of Nurses in Gerontological Nursing before the U.S. Senate Special Committee on Aging, 1978).

GERONTOLOGICAL NURSING FACULTY ADVANCEMENT

FACILITATING FACTORS

Solutions to increasing the quantity of gerontological content in basic educational programs have included such suggestions as: 1) a mandate that the National League for Nursing set up a time-table to the development of such content (Yarling, 1977); 2) that State Boards of Nursing examinations include test items specifically related to gerontological nursing (ANA Statement on the Scope of Gerontological Nursing Practice, 1981) and that such questions carry the same weight as those related to mental health, pediatrics, and other more established specialties (Brower, 1979); and 3) that Nurse State Practice Acts mandate the inclusion of gerontological nursing in their nursing programs (as is the case in Florida and Kansas) (O'Driscoll and Wister, 1979).

Actions by forces external to the professional and educational institution are likely to exert pressure for change when forces internal to the nursing profession and the educational institution do not effect change in keeping with societal needs and trends (Gress, 1979).

I hope that nurse educators will consistently prepare nurse graduates to meet the health care needs of the elderly without such dictums.

Brower further recommended: 1) the political assistance of groups such as the Gray Panthers and other senior activists groups; 2) nurses' participation in Professional Standard Review Organizations to provide expertise in auditing quality nursing and health care to the elderly; 3) membership by gerontological nurse specialists on state boards of nursing, on boards of agencies concerned with matters relating to

aging, on state and federal planning councils, and on the federal Council on Aging.

INHIBITING FACTORS

The status of faculty members with a specialty in gerontological nursing contrasts with the status of persons in the field of business, where the law of supply and demand determines the cost that society must pay for sparse commodities. Not so with gerontological nursing. My hypothesis is that gerontological nursing faculty members are probably paid less than their peers, if tenure, advanced degrees, and experience were factored in. The manifest need for a Bill of Rights for the gerontic nurse (Gambrill and Richey, in Ebersole and Hess, 1981) supports this hypothesis. Brower (1979) speaks to this issue: "We can no longer afford to be cast aside by our professional peers assigning us to positions of lower status and prestige, even when this is only an inference reflective of societal types of the aged. We will no longer consider ourselves somewhat questionable by reason of our choice to work with the elderly."

Research about attitudes of nursing students and faculty toward the elderly has been extensive. This is to be expected in a specialty where negative societal attitudes about the aged prevail. Moses and Lake (1968) concluded that a major problem in offering geriatric nursing courses was the negative attitude of faculty members. Recent research reveals that creative teaching methods and selected learning experiences have reversed student attitudes. Heller and Walsh (1976), Kart et al. (1978), Brock (1978), and Chamberland et al. (1978) reported that student attitudes toward the aged, as well as their preferences of working with the aged, were positively influenced by selected gerontological nursing learning experiences.

Gunter (1971) reported that fewer students expressed a strong interest in working with the aged after completion of a course in normal later-life development, than was the case in the beginning. Such research has often been stimulated by difficulties

in providing students with positive clinical experiences with the aged.

The paucity of gerontological nursing research and the disproportionate amount of study about attitude was documented by Kayser-Jones (1981) who reviewed five nursing journals from their beginning dates of publication through July 1980. Of the 44 research articles, seven were devoted to the study of attitudes of health professionals toward the aged. This finding is similar to that of Gunter and Miller (1977) who analyzed studies in Nursing Research from 1952 to 1976. Of the 17 studies on aging, four were on attitudes of nursing staff and students. Gunter observes: "Nursing research studies on aging will not be augmented until there are adequate numbers of nurses prepared to conduct such research" (p. 218).

Some of the rationale for studies on attitudes has been based upon the thought that if nurses understood why they are not taking care of the aged, they would know how to remedy the situation. The problem is, of course, much more complicated. For example, faculty who, as students, have consulted psychologists and sociologists about their theses and/or dissertations, as faculty members, often consult such persons when selecting research topics.

Solomon and Vichers (1979) found that the milieu of geriatric treatment, rather than knowledge, experience, and skill of the staff, was the most effective background for positive changes in attitudes. Learning experiences with the healthy aged during nursing school improved student attitudes or established new positive attitudes toward the aged (Tobiason, et al., 1979).

In the author's experience, positive learning experiences with ill and/or disabled elderly persons include, but are not limited to, the following:

1) the formulation of specific nursing care objectives stated in behavioral terms, so that students and instructor may identify maintenance and/or improvement in functional ability (biological, social, and/or psychological):

2) first experiences with patients who are able to communicate verbally and realistically;

3) opportunity for students to express feelings and attitudes about themselves, patients, families (both their own and their patients'), the staff, and other health professionals;

4) development of trust between student and instructor;

5) the ability and opportunity to relate theory to practice supported by a sufficient amount and appropriate kind of theory to make this meaningful;

6) an attitude of positiveness on the part of the instructors who are confident that maintenance or improvement of function is possible;

7) assistance of the student by the faculty with patients experiencing declines in functional ability;

8) identification of patient strengths;

9) clinical settings where nursing staff cooperate with students and faculty or, at the very least, refrain from undermining nurses' efforts;

10) provision of nursing role models;

11) opportunities for students to demonstrate what <u>they</u> can do, as well as what the <u>patient</u> can do.

This scientific and humanistic approach gradually dissolves the block of helpless feelings experienced by many nurses when working with the aged--one factor frequently deterring nurses from choosing the specialty of gerontological nursing. Such nursing practice requires a clearly thought-out understanding of what the instructor believes nursing consists. The problem of motivating the nursing student and patient is minimized by consistent implementation of this approach along with consistent administrative support of the faculty.

SETTING FOR CLINICAL PRACTICE

The distressing state of nursing homes and the deplorable conditions for the residents/patients, have been described at length in both lay and professional literature and more recently on television. Explanations for these conditions from a nursing point of view may be summarized in the statement that professional nurse staffing is so low that the patient-nurse ratio is unreasonable; wages are lower than in other health care settings;

and nurses have tremendous responsibility without commensurate authority and colleague relationships. Exceptions to these conditions are found most commonly among the non-profit homes.

Clinical settings for students may not need to be ideal, but minimum standards are needed to meet course objectives in educational programs. It will be interesting to see whether the demonstration grants of the Robert Wood Johnson teaching-nursing home programs are able to influence the quality of nursing care and also to influence legislation to appropriate more money for care of nursing home patients. This author believes that as long as the majority of nursing homes are profit-making enterprises, the quality of care will not improve until different methods of funding are found.

Homes for the aged and congregate adult living/housing provide opportunities for students to find means of maintaining health functioning of such residents, to document theory, to observe role models of nurses, and to develop positive attitudes about older people. Beginning students need quite different experiences with the elderly from that needed by students and nurses with a background in pathology.

Other kinds of settings, of course, are available for nursing student education. For instance, home care settings which are agreeable to both the home health agency and the faculty may be used for this purpose. However, this type of setting may become unavailable in some cities because of anxiety about the legal implications of students making visits to the home without one-to-one supervision. This may become a stumbling block in preparing students for the care of the aged in the community. This problem does not apply, of course, if objectives do not require the "laying on of hands" experiences.

Long-term care is one of the main issues today. Although medical science has now conquered most of the contagious diseases, long-term care is still the stepchild of medicine and nursing. Most nursing programs give great importance to the acutely ill,

as does medicine. The challenge of long-term care when the patient cannot be cured is not readily apparent to nursing or medical students unless faculty serve as positive role models, indicating how they should function professionally in such conditions.

What will be the result of faculty enrollment in continuing and formal educational courses? The question arises as to what can be done to improve the nursing profession and faculty qualifications. How will an increase in knowledge, such as from continuing education programs, affect the faculty members' position? How will their enhanced expertise be regarded by administrators? Do the numbers of graduate students in gerontological nursing programs relate to employment opportunities on faculties? We should be concerned with how many faculty appointments are available for such graduates, notwithstanding the fact that, until the gerontological nursing specialty is recognized and supported by nursing college deans and directors, gerontological nurses will continue to be recruited for service agencies rather than faculty appointments. Many of the graduate programs in gerontological nursing are struggling to enroll sufficient numbers of students. A steady, but slight, increase in interest in gerontology and the nursing of the aged has been observed by this writer.

Nursing is learning very fast that programs, practice, and other matters need to be cost-effective. How cost-effective will it be for faculty to be better prepared in gerontological nursing? Will there be less faculty turnover in courses where gerontology-prepared faculty members teach, as opposed to turnover in courses taught by faculty not prepared in the specialty? Will students be better satisfied? Will faculty be more willing to teach students in learning situations with elderly who are ill and/or disabled? Will these faculty members be assigned to the "pits" of clinical assignments--some nursing homes? Will they undergo evaluation of their course content by non-gerontological nursing faculty? Will employment of gerontological nurse

faculty favorably affect accreditation of the programs? Will it affect the appropriation of private and/or public funds for nursing?

The professional loneliness often experienced by gerontological nursing faculty is an important factor which inhibits advancement. Will there be more than one faculty member teaching gerontological nursing? Will that faculty member's teaching load be similar to that of other faculty members?

Professional collaboration and discussions provide stimulation among colleagues interested in the same specialty; invaluable, in-depth discussions not possible in the home setting become possible in meetings of gerontological nursing practice committees and other groups of the specialists.

I have welcomed the opportunities to serve on ANA's first geriatric nursing standards committee (1973) and scope of gerontological nursing practice committee (1981). Not only have I had the opportunity to assist in pointing the direction for gerontological nursing, but also to meet and discuss issues and the content to be included in nursing courses.

The basic question we are considering is: Is there a market for the nurse faculty member prepared in gerontological nursing? Nursing must evaluate not only the market need and employment prospects of gerontological nurse specialists, but also the value set on them by nursing program administrators. Although the needs of the aged are well documented and the result of the nursing of the aged is being increasingly documented as it is related to improvement of patient care and cost effectiveness, there can be very little or no positive impact on the curriculum without the support of the dean or director of the program.

Rather than continuing theoretical discussion of burgeoning population growth among the elderly and giving lip-service to reminders of increasingly vociferous public demand for better and more gerontological nursing services, it is imperative, now, to make provision for more gerontological nursing curriculum

content in answer to society's needs. The gerontological nursing specialty must be accorded recognition with corresponding salary and other professional confirmation.

It is time to retire the outmoded but still prevailing "if everyone's doing it, it must be all right" policy, which has produced a situation in which, since there have not been many gerontologically prepared faculty, many faculty members not prepared in gerontological theory and practice have been assigned to teach the specialty.

Some of these assignments were emergency measures but the emergency state is being perpetuated long past the acute stage, most likely because of a lack of recognition that, as staff nurses who come to nursing homes remark after about three weeks, "There is something different about these old folks!" That difference, which is the basis of the gerontological nurse's knowledge base, is what makes the elderly different and the gerontological specialty different (ANA, a statement on the Scope of Gerontological Nursing Practice, 1981).

THE PRESENT KNOWLEDGE BASE FOR GERONTOLOGICAL NURSING

A basic question is what is the knowledge base of gerontological nursing? And, how many faculty obtain more professional knowledge as individuals, as groups in the various states, as faculty in the Southern region? What resources are available to help provide answers to these questions? What resources are available to determine the knowledge base of gerontological nurses?

The American Nurses' Association has pointed the way in development of its gerontological nursing standards and scope statement (1973, 1976). The Association also has published an outline for continuing education courses for nurses. Certification of gerontological nursing preparation identifies those nurses with specialized knowledge and clinical expertise. The Journal of Gerontological Nursing and Geriatric Nursing: American Journal of Care for the Aging are primary sources of gerontological nursing practice today. Approximately 20 gerontological

nursing textbooks have been published in the past three years.

Robb and Malinzak (1981) assessed the extent of gerontological nurse knowledge in the nursing staff at a large Veterans Administration Medical Center and identified relationships between knowledge and selected factors commonly believed to influence levels of knowledge. Their findings are expected to give direction for continuing education programs for nursing personnel and to influence nursing academicians concerning gerontological content within curricula. The ultimate goal of the Robb-Malinzak investigation was to promote excellence in gerontological nursing practice.

The authors note that few studies have been reported in the literature, which was reviewed as far back as 1965. Of the few, one of particular interest was Dye and Sassenrath's study to identify physiological and functional conditions either as normal aging processes or as disease-related processes. "These researchers report that their gerontological nurse-subjects' most frequent error was adjudging normal signs of aging as disease indicators" (1979).

Using test items from Gunter and Ryan's (1976) works, Robb and Malinzak developed a 150-question test and self-administered it to a sample of 200 nursing personnel. The findings suggest that educational levels, specifically coursework in gerontological nursing, had positive influences on cognitive learning. The study supports the position of experts in gerontological nursing (Gunter and Estes, 1979, and Brower, 1979) that content should be included as a discrete, versus an integrated, part of nursing curricula.

Limitations in the availability of reliable tests to assess nurses' knowledge levels relating to gerontology are further discussed by Robb and Malinzak. The Psychological Corporation developed a geriatric nursing achievement test in 1977 comprised of 27 items related to the aging process in general and to socio-economic factors, medical and surgical problems, mental confusion,

community agencies, and rehabilitation. The National League for Nursing has no achievement test in the area of geriatrics/gerontology. None of the available test tools provides items structured to correspond with a nursing process (assess, provide, plan, implement, and evaluate) framework. Faculty teaching gerontological nursing need reliable tests for testing application of knowledge to nursing practice. Palmore's Facts on Aging Quiz (1978) has been challenged by Holtzman (1979) as insufficiently relevant to the knowledge base for gerontology.

Placement of gerontological nursing and its identification as a specialty within the nursing curriculum is needed. Roberts and Powell (1978) call the use of nursing homes to provide students' first clinical experience "the rape of geriatrics by fundamentals nursing instructors." Pre- and post-tests of their study, using Associate of Science in Nursing students as the sample, revealed that students' negative attitudes toward the aged had increased when fundamentals of nursing were taught with the ill aged. This would indicate that experiences with the well aged should precede those with the ill and/or disabled elderly.

Although the need for additional gerontological nurses has been documented as based on the social need of the elderly for such services, and although the professional organization has designated gerontological nursing a specialty since 1966, the number of qualified faculty and practicing nurses is in short supply. Additionally, faculty and practicing nurses so prepared are frequently not considered equitable to those in other specialties. Nursing curricula reflect the lack of priority allotted to gerontological nursing. Some resources for content in gerontological nursing are provided.

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FUTURE DIRECTIONS IN GERONTOLOGICAL NURSING

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Imagine a country with more than 11 percent of its population over age 65, yet most of its health care providers are inadequately educated to cope with the care of older adults. Recent studies by the Institute of Medicine, the Rand Corporation, and the Administration on Aging have pointed up this alarming deficiency. But these findings come as no surprise to older adults and their families.

In the five years that I have worked in the field of gerontology, many of the questions I am most frequently asked relate to finding good health care for older persons. Older people and their families want to know about physicians who specialize in aging and diseases common in old age.

Nursing schools, recognizing the need for geriatric and/or gerontological nursing, are searching for qualified faculty to teach and conduct research.

As health care spending by and for older adults is reaching critical proportions, policymakers and professionals are questioning the availability, the quality, and the appropriateness of the health care services they receive. Increases in the supply of health professionals have not necessarily resulted in enough personnel educated in the principles of gerontology and geriatrics to provide needed services. The constrained economic environment will do more than inhibit expansion and improvement in services. Increasingly, nursing leaders and educators are being asked to respond to the health service needs of the shifting age patterns of the population.

Essential to any programmatic response to demographic change is an understanding of the comprehensive needs of specific populations

and how these can be fitted into the ongoing service delivery structure. More important to nurse educators is the urgent need to conceptualize and teach within a framework that is specific to the health needs of an aging population. As Dr. Knowles mentioned in the Continuing Education Directors' meeting: one criteria for accreditation is to consider, "Is a program in alignment with the needs of society?"

The aging of the population and subsequent burst in the incidence of chronic disease and disability represent an urgent problem to a health system which is primarily focused on acute illness and cure.

Thus, nursing educators face a number of issues in challenging the present health care system of older adults. They are by no means insurmountable challenges and we do have a temporary grace period in that the real "age" explosion will not occur until somewhere around 2010, when the graying of the World War II "baby boom" takes place.

Why, we ask, is health and long-term care of an aging population emerging as a crucial issue for the 1980s? This paper will focus on three trends, which are occurring simultaneously, and will discuss how knowledge of these issues may lead to solutions of planning for the future. The trends which provide a framework for discussion are:

the number of people needing comprehensive, long-term care is increasing rapidly;

the dramatically growing cost for providing such care;

and

the inadequate numbers of health care providers to care for the older population, today or tomorrow.

COMPREHENSIVE NEEDS

Ask the passer-by on the street what he or she thinks about on hearing the words "long-term care"; the answer will probably be "nursing home." And although most public funds spent on

long-term care in the United States go toward paying costs of institutionalization, the concept of long-term care is caring for people over a long period of time--anywhere and anyhow.

In fact, most people who require help to cope with the tasks of daily living receive it in their own homes, or in the homes of their children, from community centers, churches--any place where people live or come together. Institutional care or nursing homes are the alternative when care at home or services in the community are either not available or are insufficient to meet an older person's needs.

The phrase "long-term care" typically represents a range of services that address the health, social, and personal care needs of individuals who for one reason or another have never developed, or have lost, the capacity for self-care. Services may be continuous or intermittent, but it is generally presumed that they will be delivered for the "long term."

The demographic trends highlighted by previous speakers describe the trend of an aging population. While we prefer to think of aging as a positive stage of development, we cannot ignore the risks of functional disability which increase with age. Increased longevity and the growth in the population as a whole means that more people have chronic physical illness that hinders their capacity to function. Nearly 22,000 nursing care institutions, with about a million and a half beds, and over 2,350 home care agencies are directly involved in providing care. And, an estimated 25 percent of acute hospital care is devoted to the "acute" episodes of illness encountered by those with chronic disability.

Age is not the criterion for long-term care. In fact, the number of impaired people under 65 who have major limitations is greater than the number of older adults who need help. However, prevalence of chronic conditions increases rapidly in old age and thus the growing aging population, particularly the over-70 years segment, will place a strain on long-term care services.

Older adults are the greatest users of nursing homes where 9 out of 10 residents are over 65 years of age. If present utilization rates continue, the total nursing home population will rise 54 percent over the next 20 years and will more than double over the next 50 years. Thus, in an area where a shortage of adequate personnel already exists, the demand will only increase.

Nurse educators must recognize chronicity as a part of the reason for planning comprehensive health services for the older population. In our sincere efforts to promote "normal" aging and the "well" elderly, we seem to forget the prevalence of chronic illness as people age. We try to ferret out reasons why the chronically ill are given less concern than the acutely ill patient, who always gets the most attention in our present care system. Doris Schwartz reminds us of a comment from a British psychologist: "Patients who get better do a deep service" to all of us who plan for and participate in their care.

Most of the time the chronically ill fail to do us that service, and pay heavily for their omission. When they meld two shortcomings--being chronically ill and old--they doubly disappoint us. They conflict with our enormous need to be successful, to be responsible for their dramatic recovery. They have failed us by their chronicity and we may be human enough to strike back--either by withdrawing our concern for their welfare or by supplying programs which are a far cry from the best we know how to do, even with our limited knowledge about aging.

Once educators are convinced chronic illness exists along with other physical, social, and psychological consequences of aging, then we can recognize strengths and the durability of the human organism to cope.

Monsignor Charles Fahey, chairman of the Federal Council on Aging (an advisory committee to the President) outlines some philosophical values and assumptions about the older person "at risk" (those with, or potential for, chronic illness) for

long-term care. I'll simply outline these 11 points for you:

1) At the heart of long-term care is the person at risk. Programs should be designed to work collaboratively as long-term care continues.
2) A condition or chronic illness is usually present.
3) In addressing long-term care, one is talking about functional ability, not diagnosis.
4) The normal caring system is informal (family, neighbors, etc.). This calls for a differentiation of professionals.
5) A national strategy for social support is needed.
6) Highly professional groups need to recognize what we want the voluntary effort to be.
7) There need to be more creative ways of using Titles XVI-XX of the Social Security Act.
8) There is a need for an evolution of local community systems that are not income-related.
9) Long-term care should include at least three fundamentals:
   assessment (to include psychosocial assessment and be continuous),
   case management,
   triggering of all eligibility.
10) The leadership or focal point in the community should be the:
   oversight of funds,
   understand needs,
   appropriateness of services.
11) We need to make some assumptions about cost and who should bear it. This assumption includes the need to explore cost implications of using social and informal support systems. Also, we must address more systematically the moral and ethical responsibility of cost.

COSTS OF LONG-TERM CARE

The second trend which greatly influences the professional we educate and prepare to care for the old is the impact of today's economic forces. At the same time that the number of elderly requiring health care and long-term care is escalating, costs for providing that care are skyrocketing. Some factors underscore this point:

Nursing home expenditures increased from $1.3 billion in 1965 to $7.3 billion in 1973 and to $17.9 billion in 1979.

By 1990, nursing home costs are estimated to reach $76 billion if present programs and policies continue.

Costs for long-term care doubled from 1975 to 1980 and will more than double from 1980 to 1985.

In a nutshell, government may have reached the limit in its ability to absorb increasing long-term care costs at the same time the population expected to need continuing care is growing.

At present, government is looking at alternative ways for paying for that care, not necessarily different ways for providing care.

Among the options the Administration is considering is one that would give vouchers to each enrollee equal to the average annual Medicare benefit adjusted for age, health, and other personal characteristics. The vouchers would be used to purchase coverage from competing private health insurers.

The voucher scheme is a key element in the Administration's broader plan for introducing competition into the health care market and curbing escalating costs through private initiative rather than government regulation.

By putting a cap, in effect, on federal funds for Medicare beneficiaries while simultaneously encouraging competition for each beneficiary's health care dollar, the government expects to save $100 million in the first year of this plan and $7 billion over the first five years.

How well would nursing compete in this market? How well would older adults fare in obtaining comprehensive services?

A second issue having an impact on the costs of providing health care for older adults that directly affects nursing is the expanding supply of physicians. It is expected that we will witness a 40 percent increase in the number of physicians between 1980 and 1990. Opinions are divided about the impact this trend will have. Logically, one might think that, as the number of physicians increases, they will compete for patients, and,

therefore, costs will decrease. More realistic, however, is the fact that physicians will simply think of more things to do.

In a study conducted by Dr. Karen Davis, she concluded that in areas where there were more physicians, there was a greater use of services, Medicare use was higher, and the rates charged by physicians were not lower.

The significance of this issue is observable in other countries already experiencing an overabundance of physicians. In Mexico, for example, physicians are moving into high-level management and administrative positions previously held by nurses. To date, physicians have failed to show an interest in caring for older adults with any particular recognition in specialty or practice. Gerontological and geriatric nursing is one area where the latter statement may be in our favor.

These are just two issues which indicate the economic forces which will bear on providing health care for a growing older population. One can be assured health care policy for the elderly will be carried out in the general economic and budget context for this decade--in other words, reduced federal spending, fewer regulatory controls, and little to no expansion of health care services.

PREPARATION OF HEALTH CARE PROVIDERS

Future needs for nursing personnel to care for older adults will be influenced by successes (and failures) of previous trends in nursing education and manpower development programs. Some of the more specific issues and concerns that nurse educators have to evaluate are:

1) Perhaps the greatest problem we in nursing education have had to face is that of quality and quantity of nurses prepared in the care of older adults. While the actual number of nurses needed to meet today's health services requirements is the subject of great controversy, the fact remains that the supply of new graduates, in general, has declined. Assuming the current demographic trends of an aging population will continue, in a field where a shortage of personnel

already exists, an increase in the demand for nurses prepared in gerontology will only continue.

2) Problems remain in placement and levels of gerontology content in nursing education curricula. Few programs have carefully designed content and experience for nursing education in gerontology based on scientific rationale and conceptualized into a theoretical framework for the total program. A major obstacle in curriculum development is the inadequate preparation of nurse educators in gerontology.

3) There has been little or no promotion of gerontological nursing as a career choice for recent graduates and nurses seeking advanced preparation. Despite the heightened attention given to gerontology as a distinct field of study, older adults and their health needs are not afforded high status or priority by society. Research findings assert that improving job conditions, hours, and wages will not induce health professionals to work with older adults. Therefore, many believe positive attitudes toward older adults' health services are best attainable through educational programs.

These issues in educational preparation of nurses are discussed in greater detail in a forthcoming publication I helped prepare for the American Nurses' Association Gerontological Division.

The profession, with nurse educators as some of its leaders, has the responsibility to see that gerontological nursing is promoted at all levels of nursing educational preparation. As educational programs are promoted by the profession, future generations will realize a greater appreciation in public and professional circles of the value of gerontological knowledge to good health throughout the lifespan.

Chronic illness and poor nursing home care will be euphemisms of past health care services for the elderly. Gerontological nursing will have come of age.