Effectiveness of a Geriatric Medical Student Scholars Program: A Qualitative Assessment

Linda M. Goldenhar, PhD, and John R. Kues, PhD

In 2003, the University of Cincinnati College of Medicine initiated a 4-year Geriatric Medical Student Scholars (GMSS) program in which a selected group of 14 medical students participated in a variety of extracurricular geriatrics-related activities such as one-on-one mentoring and discussion groups. These students were also required to compose journal entries describing GMSS program-related activities using a semistructured on-line computer program designed specifically for this purpose. The reflective journals, in combination with the American Geriatrics Society (AGS) competencies, were used to evaluate the degree to which the GMSS program achieved its goal of enhancing students’ understanding of the complex health and social challenges facing older adults. Using a confirmatory qualitative analysis strategy, the AGS competencies served as an a priori codebook to evaluate the student journal entries. Of the original 53 AGS competencies identified as being relevant for a first- or second-year medical student, 74% were used at least one time, and only 26% were never used. These findings strongly suggest that the GMSS program successfully moved this group of first- and second-year medical students closer to at least understanding the content of many of the AGS competencies by providing them with geriatrics-related experiences and a geriatrics-related framework they could draw on when participating in curricular and extracurricular activities. The findings also point to the potential value of using reflective journaling as a tool for conducting process evaluation of medical education interventions. J Am Geriatr Soc 54:527–534, 2006.

Key words: journaling; AGS competencies; medical students

Medical educators and researchers have written about how important it is to expose medical students to geriatrics curricula early in their medical training. The reasons they have suggested doing this include that incoming medical students tend to have less-than-positive attitudes toward older people, the rapidly aging population will require more geriatrics-focused health care, and current medical graduates are not being adequately prepared to provide the care needed by the aging population. Medical schools, sometimes with the support of funding organizations, have responded to this need by developing geriatrics-focused curricula. Research findings suggest that geriatrics-related educational interventions can improve student attitudes toward, and comfort working with, elderly persons and increasing students’ willingness to care for geriatric patients in their future practices.

In 2003, the Geriatrics Division of the University of Cincinnati College of Medicine began the implementation and evaluation phases of a 4-year longitudinal geriatrics education program for medical students called the Geriatric Medical Student Scholars (GMSS) program. The goal of the GMSS program is to expose a self-identified and selected group of medical students to a variety of extracurricular didactic and especially clinical activities designed to enhance their understanding of the complex health and social challenges facing older adults.

The American Geriatrics Society (AGS) medical student competencies provided the framework for developing and evaluating the effectiveness of the GMSS program’s educational activities. The teaching methods used to deliver the content are based primarily on the principles of adult learning theory and include role modeling/mentoring, active and self-directed learning, and reflective journaling. Qualitative analysis of students’ journal entries allowed the research question “Do students’ written reflections about their geriatrics experiences in the GMSS program correspond to the AGS competencies?” to be explored.

METHODS

Student Recruitment

At the beginning of the 2003/04 academic year, students were recruited to the GMSS program after they had the opportunity to interview an elderly person during orientation week, as well as via an e-mail campaign and
during an activities fair. Interested students attended a meeting to hear more about the GMSS program. Those still interested completed applications, which the GMSS faculty reviewed. Eight entering freshman students and six second-year students were selected to participate (5% and 4% of each class, respectively). Over the course of the academic year, one student dropped out of the program.

Mentoring
Given that mentoring has been shown to be a powerful way for people to learn personal and professional skills, the most important teaching/learning activity of the GMSS program was to establish a mentoring relationship between a GMS scholar and a geriatric medicine faculty member. The GMSS mentors received training on ways to help their mentee understand the realities of providing care to older people, interpret their experiences, and learn how to use what they learned in the program to improve their ability to provide competent health care to their elderly patients.

Learning Opportunities
The scholars attended monthly AGS student chapter meetings at which topics were presented by, and discussed with, geriatrics experts. Topics included end-of-life ethical and legal considerations, hospital–nursing home interface, personal experiences of aging, and a panel discussion by four residents of a retirement community. There were also special dinners at which experts presented on a variety of topics. Finally, scholars were expected to attend GMSS group meetings, where they discussed with their peers and the GMSS coordinators their progress, in and thoughts about, the GMSS program.

Reflective Journaling
Reflective journaling is an integral tool in adult education and has been regularly used in nursing education to help students reflect on the meaning of experiences and events they encounter during their training and to become critical thinkers. Documented benefits include a better ability to define and articulate clinical experiences and to be able to release any related emotions, observe and record clinical experiences, empathize with patients, and connect theory to clinical practice. The use of reflective journaling in medical education appears to be quite limited. One study used reflective journaling (and reflection groups) with second-year medical students to foster self-awareness and emotional development related to early clinical experiences. In addition, for the past 20 years, residents’ experiences and struggles while rotating through a medical intensive care unit were coded competencies and the number of times the two coders agreed that a passage should be coded but disagreed about which code(s) to use. The two reviewers spent approximately 20 hours each individually reading and coding the transcripts and approximately 10 additional hours (five 2-hour sessions) meeting to discuss coding convergences and discrepancies.

RESULTS
Descriptive quantitative findings pertaining to characteristics of the journal entries and examples of coded passages illustrating how participating in the GMSS program enhanced students’ geriatrics-related knowledge and attitudes are presented.

Journal Entries
The journal entries varied widely in content and focus. Of the 98 student journal entries, 50% focused on aging-related curricular activities (30 entries) or aging-related extracurricular activities (30 entries). Forty-four percent of the entries were distributed across aging-related personal experiences with older family members or friends (19 entries), general thoughts/ideas/relations related to aging (15 entries), aging-related interest areas (8 entries), and other (6 entries).

AGS Competencies
Of the original 53 AGS first- or second-year relevant competencies, 39 (74%) were used to code student journal entries at least one time. Table 1 includes a listing of the coded competencies and the number of times the two coders
Table 1. Coding Consistencies Between the Two Investigator/Coders

<table>
<thead>
<tr>
<th>American Geriatrics Society Competencies Used as Codes</th>
<th>Coder 1</th>
<th>Coder 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Awareness of the various myths and stereotypes related to older people</td>
<td>4</td>
<td>3</td>
</tr>
<tr>
<td>Recognition that ageism, like racism, affects all levels and aspects of society, including health professionals and can adversely affect optimal care of elderly patients</td>
<td>6</td>
<td>5</td>
</tr>
<tr>
<td>Recognition of the heterogeneity of older persons—a diverse group with different personalities, values, functional levels, and medical illnesses; each person needs to be viewed as an individual regardless of chronological age and to be cared for in a unique fashion</td>
<td>8</td>
<td>11</td>
</tr>
<tr>
<td>Self-awareness of the students' personal attitudes toward their own aging, disability, and death</td>
<td>6</td>
<td>7</td>
</tr>
<tr>
<td>Compassion and understanding attitude on the part of the physician for care givers of frail older people and the difficulties they face</td>
<td>6</td>
<td>5</td>
</tr>
<tr>
<td>An appreciation of the need for improving and optimizing function for older people rather than just focusing on diseases</td>
<td>7</td>
<td>1</td>
</tr>
<tr>
<td>Knowledge related to basic science</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Demography and epidemiology of aging, including the growth in numbers of older people and heterogeneity of the older population</td>
<td>2</td>
<td>0</td>
</tr>
<tr>
<td>Theories of aging including biochemical/molecular, cellular, genetic, and biopsychosocial</td>
<td>3</td>
<td>1</td>
</tr>
<tr>
<td>“Normal” aging versus diseases at the molecular, cellular, tissue, and organism levels</td>
<td>3</td>
<td>2</td>
</tr>
<tr>
<td>Loss of homeostatic control mechanisms may account for much of the aging process</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>Anatomic and histological changes associated with aging</td>
<td>3</td>
<td>2</td>
</tr>
<tr>
<td>Pathology associated with normal aging and age-associated disease processes</td>
<td>3</td>
<td>1</td>
</tr>
<tr>
<td>Physiology of aging in various organ systems</td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td>Pharmacological changes in aging</td>
<td>4</td>
<td>6</td>
</tr>
<tr>
<td>Knowledge related to clinical practice</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Geriatric syndromes and conditions; a basic understanding of risk factors, causes, symptoms, signs, differential diagnosis, initial diagnostic evaluation, and preventive strategies</td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td>Knowledge of diseases and disorders that are more common or have particular features in older people; a “broad” knowledge of pathophysiology, presenting symptoms and signs, differential diagnosis, and initial diagnostic evaluation for common diseases older people</td>
<td>6</td>
<td>6</td>
</tr>
<tr>
<td>Knowledge of psychosocial issues: identification, presenting symptoms and signs, and appropriate referral of common psychosocial problems and issues</td>
<td>6</td>
<td>5</td>
</tr>
<tr>
<td>Normal behavioral late-life changes, including retirement</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td>Psychopathology, including affective disorders, psychotic disorders, anxiety disorders, responses to medical illness, depression, and substance abuse</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Sexuality and aging</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>Home safety</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Community resources, including those used to prevent institutionalization</td>
<td>4</td>
<td>3</td>
</tr>
<tr>
<td>Adaptation to care in alternative living situations, including long-term care facilities</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Knowledge of prevention</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Primary prevention strategies</td>
<td>6</td>
<td>7</td>
</tr>
<tr>
<td>Secondary prevention, with age-appropriate screening for diseases and identification of geriatric syndromes</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>Tertiary prevention strategies</td>
<td>2</td>
<td>0</td>
</tr>
<tr>
<td>Knowledge of ethical issues in geriatric care</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Advance directives</td>
<td>4</td>
<td>3</td>
</tr>
<tr>
<td>Decision-making capacity</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Euthanasia, assisted suicide</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Healthcare rationing</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>End-of-life care</td>
<td>7</td>
<td>7</td>
</tr>
<tr>
<td>Healthcare Financing</td>
<td>5</td>
<td>1</td>
</tr>
<tr>
<td>Mechanisms and Implications (Medicare, Medicaid, managed care, capitation)</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>Cultural aspects of aging— influence of culture and ethnicity on the aging process, health and disease perception, and access to medical care</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>The components of providing culturally competent medical care</td>
<td>3</td>
<td>0</td>
</tr>
</tbody>
</table>
identified each. The calculated kappa statistic of 0.63 ($P < .001$) indicates a strong level of agreement between the two coders across the 53 competencies.²⁹ There were nine instances in which one investigator used a competency as a code at least once, but the other did not use it all. There were four instances when one of the investigators used a code three or more times as often as the other investigator.

Both coders used eight of the 39 AGS competencies most frequently. Four are attitudinal, and four relate to clinical science knowledge: recognition of the heterogeneity of older persons—a diverse group with different personalities, different values, different functional levels, and different medical illnesses; end-of-life care; self-awareness of the students’ personal attitudes toward their own aging, disability, and death; primary prevention strategies; knowledge of diseases and disorders that are more common or have particular features in older people; recognition that ageism, like racism, affects all levels and aspects of society, including health professions, and can adversely affect optimal care of elderly patients; compassion and understanding attitude on the part of the physician for caregivers of the frail elderly and the difficulties they face; and knowledge of psychosocial issues—identification, presenting symptoms and signs, and appropriate referral of common psychosocial problems and issues.

More than one quarter of the competencies ($n = 14$) were not used as a code by either investigator (Appendix 3). None of the competencies related to clinical skills were found in the students’ journal entries. This is likely because the students were in their preclinical years of training, although several competencies pertaining to the demographics of the elderly population were also not used.

Emerging Themes

The two coders (LG and JK) identified codable passages in the transcripts for which there was no code in the codebook (the AGS competencies). After deliberating over the meaning of those passages, they agreed that they reflected students’ attitudes toward becoming physicians and working with older patients. Thus, a new competency code was created and labeled: self-awareness of what doctoring (specifically being a geriatrician) is about—responsibilities, limitations, etc. Twenty-six data elements were coded with this new attitudinal competency.

Illustrative Quotations

The following quotations illustrate the effect that the GMSS program had on the scholars’ progress toward attaining the AGS medical student competencies. They are divided into the three major AGS competency categories: attitudes, basic science knowledge, and clinical science knowledge.

Attitudes

Although the students reflected on a number of attitudinal issues covered by the AGS competencies, the code most often used pertained to student recognition that older people were a heterogeneous group and that each person/patient should be viewed as an individual regardless of chronological age. The quotations below illustrate this recognition.

We saw a 94-year-old woman today who was surprisingly alert and articulate. . . . It served as a strong reminder that everyone ages differently and the life of a geriatrician is not all end-of-life cases and DNR cases.

It wasn’t what you’d expect. . . . The elderly person was still leading a full life and could expect to live more full years. The young person was fighting for her life, and the same time period will probably be much more limited for her. . . . The take-home message is that to be elderly is not necessarily to be frail, to be at death’s door. . . . By seeing this fairly “healthy” elderly patient will help me keep that in mind in the future.

The following quotations illustrate the attitude of “self-awareness of what doctoring is about (particularly being a geriatrician),” the new competency that emerged from the data (i.e., not one of the original AGS competencies).

As we age, we start to appreciate a slower-paced lifestyle. It strikes me how in contrast that is with the working style of most physicians. Doctors buzz into the examining room, speak a mile a minute, fill out some prescription, and shove the patient out the door. It makes me wonder how any patient, and especially elderly patients, feel satisfied from the physician experience and, more importantly, what they actually learn about their health. . . .

When a doctor does a home visit, he/she can learn more/different information than can be obtained from a regular appointment in the office. For example, a physician can ask to see the patient’s medications or to see what kind of lifestyle the patient leads. . . . This would include diet, support system, hygiene, etc.

Knowledge

The knowledge category includes basic and clinical science understanding. The GMSS program gave these students the opportunity to relate what they were learning in their basic science classes to geriatric medicine, as well as to bring knowledge gained during mentored-clinical experiences back to the classroom.

Basic Science Knowledge

Now that I have become more reflective on geriatric issues, the discussions of age-related changes in anatomy and physiology become more pertinent to me. I have become more attentive to these details, rather than glossing over them under the weight of material to be learned.

Dr. ——— discussed some of the physiological changes of aging: decreased sensations, such as taste, sight, and smell; decreased acidity in the stomach with decreased intestinal motility, decreased insulin production, etc. These physiological changes led to certain diseases like periodontal disease, emotional distress, decreased organ function and many more.

Clinical Science Knowledge

My mentor’s favorite example, . . . a person may present with urinary tract infection and have no complaints of dysuria or other
DISCUSSION
Evaluating the degree to which students achieve acceptable levels of knowledge and skills needed to become competent physicians is an integral aspect of medical education and most often focuses on student achievement in required courses and clinical rotations. It rarely examines learning that takes place during unstructured extracurricular experiences like the GMSS program. Extracurricular activities such as this program provide students with the opportunity to learn about aspects of doctoring including professionalism, cultural competency, healthcare ethics, and doctor–patient communication—constructs that are much more difficult to assess. In this study, reflective journaling was used as an evaluative way to capture this type of learning. Its use in undergraduate medical education has been limited, and student journal entries have never been linked with professional competencies.

The fact that 74% of the AGS competencies were used to code the students’ journal entries strongly indicates that the GMSS program was successful in its goal of getting the GMSS program participants to become aware of and perhaps understand the intent of many of the AGS competencies. It did this directly by providing them with geriatrics-related clinical and didactic experiences and indirectly by providing them with a geriatrics-related framework they could use when participating in other curricular and extracurricular activities. For most of the scholars, the GMSS program provided them with their first contact with elderly patients. They came to the clinical encounter with their own set of beliefs and biases regarding older people, and as evidenced in the journals, many were surprised, in a positive way, by what they saw. Although it has not been measured as an outcome, it will be important to determine whether these experiences enhance students’ willingness to care for geriatric patients in their future practices, as has been observed in other studies.15,16

The journaling data analyzed identified a number of AGS competencies that were not discussed in the student scholars’ journals. For example, as noted earlier, neither investigator used any of the skill-based AGS competencies to code the journal passages. Indeed, there is no way to determine whether the lack of journal entries related to these competencies reflects a deficit in the GMSS program or the curriculum in, but this information gives faculty some useful information for future content development for medical students.

Journaling may be an educational intervention itself, because it provides students the opportunity to take time to reflect on their educational experiences. It is possible that the intensity of the medical school curriculum affords students little time to process what they have learned or to reflect on how the knowledge, attitudes, and skills gained might be integrated into their professional and personal lives. It was apparent in many of the journal entries that students used the opportunity to reflect on how particular experiences might be incorporated into their future careers as physicians.

Finally, traditional deductive qualitative methods would dictate that coders review the journal transcripts and allow codes (themes) to emerge from the data rather than imposing predetermined codes, but because the purpose of this study was to evaluate the extent to which students were reflecting AGS competencies in their writings, it was decided that using the AGS competencies as the primary codebook was the best approach. It was not possible to adequately code a number of the student reflections using the AGS competencies, and a new code needed to be added to the codebook. This new code, which pertained to students’ thoughts and attitudes about becoming physicians and caring for patients, reflected the most common theme for all 12 students. The findings from a previous study24 corroborate this finding, albeit with a twist; it found that one of the three areas of stress identified by second-year medical students pertained to the role and responsibility of the physician. In both cases, the findings could be taken as an indication that educational strategies like mentoring and one-on-one precepting with experienced clinicians help medical students learn about professionalism and ethics, topics that are much more difficult to teach using traditional classroom methods.

CONCLUSION
The findings reported here indicate that the GMSS program is a feasible educational intervention and may help to enhance the medical student’s understanding of the complex health and social challenges facing older adults. In addition, the findings also indicate that student reflections about their educational experiences in the GMSS program correspond to the content areas of many of the AGS competencies. These students chose to participate in the GMSS program, because they had some level of interest in the health needs of the elderly population. Had all of the students in the class been required to journal about any or all of their clinical experiences, it is likely that the analysis of their entries would not necessarily address the content of the AGS competencies—at least not to the extent found here. In conclusion, this study points to the potential value of using reflective journaling as a tool to evaluate medical education interventions. This will require validation in future studies.

ACKNOWLEDGMENTS
We wish to thank Dr. Gordon Margolin, Ms. Elizabeth Gothelf, Dr. Gregg Warshaw, and all the GMSS faculty mentors and students for their coordination of and participation in the GMSS program. Their dedication to geriatrics and medical student education allowed these student scholars to learn and grow in ways that would not otherwise have been possible.

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Author Contributions: Linda M. Goldenhar: as evaluator on the GMSS project, conceptualized using reflective journaling and using AGS competencies to evaluate the GMSS program; designed journal entry program and explained the process to the students, and informed them as to
when their entries were due; and conducted confirmatory qualitative analysis on journal entries; and worked with Dr. Kues interpreting the results and preparing the manuscript. John R. Kues: conducted confirmatory qualitative analysis on journal entries, worked with Dr. Goldenhar interpreting the results and preparing the manuscript.

**Sponsor’s Role:** The sponsor had no role in the design, methods, subject recruitment, data collection, analysis or preparation of this manuscript.

**REFERENCES**


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**Appendix 1. Structure of the On-Line Journaling Program**

Below are five broadly defined areas designed to help you focus your journal entries. We do not expect that you will necessarily write in all five areas each time you make a journal entry, **BUT YOU MIGHT!**

As you write in each area, rather than simply reporting events, please reflect on:

- **Any specific knowledge** you gained with respect to aging and caring for aging patients.
- **Any skills** you obtained that will be useful for caring for aging patients.
- **How the activity or experience affected you** and your **attitudes** toward aging and caring for aging patients.

The five areas are:

1. **Aging-related extracurricular activities** (either with your mentor, other mentors, other GMSS or non-GMSS students).
2. **Aging-related curricular activities** (course lectures, questions you or others asked in class, any clinical experiences).
3. **Aging-related interest areas** (things you learned from Fast Facts or other materials, research questions you might want to pursue or ask about).
4. **Aging-related personal experiences** with older family members or friends.
5. **General thoughts/ideas/reflections** related to aging.
Appendix 2. Code Book Containing American Geriatrics Society Competencies Relevant for Year 1 and 2 Medical Students

I. Attitudes
   A. Awareness of the various myths and stereotypes related to older people.
   B. Recognition that ageism, like racism, affects all levels and aspects of society, including health professionals, and can adversely affect optimal care of elderly patients.
   C. Recognition of the heterogeneity of older persons—a diverse group with different personalities, values, functional levels, and medical illnesses. Thus, each person needs to be viewed as an individual regardless of chronological age and to be cared for in a unique fashion.
   D. Openness and willingness to work with other disciplines in caring for older patients (more appropriate for Year 3 and 4 students).
   E. Self-awareness of the students’ personal attitudes toward their own aging, disability, and death.
   F. Compassion and understanding attitude on the part of the physician for caregivers of frail older people and the difficulties they face.
   G. An appreciation of the need for improving and optimizing function for older people, rather than just focusing on diseases.
   H. Self-awareness of what doctoring (specifically being a geriatrician) is about—responsibilities, limitations.

II. Knowledge
   A. Related to basic sciences
      1. Demography and epidemiology of aging, including the growth in numbers of older people and heterogeneity of the older population.
      2. Theories of aging, including biochemical/molecular, cellular, genetic, and biopsychosocial.
      3. “Normal” aging versus diseases at the molecular, cellular, tissue, and organism levels. “Normal” aging is heterogeneous, affecting different tissues and organs in different individuals at different rates.
      4. Practicing physicians need to identify preventable, reversible, and treatable aging processes and manage them accordingly.
      5. Loss of homeostatic control mechanisms may account for much of the aging process.
      6. Anatomic and histological changes associated with aging.
      7. Pathology associated with normal aging and age-associated disease processes.
      8. Physiology of aging in various organ systems.
      9. Pharmacological changes in aging and relevance to therapeutic decisions.
   B. Related to clinical practice
      1. Geriatric syndromes and conditions. Students should be familiar with common geriatric syndromes and conditions and have a basic understanding of risk factors, causes, symptoms, signs, differential diagnosis, initial diagnostic evaluation, and preventive strategies.
      2. Knowledge of diseases and disorders that are more common or have particular features in older people. Although students’ individual clinical experiences may provide greater or lesser exposure to these disorders, students should have at least “broad” knowledge of pathophysiology, presenting symptoms and signs, differential diagnosis, and initial diagnostic evaluation for common diseases older people.
      3. Knowledge of psychosocial issues. Students should be familiar with identification, presenting symptoms and signs, and appropriate referral of common psychosocial problems and issues.
         a) Normal behavioral late-life changes, including retirement
         b) Psychopathology, including affective disorders, psychotic disorders, anxiety disorders, responses to medical illness, depression, and substance abuse
         c) Underreporting of symptoms and illnesses
         d) Sexuality and aging
         e) Elder abuse and neglect
         f) Suicide
         g) Home safety
         h) Community resources, including those used to prevent institutionalization
         i) Adaptation to care in alternative living situations, including long-term care facilities
      4. Knowledge of prevention
         a) Primary prevention (e.g., exercise, nutrition, and psychosocial interventions designed to maximize function to allow independent living)
         b) Secondary prevention with age-appropriate screening for diseases and identification of geriatric syndromes
         c) Tertiary prevention strategies (e.g., rehabilitation and chemoprophylaxis in the postmyocardial infarction patient)
      5. Knowledge of ethical issues in geriatric care
         a) Advance directives
         b) Decision-making capacity
         c) Euthanasia, assisted suicide
         d) Healthcare rationing
         e) Pain management
         f) End-of-life care

(Continued)
Appendix 2. (Contd.)

6. Healthcare financing
   a) Mechanisms and implications (Medicare, Medicaid, managed care, capitation)

7. Cultural aspects of aging. Students should be familiar with the influence of culture and ethnicity on the aging process, health and disease perception, and access to medical care, with emphasis on:
   a) Demography of ethnic older people in the United States
   b) The heterogeneity of the federally designated minority elder groups
   c) Risk factors and disease prevalence in these older people
   d) The components of providing culturally competent medical care

III. Skills
   A. Basic history taking
      1. Students should be competent in performing the basic elements of geriatric assessment, with standardized methods for assessing physical, cognitive, emotional and social functioning as appropriate. Specific examples include screening examinations for mental status, geriatric depression, and functional status, including activities of daily living and instrumental activities of daily living.

Appendix 3. American Geriatrics Society Competencies Not Used as a Code

Attitudes
   Openness and willingness to work with other disciplines in caring for older patients

Knowledge (general)
   “Normal” aging is heterogeneous, affecting different tissues and organs in different individuals at different rates
   Practicing physicians need to identify preventable, reversible, and treatable aging processes and manage them accordingly
   Underreporting of symptoms and illnesses
   Elder abuse and neglect
   Suicide
   Pain management
   Demography of ethnic older people in the United States
   The heterogeneity of the federally designated minority elder groups
   Risk factors and disease prevalence in these older people

Clinical skills
   Basic history taking
   Students should be competent performing the basic elements of geriatric assessment with standardized methods. Specific examples include screening exams for mental status, geriatric depression, and functional status, including activities of daily living