Editorial: Educational Gerontology – A Sleeping Giant Awakened

In 1989 an Educational Gerontology Interest Group was formed within the Canadian Association on Gerontology (CAG). By 1990 more than 140 members of CAG had identified with the Group and 17 papers were presented (Thornton, 1992). The interest group thrived and in 1996 the Board of CAG approved the formation of a Division of Educational Gerontology.

In 1991 the National Advisory Council on Aging (NACA) published the NACA position on gerontology education. This contained 15 recommendations and highlighted service provision in the present system. NACA's recommendations included a focus on personnel needs and program development, specifically human resource projections, a national inventory of gerontology instruction, guidelines for program development, faculty development and strategies to promote student interest. There has been progress. Nationally CAG has prepared an inventory of gerontology programs (Canadian Association on Gerontology, 1994). Initiatives connected with the Educational Centre for Aging and Health in Ontario have led to the issuance of curriculum guidelines in dentistry, social work, nursing, rehabilitation science, and medicine (Ontario University Coalition for Education in Health Care of the Elderly, 1993).

The NACA document also encouraged continuing education for all staff whose duties have a significant impact on the lives of seniors. It notes the need for ingenuity to meet the special circumstances of service providers in the workplace. Perhaps the message is getting through that full-day workshops off-site may not be a good fit with today's funding practices.

NACA recommended that education adopt multidisciplinary perspectives, a view now widely accepted, at least in theory. It also recommended that education in Canada address the ethnocultural diversity of seniors and their families, a dimension known in the United States as ethnogeriatrics. It suggested that training in gerontology be recognized by employers and that government and the private sector support the development of education in the field of aging. Finally, it recommended programs to assist formal service providers in responding to the needs of informal caregivers and underlined the importance of advocacy by seniors.

In 1992 Jim Thornton proposed a taxonomy for educational gerontology in Canada. Building on Peterson's (1980) work, Thornton argued that educational gerontology in Canada was composed of Senior Adult Education, concerned with the teaching and instruction of older adults; Gerontology Education, concerned with the teaching and instruction of youth and the non-specialist public; Academic Gerontology, concerned with teaching

instruction and training toward certification or specialization. The schema partitions educational gerontology into categories that distinguish more carefully between the audiences or learners. Like Peterson, Thornton separates study and research from practice. Although this editorial will focus on Academic Gerontology, especially as it relates to health professionals, it is important to recognize the whole broad field and to welcome all three groups in CAG. Parenthetically, Thornton warned about the potential distortion of the gerontology knowledge base to predominantly health issues. Thornton's contribution clarified thinking about the breadth of educational gerontology and emphasized the need for an adult education approach.

In 1995 the Bureau of Health Professions of the (U.S.) Health Resources and Services Administration released *A National Agenda for Geriatric Education: White Papers*, (Klein, 1995) and a year later a companion volume reporting on a national forum that reported on discussion of the white papers (Klein, 1996). Senior administrators in the U.S. Public Health Service called geriatric education a "sleeping giant". The White Papers represent a considerable advance practically and conceptually. Practically they list actions required, responsible agents and expected outcomes, often with time lines. Conceptually they elaborate a systems approach with greater precision than the NACA document and they bring together generic topics with discipline specific recommendations. They cover generic topics such as managed care, long-term care, case management, interdisciplinary education and ethnogeriatrics. They also provide five discipline specific reports, dentistry, medicine, nursing, public health and social work. A less focussed chapter deals with the more than 200 allied and associated health professions that make up 60 per cent of the health care workforce.

Since academic gerontology involves both study (which includes teaching and research) and service, continuing effort is needed in each. From the perspective of study we need to attract students initially by making them aware of learning opportunities, making employment attractive and requiring or rewarding additional qualifications as NACA recommended. We need to make the educational experience as stimulating as possible by adequate faculty preparation and recruitment. This is part of the blueprint set out in the NACA position paper.

Educational gerontology has important spinoffs for professional education beyond the field of aging. Its focus on multidisciplinary teamwork taught in multidisciplinary settings and its attention to ethnocultural diversities need to be major themes in professional education in any Canadian post secondary institution.

Neither the NACA position paper nor the U.S. White Papers deal with the effect that values have on professional behaviour, teamwork, and institutional procedure. We need to consider the way values influence the way professionals relate to each other and to clients. Clark (1996) has pointed out that values differ among professions. He argues that medicine

embraces scientific and humanistic values. Nurses value human dignity, and social workers advocacy and empowerment. While this formulation is an oversimplification that does not do full justice to Clark's position it does illustrate the challenge of interdisciplinary education since professions may not honour the values of other professions. On the other hand, the blend of values in a team may produce a more powerful intervention than any profession acting alone. Learning to work together remains a major challenge for educational gerontology.

Beyond individual and professional values, educational gerontology must embrace a new vision of long-term care. First we need to adopt the health promotion definition of health and apply it to older persons. In somewhat abbreviated form, the definition states: health is a resource for living to assist individuals to achieve their aspirations and cope with or change their environment. Too often we focus on assisting with coping to the detriment of enabling people to achieve their aspirations or to change their environment.

Second, as Lidz and colleagues (1992) have argued, we need to separate the medical care function from the residential function in nursing homes and elsewhere in long-term care. We need to abolish the idea that elderly people who are in some way disabled are full-time patients and should follow caregivers' orders full-time. They have suggested that the hospital model of long-term care be replaced by a hospitality model.

Third, we need to create a culture or climate within service institutions not traditionally involved in education to support learning. French (1995) has suggested that the culture of academia, which encourages questioning authority, promotes change and innovation and fosters theorizing, may clash with a culture of service that may value practice over theory and experience over innovation. What is needed is a third culture that is a fusion of, or is at least tolerant of, both perspectives.

Once embarked on this ambitious program of reform, Educational Gerontology needs to look to its own sustainability. This involves a careful analysis of the policy and legislative framework, the institutional framework, technical, financial and infrastructural resources, and human resources (Shahi, Hartvelt, & Sacks, 1997). These clearly apply to the development of sustainable educational programs in aging. The White Papers do a remarkably good job in this regard.

Educational Gerontology is awakening and is ready to move. The three branches of the field will be strengthened by working together. Educating seniors, educating the general public about seniors and educating professionals to understand aging in sickness and in health, taken together, will assist in maintaining and developing the educational programs related to aging that our society should have.

References

Canadian Association on Gerontology. (1994). Programs and courses in gerontology and geriatrics in post-secondary institutions in Canada. Ottawa, ON: Canadian Association on Gerontology.

Clark, P.G. (1996). Diversity in heath care professional socialization: Implications for geriatric education in interdisciplinary teamwork. Paper presented at the 22nd annual meeting of the Association for Gerontology in Higher Education, Philadephia, PA.

French, S.E. (1995). Creating a CTU Culture. *News from the CTU's*. Hamilton, ON: Interdisciplinary Aging and Health Program, McMaster University.

Klein, S.N. (Ed.). (1995). *A national agenda for geriatric education: White papers*. Rockville, MD: Bureau of Health Professions, Interdisciplinary Geriatrics and Allied Heath Branch.

Klein, S.M. (Ed.). (1996). *A national agenda for geriatric education: Forum report*. Rockville, MD: Bureau of Heath Professions, Interdisciplinary, Geriatrics and Allied Health Branch.

Lidz, C.W., Fisher, L.I., & Arnod, R.M. (1992). T*he erosion of autonomy in long term care*. New York: Oxford University Press.

National Advisory Council on Aging. (1991). *The NACA position on gerontology education*. Ottawa, ON: Minister of Supply and Services Canada (Cat. No. H71-212-11-1991).

Ontario University Coalition for Education in Health Care of the Eldery. (1993). *Educational development and curriculum content in aging and health: Guidelines for health professionals in Ontario*. Hamilton, ON: McMaster University, Educational Centre for Aging and Health.

Peterson, D.A. (1980). Who are the educational gerontologists? *Educational Gerontology*, *5*, 311–323.

Shahi, G.S., Hartvelt, F., & Sacks, M. (1997). Realizing sustainable public health: Implications for public health training. In G.S. Shahi, B.S. Levy, A. Binger, T. Kjellstrom, & R. Lawrence (Eds.), *International perspectives on environment, development and health: towards a sustainable world* (pp. 697–716). New York: Springer Publishing Company.

Thornton, J.E. (1992). Educational gerontology in Canada. *Educational Gerontology*, *18*, 415–441.

Alexander Macpherson