The influence of the constructs of ageing on gerontic nursing practice and education: Reviewing the past and suggesting the future

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TERMINOLOGY

As asserted by Lueckenotte (2000, p. 5), "[a]ny discussion of adult nursing is complicated by the existence of a wide variety of terms often used interchangeably to describe the specialty." My own personal preference lies with 'gerontic nursing', a term developed by Gunter and Estes in 1979 that is meant to be more inclusive than geriatric, gerontological or gerontologic nursing by not being limited to diseases or scientific principles (Leuckenotte, 2000). In my view, the term 'gerontic nursing' most precisely describes the unique art and science of caring holistically for elderly clients, and is particularly appropriate in a study that is concerned with the long-term care of older adults.

STATEMENT OF ORIGINALITY

This work has not previously been submitted for a degree or diploma in any university. To the best of my knowledge and belief, the thesis contains no material previously published or written by another person except where due reference is made in the thesis itself.

Jennifer Brooker

ABSTRACT

This narrative inquiry traces and recounts an epiphanic experience of a registered nurse on entering gerontic nursing, and her subsequent three-decade journey through the complexities and mazes of this nurse specialty. Such inquiry seeks to enable a better understanding of the realities of ageing and caring for older adults by opening up thinking and beliefs underpinning gerontic nursing work. Modern aged healthcare involves complex gerontic nursing actions, requiring highly skilled nursing personnel, but on the whole, gerontic nursing is dimly perceived and misunderstood by professional colleagues and the general public. Much of this misunderstanding is a legacy of an outdated ideology of gerontic nursing; yet these public beliefs, attitudes and interpretations are extremely powerful in determining aged care policy. As the population ages and more elderly people access healthcare services, society will be faced with an array of complex political and socioeconomic factors. This thesis aims to untangle such choices by pursuing the questions of: 'How have the constructs of ageing impacted on gerontic nursing practice and education?' 'What type of gerontic nurse will be required to provide future elderly care'? and 'How will these people be educationally prepared for their new roles?

Many of the constructs explored are dialectical in nature; that is, they have developed by inner conflict, the scheme of which is thesis and antithesis, or an original tendency and its opposing tendency. Such dialectical thinking has underpinned much of this thesis and in many instances, particularly in chapter 7, has taken the next step to the unification of these opposing tendencies; that is, synthesis, to create new understanding or meaning. Issues explored relate to: the ontology of ageing; the meaning of life; gerontophobia; Australia's changing population profile;

changing aged healthcare systems; gerontic nursing cultural dilemmas; workforce planning; elder health in the future and gerontic nursing practice and education shifts. In a theoretical and methodological context, increasing difficulty with conventional epistemologies and the science founded on them is leading nurse theorists ever nearer to a postmodernist position. Narrative becomes a means through which gerontic nursing can accumulate and express cultural knowledge and critique procedure. The thesis exemplifies narrative's profound potential for underpinning the reconceptualisation of gerontic nursing practice and education. It is narrative's capacity to foreground the relationship between daily practice and knowledge that makes it a critical tool for the future of gerontic nursing inquiry. Narrative facilitates the paradigm, or more ontological shift from the dominant medical model of aged healthcare and 'tender loving care' rhetoric, to a therapeutic, caring-healing approach which has been in the margins in gerontic nursing practice. In the context of gerontic nurse education, narrative pedagogy offers new ways of thinking even in the midst of oppressive practices. Many issues remain unresolved about how gerontic nurses can be educated for future gerontic nursing practice. It would seem that aged care in Australia is a site of such organisational and cultural change, it threatens to undermine knowledge, care and understanding and shift care to untrained staff. The thesis illustrates how such approaches cloak much of gerontic nursing practice and devalue the intimate work of caring intelligently, emotionally and physically for frail older adults.

However, while such tensions abound in gerontic nursing practice, the 21st century offers skilled gerontic nurses the opportunity to become key components in the refigured and redesigned aged healthcare delivery system. Research indicates that because few know enough about the sum of the future to impede well-constructed

attempts at engaging in any new model design, taking any action is infinitely better than none. It is on this premise that Chapter seven posits a new model design for residential long-term aged care for older adults, believing that by imagining a different future, it can then be created and become a reality.

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CHAPTER ONE - SETTING THE CONTEXT

INTRODUCTION

Reflection on practice

> At the beginning of the third millennium we are at the advent of a new time for ageing and health services. This will result in new roles for gerontic nurses and require reconceptualisation of gerontic nurse education to ensure an appropriately sized, distributed and educated aged healthcare workforce to provide the quality and range of services required. Gerontic nurses will play a dominant role in improving and transforming aged healthcare practice. However, barriers to change will be formidable due to competing demands driven by political, organisational and cultural change. As modern aged healthcare involves complex technologic and often unquantifiable nursing actions, gerontic nurses will need new skills and knowledge to learn how to live with uncertainty and have a strong vision for the future. Gerontic nursing practice will be seen to be a highly skilled, specialised activity, which unites practice, research and education in the indivisible whole of gerontic nursing praxis. It will be essential that the profession and society in general recognise these skills as essential and valued assets in a society where cure is finite. Knowledge will become the singular major value the gerontic nurse will bring to the workplace and that knowledge will become increasingly portable. It will need a systematic and planned approach to creating and responding to new models of client-driven care.

This reflective narrative represents my current stance on gerontic nursing practice and education based on over three decades of working in aged healthcare in many roles and environments. The major goal of this study is to provide a lens through which a new postmodernist theoretical story of ageing and healthcare can be facilitated. Postmodernism is not directly concerned with knowledge, but with power and political quests and the struggle to define and challenge the view of truth. It is important in the context of this thesis as healthcare systems of today

confront each and every one of the paradoxes characterising the postmodern world (Rolfe, 2000). While a postmodern position may be adopted to underpin gerontic nursing practice and education, postmodernism itself is undergoing evolutionary change; for example a move from the traditional 'classical' position to an 'ironist' position. This position accepts the view that knowledge is socially constructed and as such is contingent on the knower, but rejects the authoritarian method of science in favour of certain alternative methods (Rolfe 2000). The postmodern nurse views all paradigms, discourses and models of practice ironically. Parsons (1995) and Rolfe (2000) assert that such a postmodern position is of direct relevance to anyone who has to make decisions based on the best evidence and those who have misgivings about whose authority is invested in the nursing profession.

Highlighting the relationship between theory and practice in ageing, gerontic nursing practice and education, I seek to open up the thinking and beliefs that underpin much of gerontic nursing's work. Because I, like most other human beings, and in particular most other gerontic nurses, am a storyteller who leads a storied life and tells stories of my life, I choose narrative as biography and as a resource to create identity, establish coherence, continuity and emotionality, and to give meaning to my, and others' work as a gerontic nurse. I will tell my gerontic nursing story in the temporal context of my career spanning the three decades between 1973 and 2003. Additionally, because contemporary practices are historically embedded, I write about the history of the past of gerontic nursing practice and education in terms of the history of the present and future. My stance is supported by eminent gerontology practitioners and theorists such as Baltes (1997), Bengston and Schaie (1999) and Birren (1959, 1999), who have

stated that autobiographies of gerontologists and others who work with elderly clients can be analysed to contribute to a better understanding of both ageing and theories of ageing. These writers further argue that given the existential-ontological nature of such life stories, it becomes imperative to investigate how these have constructed gerontology and gerontic nursing.

Turning point – epiphanic experience

The thesis is based on my experiences of entering gerontic nursing practice as a registered nurse (RN) in 1973. This experience became a 'turning point' in my life in that it radically altered and shaped the meanings I give to myself and to my life projects. These meanings represent a new beginning emerging from a distinctive past identity. Such moments provide substance for searching, struggling, feeling, asserting, yielding, facing and choosing a direction that challenges and enhances the realisation of potentialities. This subjective lived experience, including the experience of writing about it, forms the raw data of the thesis and stands as the methodological starting point for the investigation undertaken, as well as the theoretical orientation for the collection and analysis of the data.

The research question

The major research question underpinning this thesis is 'How have the constructs of ageing impacted on gerontic nursing practice and education?' Related questions pertain to the type of gerontic nurses required to meet the future health needs of elderly clients and how these people will be educated. As the question

emanates from my experiences as a RN in a long-term care facility for older adults, this will be the major focus of the thesis.

Researcher's stance

For any qualitative researcher, especially autobiographic researchers, understanding our own history and prejudices before we begin is important. We should begin a study by knowing who we are and why we chose to study a certain problem. Central to the interpretive biographical approach is reflexivity of the self, or the way in which individuals influence the world around them, while modifying their own behaviour in response to information received from this world (Behar, 1996). Reflexivity demands self-awareness by the researcher, particularly regarding the difficulty they may have in representing 'self' impartially. This enables an open acknowledgement of the partiality and situatedness of all claims to knowledge. Behar (1996) further suggests that researchers recognise this subjectivity and vulnerability when they engage in writing about 'self'. I take a similar position to Behar (1996). That is, I acknowledge that I come to the research process with biases, attitudes and values that influence the research techniques I use, the data I gather, and the way in which I interpret the data. In short, I acknowledge my subjective involvement in this research. However, I also acknowledge that my subjectivity represents one of a number of ways of making sense of the world. The important point here is that opening one of the ways of knowing enables a broader understanding of how things are. Reflexivity leads to the ongoing practice of self-critique and self-awareness.

Foundation for the thesis

We are an ageing society with ever-increasing longevity. Such changing demographics have major implications for all societies, especially in terms of healthcare and type of dependency burden. More gerontic nurses will be needed to meet these increased health needs. Unfortunately, aged healthcare is not a preferred nursing option and often viewed by nurses and society as being of low status. While it seems certain that the quality of the ageing experience can be changed and improved if it is clear how specific forms of ageing are constituted, the literature on the helping professions has tended to emphasise pathological elements and of ageing, continuing the myth that age equates to illness, and perpetuating negative social stereotypes of ageing. Educationally, gerontic nurses have been poorly equipped to cope with the multi-faceted problems of ageing, gerontic nurse education continuing its allegiance to medicine by operating in an illness and disease oriented paradigm. There needs to be a shift away from traditional epistemological and ontological assumptions to a more flexible paradigm, that allows for more holistic ways to conceptualise gerontic nursing practice and education. The thesis endeavours to meet an urgent need to generate an imaginative and creative, but truthful historical explanation for the development of gerontic nursing practice and education, founded on analysis of the causes of past practice and education.

Introducing the methodology

The decision to use interpretive biography as a method of structuring this research project stemmed from an interest in exploring how experience might inform the production of knowledge (Antrobus, 1997; Birren, Kenyon, Ruth, Schroots & Svensson, 1996; Hallam, 2000). Carey (1992) claims that this approach draws from the field of qualitative research, and asserts that the introduction of qualitative research brought with it distinctions between 'soft' scholarship and the 'hard' science of quantitative research. The former produced opinions formed from coerced communication, while the latter provides a guarantee of truth. Carey (1992) refutes the arguments that position the two approaches as being diametrically opposed so that their positions represent truth versus error, knowledge versus opinion, and fact versus fancy. Instead, he suggests that although the methods may differ semantically and stylistically, they are representative of the varying forms of expression within our culture. Furthermore, as Foster, Gomm and Hammersley (1996) argue, no particular research method can lay claim to absolute truth, since it is difficult to prove the insights from one method are superior to another. Qualitative and quantitative research can never be free of the influences of values, methods and theories. These influence the type of problems researchers choose to investigate, the information privileged by the investigation, and the framework used to interpret and report that information. A substantial portion of nursing research is located within the interpretive and critical science research paradigm, and has drawn extensively from the biographical method, particularly in its use of personal narratives. First-person accounts can accomplish a broad epistemology by not only facilitating the transmission of facts from one who knows to one who does

not, but also by being told (Geanellos 1996; Rolfe, 2000). As such, it has profound potential for generating knowledge about gerontic nursing work.

Boykin and Schoenhofer (1991) postulate that knowing in nursing has praxis as its ultimate aim: creative knowledge is required and mere empirical knowledge is not sufficient. The use of narratives of nursing situations preserves the integrity of nursing knowledge and enhances understanding of nursing. It illuminates the richness of nursing. The authors propose story as "a method of communicating knowledge which assures 'groundedness' in the ontology of nursing" (Boykin & Schoenhofer, 1991, p. 245). However, they also argue that some of this knowledge is explicit and easy to put into words, while some is difficult to explain. This is particularly applicable to gerontic nursing knowledge, which is extremely difficult to bring into sharp focus for neophytes entering this profession. As posited by Boykin and Schoenhofer (1991), storytelling does, however, allow the participant to join in the story in any manner for which they are ready. It is therefore extremely useful in the transition process of neophyte to expert gerontic nurse practitioner

This will be an authored story constructed out of evidence, argumentation, language, culture and ethical choice (Kenyon, Birren & Schroots, 1991; Kenyon & Randall, 1997). It will study the relationship of facts and incidents, of themes or currents, and of social and professional issues that have influenced past events and continue to influence the present and future (Brink & Wood, 1988, 1998; Denzin & Lincoln, 1994; Hallam, 2000; Munslow, 2000). It will seek not only to state *what* happened, but *why* and *how* (Bengston & Schaie, 1999; Smith, 1981; Tschudin, 1997).

STRUCTURE OF THE THESIS

This chapter identifies the thesis research question, 'How do ageing constructs impact on gerontic nursing practice and education?' The question is perceived in the context of the researcher's own experience as a gerontic nurse practitioner, educator and researcher over the period 1973 to 2003. In addition, it seeks to peer over the horizon into a new era of aged healthcare and to present and suggest how the health future may look for elderly citizens, those who provide their care and those responsible for educating carers for their changing and complex future roles. The chapter concludes by introducing the researcher's preferred methodology and providing a brief rationale for its choice for this study. The second chapter, the literature review, seeks to identify major ageing tensions and constructs, and their impact on gerontic nursing practice and education. Any gaps in knowledge are identified and summaries of relevant data are presented. The process also strengthens the researcher's rationale for adopting an interpretive biographic, theoretical framework and methodological approach to underpin this study, and this foreshadows theoretical and methodological considerations discussed in chapter 3. Chapters 4, 5 and 6 specifically address the three domains of ageing, gerontic nursing practice, and education respectively. Chapter 7 synthesises all previous data, promulgating future directions and suggestions for gerontic nursing practice and education. The thesis concludes with the author's brief post-thesis reflections on the development of the research project.

CHAPTER TWO – LITERATURE REVIEW

INTRODUCTION

As anticipated, the literature search failed to locate studies comprehensively addressing the diversity and complexity of the interrelationship of the three domains in this study; ageing'; gerontic nursing practice, and gerontic nurse education. Additionally, few of the studies have been underpinned by narrative methodology, making this thesis quite unique. This literature review will critique what *is* known and highlight significant gaps in the knowledge base pertaining to the research question.

The major broad questions to be pursued in the review are 'What type of gerontic nurse and what model of gerontic nursing practice will be required to meet the future health needs of older adults, particularly those in long-term care facilities for older adults, and how will such persons be educated?' In addressing these questions, the literature review will be structured around a number of sub-questions such as: 'What are the major constructs underpinning this research study'? and 'How have these impacted on gerontic nursing practice and education in an historical and postmodern context'? More specifically, it seeks to answer questions about the meaning of life and ageing, projected health needs of elderly people based on demographic and other sociopolitical factors, past and current dilemmas in gerontic nursing practice and education, and possible transformative strategies.

In the first instance, because the abstract nature of many of the concepts central to this thesis challenge any endeavour to develop a knowledge base, key constructs and concepts associated with ageing, gerontic nursing practice and education will

be defined, followed by a brief discussion on the relevance to this research study. They include; culture, paradox, ontology, epistemology, myths, meaning of life, transition to age, and developmental life stage concepts. This will be followed by an exploration into the literature pertaining to Australia's changing population profiles and healthcare systems, and their relevance to gerontic nursing practice and education. Workforce planning issues will be integral to this discussion. Theoretical and methodological considerations as raised in the literature are pursued in the context of the research questions. The review concludes with a brief journey into the literature on elders' health in the future, the so-called healthcare revolution, and gerontic nursing and education shifts. Literature pertaining to methodological considerations will be critiqued in chapter 3.

MAJOR CONSTRUCTS DEFINED

Construct

The term 'construct' itself needs clarification. A construct is taken to be a framework of assumptions, perceptions, beliefs and knowledge. It poses epistemological, ontological and ethical dilemmas. It is not only negotiated by each individual, but also by society. A powerful construct will have an impact far beyond the realms in which it is made explicit and openly discussed. Therefore it is important to be aware of the relationship between the constructs of ageing and the characteristics of gerontic nursing practice and education.

However, over time, constructs may no longer fit the contemporary context, and therefore it is crucial to be able to signal when part or whole constructs are no longer appropriate. This is well exemplified by the biomedical construct, which has been so influential and remains so in many instances in aged healthcare,

gerontic nursing practice and education (Koch & Webb, 1996). The term 'biomedical' denotes the biological sciences, which directly relate to medicine. This construct focuses on curing diseases and fixing body parts. It is dominated by following instructions and reductionist and robotic tasks that take nurses away from many of the people-oriented praxis they desire. For example, Koch (1998) reports on a qualitative study carried out in the care of elderly people, who were being cared for using a biomedical nursing approach, in a 1000-bed hospital in the United Kingdom. Two major themes emerged from the fourteen elderly interviewee's narratives; a sense of powerlessness and care deprivation, and depersonalisation. Individual needs were ignored, these elderly people stating they had become mere objects of inflexible, routinised care. It was considered that any attempt to introduce more contemporary nursing models, such as those having a rehabilitative focus, would be impeded by the biomedical care construct. Further examples of the inadequacy of the biomedical construct approach to gerontic nursing practice will occur throughout this thesis.

Culture

Traditionally, the term 'culture' referred only to the high cultural activities of the arts, for example, the works of Mozart, Botticelli and Shakespeare. More recently, the term has come to refer to what people do in their leisure time and to the heritages and traditions of organisations, people and the folklore of ethnic groups. There has been a very big change in the way 'culture' is understood. During the 1990s the term was increasingly used to refer to work itself: the culture of an organisation, corporate culture, the cultural image an organisation presents to its clients, the culture of a work team, or the learning culture of an

organisation (Cope & Kalantzis, 1997). It is now used to describe the human bonds, shared goals and aspirations that drive people at work. Culture, however encountered, is the lens through which others are viewed and judged. In fact, chapters 4, 5 and 6 are structured around general cultural concerns, and the sub-cultural concepts of 'ageism', 'emotionality', 'transition process' and 'models' pertaining to ageing, gerontic nursing practice and education respectively. This conceptual framework is represented pictorially and schematically in the appendices in an endeavour to further illustrate the complex interrelationship of the three domains (which I also claim to be a unique representation). Additionally, it will be seen that much of the promulgated data is dialectical, due no doubt to the chaotic nature of gerontic nursing practice.

The word 'culture' is vital to an understanding of both the organisation of gerontic nursing work and life after work, and so it is a central tenet in this thesis. Cope and Kalantzis (1997) assert that while the most common approach to defining the concept assumes the word 'culture' emerged from 'sameness'; in essence, the reality is one of 'difference'. Thus the 'paradox' of culture is that it is about cohesion through such diversity.

Paradox

Paradoxes are based on things that seem at first glance to be contradictions or irreconcilable opposites. Cope and Kalantzis (1997) suggest that paradox depends on the discovery that what appears to be a contradiction is in fact a synergistic relationship (Cope & Kalantzis, 1997). These authors further assert suggest that the paradox of cohesion through diversity can be used to understand how organisations work. In the context of this thesis, such a paradox may be

applicable to gerontic nursing work. Cope & Kalantzis (1997) use the term 'productive diversity' to describe the holistic approach of viewing culture as multiplicity, hybridity, fluidity, and negotiation. Such productive diversity is a relationship between recent traditions and the necessity to negotiate change. They consider there to be a need to forge a culture of collaborative diversity: a creative culture, able to come up with quick solutions, able to go beyond, around and at a tangent to prevailing standards.

Paradoxes, healthcare systems and postmodernism

The 'paradox' construct is also useful in understanding complex healthcare systems. Spitzer (1998a, p. 169) asserts that healthcare systems of today confront "each and every one of the paradoxes characterising the postmodern world", an example being the paradox of justice, which is challenged by the question of equity. The major economic problems in healthcare systems all over the world today indicate a failure to anticipate such changes as; the overwhelming involvement of expensive technological innovations in the healthcare system, the significant increase in life spans, and the emergence of knowledgeable clients and their demands for quality.

In an ageing context, the 'ageing paradigm' suggests that the healthcare system will always suffer from the mismatch between what was planned and what really happens (Holmer & Holstein, 1990; Spitzer, 1998a). When looking at the healthcare system through the ageing paradigm prism it becomes apparent that like many other central systems, healthcare systems are confronting a growing number of questions which have no definite solution, but rather involve a large number of alternatives approaches.

The ontology of ageing

As both ontological and epistemological perspectives ageing, gerontic nursing practice and education are pursued in this thesis, it is important to differentiate the terms. 'Ontology' refers to a claim or set of assumptions about the nature of reality. Ontology makes claims about what exists, what units make up what exists, and how these units interact with one another. It specifies the nature of what we want to know about (Rice, 2000). In comparison, 'epistemology', refers to a set of claims or assumptions about the means by which it is possible to gain knowledge about reality, whatever the ontological position states of that reality. It presents a justification for what can be regarded as knowledge (Rice, 2000). The ontology of ageing represents the lived experiences of getting old, both good and bad. Such experiences shape who people are, how they regard their health, and what they will seek from healthcare. Gerontic nurses need to appreciate such perspectives in order to connect with elderly clients in caring ways (Rice, 2000). Epistemological viewpoints on ageing are represented in such constructs as the 'myths' and 'realities' of ageing**.**

Myths and realities of ageing

Whereas 'reality' describes and acknowledges the various interpretations of people's life experiences, 'myths' describe things as if they were natural and real (Baudrillard, 1987; Berger & Luckmann, 1996; Gergen, 1991). For example, in the context of gerontic nursing, Nazarko (1998) promulgates the existence of the following myths: nurses are women; good nurses are 'doers' not 'thinkers'; and the 'task' myth, which adopts a reductionist approach on the pretext that this is a more cost effective model of care.

Myths deny that people create their own reality. Thurer (1994) describes myths as rituals, beliefs, expectations and symbols that pervade everyday life. This taken-for-granted knowledge assumes an eternal existence based on natural facts surrounding processes such as ageing. Myths give the impression that they exist independently and are apart from people's interpretations of the world. However, myths do not evolve from the nature of things, but rather from the way people understand things and pass them on as indisputable facts. For example, in his early work, Lyotard (1979) identified a number of advanced stories in the form of myths, legends and apocryphal tales, which bestow legitimacy on social institutions or represent positive or negative models. Exemplifying this assertion is 'the lady with the lamp' legend, which provides nursing with a blueprint to guide practice. In much the same way, the apocryphal tales of the life of Jesus provide Christians with a blueprint for moral conduct. Such myths, legends and apocryphal tales allow a discipline to define its criteria of competence on the one hand, and on the other, evaluate, according to those criteria, what is performed or can be performed within it (Lyotard, 1979). Later chapters will further discuss the relevance and impact of such myths on past and present gerontic nursing practice and education, and will also introduce and discuss further relevant epistemological viewpoints.

Ontology and the meaning of life

The previous discussions foreground dialogue on 'meaning of life' and its unique place in human existence. A review of the literature indicates that questions about the meaning of life reach back to the earliest period of Greek philosophy, and

indeed the first explicit theory of the causation of ageing is found in Greco-Roman medicine (Grant, 1963; Grant, 1996; Moore, Metcalf & Schon, 2000; Zeman, 1945a&b). It was Socrates who framed the axiom 'the unexamined life is not worth living' (Tolstoy, 1940). Socratic questioning found an answer in Platonic doctrine of man [sic] and the cosmos. For Plato, the answer was wholeness: the balanced functioning of all the powers of the human soul. The Platonic answer was matched by a system of education for lifespan development where each stage of life would prepare the way for the final version. In other words, meaning is contingent on the circumstances of life. Socrates postulated that each life stage has its own integrity and that this enables us to bear the existential pain of ageing, the facts of loss, and the disappearance of the past. Stoicism took its inspiration from Socrates. Stoics were the first philosophers to offer a coherent response to the philosophic problems of ageing (Tolstoy, 1940). Both ancient and medieval civilisations took for granted the contemplative mode of life which represented the highest possibility for human existence. By contrast, the modern world, since the 17the century, has favoured a life of activity over a life of contemplation. This fact is fundamental to understanding the modern horror of old age, which is the horror of vacuum, the limbo state of inactivity (Jecker, 1991). In the 20th century philosophy, the old problem of the meaning of life for a time disappeared, but when it resurfaced it was assumed that the solution must lie in some form of privatism: the meaning of *my* life. Modern philosophy has rejected any appeal to transcendent sources of meaning. As we become an increasingly ageing society, the collapse of a coherent framework for meaning in old age becomes a pressing social and cultural problem. This problem cannot be resolved without clarification of the philosophical issues; the meaning of my life, the meaning of human life, and the meaning of the cosmos.

It is the global sense of meaning that comes to attention at times of crisis, such as death and bereavement (Jecker, 1991). The final paradox of the modernist ambivalence to old age is seen in the ideology and technology of medicine: 'keep people alive for what'. This paradox is evident to anyone who works with elderly clientele.

'Meaning' has recently been identified as a significant factor in health and wellbeing. For example, Moore *et al*. (2000) state that:

> [m]eaning is a common human quest or a map known or felt, that guides decisions and action, that gives cohesion to life, that weaves past, present and future together in continuity that shapes patterns of behaviour in relation to the common and uncommon challenges in life's existence to discover what it means to them and to gain a better understanding of themselves (p. 28).

The significance to this thesis is that by studying how older people experience meaning in their lives, we may learn more about the human experiences of joy and hope, the capacity to respond to opportunities and manage problems in our lives.

Ageing and experiencing meaning in life

Moore *et al*. (2000) suggest that a feeling of being cared about, or having a 'caring connectedness' with others, is a significant factor for older people in having a sense of meaning and purpose in their lives. This suggests a need for deeper reflection and investigation about meaning and ageing. The thinking used to achieve these insights is based upon hermeneutics as described by Heideggar

(1962), who views humans as beings who seek to understand and interpret their world. This approach is of significance to gerontic nurses, especially in long-term care of older adults, as they have the most lengthy contact with elderly clients of any healthcare worker. In a more practical context, the data suggest that the pursuit of meaning in life in older clients should be integral to any model of gerontic nursing practice, particularly those clients placed in long-term care.

Feeling old and being old

Closely aligned to 'ageing and experiencing meaning in life' is 'feeling old and being old'. The need for research on the experience of ageing has been emphasised by several authors (Covey, 1992; Jaffe & Miller, 1994; Kenyon, 1993; Sherman, 1994). Perhaps the most significant study in the context of this thesis is that undertaken by Nilsson, Sarvamiki and Ekman (2000). Their aim was to improve understanding of the ageing process in later life. Fifteen elderly persons, aged 85-96 years, living in their own homes, were interviewed indepth. Data were analysed using a phenomenological-hermeneutical approach. Eight of the elderly persons reported that they felt old. The thematic life stories from those who felt old is important, as in gerontological research there is a significant dearth of such viewpoints. These eight elderly people characterised feeling old as: being able to date the beginning of feeling old; fear of helplessness and of being unable to manage one's life situation; not recognising one's former self; and feeling different from others (Nilsson *et al*., 2000, pp. 42, 43). A descriptive-interpretive approach based on Ricoeur's philosophy (1971, 1976) was used to illuminate the meaning of these very old person**s'** experiences (Nilsson *et al*., 2000, pp. 42,43). Feeling old did not seem to equate with chronological age, but

seemed to emanate from some crisis in their lives, such as a death of a loved one, sustaining some trauma such a having a fall, or becoming physically or mentally ill. According to Selder (1989) such characteristics correlate to the main properties of a transition process which occurs when a person's reality is disrupted. This factor is significant to gerontic nursing practice, as transition phases often equate with the older person's admission to a long-term care facility.

Nilsson *et al*. (2000) also highlight the significance of their study to gerontic nursing practice by asserting that nurses can make a difference by understanding how these older people feel about themselves and about feeling old. Nurses can facilitate a successful transition process for the older person in their care. The authors suggest that the nurse's goal is to examine the individual's uncertainty to create a new reality and a sense of control.

Conversely, when analysing thematic life stories of those who were old but did not feel old, Nilsson *et al*. (2000) speculate that these elderly persons take a different attitude to old age and have developed strategies for managing age-related changes. This finding is also of significant to gerontic nursing as assessing older clients' adaptive capacities becomes a crucial element in ensuring optimal levels of care and quality of life in long-term care facilities. Thus the gerontic nurse has an 'adaptive' role as well as the traditional 'caring' role.

The sub-cultural concept of 'transition process' is integral to each of the domains in this study, that is, ageing, gerontic nursing practice and education, and so will be discussed and analysed further in Chapters four, five and six respectively.

Developmental life stage concept

Nilsson *et al. (*2000) develop Erikson's (1982) concept of developmental life stages. In order to better understand the original challenge of ageing, Erickson (1997) revised his eight-stage theory to add a ninth stage, the essence in which the dystonic element outweighs the syntonic ones so that the distinguishing qualities of those who felt old were very much in line with the dystonic dominance in the ninth stage. Thus there was a mistrust of the older person's own capacities and a reduced autonomy, repressed as fear, anxiety and powerlessness. Such experiences of feeling oneself as being different will cause confusion about one's identity. Erikson (1997) argues that this feeling diminishes the older person's capacity to meet daily demands and taxes their adaptive capacities.

AUSTRALIA'S CHANGING POPULATION PROFILE

Based on current projections, the proportion of the population aged over 65 years in Australia could rise from around 12% in 2004 to 18% by the year 2021, reaching 26% by 2051. Furthermore, the over 80 cohort will also double and triple by 2051. Conversely, the proportion of the population between 15 and 64 years of age could fall from around 67% to 65% by 2021 and 60% by 2051 (Australian Bureau of Statistics (ABS), 2001). In the context of elder health, the number of people ageing with a disability and/or chronic illness long-term is also expected to increase in the near future (Australian Institute of Health & Welfare (AIHW), 2000a). Currently, over 70% of the burden of illness experienced by the Australian population is associated with the national human priority areas of cardiovascular disease, cancer, mental health areas, diabetes mellitus and asthma

(AIHW, 2000a). Physical impairment resulting from these chronic illnesses will be significant and an important factor for depression (Murray & Lopez, 1996). Sensory loss, falls and conditions associated with brain ageing also affect the health of people as they age. These factors influence morbidity, often resulting in social isolation and a significant reduction in quality of life and social isolation.

Old age and chronic illness – dialectical assertions

Old age itself does not equate with disability and chronic illness. An equally valid, but dialectical assertion is to view the perceived 'ageing society' as not ageing but benefiting from an extended period of good health which is largely a consequence of technological advances and healthier life styles. An ageing society is further dialectically exemplified by the opposing views of the incidence of illness being delayed to older age, meaning shorter periods of ill health and disability in a person's life (Fries, 1989). This is opposed by the hypothesis that while life spans continue to increase, chronic illness and disability may also increase, resulting in longer periods of life spent in ill health (Fries, 1989). There is also the view that any gains from preventable illness or death of one type are cancelled by increases in another (Fries, 1989; Mathers, Voss & Stevenson, 1999). Of significance to gerontic nursing in any discussion of chronic illness in older people's healthcare is gerontic nursing's 'adaptive' capacity. This capacity impacts on 'models of care' so that gerontic nursing care can move from a problem focus or deficit perspective, to one that focuses on personal capacity and promotion of health and well being (Tombs, Barnard & Carson, 1995).

Rehabilitation – a new model of aged healthcare?

Several researchers (Borst-Eilers, 1997; Easton, 1999; Raffel, 1997; Temmink, Francke, Hutten, Van der Zele & Abu-Sadam, 2000) assert that a rehabilitation approach could represent a new focus in aged healthcare. Therefore it is important to consider the way in which rehabilitation for elderly people is conceptualised and practised. In the 1980s a rehabilitative approach was not the norm in many long-term aged healthcare institutions, many confining it to specialised departments where a multidisciplinary team endeavoured to restore a person with a disability (for example, stroke, amputation) to the fullest physical, mental, social, vocational and economic ability of which he or she is capable.

The literature provides support for my observation from professional experience that gerontic nursing's rehabilitation role lacks clarity and is not valued (Nolan, 1997; Nolan, Booth & Nolan, 1997), reflecting the current dominant view of gerontic rehabilitation nursing as largely a physical task. It seems there is need for a realistic appraisal of the knowledge and skills required to deliver 'expert' care and how this can be meaningfully incorporated into gerontic nursing education programs and models of care. Despite this need, the literature review failed to illuminate any specific gerontic rehabilitation nursing texts published since Easton's text in 1999, thus representing a significant gap in gerontic nursing knowledge.

Difficulties in reconciling these views of gerontic nursing practice and education have led many professionals in aged healthcare to question the existing paradigm. For instance, Burggraf and Barry (1995,1998) question if it is possible that the gap in care that arises from traditional divisions between gerontic and

rehabilitation nursing involves the sort of puzzles, problems and anomalies that Kuhn (1970, 1995) sees as leading to the discovery of new ideas and eventually to revolution, a revolution that creates a new paradigm. Such questioning foregrounds the possible need for the beginning of new theories emerging from the old, and acceptance that elderly clients are to be valued and that independence can and should be maintained for as long as possible. It is anticipated that this thesis will contribute to gerontic nursing's knowledge base to lead to such new theoretical development. Suggested strategies will be advanced in Chapter 7.

Ageism, ageing, gerontic nursing practice and education

As (from my experience) ageist attitudes predominantly prevail in such outdated viewpoints of gerontic nursing practice and education as advanced above, it is useful at this point to focus the literature review on the concept of 'ageism'. Behrens (1998) posits that ageism exists but is difficult to quantify, as it is insidious and hard to detect. The term was first coined by Butler (1963) to define the systematic stereotyping of, and discrimination against, people because they are old. This definition is now considered outdated. A more recent definition (Behrens, 1998, p. 10) suggests that "[a]geism means unwarranted application of negative stereotypes to older people." Such ageism creates its own self-fulfilling prophecies and promotes lifestyles that damage individual potential. This stigmatising process affects the way older people feel about themselves. They are then in some way controlled, and their possibilities in life are defined (Andersson, 1997; Grant, 1996; McMinn, 1997; Mendes, 1997; Minkler, 1996). Consistent with this widespread social prejudice, many in the nursing profession hold ageist attitudes and do not choose, nor enjoy, working with elderly clientele.

A research project (Happell & Brooker, 2001), conducted in Victoria, Australia investigating the career preferences of undergraduate (UG) nursing students found that 247 of 793 total respondents ranked working with older adults as their least preferred option. Reasons given by students for their choices demonstrate a negative view of gerontic nursing work, largely based on inaccuracies and misconceptions. The research identified six major themes underlying this attitude: the boring, uninteresting or frustrating nature of caring for older adults; nurses' fear or discomfort generated by exposure to death and dying; the depressing environment associated with the negative characteristics of clients, for example, concerns that older adults will not get well; lack of skills and attributes required for this nursing specialty; negative previous experiences with working with elderly clientele; and less diversity of illness in comparison with other nursing specialities. We concluded that achieving a high standard of care for elderly clients depends on the ability to attract quality, motivated and interested staff who consider elder care to be a viable and worthy field.

Some researchers (Ellis & Miler, 1994; Judge, 1993; Kaliath & Gillespie, 1998; Leiter, Harvie & Frizzell, 1998; Somers, 1995; Stevens & Herbert, 1997) have studied the relationship of such ageist attitudes to job satisfaction and standards of care. The most powerful themes emerging are; the profoundly low job satisfaction felt by gerontic nurses, lack of professional support, lack of ability to influence the working domain, and deprivation of reward. Job satisfaction and dissatisfaction literature will be critiqued later in this chapter. On a more positive note, ageism appears to be beginning to come under attack as older people exert increased political influence and begin to challenge some firmly held assumptions of old age and aged healthcare practices.

Ageism, gerontophobia and resilience

An important dimension of ageism is 'gerontophobia', which identifies old age with disability, gerontophobia assumes that: namely: old age disabilities are universal; necessarily irreversible; and solely determined by biological processes (Fulcher, 1989; Loiver, 1996; Oliver, 1990; Young, 1990). Such assumptions disadvantage and oppress elderly clients and foster the concept of ageing as a disability (Davis, 1994; Phillips, 1996). Dialectically, the concept of gerontophobia is opposed by the concept of 'resilience', a powerful force in the adaptive capacity of both the elderly clients and gerontic nurses.

'Resilience' describes a process whereby people overcome adversity and go on with their lives (Dyer & McGuiness, 1996). It is a dynamic process, influenced by protective factors that serve to modify the effects of adversity (O'Leary & Ickovics, 1995; Polk, 1997; Rutter, 1985; Werner, 1993; Werner & Smith, 1982). It "evokes the promise of something good resulting from misfortune, hope embedded in adversity" (Dyer & McGuiness, 1996, p. 276) and finding one's unique path in life (Werner, 1993). As opposed to marginalisation, it parallels the concepts of hardiness (Kobasa, 1979), determination, tenacity and fortitude (Felten, 2000: Felten & Hall, 2001; Jacelon 1997). It fosters an ability to retain renewed value in life and to transform negative events into personal growth and opportunities. In the context of this research study, it is of relevance, as some researchers (Dyer & McGuiness, 1996; Morrison, 1990; O'Leary & Ickovics, 1995; Rutter, 1985) assert that the characteristics of resilience are highly influenced by nursing approaches and organisations' ideologies, and that there is a shifting balance between vulnerability and resilience through a genuine caring

presence. Further, it evokes the questions of: 'How can gerontic nurses support the development of such protective factors?' and 'What keeps older people happy?' Some strategies have already been advanced relevant to meaning in life and transition to old age.

Social institutions and behavioural constructs

As a prelude to the discussion of changing aged healthcare systems, it is useful to briefly discuss and critique social institutions and behavioural constructs in the context of this thesis.

The term 'society' refers to the many interrelated institutions such as family, medicine, church and law that represent major societal interests. According to Berger and Luckman (1966), social institutions are necessary to fulfil the need that people have to live a life of order and meaning rather than chaos. Institutions are dynamic phenomena that have developed over time and continue to develop. The rate of development varies between institutions with some making rapid change and bearing little resemblance to their original format. Other institutions appear to change but at the same time come under the influence of past ideals. In the context of this thesis it is argued (Burggraf & Barry, 1995, 1998; Nazarko, 1998) that development and change within aged care facilities (especially long-term care facilities) has been slow and tortuous, defined by fairly rigid and hierarchical behavioural constructs. Such behaviours eventually become taken-for-granted consequences. Many people understand aged healthcare institutions as taken-for-granted entities that have an objective reality; that is, the conventions, beliefs and attitudes of the aged care facility become an objective fact having a reality of their own that is independent of people. Foucault (1975)

posits that the discourse of such institutions is contained in the language of both spoken and unspoken messages. These act to endorse and sustain the institutions by acting as agents of power through the ability to marginalise, include, exclude, empower and disempower. In such situations it is difficult to implement change, as the majority of people within the institution perceive its culture by following the conventions that they believe are objective facts. Hence the behavioural constructs originally shaped by people in turn shape them. Berger and Luckman (1966) consider such institutions as generating normative constraints that result in stale, recurring patterns of behaviour that a society approves of and values.

CHANGING AGED HEALTHCARE SYSTEMS

According to a number of researchers (Bowen, Lyons & Young, 2000; Clarke & Croft, 1998; Falk-Rafael, 1996; Johnson, 1998; Jorgenson-Huston & Fox, 1998; Saltman & Figueras, 1997), healthcare systems will see many changes in the near future, including: a greater emphasis on prevention and wellness; a population perspective; intensive use of information; a focus on the consumer; knowledge of treatment outcomes; constrained resources; coordination of services; reconsideration of human values; expectations of accountability and growing independence. However, until recently, the approach to aged healthcare did not develop beyond a standard custodial subsistence philosophy, whereby older people receiving care were treated as inmates in institutions or asylums (Bevan & Jeeawody, 1994). Recently there has been a widespread interest and change in aged healthcare in Australia, reflecting such influences as: society's changing attitudes to healthcare for the aged, increased political power of the elderly, and shifting emphasis from institutional care to community and home-based care. As

the population ages and more elderly people access healthcare services, society will be faced with many political and socio-economic dilemmas (Barowski, Encel & Ozanne, 1997; Institute for Primary Healthcare, 2001; Jecker, 1991). These include such possible future challenges as: demographic shifts to ageing; concern for social justice; growth and expansion of managed care organisations; continued focus away from hospitals to community; integration with complementary and alternative medical approaches; accountability and performance-based care; increasing costs resulting from technology explosion; and increased value placed on the practice of health promotion. Such advances will continue to challenge the moral obligations of aged healthcare. Other researchers (Bent, 1999; Callahan, 1987, 1989, Henry, 1999; Johnstone, 1999; Minkler & Estes, 1991) ponder more moral and ethical questions, such as: 'Will aged healthcare organisations be responsible for providing medical care or supervision to those manifesting decremental process associated with ageing?' 'What are the limits of resources that can be allocated to healthcare?' 'How will society counteract the opposing perils of ageism, whereby on one hand healthcare for the elderly is influenced by a defeatist attitude and on the other hand, rapid technological advances have led to overly aggressive medical and surgical approaches?'

In terms of health needs and choices for elderly clients in the future, Spitzer (1998) proposes the following: coordinated care between healthcare stakeholders; a client focused approach; the emergence of new treatment modalities; monitored and managed care in periods of relapse and hospital readmissions; and care geared at promoting the interests of clients with a social health problem, by agitating for adequate legislation, social rights and allocation of resources.

Oberski, Carter, Gray and Ross (1999) believe that such a salutogenic approach (one which focuses on activities that build and create health rather than on the destructive forces of disease) will continue to grow in popularity. Again, questions of importance will parallel those cited in this thesis, for example: 'What sort of gerontic nurse will be required to meet these future challenges?' and 'How will such personnel be educated for their changing role?'

Some outcomes seem inevitable, as exemplified by the literature. For instance, O'Neil (1999) asserts that there will be a need for new parameters, an expansion of public information about healthcare systems and, an involvement of the elderly public in what health means for ageing communities. In a similar vein, Spitzer (1998a) asserts that the continued expansion of computerised and innovative technologies, and the client's ability to access relevant health data will turn data management in the healthcare system into a critical element in the future.

GERONTIC NURSING CULTURAL IMPLICATIONS

Jackson, Mannix and Daly (2001) believe there is a need for substantial structural and organisational culture change in gerontic nursing practice. Such change is particularly relevant to staffing issues, where there are global and national shortages of skilled aged healthcare workers (OECD, 1998; Stein, Heinrich, Payne & Hannen, 2000). Additionally, an analysis of the state of nursing in the context of these transformations indicates that the caring paradigm does not ensure the existence of the profession in this era (Rolfe, 1996; Spitzer, 1998a). This is because of increasing difficulties in consolidating the economic and quality issues into the core of nursing, and in understanding the complexity inherent in health-related situations.

A major gerontic nursing cultural dilemma or challenge is the emotional aspect of the caring role, which literature reveals to be poorly interpreted, undervalued and misunderstood by society and the mainstream nursing profession (thus representing a further gap in the knowledge). As such, along with 'ageism', 'transition process' and 'models', 'emotionality' is a sub-cultural concept integral to chapters 4, 5 and 6 which pertain to ageing, gerontic nursing practice and education respectively.

Emotionality and gerontic nursing practice

Emotional labour, as in gerontic nursing practice, is defined as work involving the self-manipulation of feelings in order to do the job (Denzin, 1984; Hochschild, 1979, 1983). Several researchers (Aldridge, 1994; Behrens, 1998; Gattuso & Bevan, 2000; Lee, Mitchell, Wise & Fireman, 1996; Robbins, Lloyd, Carperne & Bender, 1992; Wheelwright, 1995) consider that emotional aspects of nursing, such as emotional exhaustion, depersonalisation, lack of personal sensitivity, cynicism and avoidance of client contact, are manifestations of low job satisfaction and have serious consequences when occurring in healthcare sectors. Others (Kaliath & Gillespie, 1998; Leiter & Schaufeli, 1996; McDowell & Forsyth, 1990; Staden, 1998) conclude that it is not surprising that these workers experience cognitive dissonance in attempting to reconcile demands of efficiency and caring, and that it becomes common sense to take a humanistic approach to care, resisting the managerialism and economic rationalism still dominant in Australia.

Bradby's (1990a) study of four cohorts of first-year nursing students found that entrance into the culture of nursing is often accompanied by feelings of being

overwhelmed, bewildered and overpowered. The research aimed to discover the reality of the experiences for trainee nurses through interviews and essay writing, keeping a diary, writing a letter to a potential recruit, a self-report, and psychometric tests for self-esteem and anxiety. During their mandatory clinical placements, these nursing students were required to cope with many personal and sensitive areas such as; coping with elderly clients' altered body images, very ill and dying clients, and attention-seeking and mentally confused clients (Bradby, 1990b). On analysing the trainees' narratives, Bradby (1990b) ascertained that such aspects stimulated defensive responses.

Despite the emotional difficulties associated with clinical work, Bradby (1990a) discovered that the majority of students felt relatively comfortable after two to four weeks. Those who experienced problems seemed to be vulnerable individuals demonstrating low levels of self-esteem and high anxiety levels. Once such sense making had occurred, students integrated well into the work role (Bradby, 1990a).

Emotionality, status passage and sense making

Although all those within the nursing profession are able to relate similar anxiety provoking experiences, little research has been undertaken to explain how nurses actually learn to cope and come to terms with their value confusion. Some researchers (Bradby, 1990a; Kramer, 1974, 1985; Louis, 1980) have sought to highlight this deficit, believing the entrance into nursing, especially for the first time, represents a 'status passage' (the process of changing from one social status to another). Louis (1980) adds that the general integration into an occupation and into the 'institutional norms' can be termed as 'sense making'. Bradby (1990b)

concludes that in some areas of nursing work, little seems to have changed since the 1950s, perhaps due to the fact that some nursing work is so taken for granted it is not worthy of special study.

Stress, moral distress and gerontic nursing practice

'Emotionality' in the context of gerontic nursing practice has also been explored in the context of both 'stress' and 'moral distress'. It has been asserted (Borrille, Wall, West, Hardy, Shapiro & Haynes, 1998; Kaliath & Gillespie, 1998) that because gerontic nurses are subject to high stress loads (for example, associated with such factors as 'reality shock', unrealistic workloads and poor working conditions), they tend to succumb to a culture of work which seeks to test out whether they are good enough personally and professionally to do the job. Striving for perfection, many try hard to contain their own anxieties and vulnerabilities. Professionals learn to cope by splitting emotions off from intellect, thus repressing painful memories. This displacement of personal distress is characterised as workaholism, and may be gerontic nurses' defence against disillusionment, dissatisfaction and a sense of inadequacy in meeting the perceived standards others expect of them. However, the literature on expressed job satisfaction and dissatisfaction in gerontic nursing practice does not deal specifically with this issue. It may well be that gerontic nurses are just not equipped or willing to express stress-related concerns.

Moral distress in the context of gerontic nursing practice can be perceived as an acute form of psychological disorientation in which gerontic nurses question their professional knowledge, what kind of nurses they are, and what kind of nurses they are becoming (Kelly, 1998). Theoretical explanations of moral distress are

grounded in social interaction (Denzin, 1978; Goffman, 1961) and moral psychology. Kelly (1998) undertook a study with participants who had been practising nursing for one year. The purpose was to explain and interpret how new graduate nurses perceived their adaptation to the 'real world' of hospital nursing and what they perceived as major influences on their moral values and ethical roles immediately following graduation (Kelly, 1998). Several stages of the adaptive process to the informants' role were identified: getting through the day, coping with moral distress, self-alienation, coping with lost ideals, and integration of new professional self-concepts. Moral distress was a consequence of the effort to preserve moral integrity, and was characterised in this study by self-criticism (associated with self-doubt and a lowered self-esteem) and self-blame (associated with powerlessness and disappointment). Moral distress was most felt when neophytes realised that they would never be able to become the kind of nurse they initially aspired to be (Kelly, 1998).

A further sub-topic of 'emotionality' of significance to this thesis is that of 'emotional engagement and detachment'. In this context, Henderson (2001) highlights the relevance of emotional engagement and detachment in pursuit of excellence in work practice. This large qualitative study involved four focus group interviews with 49 nurses from Canada and the United Kingdom. The interviews explored the nurses' backgrounds, beliefs, values and personal and professional experiences, which have an impact on the care of abused women. Although most of the nurses supported the impact of emotional engagement, others emphasised the need for detachment and objectivity. The informants in Henderson's study (2001) assert that such distinctions are a requirement of excellence in nursing practice. The question arising from this study lies in

ascertaining if emotional engagement in their work is a necessary part of caring, or whether it is possible for nurses to 'care' effectively without 'feeling' (Henderson, 2001). While this question is of significance to gerontic nursing practice and thus to this thesis, the literature search failed to reveal a satisfactory answer. Some nurse researchers (Froggatt, 1998; Watson, 1990) have touched on the topic; however, a gap in the knowledge in this context remains.

Women's emotional work in aged care

In the context of aged care nursing, Gattuso and Bevan (2000) undertook a phenomenological study with 16 women involved in rural aged care nursing work in order to generate theories and concepts related to women's emotional work in aged care. Findings from three participants' narratives revealed high levels of stress among aged-care nurses (Gattuso & Bevan, 2000); as nurses endeavoured to balance emotional engagement and detachment. A further concern expressed by the informants was the dilemma associated with the dual caring role of 'mother' and 'nurse' (Gattuso & Bevan, 2000, p. 894). The authors highlight the need for further research in the development of best practice models while heeding the potential consequences of dual caring associated with this 'maternal' model of care.

Support systems

Bradby (1990b) identifies a lack of support from trained nurses in wards to assist neophytes to adapt to the nursing role. In a similar vein, Henderson (2001) concludes that it remains crucial for nurses to receive support and encouragement from their peers, supervisors and management personnel. Other researchers

(Morton-Cooper & Palmer, 2000; Robbins *et al*., 1992) advocate the introduction of support systems in healthcare facilities to alleviate nursing dilemmas associated with emotional aspects of nursing work. Brookfield (1993) sees such support as being multi-faceted: as a defence against feelings of disillusionment, disorientation and burnout; as a framework for clarifying human values and as a means of providing skill rehearsal and appropriate role models in the workplace.

WORKFORCE PLANNING IN AGED HEALTHCARE

The extent and nature of change in demand for health and aged care services cannot be predicated on the basis of changing demographics alone. An appropriately sized, distributed and educated aged care workforce will be required to provide the range of services that our ageing population will require (OECD, 1998; Williams, Chaboyer & Patterson, 2000). Government service providers and program organisers will have the challenge of improving the attractiveness of the aged care sector for care professionals, as well as addressing training, career progression and other issues (Commonwealth Department of Health & Aged Care, 2001). All members of the care workforce will require knowledge and skills to deliver care to the growing population of older people. The management of multiple and complex conditions, mental health issues and neurodegenerative disorders will be top priority (Commonwealth of Australia, 2001).

Staffing levels – issues for consideration

Existing Commonwealth legislation does not prescribe the numbers of qualified nurses in high-care residential aged care facilities; level of qualifications of nursing and personal care staff or numbers and qualifications of all other staff and appropriate skills mix necessary to ensure quality outcomes to residents (Department of Human Services, 2000). The Commonwealth Aged Care Act (1997) requires only that the approved provider supply such care services as specified in the Quality of Care Policies, and maintain an adequate number of appropriately skilled staff to ensure that the care needs of clients are met (Aged Care Act, 1997, Section 54-1). While there are no existing requirements for the staffing mix in residential care facilities, there is a significant shortage of appropriately educated nursing staff (Jackson *et al*., 2001). It has become increasingly difficult to attract and retain staff in some circumstances (Department of Human Services, 2000; Kuehn, 1990; Latrobe University, 2001; Nay & Closs, 1998; Nazarko, 1997b; Walker, 1997). In reality, determining the staffing levels and staff-resident ratios in aged healthcare requires consideration of types of staff, costs of particular staffing needs and workforces and labour market needs.

In Australia, clinicians in gerontic nursing constitute 14.3% of the nursing workforce, but these numbers are rapidly declining (AIHW, 1998). The number of nurses working in public nursing homes decreased from 22,209 in 1993 to 15,873 in 1997, a fall of 28.5%, with a fall of 21.1% in numbers of nurses in private nursing homes.

Job satisfaction/dissatisfaction and gerontic nursing's culture

The centrality of job satisfaction or dissatisfaction in the delivery of quality aged healthcare has been confirmed by several researchers (Avorn, Ratner & Crawford, 1997; Greishaber, Parker & Deering, 1995; Latrobe University, 2001; McNeese- Smith, 2001; Queensland Health, 1999; Moyle, Skinner, Rowe & Gork, 2003; Tovey & Adams, 1999). Commonly emerging dissatisfaction elements, as reported by participants in these studies include; the employment of unskilled people in aged healthcare places, unrealistic expectations of qualified staff (many of whom elect to leave the profession on these grounds), and lack of understanding of the physical and emotional demands of gerontic nursing practice.

Tovey and Adams (1999) undertook a qualitative study to determine the changing nature of nurses' job satisfaction. While it compares the major sources of satisfaction and dissatisfaction experienced by acute ward nurses in an English National Health Service hospital (NHS), many of the findings have relevance for this research project. The authors found that the majority of categories related to comments about sources of dissatisfaction such as; pressures associated with new roles, role conflict, 'tight' resources, using new technology, a perceived lowering of standards of patient care, coping with increasing paperwork, and the experience of working in a rapidly changing environment. Their research results also demonstrate that nurses have different levels of job satisfaction and that in order to develop a more accurate picture it may be necessary to develop different measurements for different grades, particularly for those with a ward leadership and enhanced managerial role. The authors assert that keeping abreast of how the

changing healthcare environment affects nurses' job satisfaction is an important policy issue, particularly if the retention of nursing staff is to be improved.

Many of these findings parallel Moyle *et al's*., study (2003), which sought to identify satisfaction levels of RNs, Enrolled nurses (ENs) and Assistants in Nursing (AINs) in two Australian nursing homes. Qualitative data were collected via focus group interviews with 27 informants, and analysed using Tesch's (1990) approach. Seven themes were identified:

1 Long-term care is a workplace of convenience.
2 Contact with residents promotes enjoyment and encourages admiration of residents and job satisfaction.
3 Job satisfaction comes from resident gratification.
4 Satisfaction is raised when working with people who work well within a team, whereas dissatisfaction occurs when staff are considered inappropriate to work in long-term care.
5 Job dissatisfaction increases when tasks and time constraints prevent the opportunity to relate to residents and offer the opportunity for error.
6 Job dissatisfaction occurs when tensions are not recognised within the workplace.
7 Staying over time at work creates both job dissatisfaction and job satisfaction.

Moyle *et al*., (2003) also identify the managerial factors that impact on job satisfaction for nursing staff in long-term care of older people and argue that these are integral to maintaining optimal productivity levels and quality care outcomes.

HEALTH OF ELDERLY PEOPLE IN THE FUTURE

Since 1788 Australia has sought to develop the skills, services and facilities to provide effective healthcare for older adults (Bevan & Jeeawody, 1994). Unfortunately, until recently, the approach did not develop beyond the institutional, custodial caring approach. Recently, there has been widespread interest and change in aged healthcare in Australia, as reflected in the Uniting Care Study (2001). Uniting Care Ageing and Disability Services (UCADS) is the largest provider of aged care in NSW and the ACT, caring for some 15,000 clients (UCADS, 2001). It has been actively planning initiatives to cope with changing health needs of elderly people. Their study sought to identify the skills and resources required for such future health needs of elderly people. This review identifies staffing issues, including poor rates of pay, problems with staff retention, and making aged care attractive as an occupation, as key future concerns (UCADS, 2001).

In general it would seem that the UCADS generated more questions than answers to the complex issues surrounding future health needs of elderly clients. However, the report does make a number of predictions for 2010 (UCADS, 2001): healthcare organisations that are consumer friendly will be the winners; resources must be reallocated to train the workforce to deal with empowered clients and technology; the emphasis will be on prevention of disease and functional decline; consumers will want more without wamting to pay for it; and ethical dilemmas will proliferate.

PriceWaterhouseCoopers (PWC, 2002) take a more global view of the future healthcare industry in presenting their views for the years 2002 to 2012. They

conducted interviews with more than 65 key workers in the healthcare industry specifically involved in future health planning in the US, Europe, Canada and the Pacific Rim. In addition, they dialogued with an independent research organisation to survey more than 650 top executives in health systems, health plans, physicians' groups, policy makers and government officers in the these countries as well as in Australia. A major challenge identified is the soaring prices to be paid to treat the growing volumes of ageing clients. The report considers the shortage of suitably qualified staff to care for elderly clients, and dissatisfaction expressed by both aged healthcare staff and clients. It concludes that demand on healthcare workers (particularly gerontic nurses) will keep turnover high. Additional stress will be exerted on remaining staff to adapt to technology and empowered clients. The increased interaction between ageing, technology and consumerism will force policy makers to make difficult choices, such as how to pay for pharmaceuticals. The report argues compellingly for rapid change, as healthcare organisations now face growing demand with limited supply. On the demand side are ageing clients whose health is deteriorating and who require more services as well as pharmaceutical and medical technologies. On the supply side are capital limitations by investors and taxpayers, shortages of willing caregivers and ageing physical plants sagging under the current volume of patients. Some suggestions and recommendations for the future include: leading hospitals will succeed by targeting high-margin, high-volume and high-quality services; demands of healthcare workers will keep turnover high; ageing physical facilities must be replaced or renovated; caregivers and clients will demand information at their fingertips; and physicians will want better support to benefit from new technologies.

Of particular relevance to this thesis are the concerns and suggestions offered by this PWC study for aged healthcare. One major concern identified by their study was time spent on paperwork to the detriment of direct nursing care. In some instances this had actually driven nurses away from the profession. In terms of education, the study identified the opportunity to learn as a major positive influence on employee commitment, a finding consistent with those of Moyle *et al*. (2003). Unfortunately, when finances get tight, aged healthcare facilities often cut education departments. .

Such issues continue to challenge moral obligations of aged healthcare (Bent, 1999; Callahan, 1987, 1989; Henry 1999; Johnstone, 1999). We can expect to see continued demand for aged care and supported accommodation services (Cooper & Hagan, 1999). However, while the numbers of people living in aged care homes will increase as the population ages, the proportion is expected to remain at 8% of the total population until 2021 (ABS, 2001). More flexible care arrangements are likely, such as the hospital sector enabling older people in aged care homes to receive all their care services within the aged care facility. We can also expect to see increased demand for care services in clients' own homes. This trend may result in new roles for health professionals (Department of Health & Aged Care, 2001; Hall-Long, 2000; Heller, Oros & Dumey-Crowley, 2000). People will be discharged from hospital with the capacity to get better and it will be important that the health system has a strong focus on restorative and preventative measures (Duckett & Jackson, 1999). Hospital-driven care will become the smallest component of health services required. The 60% of nurses still practising in these agencies will need to rethink their work and place in the health system (Duckett & Jackson, 1999; Gilford, 1998; Porter-O'Grady, 2001a,

2001b). Innovative communication techniques and strategies will monitor clients wherever they may be along the continuum of care and allocate services based on their specific needs at these points. Consumers will have more access to information, but will require assistance in obtaining, interpreting and understanding it, and using it to the best advantage (O'Brien, 2001; Schilp & Gilbreath, 2000; Spitzer, 1998; Thede, 1999).

It seems that consumers will need two things from nurses during the next two decades: education and care management across the life continuum. This will cause nurses to move from primarily procedural activities to relational, educational and care management activities. More services will be provided 'in place' than ever before. Institutions will cease to be a major option for treatment and client management. Healthcare communities, group residences and progressive services systems will emerge as the main thrust for specific health services adjusted by both age and demand. Such predications are highlighted in Queensland University of Technology (QUT) *Principles Paper* (2004). Elements of this important document will be illuminated throughout this thesis. But in the context of this section, the important factor is that "[t]he Australian government has recognised the need for the healthcare workforce to respond to the changing requirements of the Australian population." (QUT, 2004, p. 1) [and] … recognise the need to promote nurses caring for older people" (QUT, 2004, p. 3).

As the Human Genome Project (codifying and classifying the entire human DNA structure) finishes its work, whole new concepts of treatment and therapeutic management at cellular level will emerge as the foundation for clinical treatment. Nursing leaders will need to begin to see the work of gerontic nurses differently.

The future of aged healthcare seems complicated and uncertain. Its destiny is linked to public policy regarding healthcare reforms, long-term care and distribution of resources. However, McBride (2000) states that it is important that the professional nurse play a dominant role in improving and transforming aged healthcare practice.

GERONTIC NURSING PRACTICE AND EDUCATION SHIFTS

In some ways, nurses are confronting the same challenging future as Florence Nightingale did more than 100 years ago. There remains a need for a new context for practice and different service models with society facing changes it is not prepared to address. In a more general context, there will be a need to establish education and practice policies that acknowledge and plan for the projected demographic and economic shifts (Barron, 1999; Kanitsaki & Johnstone, 2002; Porter-O'Grady, 2003b). In the context of gerontic nurse education, the dilemma is that much education still focuses on institutional settings and prepares beginning practitioners for a world that is quickly disappearing. Nurse education on the whole still operates in an illness and disease oriented paradigm. Behavioural competencies (objectives) are often still in vogue in educating student nurses (Boud & Garrick, 1999; Ramsey, Franklin & Ramsey, 2000; Usher, Bryant & Johnston, 1997).

Researchers have endeavoured to identify projected educational needs of gerontic nurse practitioners, particularly those in long-term care or residential care settings for older adults. For example, Oberski *et al*. (1999) undertook focus group interviews with RNs discussing issues of role definition and attitude change to ageing and older adults, and in the way RNs are prepared for the

specialty. In a similar vein, using a repertory grid method, Retsas and Wilson (1997) sought to identify the extent to which RNs believed themselves to be effective as nurses working in aged healthcare They concluded that there needs to be further research to capture underlying factors that allow the elderly to adapt successfully to old age that could be reflected in gerontic nurse educational programs and in models of gerontic nursing care. Glass and Todd-Atkinson's cross-sectional study (1999) of gerontic nurses**,** to identify felt educational needs, supports previous assertions that gerontic nurses are poorly prepared educationally to meet the health needs of elderly people. Robertson, Higgins, Razmus & Robinson (1999) focused on the relationship between continuing education and job satisfaction among RNs working in long-term care settings, in their descriptive, correlational study. They conclude that nurses who participate in more continuing education activities scored higher on the job satisfaction scale. These findings are congruent with similar studies (Carr & Kazzwonski, 1994; Coward, Hogan, Duncan & Horne, 1995; Suggs, R**o**se & Mittelmark, 1993).

In the context of gerontic nurse education curricula in undergraduate programs, QUT's *Principles Paper* (2004) is again relevant. The paper offers a review of major principles for learning and teaching aged care in UG nursing curricula: expertise in aged care is necessary to facilitate the integration of aged care content and for teaching the aged care content in the UG nursing curricula; the involvement of industry and clinicians in aged care is important in the teaching of aged care in UG nursing curricula; evidence of evaluation of aged care content in consultation with industry, consumers and professional bodies and consumers should be provided regularly; aged care content in the UG nursing curriculum

should be a significant component, integrated across the curricula, incrementally throughout each year of study and as a significant core component of the senior year of study; students need opportunities to integrate theories of ageing and clinical practice in aged care settings; it is necessary to include aged care issues in relevant subjects throughout the UG nursing curriculum; and evidence of assessment of both theoretical and clinical components of aged care content should be present and identifiable over the three years of the Bachelor of Nursing course. Areas of aged care content are then identified for inclusion into the UG curriculum.

While this proposal sounds promising, the reality is that the proportion of workers without tertiary qualifications is steadily increasing in long-term care facilities for older adults. The *Principles Paper* (QUT, 2004) identifies barriers to the implementation of this core curriculum, many paralleling issues raised previously. These barriers include: ageism and the poor image of aged care nursing provide a barrier to placing aged care as a priority in UG nursing curriculum**;** there is a broad variation in the quality of aged care clinical placements available for students; a national and international shortage of academic staff with aged care expertise as well as post-graduate clinicians with aged care experience; the variety of curriculum models for UG nursing courses used throughout Australia, and resistance by academics to further modification to the curriculum.

Changing role of staff nurse/practitioner

Nursing is a practice discipline, and providing positive experiences for students in the practice setting is essential for learning to occur. Such experience has a profound effect on the degree and type of learning that takes place, as well as a significant impact on how students are socialised into the nursing profession (Redier & Riley-Giomariso, 1993).

There is an increased recognition in nurse education of the value of staff. Nurses are experienced critical thinkers and clinical decision-makers who can make important contributions to students' clinical education (Atack, Comacu, Kenny, Labelle & Miller, 2000). While one part of the learning stems from the types of experiences available on any given unit, an even greater part of the learning takes place as a result of interactions between nurses and students (Beddome, Budgen, Hills, Lindsey, Duva & Szalay, 1995). Melander and Roberts (1994) consider there to be a need to look beyond the traditional preceptorship model in developing practice components of nurse education. They argue for equal partnerships between students and staff to achieve student learning and quality client care. Such practice may include: clarifying and developing the teaching role of the Registered Nurse (Beddome *et al*., 1995); helping staff to adopt teaching strategies; sharing information with staff; developing communication skills; and fostering a climate of respect in which staff are encouraged to view students as 'junior colleagues' (Melander & Roberts, 1994). A model of care that may facilitate these changes may be the development of Gerontic Clinical Development Units (GCDUs).

Gerontic Clinical Development Units (GCDUs)

According to Greenwood (1999), Clinical Development Units provide an appropriate context in which to improve the nursing care of elderly people as they aim to develop consumer-focused and research-based nursing practice. The quality of the healing environment is of great importance to those interested in improving the care of elderly people. Greenwood further asserts (1999) that Clinical Development Units are based on the belief that nursing is not simply supportive and complementary to medicine, but theoretical in its own right. Later chapters pursue the concept of CDUs, especially in the context of gerontic nursing, in greater depth.

The gerontic nurse specialist – the key to efficient and quality gerontic nursing care?

A further strategy is the continued offering of specialised gerontic nurse education at postgraduate level, now available in many Australian universities. It has become increasingly evident that gerontic nursing can be perceived as nursing in its purest form (Nazarko, 1995) and thus requires specialist practitioners to fulfil the complex role of caring for older people. McCormack and Ford (1999) posit three themes underpinning the specialist/generalist nurse debate, which they assert concern issues of: role definitions and gerontic specialism; the social/medical themes which address the shift towards a social model of care; and the psychological health/mental theme which represents the need for greater integration of skills and knowledge.

A major challenge now facing the discipline is how to define its scope of practice and fulfil its philosophic commitments in this new era of healthcare. McCormack and Ford (1999) assert that in contrast to the generalist, the practice behaviours of the specialised nurse are directly attributable to their knowledge base. This knowledge is a synthesis of propositional (actual or classroom) knowledge and practices. Practice at this level has transcended the 'technician phase'; there is less reliance on technology and more on the client. Here the machinery is viewed as an extension of the client. McCormack and Ford (1999) further posit that the most significant contributions attributed to the expertise of gerontic nursing arises from exposure and reflection and the relationship between power and knowledge. Specialist nurses see power as being derived from professional recognition. Such issues are further addressed in later chapters.

Fairweather and Gardner (2000) assert that healthcare operates in a complex environment that demands expert care from competent clinicians in a highly technical and continually changing healthcare milieu. They further suggest that the educational needs of preparing specialist nurses is grounded in providing a strong contextual experiential-based component. Additionally, there is a strong requirement that reflective practice be incorporated into the education curriculum. Such educational preparation is particularly relevant when preparing nurses to care for the more vulnerable populations such as children, elderly clients, and/or mentally impaired clients. In this context, vulnerability is defined as the experience of being exposed to, or unprotected from, health-damaging environments (Vezeau, Peterson, Nakao & Ersek, 1998). According to these authors, vulnerable populations lack political power, economic resources and social integrity. Additionally, they may belong to a culture viewed as being

different from the norm. They are generally marginalised from the societal centre, resulting in alienation, stigmatisation and segregation. It is imperative that gerontic nurse education addresses such issues of vulnerability and delivers educational programs designed to develop specialised knowledge, explore values, and develop skills necessary for working with vulnerable populations. There is strong evidence that gerontic nursing specialists (usually RNs with postgraduate qualifications in gerontic nursing) improve quality and decrease the cost of care in long-term care facilities for older adults (Ford & McCormack, 1999; Fulmer, Flaherty & Medley, 2001; Mezey, 2001; Mitty & Mezey, 1998; Nazarko, 1997b). They also practise at more advanced levels as exemplified by Benner's (1984) 'novice' to 'expert' model', 'novice' practising from a theoretical or knowledge-based level and 'expert' functioning from an intuitive approach. This viewpoint will be further validated in later chapters, and is in fact a central tenet in this thesis which seeks to illuminate such transitions and transformations.

In concluding the literature review it is evident that the aged healthcare system is entering a new era of competition entailing demand for high quality, individual choices and economic restructuring. Such conditions will require gerontic nurses to carefully examine the fit of their services with the demands of their clients. This thesis aims to open up the thinking and beliefs that underpin much of gerontic nursing's work, and provide a lens through which the construction of a new postmodernist theoretical story of ageing and aged healthcare can be told.

SUMMARY

The literature review has shed light on the major research question of 'How have the constructs of ageing impacted on gerontic nursing practice and education?' This was achieved in the first instance by identifying and defining key underpinning constructs: culture, paradox, healthcare systems, the ontology of ageing, and myths and realities of ageing. It was established that much of the data is diametrically opposed, supporting the decision to incorporate dialectical thinking as a method of presentation to expand naïve understanding, leading to new understandings.

While it was established that to date we are no closer to understanding the complex process of ageing, researchers (Grant, 1963; Grant, 1996; Jecker, 1991; Zeman, 1945a, 1945b) did illuminate the inevitability of the human life course; each individual being given a finite quantity of material on which life depends. They also made the significant contribution to the proposition that the ageing process itself is not a disease. More recently, other studies (Jaffe & Miller, 1994; Kenyon, 1993; Nilsson *et al*., 2000; Sherman, 1994) have sought to illuminate 'old' and 'old old' peoples' experiences of feeling old in order to better understand the ageing process in later life. The consensus is that 'being old' does not necessarily equate with 'feeling old', but rather with biopsychosocial age-related changes which may threaten quality of health and life of older people. Of significance to gerontic nursing is that successful ageing, or transition to 'old old', can be facilitated by gerontic nurses, whose goal is to minimise the older person's uncertainty in order to create a new reality and sense of control (Agren, 1995; Roy, 1996; Schumacher, Jones & Meleis, 1999). Such enhanced

understanding of how older people experience ageing assists in redefining the value of aged healthcare (Geanellos, 1996; Hagberg, 1995; Oberg, 1997; Wallace, 1994).

Australia's changing population profile was explored in the context of health burden, disability and chronicity. The emergence of 'the disability model of care' in gerontic nursing practice was seen to impact negatively on care standards. The potential of the opposing model of rehabilitation was explored, foregrounding the possible need for the emergence of new theories of ageing and models of aged healthcare emerging from the old. Negative consequences associated with the ageist construct and implications for gerontic nursing practice were explored in some detail. It was established that such stigmatisation controls elderly people and limits their life possibilities (Grant, 1996; Haight *et al*., 1994; McMinn, 1997; Mendes, 1997; Minkler, 1996). The interrelationship of ageist attitudes with gerontic nursing's low job satisfaction was strongly indicated (Ellis & Miler, 1994; Judge, 1993; Kaliath & Gillespie, 1998; Leiter *et al*., 1998), particularly its effect on the culture of gerontic nursing practice (Greishaber *et al*., 1995; McNeese-Smith, 2001). While it seems certain that the gerontic nursing culture requires radical change, the literature supports the viewpoint that such activity is complex and fraught with conflict. However, few strategies to achieve such change were forthcoming, indicating the need for further exploration and reflection in later chapters. Certainly contributing factors to the culture dilemma, particularly those associated with emotionality (Behrens, 1998; Gattuso & Bevan, 2000; Hochschild, 1983; Lee *et al*., 1996; Robbins *et al*., 1992; Wheelwright, 1995) were clearly identified and some supportive measures suggested to ameliorate negative consequences (Morton-Cooper & Palmer, 2000;

Robbins *et al*., 1992). However, not all these measures appear to be underpinned by sound conceptual and theoretical analysis (Porter-O'Grady, 2001a&b). Issues surrounding the emotional engagement /detachment dialectic were pursued in the context of achieving excellence in practice. Unfortunately no clear-cut answer was forthcoming, indicating a significant knowledge gap in this domain. This finding further validates the integral nature of the sub-cultural concept of 'emotionality' in Chapters 4, 5, and 6.

The pursuit of knowledge and understanding of these constructs of ageing in the context of gerontic nursing practice and education has enabled the researcher to better understand her own past actions and experiences in aged healthcare. Additionally, such insight facilitates the narrative process as the preferred method and methodology to underpin this study. However, perhaps the most illuminating insight is that while contradictions continue to shape gerontic nursing's culture, they are largely untheorised (Rolfe, 1997). Additionally, while it is necessary for gerontic nursing to debate its reconceptualisation, the public will create the demand for nursing labour that will determine nurses' roles in the future.

CHAPTER THREE - THEORETICAL AND METHODOLOGICAL CONSIDERATIONS

INTRODUCTION

Methodology means the theoretical assumptions of how knowledge is generated and valued that underlie the choices of methods (Van Manen, 1990). It refers to the philosophical framework; the fundamental assumptions and characteristics of the work being undertaken. This chapter addresses such considerations.

Theorising is a reflexive activity shaping empirical investigations (Bengston & Schaie, 1999). It is a way to organise what we think we know. It is a critical activity. Such theorising is important in the integration, cumulative development and explanation of knowledge and the predictions about what is not yet known or understood (Meleis, 1997). Theory, in the context of gerontic nursing practice and education, is the means by which data are transformed into meaningful explanation and stories about the processes of learning and about caring for older clients (Hall, 1999).

THEORY BUILDING IN GERONTOLOGY, GERONTIC NURSING PRACTICE AND EDUCATION

There is no one grand theory to explain the ageing phenomenon (Wallace, 1994; Gubrium, 1990; Schaie, 1999) and theory development in gerontic nursing practice and education is in its infancy (Cowling, 1987). However, to move forward, to make predictions about what is yet known, observed or understood and to devise interventions to improve human conditions, requires a critical

analysis of what is known about theory development in gerontology and gerontic nursing practice and education (Cole, Achenbaum, Jakobi & Kastenbaum, 1993).

METHODOLOGICAL POSITIONS OF ' POSTMODERNISM' AND 'NARRATIVE'

As the methodological positions of 'postmodernism' and 'narrative' provide the main theoretical underpinning for this study, these positions are now explored.

Postmodernism

Postmodernism was first employed in 1917 by German philosopher Rudolf Pannwitz to describe Nietzsche's prediction of the nihilism of the 20th century. It emerged as a philosophic event in the 1980s as modernists recognised the limitations on the new view of science research and its paradigm (Rolfe, 2000). Postmodernism is not directly concerned with knowledge, but with power and political quests and the struggle to define and challenge the view of truth (Rolfe, 2000). This is why I chose such a methodological position to provide insight into who has power and why and how can gerontic nursing reclaim its power base.

Postmodernism and nursing

Increasing difficulty with conventional epistemologies and the science founded on them is leading nurse theorists ever nearer to a postmodernist 'antiphilosophic position'. Indeed, the whole notion of nursing theory is being called into question, and postmodernists would regard such theory as outmoded and unproductive (Usher *et al.,* 1997). It would seem that the current scientific

paradigm underpinning nursing practice (and gerontic nursing practice) is no longer appropriate (Spitzer, 1998b). A new paradigm is required to facilitate the investigation of human phenomena. While a postmodern position may be adopted to underpin gerontic nursing practice and education, it will be seen that postmodernism is itself undergoing evolutionary change, for example, a move from the traditional 'classical' position to an 'ironist' position.

Classical and Ironist postmodernism

Because many postmodernists opposed the total relativism of the 'classical' postmodern position, the 'ironist' position of postmodernism evolved. This position accepts the view that knowledge is socially constructed and as such is contingent on the knower. However, it rejects the judgemental relativism (the argument that we cannot judge between different truth claims) and the authoritarian method of science (Rolfe, 2000). The postmodern nurse views all paradigms, discourses and models of practice ironically. An ironist perspective nurse of the future can play whatever language game is most appropriate. Such a perspective enables the nurse researcher to put forward the unpresentable in presentation itself (Tambling, 1991), making it possible to collaboratively share the nostalgia for the unattainable, to search for new presentations in order to create a stronger sense of the unpresentable (Tambling, 1991). It is on this premise that I choose an ironist postmodern position in relaying the somewhat obscure and complex narratives underpinning much of ageing and gerontic nursing practice and education. In so doing, I reject those who are *in* authority (that is, having power) in favour of those who *are* an authority (that is, having knowledge). This parallels Lyotard's (1979) assertion that it is not a question of

what is real and what is not, or, even what counts as knowledge and what does not - or as interpreted by Rolfe (2000), not so much as who decides *what* knowledge, as who knows *what has to be decided*. Parsons (1995) and Rolfe (2000) assert that such a postmodernist position is of direct relevance to anyone who has to make decisions based on best evidence and those who have misgivings about whose authority is invested in the nursing profession.

Postmodernism and gerontology

In the context of gerontology (and thus nursing gerontology) the contribution of postmodernism is the insight that all knowledge is metaphorical, historical and contextual (Cole *et al*., 1993; Gadow, 1995; Gubrium, 1993; Kenyon *et al.,* 1991). In other words, it is storied. Among other things this means that all theories of gerontology and nursing gerontology are narratives (Bengston & Schaie, 1999). From this point of view, a theory of gerontology or nursing gerontology always contains a story with implicit and/or explicit meanings, that is ontological images of human nature (Bengston & Schaie, 1999).

Storytelling and narrative differentiated

Prior to exploring the methodological position of 'narrative' in the context of ageing and gerontic nursing practice and education, it is useful to first clearly differentiate the terms 'narrative' and 'storytelling' as they are used in this thesis. The two terms have been used interchangeably in much of the literature relevant to this research. However, Wiltshire (1995) differentiates the terms as, story being informative, while narrative is meditative and theoretical. Thus a narrative is conceptually more sophisticated than a story (Wiltshire, 1995). Narrative

involves the blending of theories with empirical or experiential material (Wiltshire, 1995). Polkinghorne (1988) makes the distinction that narrative refers to a type of organisational scheme expressed in story form, or a meaning structure that organises events and human actions into a whole. Thus while narrative *includes* stories, it is *more* than a single story. Emden (1998a) places this in a broader context by referring to 'a cultural narrative', for example, a nursing narrative perceived as all nursing cultural wisdom as conveyed through the stories of its scholars. In a similar vein, Walker (1997) considers that narrative remembering can constitute a mode of research that provides a means of articulating the trivial, ordinary and everyday routine of practice as a struggle through which we can accumulate and express cultural knowledge and criticise procedure. Bailey and Tilley (2002) summarise by asserting that narrative can be regarded as both a research method as well as a methodological imperative for better understanding the practices and language which help us shape our nursing practice. For example, narrative facilitates the paradigm or ontological shift from the dominant medical model of gerontic nursing practice to a therapeutic caring-healing approach (a desired outcome for this thesis). Nursing theories such as 'the primacy of caring' (Benner & Wrubel, 1989) and 'nursing as caring' (Boykin & Schoenhofer, 1993) suggest that narrative is also beginning to assume a role of theory development within gerontic nursing science. In the context of gerontic nurse education, Baker and Diekelmann (1994) and Diekelmann (2001) herald narrative discourse as the new pedagogy for the 21st century, as it can transform nurse education and create new understandings about thinking in nurse education. It offers a new frontier where there is transferred knowledge and construction of practice. Thus narrative's capacity to connect theory with practice, to foreground

the relationship between daily practice and knowledge, makes it a vital factor for the future of gerontic nursing inquiry.

Narrative

Through a postmodern prism, 'narrative' adopts an attitude of incredulity, a radical questioning of taken-for-granted beliefs and assumptions that underpin the entire project of modernist science. Such an attitude is appropriate to underpin this thesis as it enables me to not so much argue *against* empiricist science, but against its privileged position as the 'one story', the *only* valued way of distinguishing what is true from what is false. This attitude also enables an adherence to Usher and Edward's (1994) credence that nurses must move from thinking *about* nursing to beginning to think *as* nursing, so becoming deeply connected to life on every level of existence.

Postmodern research and reflective narrative

Rolfe (2000) suggests that in some ways nursing's move towards reflection in and on practice can be seen as part of a more general postmodern move away from the legitimate function of the metanarratives. And further, writing reflectively of our experiences produces a different, but equally valid, kind of knowledge from that obtained from scientific research. Narrative writing therefore is a creative act of synthesis, a way of constructing theory and knowledge in its own right as a methodology of doing research. Postmodernism, with its call to allow individuals to tell their own stories, is predicated to the notion of 'rational' humanity as an active an articulate self. What remains problematic is that many of the oppressed do not create conception of their own

existence. Rolfe (2000) further argues that writing has much in common with Schon's notion of reflection-on-action, and cites Van Manen (1990) as suggesting that writing creates a specific state of mind in which reflection can take place, the so-called 'reflective cognitive stance'.

Postmodern research and the narrative traditions

For Lyotard (1979) narrative knowledge, deriving as it does from individual 'little narratives', is a legitimate form of postmodern knowledge. Narrative knowledge involves more than the simple transmission of the facts from one who knows to one who does not; a narrative also carries an implicit message about the culture, and what is being transmitted. It also carries a set of pragmatic rules that constitute the social bond.

Postmodernism entails neither an acceptance nor rejection of all narratives, but instead an attitude of incredulity, a radical questioning of taken-for-granted beliefs and assumptions that underpin the entire project of modernist science. The stories nurses share daily, the narrative structures which are inherent in the fragile chains of spoken words, come to be known as dialogue and are perhaps the most central structures in making sense of nurses' everyday experiences.

Narrative and gerontology (and nursing gerontology)

The fundamental focus for a narrative gerontology (and nursing gerontology) is the lived experience of the life world of the ageing person. The narrative of ageing, although not a theory, offers an opportunity to inform theory by emphasising the whole person. It offers the possibility and challenge to put the

pieces back together, in conjunction with much research in ageing (and gerontic nursing) that examines specific aspects only (Bengston & Schaie, 1999).

Narrative and gerontic nursing practice

In the context of gerontic nursing practice, narrative provides a picture of the way gerontic nurses construct their reality through expressions of their feelings, ideas, images and aspirations. It involves the blending of theories with empirical or experiential material (Wiltshire, 1995). The study of narratives in gerontic nursing practice links the sciences with history, literature and everyday life to reflect the increasing reflexivity that characterises contemporary gerontic nursing inquiry. However, Koch (1998) cautions that if narrative is to be considered relevant and not suspect as a path for gerontic nursing knowledge, a reflexive approach to understanding narrative in relation to gerontic nursing must be assumed. Evidence of such an approach is exemplified throughout this thesis.

Because this study is concerned with the marginality of elderly clients and their caregivers' voices in a highly technical, cure-oriented system, narratives in this thesis are also viewed in a liberation context. Liberation narrative is not limited to physical nursing interventions or to status inequity issues. It includes many stories about freedom of biases and misunderstandings that limit caring practices, whatever the sources of inhibition, for example: timidity, fear of risk, fear of disclosing vulnerability, fear of intimacy and responsibility, avoidance of suffering, the tyranny of bureaucratic demands, or the tyranny of rules and procedures (Freire, 1985; Freire & Shor, 1987; McAllister & Ryan, 1996; Riessman, 1993; Tambling, 1991).

Theorising gerontic nurse education – a narrative pedagogy perspective

In nurse education and research there has been a history of attempts to mimic a medical science model which limited nursing science to restrictive thinking related to empirical knowledge as the primary way of knowing, while rejecting at worst, or at best not honouring, nursing's diverse and whole ways of knowing and being. Such limited emphasis on empirical and behaviourist science eclipsed and silenced nursing's values, philosophy and caring ethos from its natural prominence and place in the health system. Moreover, such distortions during the rise of 'modern' technical medicine were compounded by the culture of a patriarchal system further restricting nursing from its full development as a distinct discipline within both practice and academic settings. However, during the past two to three decades, nursing scholars and clinicians at multiple levels have questioned and revised nursing's foundations for education, practice and research. Nursing's re-connection with its roots and values is now, at the professional practice level, beginning to have an impact on the health and healing of individuals, families and communities. At a disciplinary level, Johns (1995) posits that this re-connection and re-vision is allowing for a more actualised health and human caring profession to emerge for a new century.

Narratives have always been a path to knowledge in nursing care. In an educational context, Diekelmann (2001) asserts that narrative pedagogy may be described as a research-based, innovative alternative for reforming nurse education. By interpreting common experiences, narrative pedagogy reveals how extant practices in nurse education open up and close down on the possibility of reforming contemporary nurse education: "[narrative] revisions nursing education

and provides neoterics approaches to schooling, learning and teaching. [It provides] new ways of thinking…even in the midst of oppressive practices" (Diekelmann, 2001, p. 65).

Narrative can also help nurses to learn the skill of involvement and being open to experience. It is especially useful for the sharing of experiences of disillusionment, and of facing loss, death and suffering. In terms of helping gerontic nurses make the sometimes difficult transition to the 'real world' of gerontic nursing, narrative pedagogy is an excellent way of knowing emotional literacy, that is, the ability to deal constructively with emotions in a mutually beneficial way (Clandinin & Connelley, 1987; Diekelmann, 2001).

The chapter now moves on to address theoretical and methodological considerations related to interpretive biographical methodology, particularly autobiography. It will explore key underpinning assumptions, advantages and limitations, and criteria to assure quality.

INTERPRETIVE BIOGRAPHICAL METHODOLOGY

The emergence of biography and narrative perspectives in gerontology and nursing gerontology has built on the work of Gubrium (1993) and has been extended by Coleman and Jerome (1999). Its emergence is seen as a response to the limitations of traditional theorising in the study of old age and healthcare for elderly people (Kenyon & Randall, 1997; Oberg, 1997; Ricoeur, 1976). Biographical inquiry offers nursing an epistemology that is both ethically and aesthetically congruent with the practice of engagement (Gadow, 1995). Wiltshire (1995) argues that the focus on narrative forms is related to the

development of the nursing profession and an alternative epistemology to science, and to nurse theorists' mistrust of 'enlightenment modes'. Biographical methodology is a combination of research approaches, which draws upon life stories, life histories, case studies, oral histories, personal narratives and self-stories (Denzin, 1989a). Interpretive biography is a form of biography that is based on the author being present in the study and openly recognising that biographical writing is in part autobiographical on the part of the author. According to Ricouer (1988), theories of interpretation, such as narrative, become the activity that produces plots, rather than the plot itself. Such narrative reality may be viewed as dynamic, able to cast new light on that which has previously been experienced as familiar (Emden, 1998a; Frid, Ohlen & Bergbom, 2000). Every text is a self-statement and carries an individual signature. Autobiography suggests the power of agency in social and literary affairs. It gives voice to people long denied access (Birren *et al*., 1996).

Autobiography

Autobiographical method shares the theoretical assumptions underpinning the society of subjectivity, and more recently, the society of emotions. Both these methodologies are largely influenced by the school of thought known as 'symbolic interactionism', which asserts that human beings act toward things on the basis of the meanings that the things have for them (Blumer, 1969). Additionally, they are influenced by 'interpretive interactionism', which speaks to the interrelationship between private lives and public responses to personal troubles, and attempts to make the private world of lived experience accessible to others (Denzin, 1989a; Ellis & Flaherty, 1992; James & Gabe, 1996).

In his influential essay Jerome Bruner (1987) powerfully articulates complex interconnections between lives lived and narrative of lives: between autobiographical acts, the contextual, provisional performances that we give shape to, and how we remake ourselves through memory, experience, identity, embodiment and agony (Ruth & Kenyon, 1996). Understanding the profound complexities of these actions enables us to better grasp the essence and complexity of gerontic nursing (Kenyon & Randall, 1997; Smith & Watson 2001). Sandelowski (1991) sees such conceptualisations of human beings as narrators, and their products as texts as constituting a potentially critical moment for nurse scholars because it can reveal suggestions and solutions for many problems not amenable to analysis by other methodologies.

Autobiography is a special case of life writing (Bowen, 1968; Denzin & Lincoln, 1994; Richardson, 1992; Thompson, Skowronski, Larsen & Betz, 1996), of dealing with 'text as text' and thereby explaining its meaning (Ricoeur, 1971, 1981; Wiklund, Lindholme & Lindstrom, 2002). Autobiography becomes the dialectical counterpart to understanding in the interpretation process, and must be followed by action and change where the interpretations are linked back to the empirical context (Wiklund *et al*., 2002). Autobiography is also one of the most difficult forms of writing. Difficult as it is to tell a story, it is more difficult to retell stories that allow for growth and change. In developing the narrative experience, there must be a reflexive relationship between living the story, telling the story and retelling the story. Such storytelling identifies and accurately describes submerged realities and often unfolds the reality shock of reflection. It unravels the social, economic, cultural, structural and historical forces that shape, distort and otherwise alter problematic life experiences (Bertraux, 1981). Frid *et*

al., (2000) assert that such narrative can mediate multiple, apparently disparate elements into a heterogeneous synthesis anchored in concrete human experiences; it reveals the lived world, but evolved in a relational situation, since the narrator always assumes some type of dialogical situation.

By confining the timescale of this study to the years in which I worked as a gerontic nurse practitioner (1973 to 2003), I have been able to explore and analyse the sociocultural contexts of my own subjective formation, thereby making personal biography a methodological tool to structure the research and at the same time placing personal experience in a public context. Historical and postmodern approaches are used to create a multi-layered narrative.

Key underpinning assumptions of interpretive biography

Interpretive biography relies heavily on the theoretical underpinnings of the qualitative research paradigm. It shares its strengths by including the use of inductive and abductive strategies to investigate topics, such as the search for meaning and the essences of human experience not otherwise amenable to investigation by other research methods, and its emphasis on causal explanation (Blaikie, 1993; Denzin & Lincoln, 1994; Ellis & Flaherty, 1992; Moustakas, 1994; Patton, 1990). It has as its focus a reflective/reflexive examination of the meaning of the subjectively perceived human lived experience and the physical, social, political, cultural, moral and historical context of that experience (Conway, 1990; Damasio, 1994; Thompson *et al*., 1996).

In interpretive biography, it is one's (or others') experiences that are the object of investigation, with the subjective sense of self, being the principal element of that experience (Ellis & Flaherty, 1992). In beginning such an inquiry, several key assumptions need to be made. A subjective experience entity designated by the term 'self' really exits, has lived a life, and has probably deeply felt the human emotions of shame, love, hate, guilt, anger, despair and caring for others (Denzin, 1992). Additionally, this 'self' has a lived duration (a temporality), that is, a subjective sense of temporal duration and life story that has endured over time (Ellis & Flaherty, 1992). It is then important that all or part of this self-life story can be captured and represented in a text embracing and expressing all the complexities, contradictions, improvisations, ambiguities, subtleties, multiplicities, vulnerabilities and revelations of these self-lived experiences (Denzin, 1989a; Ellis & Flaherty, 1992). Then, as the 'self' knows his or her life and hence is in the best possible position to write about it, the 'self' should have the last word about it (Denzin, 1989a). This experience of 'self' stands as the methodological starting point for the investigation being undertaken, as well as the theoretical orientation for the collection and analysis of data (Denzin, 1989a). Finally, through perception, cognition, and emotion, the interpretive biographical researcher defines themself and interprets and makes sense of their own experiences (Denzin, 1989a). In the light of this, the research rejects the theoretical position, that is, the imposition of some grand external theory such as Marxism, feminism or post structuralism on its project. Instead, it takes the 'internal' theorising, the everyday making sense of one's experience of the subjective self, as the principal instrument for interpreting the meaning of that self's own lived experiences (Johnstone, 1999). Once such an intrpretation has been achieved, it can be formally put forward to advance theoretical

understandings of the human condition and commonalities in existential human experiences.

Advantages and limitations of interpretive biography methodology

Interpretive biography offers many advantages to the nurse researcher: it is unobtrusive; it offers an opportunity to develop a distinctively nursing research method; it can generate a vast amount of material that could be subsequently used in other unobtrusive research; and it enables the actual production of post-modernist narratives as opposed merely to just talking about the need to write such narrative. However, there are also several limitations and dilemmas attached to this methodology (Smith, 1994). Limitations include (Johnstone, 1999): getting the methodology accepted as a bona fide and credible research methodology; the researcher choosing the methodology in the misguided belief that it provides an easy option and simple alternative to undertaking more orthodox kinds of social research inquiry; it is risky in that honest self-disclosure of the nature required by the interpretive biographical methodology could prove to be a threatening experience; it may be difficult to defend the disciplinary value of the interpretive biographical methodology, even when the research site is firmly and demonstrably located within nursing domains; and the application of the research outcomes to nursing might be less obvious than in those of other research methodologies.

Mishler (1986) and Polkinghorne (1988) both present dilemmas associated with the use of biographical inquiry. They both raise issues regarding 'core' and 'emplotment' (the two main components of narrative analysis). Mishler (1986) highlights the difficulty of specifying the boundaries of these narratives.

Polkinghorne (1988) is concerned about the lack of a single typology or system of categories to describe plots. Bruner (1987) also points out that the reflexivity of self-narrative creates dilemmas, for example, by what criteria can one determine the rightness of a story? But Sandelowski (1993, p. 8) speaks of the "artfulness of biographical narrative inquiry" and the advantage of " softening our notion of rigour to increase the playfulness, soulfulness, imagination and technique we associate with more artistic endeavours".

Assuring quality in interpretive biographical inquiry

Given the limitations and dilemmas associated with biographical methodology, it is vital that biographical researchers clarify what is meant by the concept of 'quality' in their findings. Many scholars and nurse researchers using qualitative strategies have been concerned with assuring quality in their work, and have endeavoured to resolve, or at least clarify, the 'quality' dilemmas (Emden, 1997; Emden & Sandelowski, 1999; Emden, Hancock, Schubert & Derbyshire, 2001; Guba & Lincoln, 1989; Hammersley, 1992; Lincoln, 1995; Nolan & Behi, 1995; Polkinghorne, 1996; Sandelowski, 1986, 1993, 1998). The early literature reveals that the concept of validity and reliability, as understood from the positivist's perspective, is somewhat inappropriate and inadequate when applied to interpretive research. For some researchers, the concern over validity and reliability has translated into methodological inflexibility. Others appear to ignore the issue of validity, as evidenced by the lack of reference to these issues in accounts of their work (Sandelowski, 1993). For the interpretive researcher using narrative analysis, the historical truth of an individual account is the primary issue. As a result, alternative ways of determining quality of knowledge

generated within the interpretive paradigm have emerged. These strategies are based on the recognition of paradigmatic epistemological difference. The language of this dialogue reflects the evolution of the understanding of trustworthiness, credible authenticity and/or goodness. This work reflects a fresh understanding with respect to both validity and reliability within the community of qualitative researchers. It is now recognised that the notion of validity, when employed within the interpretive paradigm, must not just be redefined, but reconceptualised. Lincoln (1995) reconceptualises the trustworthiness criteria as based in the ontology of positivism (truth) and therefore authentic criteria based on the relativism of the qualitative model.

The recent writings of researchers engaged in narrative analysis reflect the evolving complexity of the quality issue within the interpretive perspective. For these researchers, the reformation of terms such as 'trustworthiness' and 'credibility' has positively changed validity from an objective reality to the process of confirmation and validation. Trustworthiness, not truth, is the key semantic difference; the latter assumes an objective reality, whereas the former moves the process into the social world (Guba, 1981). Through the process of validation the researcher allows the reader to judge the authenticity and trustworthiness of their work. This predominant strategy is simply to make the research process visible, allowing systematic scrutiny (Sandelowski, 1993).

In the past decade nursing authors have presented a great variety of criteria for judging quality in qualitative research (Sandelowski, 1993; Thorne, 1997). Burns and Grove (1993) proposes five standards that can be used to establish the quality of qualitative research: descriptive vividness; methodological congruence;

analytic preciseness; theoretical connectedness, and heuristic relevance. Munhall (1998) offers the following criteria: the phenomenological nod, resonancy, reasonableness, repressiveness, recognisability, raised consciousness, readibility, relevance, revelation, and responsibility. Leninger (1994), drawing on the work of Lincoln and Guba (1985), proposed six criteria; credibility, conformability, meaning-in-text, recurrent patterning, saturation, and transferability. Conversely, Heshusius (1990) argues the need to farewell criteriology altogether, and that 'it is the mark of naivety to be dependent on a lot of criteria to arrive at something you can trust. Thorne (1997) argues the need for moral defensibility, disciplinary relevance, pragmatic obligation, contextual awareness, and probable truth. Others have put a case for qualitative research to include a criterion of uncertainty among the indicators of goodness and quality research (Emden & Sandelowski, 1999). Criteria such as validity, reliability and generalisability that are used to represent standards of traditional quantitative research are reconceptualised or decreed to be of less importance. Alternatively, such criteria take on a new meaning when used in the context of biographical inquiry, suggesting that a good narrative is often written according to a sense of the overall story that has been told, and provides a plausible account of life. For example, Gitlin, Bringhurst, Burns, Cooley, Myers, Price, Russell & Tiess, (1992) argue that in the case of qualitative research, validity does not refer to the truthfulness of data extracted via the research process. Instead, it can be used to determine the degree to which the research process achieves its goals of emancipation and change.

DATA COLLECTION, REDUCTION AND ANALYSIS

As there must be a variety of data forms used in interpretive biography (Ricouer, 1976, 1981), this research drew on the large amount of material that had been collected and incorporated into my reflective/reflexive 'methodological log', which has been an ongoing enterprise since beginning my first postgraduate thesis in aged healthcare education in 1990.

Methodological log and reflective/reflexive writing

Lincoln and Guba (1985) and Patton (1990) describe a methodological log as capturing in diary form a variety of information about self and methods, and documenting decisions and the rationale for the selection of, and changes of methods. It enables the researcher to monitor what is going on throughout the research process. Writing the log is a synthesis, the building up of something from a variety of components. Rolfe (2000) posits that such reflective/reflexive writing from our own experiences provides a different but equally valid kind of knowledge from that obtained from scientific research. It is composed of a variety of research-generated data that must be constantly recorded and skilfully organised throughout the research process (Koch & Harrington, 1997). Such writing is a way of knowing, a method of discovery and analysis.

Apart from my master's thesis, such data forms include: narrative pertaining to my own facticity; published articles in refereed journals (personal and joint authorship); conference papers; materials written for the Graduate Diploma/Master of Gerontology (Monash University); chapter contributions to texts; and relevant data gathered from journals and periodicals. This large volume of information has been systematically condensed, edited, sorted and

linked, until gradually patterns and themes have become apparent. In this way data have been transformed from a journalist report into academic research.

Reflective journal and reflective writing

Through reflective writing researchers not only come to understand knowledge, but can also construct theory and knowledge in its own right. Van Manen (1990) suggests that such writing creates a specific state of mind classed the 'cognitive stance', whereby researchers create something new, a creative act of knowledge generation; that is, researchers are creating and writing themselves in a postmodern context. Such text is organised, justified and supported by reasoned argument. It makes the implicit explicit, and therefore open to analysis. Barthes (1977) took this argument further to suggest that the processes of writing and research are inseparable.

Denzin (1996) suggests seven strategies to shape such work: facts are treated as social constructions; blurred genres are acceptable, for example, literary and autobiographic; use of the scenic method is advocated, that is, 'show' rather than 'tell'; construction of real people is made; multiple points of view are used to establish authorial presence; multiple narrative strategies are deployed; and writers position themselves as normal witnesses to radical societal changes. Writing within Denzin and Lincoln's (1994) framework requires the researcher to write visually in a way that reflects how what is seen is felt. Additionally, the writer must be willing to write in a way that affirms the self-narrative as a mode of inquiry that should be judged not so much against the standards and practices of sciences, but rather against the practical, emotional and aesthetic demands of life. The writer must take the risk of writing expressively and creatively, using

multiple modes of self-expression and resist the orthodox expectations of academic scholarship.

However, Koch and Harrington (1997) identify some criticisms of these strategies: writers could be accused of falsification; there appears to be no agreed upon method for validating the text; and the place in the text could be challenged. Gadamer's (1976) philosophy guides us through these criticisms by appealing to writers to incorporate a reflexive account into their research product and thereby describe to readers what is going on while researching. The reader will decide whether the research product is believable or plausible. This means gathering data with awareness of this process operating in a world of alternative representations, which serve to shape the research product with social, political and critical insight. The researcher becomes 'immersed' in this process (Ellis & Flaherty, 1992; Moustakas, 1994).

Immersion

Once immersed in the experiences of self, the researcher documents the key ingredients of the epiphany, including the turning point experience of the existential moment. This process involves a rich description of the salient event itself in which a collision with another worldview took place; the decision-making required as a result of this collision; the emotions associated with the making of the required decisions; strategies for coping and stresses associated with this moment; the symbolic environment in which the moment took place; the problems experienced; and the experience of having the experience (Ellis & Flaherty, 1992; Moustakas, 1994).

Incubation/illumination/contemplation

The ‘incubation’ process follows this data collection whereby the researcher retreats from the intense concentration focus of the project to enable another level of the expansion of knowledge and understanding to take place (Moustakas, 1994). The next process of ‘illumination’ occurs when the researcher experiences a breakthrough into conscious awareness of qualities and a clustering of qualities into themes inherent in the question. These set the parameters for writing the final account. The researcher then enters a stage of contemplation. This stage requires deep introspection and reflective examination of the meanings uncovered. Once emergent themes, distinctive qualities of the experience, meanings, understanding, and thick descriptions and representations have been distinguished and selected, the account can be written.

The process of analysing this data has been based on Ricouer’s (1976) notion that there cannot be only one method. The researcher must try different methods of presentation to expand naïve understandings, leading to new understandings. Methods for the study of personal experience, as in this thesis, are simultaneously focused in four directions: inward and outward and backwards and forwards (Denzin & Lincoln, 1994). The inward focus refers tothe internal conditions of feelings, hopes, aesthetic reactions, or moral dispositions. Outward incorporates existential conditions, that is, the environment, or what Bruner (1999) calls ‘reality’. The backwards and forward processes refer to temporality, past, present and future. To experience an event experientially is to experience it simultaneously in these four ways and to ask questions pointing each way.

Narrative research theorists call for the use of analytic induction (Denzin & Lincoln, 1994). There are regularities to be found in the physical and social worlds and that the theories or constructs derived from research should express these regularities as accurately as possible (Denzin & Lincoln, 1994). Thus, several methods were adopted in the study of phenomena within this research. This enhanced validity, and assisted in overcoming the very real danger of bias associated with adopting interpretive methodology. Methods incorporated include: reflection on and in practice, reflexivity, dialectic thinking, thematising, and narrative analysis. Each of these methods is now discussed.

Reflection on practice

Reflection entered the discipline of nursing as a radical alternative to technical rationality. Its promise was to revolutionise the way nursing knowledge is contextualised, generated, taught and applied to practice. Allen (2001) posits that through analytical and critical reflection, we can examine the ontological and ethical foundations of knowledge and praxis in nurse education and practice, and establish parameters for knowledge development for the future. The concept of reflection is gaining a significant foothold in the lexicon of gerontologists. Schon (1983, 1987) asserts that reflection is a social form of knowledge that professionals have and that this knowledge resides in practice and is constituted and held differently. One of Schon's (1983, 1987) major concerns is that professional practice, whether it be that of the lawyer, engineer or gerontologist, has been so grounded in instrumental rationalism and the science of conventions, that the actions of practitioners often become nothing more than the identification of a problem which is to be solved by applying one or other of the prescribed rules in the practitioner's store of professional knowledge. In contrast with this

overly technical and conventional approach, Schon (1983, 1987) advocates more attention to the idea of practical professional knowledge and in particular, to the indeterminate, swampy zones of practice (Schon, 1987) that lie beyond the cannons of instrumental rationalism. Reflection is a conscious process in which we think critically (Fay, 1987) about our thinking and actions in a way that gives rise to on-the-spot experiments.

Reflection on practice occurs when details of experiences are recalled through rich descriptions and analysed through careful unpicking and reconstructing of all the aspects of the situation to gain fresh insights and make amendments if necessary (Foster & Greenwood, 1998; Heath, 1998; Lyons, 1999; Wilkinson, 1999; Williams, 1998). Schon (1983, 1987) suggests that reflection is a special form of knowledge that professionals have, and that this knowledge resides in practice and is constituted and held differently.

Reflective practice involves the practitioner paying attention to 'significant' aspects of experience in order to make sense of it within the context of the practitioner's intention. By reflecting on and taking action to resolve the contradictions between espoused beliefs and actions, practitioners come to know themselves within the context of their work and learn to become increasingly effective in achieving desired outcomes (Atkins & Murphy, 1993; Maeve, 1994; Palmer, Burns & Bulman, 1994). The reflective approach is implicitly critical, in contrast with the instrumental approach that encourages nurses to adopt a non-critical stance. Such a stance denies practitioners the opportunity to articulate their own beliefs and values about nursing, and in the process, seduces practitioners into a web of conceptual attraction and illusion which ultimately

lacks meaning (Bevan & Jeeawody, 1994; Johns, 1995). Reflection, according to Piaget (1962), is a dialectic process by which higher order knowledge is created through the effort to reconcile lower elements of knowledge. In a postmodern context, writing is the perfect medium for the creation of knowledge, as it is both a creative act of synthesis and a way of constructing theory. Such writing is knowledge in its own right as well as a method of doing research. The writer begins to construct knowledge and is herself/himself unsure of what will emerge until she/he begins to write. Rolfe (2000) argues that writing has much in common with Schon's (1983, 1987) notion of reflection-on-action and cites Van Manen (1990) as suggesting that writing creates a specific state of mind in which reflection takes place, the so-called 'reflective cognitive stance'. Rolfe further adds (2000) that when we write, we are writing ourselves; the reader reads their own meaning into it.

Antrobus (1997) considers that nursing knowledge is constructed from reflecting upon experiences of nursing, with the purpose of enabling the nurse to understand and learn through lived experience. Then, as a consequence, action can be undertaken towards developing increasing effectiveness within what is understood to be desirable practice. Nursing knowledge, then, is created by the process of reflection as a dynamic integration and construction of the empirical, the clinical and the personal, in the context of the activity of doing (Antrobus, 1997; Lyons, 1999). An excellent nursing application of this research method is seen in Lumby's doctorial work (1994). She views reflection as a way for practitioners to 'validate' their paradoxical lives. By this she acknowledges the real world of practice that constrains nurses from being the people they might want to be.

Critical reflection

Critical reflection builds another quality into the process of reflection, in that it seeks to locate the reflection within the broader theoretical framework, with a view to testing out both the theory and the object of reflection. The distinctiveness of critical reflection is its claim to be emancipatory, to set people free and enable them to attain power and control over their own lives (Gibson, 1986; Mezirow, 1981). This is achieved by thinking critically and creatively to pursue meanings that enable people to make increasing sense of the world in which they live. As a methodology of scholarly enquiry, critical reflection is relatively new to nursing (Duffy & Anne-Scott, 1998). It was developed as an alternative theory, which although incorporating elements of positivism and hermeneutics, went further by adding a third dimension, emancipation. By using critical reflection, one can uncover the structures that support unjust social systems. Several writers have advocated its use in nursing (e.g. Clarke, 1993; Ray, 1992; Wilson-Thomas, 1995).

Reflexivity

Consistent with reflection and critical reflection is the process of reflexivity, or, as so aptly termed by Koch (1998, p. 1187), "the critical gaze turned toward the self in the making of the story". Reflexivity demands self-awareness by the researcher, particularly regarding the difficulty they may have in representing 'self' impartially (Gergen & Gergen, 1994). This enables an open acknowledgement of the partiality and situatedness of all claims to knowledge. Behar (1996) further expands the notion of reflexivity with her suggestion that researchers recognise this subjectivity and vulnerability when they engage in

writing about self. Such writing about 'self' is guided by Gadamer's (1976) philosophy which holds that such writing operates in a world of existing alternative representations, which serve to shape the research product with social, political and critical insights.

Dialectical thinking

Such writing involves dialectic thinking, which proceeds as if by debate between conflicting points of view. It invokes recognition that every concept contains within itself its own negation, and can only be understood by apprehending its antithesis (Kessler, 1992). This becomes the dialectic counterpart to understanding in the interpretive process. Dialectic thinking has been identified in the literature on ageing, gerontic nursing practice and education. For instance, the defeatist attitude of managing aged healthcare, as opposed to overly aggressive medical and surgical approaches for the elderly fuelled by recent rapid technological advances (Barowski *et al*., 1997). Dialectic thinking is also evident in society's perceptions of gerontic nursing practice. On the one hand society acknowledges the contributions of gerontic nurses, while on the other hand, society operates from an outdated ideology whereby it greatly undervalues them (Hallam, 2000; Schroeder *et al.*, 2000). Such dialectic thinking and perceptions are significant to gerontic nursing practice and education as they may influence the development of policy-making in aged healthcare (Gilford, 1998; Hallam, 2000). Dialectic thinking is exemplified in the appendix of this thesis, in which identified themes are analysed and synthesised within a dialectical framework. This process was most useful in clarifying my own personal understandings of data and ability to write creatively and logically.

Thematising

One method for structuring analysis is thematising (Ricoeur, 1981). To render a comprehensive interpretation the researcher must be able to go creatively beyond the structural analysis. Themes are a means of discovering the essence of the experience by encapsulating and reflecting upon it. They also provide a means of establishing order and sense in the writing process. Clustering of themes furthers this process by providing access to a large pool of information allowing a depth and richness of understanding and the potential to incorporate the dialectical nature of these themes. Thematic analysis facilitates comprehension, synthesis and theorisation of research findings. It is especially useful in research based around epiphanic experiences (such as this thesis). It is important to thematic analysis as by evoking and presenting a single narrative experience, gerontic nurses are reminded of the tensions between what is taken for granted by them and what is potentially life threatening. The interpretation process involves bringing together contradictions, paradoxes, symbols and images, thus evoking productive meaning. In this manner, interpretation is aimed at potential meanings in the future, rather than the narrator's original intention.

Thematising and my facticity

Reflection on/in practice

> I found this process to be both complex and enlightening, as well as very time consuming. Identifying the major themes across the three domains of ageing, gerontic nursing practice and education was not too difficult, as these easily fell into the two categories of 'culture' and 'narrative'. Where I became perplexed was in the identification of sub-categories pertaining to 'culture' across three such complex and diverse domains. Intense concentration over

> several weeks enabled the identification of 158 themes. Next came the agonising task of clustering these into manageable and logical categories. Illumination occurred with the identification of the four sub-categories of 'ageism'; 'emotionality'; 'transition process' and 'models'. This represented a major breakthrough for me. I vividly recall my intense excitement at this point in the research process, as I could finally see it was possible for me to verbally (in the form of writing), schematically and diagrammatically represent this complex interrelationship. However, the process was never going to be simple, as each of these sub-categorical concepts/themes has elements that are dialectically opposed and can be manipulated narratively by skilled gerontic nurse practitioners.

The verbal (written) representation is evident in the thesis content. To view the schematic and pictorial representation, please refer to the appendices of the thesis. These representations became increasingly important to me as I progressed through the research process and in fact now form the conceptual framework, especially for the proposed new model of gerontic nursing care as promulgated in chapter 7.

Narrative analysis

The narrative analysis took a number of analytic forms, moving from field to text to reader to research text, utilising the complex reflexive approach. Narrative is the written account that tells the story of practice and representations (Polkinghorne, 1995). It takes the unfolding journey, paying close attention to the steps along the way for their significance within the whole journey. To construct an adequate narrative is to weave an unfolding pattern; this becomes the plot of the narrative (Fay, 1987). Such narrative is persuasive, because it can accommodate contradictory experiences and the complexity of experience (Johns,

2002). Narrative analysis has two main components: core story creation and emplotment. Core story creation is a means of reducing full-length stories to aid the natural analytical process. It grows out of the repeated asking of questions concerning meaning and significance, and looks for patterns, narrative threads, tensions and themes, either within or across the individual personal experience (Emden, 1998a; Mattingly, 1994; White, 1973). Constituent themes are identified and woven together to create a cohesive core story. The goal of the narrative plot is to realise desirable and effective practice. Emplotment is the way in which a sequence of events fashioned into a story are gradually revealed to be a story of a particular kind (White, 1973). The significance is disclosed, that is, it ascribes sense to the story (Emden, 1998a), or, as suggested by Mattingly (1994), makes individual events understandable as part of a coherent whole, one which leads compellingly towards a particular ending. Plot gives narrative direction and focus (Mattingly, 1994). It is the plot that makes individual events understandable as part of a coherent whole, one which leads compellingly towards a particular ending (Mattingly, 1994).

SUMMARY

This chapter has explored the theoretical assumptions of how knowledge is generated and valued and how these have influenced my choice of methods. It traced the philosophical framework and fundamental assumptions and characteristics underpinning the study. While no one grand theory of ageing has been identified (Bengston, Burgess & Parrott, 1997; Schaie, 1999), many minitheories have been promulgated, these facilitating the process of understanding the complex ageing phenomenon. However, it remains

evident that a paradigm shift is required to facilitate the investigation of complex human phenomena such as ageing, gerontic nursing practice and education. The increasing difficulty with conventional epistemologies and the science founded on them suggests the need to adopt a postmodernist antiphilosphic position (Rolfe, 2000). Several researchers (Lee *et al*., 1997; Gadow, 1994; Gubrium, 1993; Kenyon *et al*., 1991; Stryker, 1996) posit that the contribution of postmodernism to gerontology and to nursing gerontology is the insight that all knowledge is metaphorical, historical and contextual; in other words, it is storied. It is on this premise that narrative methodology offers the opportunity to inform theory in this thesis by emphasising the 'whole person', as opposed to much research in aged healthcare that examines only specific aspects of personal experience (Bengston & Schaie, 1999).

My methodological choice of interpretative biography was validated as the most appropriate method of structuring the thesis and exploring how personal experiences might inform the production of knowledge in gerontic nursing practice and education. Key underpinning assumptions, advantages and limitations associated with the methodology were identified and discussed, together with strategies to ensure quality of inquiry. Finally, methods of data collection and analysis were considered and outlined: reflection on/in practice, reflexivity, dialectical thinking, narrative analysis, and thematising. The themes of ageism, emotionality, transition process and models were selected as most appropriate to highlight the interconnectedness of theory and practice and to make sense of complex and often abstract constructs.

Chapters 4, 5 and 6 now explore, discuss and analyse selected themes in the context of ageing, gerontic nursing practice and education respectively. ‘Narrative’, as the chosen underpinning theoretical and methodological framework, will be integral to all three chapters.

CHAPTER FOUR – AGEING CONSTRUCTS

INTRODUCTION – THE AGEING PROCESS

To foreground discourse in this chapter, it is useful to offer a brief review of key aspects associated with the dialectic nature of the 'ageing process' and a reflection on how I approached engagement with the three domains of ageing, gerontic nursing practice and education. The literature review identified many of these aspects and they were consequently explored in the context of their impact on gerontic nursing practice and education. It was established that the process of ageing itself is difficult to define. Some facts are indisputable; such as chronological and biological ageing beginning at conception of life, with senescent changes (functional decline) usually apparent after sexual maturation (Curtis, 1961; Finch, 1990; Martin, Sprague & Epstein, 1970; Williams & Williams, 1959). It is also evident that ageing has emerged as one of the most complex subjects facing modern science (Bengston & Schaie, 1999). While numerous theories of ageing have been postulated over time, it is important to note that as yet, there is no single grand theory to explain ageing, but many minitheories (Birren, 1999; Schaie, 1999). Additionally, while there is no unitary theory of ageing, most of the foundations of gerontological theory building, most fall into the category of 'aspect theories' in that they address some part, or dimension, of the phenomenon of ageing (Bengston & Schaie, 1999).

Some of these theories date back many years. Zemin (1945a, 1945b) associates the beginning of modern science in the early renaissance with an attempt to ward off death and prolong life. Science during the period 1483 to 1600 AD was characterised by the ambivalence regarding the concept of ageing (Zemin,

1945b). During the renaissance, exploration of the causes of ageing and different rates of ageing occurred. Theories about the ageing process included the notion that the body's moisture was consumed by its natural health, leading to the dryness seen in old age (Zeman 1945b). A distinction was also made between the internal and external causes of ageing, as well as between the normal biological conditions of ageing and pathological ones. With this notion came the conviction that one could take precautions against some of the pathological conditions of old age. It appears the desire to ward off the infirmities of old age has gradually become linked to health promotion activities.

Survivorship curves (Fries, 1989) suggest that over the course of three million years, the potential lifespan has doubled (Baltes, 1997; Kenney, 1989). Brain size has increased over the same period of time, and it has been deduced that the brain probably plays some central role in the ageing process. Biologically, Bond, Coleman & Parce (1993) describe ageing as being universal, progressive, intrinsic to the organism, and degenerative. Most molecular theories of ageing (Estes & Binney, 1989; Hayflick, 1977; Hayflick & Moorhead, 1961; Stanley, Pye & MacGregor, 1975) suggest that damage to cells and molecules underlie the ageing process. Conversely, by viewing ageing in a social context, it may be seen as a process of establishing what is expected of elderly people at various ages (Phillipson, 1998). Such a view involves the study of issues such as: social roles; self-concept; life course; age norms; age grading and social support; group behaviour of older people; and the impact of the older person on the social system (Baltes, 1997). Psychological ageing on the other hand involves changes in our minds and mental activities. It is concerned with the relationship between the individual and the social environment, and with their adaptation to both

internal and external experiences (Bengston, Burgess & Parrott, 1997). Psychological competence is related to a sense of control. This concept is important as it would indicate a link between what a person believes to be their choices, their resultant mood and subsequently with their competence.

Because the ageing process is so exceedingly complex, any study of ageing faces a complex task in reconciling different approaches and apparently conflicting evidence (Estes, 1993; Moody, 1992; McCallum & Geiselhart, 1996). For example, on the one hand there is biological evidence that the ageing process entails effects that will eventually be shared by everyone who lives long enough (Estes & Binney, 1989; Kenney, 1989). On the other hand, psychological characteristics and physiological manifestations of ageing show considerable variation depending on cultural, structural and personality factors. Again, this is of importance to gerontic nursing practice and of relevance to this thesis, as it highlights the potential for gerontic nurses to challenge and improve the ageing experience for elderly clients if they are aware of how specific forms of ageing are constituted by specific social forces. Fulcher (1989) exemplifies such a specific form of social force in the 'medical model' that professionalises disability, through identifying the medical professional as 'expert', the one who fixes the disabled person through exercising his or her professional authority and expertise over that person. In Western society, this disability paradigm is dominant in medicine and healthcare and raises many tensions, for instance, those between acute and chronic illness in aged healthcare (Goodall, 1995; Temmink, Francke, Hutten, Van der Zele & Abu-Sadam, 2000; Tombs *et al.,* 1995; Woog, 1992). Traditionally these concepts have represented opposing sides of the range of aged healthcare, yet there is not a sharp dividing line between what is acute

and what is chronic illness (Burggraf & Barry, 1995). The problems of reconciliation between these views has led to a questioning of the existing science/medicine paradigm (Kuhn, 1970; 1995). Modern aged healthcare systems do not cater well for these elderly individuals with chronic healthcare needs, primarily because services operate in a simple acute disease model of healthcare (Finkelstein & Stuart, 1996).

AGEISM AND THE AGEING CULTURE

It has been established that a modern definition of ageism aligns it with the unwarranted discrimination against people on the grounds of age alone, leading to stereotypical assumptions about how people are viewed throughout life (Behrens 1998). This most negative viewpoint depicts older people as useless drains on the energies of the young. However, an opposite viewpoint conceptualises ageing as a 'peak experience', a time of high personal achievement and growth. Maslow (1970, p. 48) argues that all people, although some more than others, have what he termed 'peak experiences' throughout their lives, defining them as:

> moments of ecstasy which cannot be guaranteed, cannot even be sought. But one can set up the conditions so that they are more likely; or one can perversely set up conditions so that they are less likely.

However, narratives from some elderly interviewees regarding the ageing experience seems to more support a negative viewpoint. For instance, this narrative reflects negativity through a feeling of powerlessness (Nilsson *et al*., 2000):

> [y]es, you can get more tired and listless and that…I don't exactly know, it's difficult to explain; yes, age begins to tell, then you become so powerless, it's too bad I think, you want to do so much and then when you start, no it's impossible, you have to wait for some other day and some other day will probably never come [chuckles], it doesn't look like it (cited in Nilsson *et al*., 2000, p. 44).

A further passage reflects negativity in this elderly interviewee's feelings of being a burden to others:

> [y]es, I'm afraid, because my legs are so weak, that's where my trouble is - yes, they're weak, and the worst of it is that I have some dizziness too and that makes me anxious. I'm afraid of falling over. Now I'll have a friend coming to pick me up tomorrow and accompanying me to the dentist's…but I'm dreading it - yes, I'm a bit uneasy in general which I haven't been before, because I know my limits now (cited in Nilsson *et* a*l*., 2000, p. 44).

Pessimistically, increasing longevity may be seen as a crisis of unprecedented proportion, depleting society's limited resources, tightening the competition for a shrinking job market, and placing a drain on the finances and other energies of the young generation. Conversely, it may be seen as an opportunity of unprecedented proportion for the continued psychological and spiritual growth of humanity by individuals who have reinvented the experiences of a lifetime into a deeper understanding of the human condition. This phenomenon of an increased life expectancy may redefine the values of work and productivity, healthcare, intergenerational relationships, and the meaning of human life itself.

A positive attitude towards the ageing process, as exemplified by both nurse and client, can facilitate a healthy transition to old age. For instance, Wondolowski (1990) argues that if aged healthcare practitioners could be guided by the practice of sharing peak experiences with their older clients, and to look for positives rather than negatives, they would facilitate the older person's exploration of creating the lived health experience.

Knowledge about ageing is passed from one generation to another by means of socialisation and other processes of cultural transmission. Such knowledge is shaped by perceptions, beliefs and often non-rational forms of dialogue. This incorrect information is acquired through biased historical persuasions of members of powerful groups. Ageism is disempowering and brutal to elderly people and may encourage them to retreat to solitary lives (Pountney, 1998). Such solitude may impede the maintenance or acquisition of desired relationships and independence and self-determination in self-care. The consequences may be a higher incidence of dependency, which may also precipitate a state of depression.

To make sense of their experience in the face of such adversity, elderly people often seek meaning (Moore *et al*., 2000), which may become a significant factor in their health and wellbeing. For example, they may seek such meaning making and self-understanding through life stories, as exemplified by this elderly interviewee:

> [i]f I want to know myself, to gain insight into the meaning of my own life, I too, must come to know my own story. I must come to see, in all its particulars, the narrative of the self – the personal myth that I have tacitly, even unconsciously, composed over the course of my years…for the elderly, perhaps more than any other group, narrative is the primary form by which human experience is made meaningful (cited in Moore *et al*., 2000, p. 28).

Such issues will now be pursued in a discussion and analysis of the second sub-construct of the ageing culture, 'emotionality'.

EMOTIONALITY AND THE AGEING CULTURE

The sub-construct of 'emotionality' has already been discussed in several contexts in chapter 2, where it was established that emotionality may be defined as work involving the self-manipulation of feelings in order to do the job (Hochschild, 1983). In an ageing context, brief mention was made of Nilsson *et al. (*2000) who undertook a study to illuminate a very old person's experiences of feeling old in order to get a nuanced understanding of the ageing process in later life. They believe that an emotional understanding of how people experience ageing assists in redefining the values of aged healthcare. Such an understanding, they assert, will be a pre-requisite when the goal is to live individually and make it personally suited, based on the personal and individual needs. The isolating consequences of changes in emotionality are also of relevance to gerontic nursing practice, as isolation in the elderly is frequently associated with loneliness, which can be a devastating condition, more so than physical illness, and can in fact lead to fatal illness (Australian Social Trends, 1999).

Loneliness and ageing

Loneliness is a feeling and a stage of being (Berkman & Syme, 1979; Moustakas, 1975). The work of Sadler (1974) explores loneliness through four dimensions, which are existential in origin (cited in Nay & Garrett, 2003). The first dimension is cosmic in nature and refers to the universe, deity, and source of meaning. In the cosmic dimension, loneliness occurs when the person feels stripped of their identity with the natural environment or physical source. Nay and Garratt (2003) assert that such a cosmic dimension of loneliness has a bearing on understanding the seeking of, and returning to, religion and spiritual practices and beliefs by old people. The second dimension of loneliness is cultural, while the third is social in nature. Nay and Garratt (2003) consider that the establishment of a social identity that is known to others and considered to be worth something is necessary for establishing social relationships. The fourth dimension of loneliness is interpersonal in nature, and can occur when a person feels cut off from those they care about. Understanding these dimensions of loneliness is useful in understanding the difference between depression and what may be considered 'normal' reactions to life events (Nay & Garratt, 2003).

The Geneva Association (2000) identifies sociality and loneliness as key factors in health and wellbeing in older people. In most European countries, a positive correlation exists between social activity and levels of life satisfaction. Reciprocity appears to be central in daily elder living (The Geneva Association, 2000). One factor partly responsible for social isolation of older people is enforced retirement at the age of 65 years. Currently the Australian Federal Government is considering opportunities to keep older people in the workforce

for as long as possible through such strategies as; modified working conditions, gradual retirement, flexible work schedules and continuing training.

In a gerontic nursing context, it may be possible to ameliorate such loneliness by harnessing some of the benefits associated with information technology. Such increased information technology accessibility may minimise many of the negative effects associated with isolation and alienation. This adaptive potential will be pursued in later chapters.

Ageing and experiencing meaning in life

Meaning in life has been identified as a significant factor in health and wellbeing in later years (Moore *et al*., 2000). An example of this is the concept of 'caring connectedness' (Moore *et al*., 2000, p. 27). Elderly people who believe they have others who genuinely care *about* them, rather than *for* them, have a deeper sense of meaning and purpose in their lives than those who perceive themselves to be alone. This is of special significance in long-term care of older adults, and suggests that a model of care that fosters a sense of 'caring connectedness' will have optimal outcomes in terms of successful transition to old age (and institutionalisation) and enhanced quality of life.

Meaning in life has also been perceived in a developmental life stage context. Erikson (1997), in his revised eight-life stage theory, asserts that there is a mistrust of the older person's own capacities and a reduced autonomy, repressed as fear, anxiety and powerlessness. Such experience diminishes the older person's capacity to meet daily demands of living and taxes their adaptive capacities, thus threatening their functional health and independence. In this

context, retaining meaning in one's life as one ages may well be viewed as a significant developmental task for completing life.

AGEING CULTURE AND TRANSITION PROCESS

A life transition is a process over time (Schumacher & Meleis, 1994; Schumacher, Jones, & Meleis, 1999) that forms a bridge between two relatively stable periods in life. A transition is initiated when a person's reality is disrupted (Selder, 1989) and this brings about changes in fundamental life patterns. A person's life and reality are structured in a way which is relatively stable over time with assumptions and expectations that create meaning (Murphy, 1990). Nilsson *et al*. (2000) postulate that feeling old equates with being in a phase of transition in later life (Barba & Selder, 1995; Golan, 1981). Their research supported Selder's (1989) previous findings, identifying the four reported characteristics of feeling old as; being able to date the beginning of feeling old, fear of helplessness and being unable to manage one's life situation, not recognising one's former self, and feeling different from others. These characteristics correspond to the main properties of a 'transition process'. Elderly interviewees who felt old were enduring the process of transition marked by disequilibrium. The process is influenced by different factors, among which the most important are; the individual appraisal of the meaning of the transition, expectations for the future, and level of knowledge and ability to meet the demands of the situation (Nilsson *et al*., 2000; Selder, 1989). In order to achieve a healthy and successful transition the individual needs to redefine its meaning and obtain knowledge about the process of adapting and expectations. The concepts are relevant to gerontic nursing practice and thus to this thesis, as it

indicates that gerontic nursing's goal should be to create a new reality and sense of control. When a person's reality is disrupted, and he/she is no longer able to recognise the structures of life transitions, uncertainty will be a dominating experience. Life transitions relevant to gerontic nursing can be developmental, situational, organisational, or related to illness (Barba & Selder, 1995; Schumacher & Meleis, 1995). In this study, transitions are mainly of the situational type, i.e. the individual encounters unexpected events that will require adaptation and of the health and illness type, which can involve acute or chronic illness. The consensus is that feeling old when you are very old, is a social experience related to being in a state of transition within the ageing process. It would seem then that there is a risk that very old people may end up in unhealthy transitions, that is, vicious circles of uncertainty and vulnerability (Schumacher *et al.*, 1999; Selder, 1989), if their being in a phase of transition is not attended to. It may well be that skilled gerontic nurses may facilitate a successful transition process once they have gained an understanding of its relevance and the required skills to achieve such positive outcomes.

MODELS AND GERONTIC NURSING PRACTICE

According to Jackson *et al*. (2001) models have a critical role in determining action and outcomes. This is exemplified in 'the deficit model of ageing', whereby stereotyping the elderly person as disabled may make them feel inferior and of less value to society (Fulcher, 1989; Oliver, 1996). Dialectically, the opposing construct of 'resilience' fosters an ability to gain renewed value in life and transform negative events into personal growth and opportunity (Dyer & McGuiness, 1996). Following from this discussion is the potential of 'protective

factors' to ameliorate some of the negative elements associated with deficit models of ageing. An example of such a protective factor may be seen in the 'caring connectedness' model. Such factors will be explored further both chapters 5 and 7.

NARRATIVITY AND AGEING

Narrative, in the context of ageing, is a scheme by which human beings give meaning to their experience of temporality and personal actions. Narration enables new meanings and further possibilities. It presumes an existential-ontological image of human beings as story tellers and story listeners, that is, human beings not only have a story but they are stories, and they think, perceive and act on the basis of these stories (Bruner, 1991; Gergen & Gergen, 1985; Josselson & Lieblich, 1993; McAdams, 1993; Nash, 1990). Narrative gerontology has profound potential for generating and learning about gerontological nursing work (Fairbairn & Mead, 1993; Kropf & Tandy, 1998). Moore *et al*. (2000) assert that for the elderly, narrative is the primary form by which human experience is made meaningful. Meaning is supported also through the therapeutic and adaptive capacity of the life review and reminiscence processes (Hagberg, 1995). Narrative also provides a voice for those who are silenced or in the margins. It makes ageing visible, fosters hope and connectedness among marginalised people, and educates those who wish to become allies in liberation struggles (Agren, 1995). A schematic representation of the analytic framework for 'ageing' may be seen in the appendix of this thesis. Exemplars of ageing narratives in the context of gerontic nursing practice and education will be pursued in chapters 5 and 6 respectively.

SUMMARY

This chapter explored the selected themes of ageism, emotionality, transition process and models in the context of 'the culture of ageing'. The dialectical nature of the ageing process is seen to be influential in successful ageing transition. It also offers gerontic nurses the opportunity to facilitate such successful transitions by emphasising positive aspects and seeking to strengthen elderly clients' resilience to ameliorate age-related adversities.

CHAPTER FIVE – AGEING CONSTRUCTS: IMPACT ON GERONTIC NURSING PRACTICE

INTRODUCTION

This chapter begins with a journey back to a cold winter day in 1973 when I was first introduced, in the capacity of a registered nurse, to the aged healthcare specialty. This reflective narrative is central to the thesis, as it became the 'epiphany' that began a lengthy career spanning three decades from 1973 to 2003.

Setting the context – 1973

Reflection on practice

> Before embarking on the narrative, let me set the scene for you. I am thirty-two years of age with two small daughters, aged six and four years. I completed my initial nurse training in 1958, and have been working, sometimes on a part-time or casual basis, as a registered nurse in a large acute care hospital, mostly in the surgical wards. My husband is transferred to a regional city and so I have no choice but to farewell my surgical nursing and look for new nursing employment in my new city. Nursing jobs in acute care at the major hospital in this city are few and far between, and if there are any vacancies, they don't suit my lifestyle as a young mum. However, the city has an enormous (and I mean huge – over 1000 beds) aged care facility, and I'm informed by many that nursing jobs are readily available with flexible hours. I must admit that the thought of working with elderly clients in such a large institution does not really enthuse me. I drive past this facility many times before finally gathering the courage to make an appointment to see the 'matron' (as she is termed). Comments from all I have encountered in the community have not helped the situation either, many relaying quite horrible stories of life within the walls of this institution.

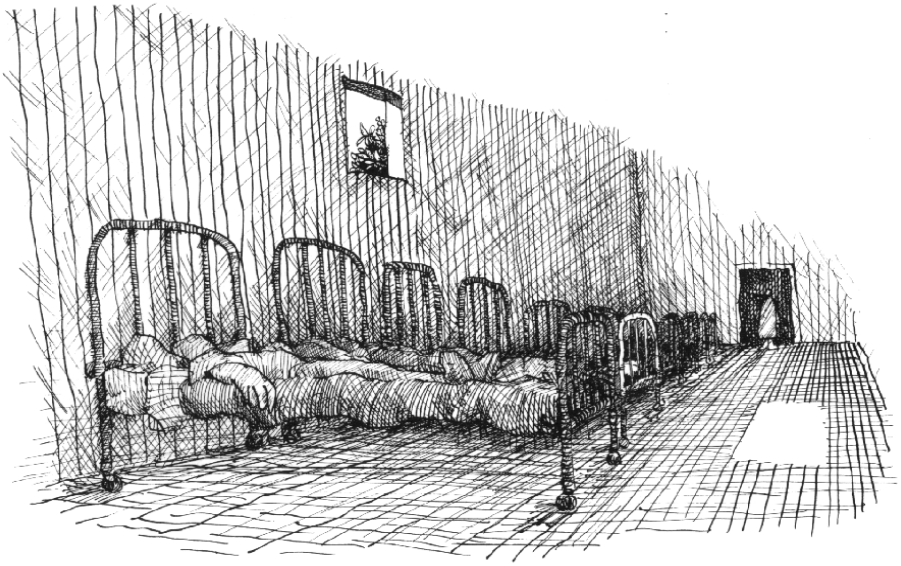
Most of the elderly people in this city in fact still refer to this aged care institution as 'the benevolent asylum', or 'the old benev', and live in dread and fear of ever having to become an inmate. It seems that admission to this facility is compared with a life sentence of despair, loneliness, deterioration and ultimately death. However, I do need a job, and after a brief interview with 'the matron', I'm hired. What follows is a narrative relaying my first impressions of my first shift in this aged healthcare facility.

Epiphanic experience

It is 8.30 am on a dreary winter's day. I have just taken two small reluctant starters to their new school and I'm about to embark on a new job. I'm feeling quite jittery, as I have never worked in aged care before, preferring the heady excitement of the fast paced surgical wards. Still! How hard can it be? After all, these are just old people who need some 'tender loving care'. The shifts are good; I finish at 1pm and will be able to pick the girls up from school.

It's 1973 and institutionalisation is in vogue. This facility is multi-storeyed and HUGE. It is home to hundreds of frail, elderly people. I squeeze into a parking lot and approach the building, still with trepidation. In the lobby I encounter a group of elderly men. Some are just sitting staring vacantly; others, in wheelchairs or sporting a variety of wheelie frames are looking expectantly at every newcomer that comes through the doors. I wonder what they are waiting for? Impatiently I push past them to take the lift to my allotted station, S2; this impersonal destination referring to the south wing of the second floor, which is home to over fifty frail, elderly women. The general tone of the place is already giving me the creeps. It is SO dark and gloomy and the smell is overpowering – a mixture of ammonia and sickly sweet jelly crystals (I was to discover that this was a new cleaning fluid

guaranteed to mask the odour of urine). I disembark on the second floor and look hopefully for some friendly face to welcome me. What a joke! A crabby woman in a green uniform points me in the direction of what looks like one wing of three in this part of the building. I open the door to absolute shambles, and the noise level is incredible. There doesn't seem to be any nursing personnel anywhere, only two stark rows of fifteen old white iron beds complete with bed rails, each housing an unidentifiable mass.



(Tully, 1986, p. 10)

Down the middle of this ward are a series of water heaters, which make ideal dumping grounds for bedpans, dishes, trays and piles of linen. If I had thought the smell on the way up was bad, this was fifty times worse. Apart from the strong ammonia and foul faecal odour, there was this overriding pungency that reminded me of contaminated meat (I was later to discover that this came from the many suppurating bedsores that were so prevalent at this time). I scuttle out of the ward and wish I could go home. With this thought in mind I am suddenly nabbed by a nurse who greets me with 'Thank God you're here, it's bedlam'(as if I need to be told).

The morning is unforgettable. I soon discover that each bed contains an elderly lady requiring urgent and lengthy attention. I am struck by the fact that they all look exactly the same; they are all wearing white gowns (missing most of their ties), all have VERY short haircuts and all are confined to bed. The furnishings are meagre and dismal. Between each bed there is just room for an old stainless steel locker and a tiny old wardrobe. The floors are dark wood and the walls, dark brick. The curtains around each bed are hospital green and mostly falling off their hooks. The blinds are a dismal grey and most are in a dilapidated state.

I spend the next four hours in a dazed state going from bed to bed trying to get these little old ladies to swallow an assortment of pills that have to be crushed in plum jam. Following this ritual, I then proceed to dress the horrendous pressure sores each lady displays. Some of these are of nightmarish proportions. The smell of Eusol foaming the debris from these wounds remains in my nostrils to this day.

Lunch is a further harrowing experience. Each lady receives two stainless steel bowls of undistinguishable food and each has to be fed this concoction. As there is only one other nurse per wing beside myself, and the time allocated for this task is only thirty minutes, the procedure involves running from bed to bed, shovelling food into reluctant mouths. At the end of this shift I am emotionally and physically shattered. I would not have believed such conditions could exist, or that this type of nursing could be so overwhelmingly draining. Surely something can be done to improve things!

Reflection on practice

At the start of my career I had never given much thought to nursing culture and certainly had never reflected, or even discussed constructs such as 'ageism', 'emotionality', 'transition process' or 'models'. I just did the tasks associated with nursing and accepted taken-for-granted assumptions about what nursing is or isn't, and expectations of me as a professional. But this aged care facility was so different from anything I'd ever previously encountered, and nothing had prepared me for the reality shock I suffered. I assumed that I was the odd person out, and that in time I would become used to it all, and so just got on with it. Now, thirty years on, with all the knowledge and experience to hand, I feel saddened that I had to undergo such moral distress and feel so alone with it all those years ago. Even today, surprisingly little research has been undertaken to examine how gerontic nurses learn to cope and come to terms with such value confusion. Bradby's (1990a) assertion that little appears to have changed since the 1950s, due to the fact that some nursing work is so taken for granted, it is not worthy of special study, seems to 'ring true'.

The facility most certainly contained all the key elements of institutions (Cummins, 1971; Goffman, 1961): all activities in the same place, under authority (loss of contact with outside); daily activities with a large group of others, all treated the same and required to do the same; phases of day's activities tightly scheduled; imposed rules and enforced activities that further the aims of the institution rather than the individual (Robertson, 1986). On reflection I am also saddened to realise that the elderly clients' responses were ones of 'learned helplessness' (Robertson, 1986), whereby they exhibited behaviours such as passivity, intellectual slowness, social isolation;,depression, and were certainly given little opportunity to exert control over their own lives (Jackson & Raftos, 1997). Robertson (1986) asserts that often the only way an elderly institutionalised resident can gain control is by

behaving badly. Even though the responses they get may be irritation and anger on the part of the staff, at least they are getting human attention. An example of such behaviour comes readily to my mind when I recall caring for one of my favourite ladies in this institution whom I will call Maude. Maude had been moved from the rehabilitation ward down to S2. Her medical notes classified her as 'not fit for rehabilitation'. This translocation represented a big change in models of care, as elderly clients in S2 were almost totally institutionalised and the principles of restorative and rehabilitative care were definitely not adhered to (even though this philosophy was promulgated by the organisation). Needless to say their functional and mental conditions deteriorated markedly and rapidly. But Maude was a fighter with high levels of resilience. Although she was unable to communicate orally (as a result of a cerebrovascular accident), she displayed her anger in more physical ways with demonstrations of behaviour uncharacteristic for her. For example, she was particularly aggressive with me, and whenever I entered her area she would demonstrate this by hurling a slipper at me with deadly accuracy and surprising force. A more passive display of her seeming aggression involved eating the dried flower arrangements which were scattered throughout the ward. It is sad to relate that eventually even this tenacious old lady succumbed to the devastating effects of learned helplessness and became a passive recipient of care. Perhaps even worse was the learned helplessness and institutionalised behaviour displayed by the nursing staff. I recall how appalled I was at the beginning to witness the robotic, institutionalised, custodial type of care these ladies received. This was especially apparent in the 'assembly line' approach in the bathrooms, where there seemed to be a 'chain gang' that progressed these ladies through the undressing, showering, redressing process, in detached, robotic movements. Equally abhorrent were the pre-meal toileting schedules, where up to eight ladies were placed on commodes in a ring in the middle of the

> ward while the staff carried on with other duties. On some occasions, if they had not yet voided or defaecated, they were fed their meal while still sitting on these commodes. Of significance is that after working on these wards for some time, I became almost socialised into these horrid processes myself. Looking back now I can see that such behaviour was indicative of a state of learned helplessness and powerlessness on behalf of the staff themselves. They received very little support from management and certainly were not made to feel valued or appreciated. They were not encouraged to have an opinion or to challenge some of the taken-for-granted assumptions and beliefs about the approaches to healthcare for these elderly people. Ongoing professional development in terms of gerontic nursing continuing education programs was non-existent.

I now better understand Robertson's (1986) challenging question:

> Do hospitals and homes send people mad? The rigid way in which some institutions are run leaves little opportunity to the individual, especially the elderly, to exert any control over their lives (Robertson, 1986, p. 29).

This narrative and discussion foreground the following analysis of ageing constructs and their impact on gerontic nursing practice. As with the previous chapter, I begin with a general discussion on cultural elements, relating them with data previously presented in chapters 2 and 4. This involves topics such as; unprecedented global changes in aged healthcare, technological innovations, cultural and environmental dilemmas according to contemporary research studies, and a brief discussion pertaining to changing gerontic nursing practice culture. This discussion and analysis foreground the discussion of the four sub-constructs of 'ageism', 'emotionality', 'transition process' and 'models', across the three

domains of ageing, gerontic nursing practice and education. As dialectical thinking is a central tenet in this thesis, these sub-constructs will be discussed and analysed in this context; consistent with Hegel's (1977) postulation that an entity must be considered not only by the positive or confirming aspects, but also by the nature of qualities or features of its opposite. Finally, gerontic nursing narrativity is explored and analysed

GERONTIC NURSING DILEMMAS

International trends and unprecedented global changes

We are living in an era of unprecedented global changes and changes in the gerontic nursing world of work (Cope & Kalantzis, 1997). Burns (2002) posits that globalisation is changing the way enterprises are managed and work is performed. The focus on productivity, quality, efficiency and competitiveness derived from innovative skills and evaluative improvements has made the quality of life of the workforce, and consequent training, critical components to competencies (to be explored in later chapters). For many people in the Western world, the unprecedented expansion of everything from technology to communications to shopping has brought with it not only increased demands of choice, in itself something of a complexity, but also an expanding potential for 'feeling out of control'. On a personal basis, I find that as I age, the challenges associated with new technology such as mobile telephones, new software products, complicated digital video display recorders, digital cameras, becomes increasingly challenging. But technological change is not just about machinery; it is also related to systems and methods. It is really the way we organise ourselves in productive enterprises. As it is a human process with human choices

and decision-making at the centre, technology is also a strongly value-laden force (Burns, 2002).

Some of these issues were previously discussed in the context of aged healthcare: for example, the fact that newer communication techniques and strategies will fully track clients wherever they may be along the continuum of care and allocate services based on their specific needs (Brooker, 2000), a process identified as *mass customisation of services*. The implications for aged healthcare and gerontic nursing are significant, as the key to ensuring rational, evidence-based practice will rest in maintaining a dialogue among the community, formal and informal caregivers, professional networks, employers and educators (Brooker, 2000). Information Technology will greatly enhance this process (Cooper & Hagan, 1999; Ingram, 2000; McCormack & Ford, 1999; McMurray, 1999; O'Brien, 2001; Schilp & Gilbreath, 2000; Spitzer, 1998a, 1998b; Wakefield, Flanagan & Pringle-Specht, 2001). Gerontic nursing needs to be able to make use of finite resources available and to come to understand what it means to live and work in this information age (Adderley, Hyde & Mauseth, 1997; Broome, 1990; Gething & Boonseng, 2000; Greenwood & Gray, 1998; Jeglin-Stoddard & DeNatalie, 1999; Johnson, 1998; Thede, 1999).

Structural and organisational changes

In a more structural and organisational context, Jackson *et al*. (2001) believe there is a need for substantial cultural change in gerontic nursing practice, particularly in view of global and national shortages of skilled aged healthcare workers (Bowers, Esmond & Jacobson, 2000; Department of Human Services, 2000; Duckett & Jackson, 1999; Jackson *et al*., 2001; OECD, 1998).

Additionally, many of those who remain working in this specialty are experiencing considerable job dissatisfaction due to a number of complex and interrelated factors. This dissatisfaction has been established in research studies. Of particular interest and relevance to this thesis are studies undertaken on job satisfaction in Australian nursing homes by Carter and Phillips (1987) and Moyle *et al*. (2003). Key factors from these studies will be discussed. Of additional interest is the fact that although these studies took place sixteen years apart from each other, results are not dissimilar, supporting the view that little seems to have changed in some areas of gerontic nursing practice since the 1950s.

Carter and Phillips (1987) undertook the first Australian study to address staff movement to and from nursing homes for the aged, in an attempt to unravel the complex reasons gerontic nurses may have for leaving their job. Questionnaires were circulated to 44 nursing homes (1243 nursing staff, RNs and ENs) in the metropolitan area of Melbourne, Victoria, with a 51% response rate. Comments received from interviewees were divided into five main categories: conditions of work, rostering, career structure, salary, and communication. General comments were that nursing staff was not allocated according to client frailty (health need); dependency of clients was perceived to be increasing and staff/patient ratios were too low in many nursing homes. In addition to the physical stress of gerontic nursing, interviewees addressed the emotional stress of working with a client population in which more than half may have some extent of confusion (Carter & Phillips, 1987).

In the context of career structure, comments mainly focused on the difficulty of combining a career with family responsibilities and lack of retraining and refresher courses. For example:

RN1 Should be more chances to update geriatric skills, i.e. weekend seminars (cited in Carter and Phillips, 1987, p. 50).

RN2 Chances to get ahead are there if you're working full-time but this is difficult with a family (cited in Carter & Phillips, 1987, p. 50).

RN3 Registered nurses with children in their late teens reassess their career or lack of it. Job sharing may be one option, career structure and portable superannuation another (cited in Carter & Phillips, 1987, p. 50).

Communication was seen as a very important means of improving standards of care. A number of nurses were aware of the importance of lack of communication between management and staff. For example:

RN We get no feedback from management on how well the job is done. Administration make decisions without any recourse to Director of Nursing or staff (cited in Carter and Phillips, 1987, p. 51).

In terms of emotional demands, many interviewees expressed work stress associated with the more specialist nature of their clients' care, and in many cases, the poorer working environment.

When comparing these comments with my early gerontic nursing experience, as expressed in narrative at the beginning of this chapter, I am amazed at the similarities between the two, despite the fourteen years difference. I too had chosen the job to fit around the needs of my family life and I also bemoaned the lack of professional development and career advancement. In fact, I felt that once I left the acute care sector to work in aged healthcare, I would never be able to return to the field and would be 'stuck with the geries forever' (a horrid statement in retrospect). I also felt there was little support or positive feedback and certainly found the work to be stressful and emotionally draining.

Comparing Carter and Phillip's study (1987) with that of Moyle *et al*. (2003) is also illuminating. The latter, through focus group interviews with twenty-seven registered nurses and assistants in nursing in two nursing homes in Queensland, sought to ascertain factors that contribute to workplace satisfaction and dissatisfaction in long-term care of older people. Interviewees cited the following contributory factors: long-term care is a workplace of convenience; contact with residents promotes enjoyment; job satisfaction comes from resident gratification; satisfaction is increased when working with people who work well with a team; job dissatisfaction is increased when tasks and time constraints prevent resident interaction; and staying overtime at work creates both job satisfaction and dissatisfaction (Moyle et al., 2003).

In the context of workplace flexibility, results from the study by Moyle *et al*. (2003) correlated with both my experiences and Carter and Phillips (1987) research. For example:

RN I had been out of nursing too long to go back to acute care and I could get a job part-time that fitted around my family…it used to be simple but it's not anymore (cited in Moyle *et al*., 2003, p. 172).

Brooker (1973)

The shifts are good. I finish at 1pm and will be able to pick the girls up from school.

RN I work in a nursing home only because I can choose my holidays and hours. I would prefer to work in a surgical hospital (cited in Carter & Phillips, 1987, p. 50).

EN Convenient hours keep nurses in nursing homes (cited in Carter & Phillips, 1987, p. 50).

Staffing levels are also seen to be of concern across both research studies and in my own facticity. For example:

Although staff recognized staffing levels were a result of government funding, they felt frustrated and impotent because they perceived that these did not provide adequate resources for the frail ageing population (Moyle *et al*., 2003, p.173).

RN There should be more than one qualified nurse on. The AINs try and do their best but often they're just running back and forth asking the RNs questions and we spend a lot of time dealing with that (cited in Moyle *et al*., 2003, p. 173).

RN The job is frustrating because there is not enough time to talk to patients and help them in little ways; they are human and I feel I'm putting them through a car wash (cited in Carter & Phillips, 1987, p.50).

And from my own facticity:

Brooker (1973)

> There doesn't seem to be any nursing personnel anywhere…as there was only one other nurses per wing beside myself, and the time allocated for this task [feeding clients lunch] was only thirty minutes, the process involved running from bed to bed, shovelling food into reluctant mouths.

These results were also similar to those of other researchers (Huston, 1996; Johnstone, 2002; Laschinger & Havens, 1996; Latrobe University, 2001; Nazarko, 1998; Stein *et al*., 2000; Tovey & Adams, 1999). The most significant factors affecting the attrition and retention of registered nurses in the workforce were identified as: the profoundly low job satisfaction felt by nurses, the importance of a supportive work environment, the importance of training programs, and work commitment.

However, while such factors (and often contradictions) continue to shape gerontic nursing's culture, Rolfe (2000) asserts that they remain largely untheorised, suggesting a need for reconceptualising the way in which gerontic nursing practice is viewed and practised. Such positive thoughts will be pursued in chapters 7 and 8. Walker (1997) offers storytelling as a strategy and structure through which gerontic nursing can accumulate and express cultural knowledge and critique procedure. He speaks of his intense pain in seeing institutional nursing trying so hard to transform practice, yet being defeated by institutional oppression.

It seems that while gerontic nursing's culture is in need of radical change, this will be no easy task. A major barrier is society's (and the nursing profession's) outdated ideology of gerontic nursing practice (Goldman, 1995, 2000). Many see this practice simply as requiring 'kind' and 'caring' personnel with minimal educational preparation. It remains to be seen whether aged care workers of the future will succeed in reshaping the rhetoric of 'tender loving care' that still cloaks much of gerontic nursing's work into a discourse that gives economic and intellectual value to the intimate work of caring intelligently, emotionally and physically for frail elderly people. Again, such aspects will be further pursued in later chapters.

AGEISM CONSTRUCT AND GERONTIC NURSING PRACTICE

It has been well established that many gerontic nurses hold ageist attitudes and do not enjoy working with elderly clients (Brower, 1985; Ganong, Bzek & Manderino, 1987; Happell & Brooker, 2001; Kaliath & Gillespie, 1998; Philipase, Tate & Jacobs, 1991). The most powerful influencing factors are the profoundly low job satisfaction felt by gerontic nurses, lack of professional respect and support, lack of ability to influence the working domain, and deprivation of rewards (Ackroyd, 1993; Kangas, Kee & McKee-Waddle, 1999; Karlin, Schneifer & Pepper, 2002). Many researchers (Aiken, Clarke, Sloane, Sochalski, Russe, 2001; Heasel, 1999; Mills & Blaesing, 2000; Shields & Ward, 2000; Winter-Collins & McDaniel, 2000) have identified evidence of widespread dissatisfaction among gerontic nurses in aged care facilities. This dissatisfaction has serious significance for gerontic nursing in Australia, as achieving a high standard of care for elderly clients depends on the ability to attract qualified,

motivated and interested staff. Burns (2002) believes there is a need to redirect management philosophy towards more democratic and participative organisations, with an acknowledgement of the vital importance of a workforce that has job satisfaction, is encouraged to be responsible, and that uses its initiative and self-direction.

The ageist element in gerontic nursing is well exemplified in my own collaborative paper (Happell & Brooker, 2001) which presented the findings of a research project conducted in Victoria, Australia, investigating the career preferences of undergraduate nursing students. Questionnaires were administered to 847-year one undergraduate nursing students in Victoria (Happell, 1999). Working with elderly people was located within the first three preferences for only 7.3% of students, while 59.5% ranked it within their last three choices (Happell, 1999). A negative view of the clientele, the working environment and/or one's own previous experiences with the elderly were cited as reasons for such low ranking (Happell, 1999). Some comments by student nurses illustrate these reasons:

SN 1 I have had experience with working with the elderly and I found it unrewarding and boring and unchallenging (cited in Happell, 1999, p. 502).

SN 2 Elderly people don't interest me and they are just so wrinkled and annoying (cited in Happell, 1999, p. 502).

SN3 I find it very stressful being around elderly - particularly those who are sick (i.e. in nursing home). I would feel very depressed/ disturbed by working constantly with elderly people – I get too emotionally upset (cited in Happell, 1999, p. 503).

SN4 I think that working with elderly people is too tiring and requires a lot of physical activities like lifting. It is also very disgusting as you have to clean up messy things. Some of them are very bossy (cited in Happell, 1999, p. 503).

The results of Happell's study (1999) are clearly consistent with the literature (for example, Ganong *et al*., 1987; Philipase *et al*., 1991; Stevens & Crouch, 1992). This is most unfortunate, as while such attitudes and misconceptions about caring for older people abound, the nursing profession will continue to struggle to attract nurses to undertake a career caring for older adults (Happell & Brooker, 2001). Providing examples of best practice, both theoretical and during the clinical practicum, may rectify the negative image of gerontic nursing by student nurses. Additionally, those working with elderly people need to document and disseminate their strategies and experiences to contribute to the body of gerontic nursing knowledge.

In a gerontic nurse education context, however, other researchers such as Stevens and Dulhunty (1992) and Stevens and Crouch (1992) suggest that the three-year nurse education program does little to challenge student nurses' negative views about caring for elderly people. However, the revised student undergraduate nurse curriculum evolving as a consequence of the project commissioned by the Australian Government and developed by Queensland University of Technology (QUT, 2004) may ameliorate this situation. The *Principles Paper* will again be discussed in the context of this thesis in chapter 7.

On the other hand, working in the more highly technological areas of nursing practice, such as operating theatre, emergency departments, and surgical wards

became an increasingly popular aspiration over the three-year period. Stevens and Delhunty (1992) conclude that:

> [t]he evidence …would suggest that pre-registration nursing education programmes produce registered nurses who are socialised during their student years to perceive 'real' nursing as a role associated with acute general hospitals and the manipulation of technology and 'machines that go beep' (Stevens & Delhunty, 1992, p. 109).

Happell (1999) concludes in her study that:

> [t]he nursing profession must seek actively to portray the equal importance of all aspects of nursing care, and to deter the situation where certain aspects of practice are considered more important and/or more desirable than others (Happell, 1999, p. 505).

Ageism and economic rationalism

Nay and Garratt (2003) argue that ageism in the healthcare system needs to be considered in the context of the set of public administration principles often refered to as 'economic rationalism'. In a similar vein, Pusey (1992, 1993) considers that any significant opposition to the reforms led by economic rationalism are nullified by the endemic ageism occurring in health and welfare services for the elderly. Pusey (1993) further adds that the entire notion of caring for older people is under threat because nurses and medical practitioners are becoming 'autistic choice-receivers', that is, by allowing economic efficiency to control their clinical environment. In doing so, they are actively (although perhaps not intentionally) practising a form of bigotry towards the majority of

people most in need of their services. Such a practice is exemplified in long-term care in the continued tensions between documentation and caring, the former a mandatory activity required to ensure ongoing government funding, and in acute care settings, in that the levels of staffing in the aged care wards differ from most other wards. A further example is seen in the use of volunteers or untrained assistants. These personnel rarely work in intensive care, theatres or heavy surgical wards, but they are increasingly utilised (especially in private hospitals) on wards where older people are in the majority. The main argument for employing untrained assistants is an economic one: untrained assistants are theoretically cheaper. However, McCoppin and Gardiner (1994) dispute these assumptions, believing that the cost of mistakes and inefficiencies occurring as a consequence of employing untrained health personnel are likely to outweigh the savings made on cheaper wages. Kuehn (1990) asserts that high proportions of non-qualified nursing staff lead to the likelihood of regulatory intervention and create a burden of paperwork and stress not experienced in other settings. Jackson *et al.* (2001) consider that understanding the impact of economic and policy decisions on nursing and the nursing workforce is crucial in order to seriously address the critical and ongoing problem of sustaining a viable and highly skilled workforce.

Deregulation, ageism and economic rationalism

Some of the major issues facing clinicians in caring for older people are a direct product of economic rationalism (Gee, Hull & Lankshear, 1996; Pusey, 1991, 1992; Rees, 1994). Nurses acquiesce in reductions in services, and staff find the demands made by older sick people are unacceptable in a health system stripped

of its staffing assets (Nay & Closs, 1998; Nay & Pearson, 2001). Yet nurses still lack the will and cohesion to use the industrial strength and conviction of its large numbers of working members to stop the reductions. The staffing of the residential aged care sector has largely been deregulated. This has allowed a proliferation in the sector of untrained workers at the expense of jobs for trained personnel, such as enrolled and registered nurses.

Fairweather and Gardner (2000, p. 32) argue that "[i]herent in the practice of the specialist nurses is ownership, accountability and responsibility". In a similar vein, Styles (1982, p. 21) describes such a professional nurse as having "a deep and abiding awareness of purpose and direction in place of a set of objectives or standards". According to Griffin (1983), professional practice is determined through professional caring that is the moral emotion of respecting the dignity and autonomy of another human being. Fairweather and Gardner (2000) further caution that as healthcare is now practised in such complex environments, expert clinicians are required to deliver appropriate care. Their study (2000) of the construction of practice and knowledge empirically demonstrates that specialist nurses define themselves through the synthesis of education and experience. Chapter 2 explored some aspects of the debate about generalist aged healthcare workers and nurses versus specialist gerontic nurses. As I consider this to be a central tenet in this thesis, the topic is further analysed and synthesised in chapter 7.

Evidence suggests that the numbers of qualified nurses in aged care are decreasing at the same time as demands for care are increasing (AIHW, 2000). Recruiting and retaining sufficient qualified nurses in aged care constitutes a

major challenge to quality care outcomes (Commonwealth of Australia, 2001; Commonwealth Department of Health & Aged Care, 2001; Estes & Swan & Associates, 1993; Karlin *et al*., 2002; McNeese-Smith, 2001; Queensland Health, 1999; OECD, 1998; Tai, Bame & Robinson, 1998; Wagner & Huber, 2003). Registered nurses are cost effective, and increasing unqualified staff to cut costs reduces short-term salary costs, but increases overall long-term costs (McCormack & Ford, 1999; Wagner & Huber, 2003).

EMOTIONALITY AND GERONTIC NURSING PRACTICE

In chapter 2 'emotionality' was discussed in the context of dilemmas in gerontic nursing's culture. It was established that entering into the nursing specialty of caring for elderly clients (especially for the first time) can be an overwhelming experience. This is validated by literature (Bradby, 1990a&b; Christman, 1991; Gaberson & Oerman, 1999; Hamel, 1990; Kramer, 1974, 1985; Reutter, Field, Campbell & Day, 1997; Ward, Bochner & Furnham, 2001; Williams & Williams, 1959) and also by my personal experience. While little research has been undertaken to examine how gerontic nurses learn to cope with such high levels of emotional demand, some researchers (Bradby, 1990a; Kramer, 1974; Louis, 1980) have suggested that such an experience might equate with a 'status passage', whereby participants are required to undergo a process of change from one social status to another. Other researchers (Glaser & Strauss, 1971; Louis, 1980) posit that such a process is accomplished when the participant has managed to 'make sense' of, or integrate into the 'institutional norms' associated with caring for elderly clients. Hedin (1986) and Rather (1994) assert that explanations of internalised powerlessness and oppression are vital to

understanding this phenomenon. Emotional consequences associated with an outdated ideology of gerontic nursing practice have also been addressed, such as those associating nursing (and particularly gerontic nursing) with the femine qualities of being loved and kind, and the vocational drive to care for people (Bowden, 1997). Gattuso and Bevan (2000), whose study examined work within the predominantly female environment of aged care nursing, identify phenomena, that must be accounted for in a theory of emotional labour. Many of the expectations which arise from this idealised representation centre around the way nurses manage their emotions. They must always appear kind and caring, but must be calm and detached (Bolton, 2000; Cole, 1999; Fineman, 1993).

Viewpoints of nurses concerning the definition of emotional labour in the 'caring' role of nursing are exemplified in Smith and Gray's paper (2001), which explored current definitions and meanings of emotional labour, students' views of education, and clinical support of emotional labour.

N1 [c]ontinuous contact, feeling like you're on-call 24 hours a day and always available to the public, and 'giving the patient the feeling of being safe and warm (cited in Smith & Gray, 2001, p. 44).

N2 A part of nursing is to show you care for them, even if you're having a terrible day and are fed up yourself and with everyone else (cited in Smith & Gray, 2001, p. 44).

N3 I think if you are emotionally burntout, you don't give anything emotionally and patients soon cotton onto that fact. There are lots of nurses who are burnt-out and who don't know how to cope and do erect a wall. But then if you continually give and give and give and give, all the things I might be saying might be the right things, and I might have learnt to say all the right things, but they might not really mean anything to me anymore (cited in Smith & Gray, 2000, p. 46).

Henderson's recent study (2001), as discussed in chapter 2 also supports these assumptions. One of the most consistent themes arising from this study involved nurses' views regarding the relevance of emotional engagement and detachment in the pursuit of excellence in their practice. In a similar vein, Leiter *et al.* (1998) established that the clinical health sector experiences the highest levels of emotional exhaustion and burnout, reflecting depletion in emotional energy. They argue that this is most clearly a signal of distress in emotionally demanding work, and results in depersonalisation. Personal sensitivity is an essential quality in therapeutic relationships. It can be renewed through rest, learning, social support and successful experiences. In the absence of these, chronic exhaustion ensures disengagement and depersonalisation. Leiter *et al*. (1998) considered that burnout is related to lack of experienced reciprocity at the organisational level, and that when individuals feel they invest more in their organisation than they receive, they burn out. It would seem that when people are no longer free to negotiate their own rate of emotional exchange, when emotional management becomes another saleable aspect of labour power, the feelings become commodified (Beck, 1995; Cole, 1999; Ellis & Miler, 1994; Maslach, 1982; Tschudin, 1997). It is clear that nurses not only experience strong emotions in

the context of work, but also consciously use these emotions to hone, refine and improve their practice. This is a high-level skill, and one which requires dual caring and great honesty, tenacity and perseverance.

Dual caring (the maternal model of caring) will be explored in greater depth in relation to the sub-construct of 'models' later in this chapter. However, as the complex construct of 'care' has emerged quite predominantly in this discussion and analysis of emotionality, some time needs to be devoted to it before moving on to the next sub-construct of 'transition process'. There appears to be some confusion in this country between the professional nurses and personal carers and this appears to lie in a misunderstanding of the nurse's role (Nay & Pearson, 2001). 'Caring' as a moral ideal or the foundation for nursing is perceived to be the core of nursing (Bishop & Scudder, 1997; Bolton, 2000; Wilson, 1993). It has five dimensions: knowing, being with, doing for, enabling and maintaining belief. Older clients desire 'care' which observes and enhances individual dignity through the ability to make choices and exercise control over their lives, to be treated with dignity, and with positive attitude by nurses. They identify the attributes of 'caring' as protecting, supporting, confirming and transcending. One of the most important issues in this debate on the caring construct revolves around the nature of caring, both as a concept and as applied to the core of the nurse's role. Nursing's central dilemma has been persuasively described as "being ordered to care in a society that refuses to value caring" (Reverby, 1987, p. 85). The personal emotional investment is virtually unrecognised and is certainly unacknowledged, but clearly involves feeling and personal vulnerability (Baker & Diekelmann, 1994; Barker, Reynolds & Ward, 1995).

Such vulnerability has been well exemplified in my own facticity (Chapter 5). For example:

Brooker (1973)

> I scuttled out of the ward and wished I could go home…at the end of the shift I was emotionally and physically shattered. I would not have believed such conditions could exist, or that this type of nursing could be so overwhelmingly draining.

And by Henderson (2001):

> The decision of any individual nurse to care for (or emotionally engage with) a client is therefore one which exposes the nurse to the potential for personal costs or benefits as well as professional ones (p.131).

The consequences of gerontic nurse caring are often witnessed as moral integrity and distress (Yarling & McElmurry, 1986). When one is bombarded by such events and actions that shock one's moral integrity, one either gets away from it all, or deadens its impact by not seeing it anymore. Moral distress occurs when nurses cannot provide the care they believe is appropriate because of the facility's restraints and are thus forced into collaborating in behaviour they judge to be unethical. This is exemplified by my previous discussion pertaining to nursing models and also by this nurse interviewee in Kelly's study (1998). She sought to describe, explain and interpret how new graduate nurses perceive their adaptation to the 'real world' of hospital nursing and what they felt were the major influences on their ethical roles and moral values in the two years following graduation. Symptoms of moral distress closely parallel symptoms of depression.

A negative view of self and identity, manifested by feelings of worthlessness, self-blame or negative self-evaluation is symptomatic of clinical depression (Higgins, 1989; Jack, 1991). Because persons have a strong need to be the kind of persons they believe themselves to be, the awareness that they are not living up to one's values and principles causes themselves grief and distress (Higgins, 1989). They learn to rationalise, a form of self-deception, and provide themselves with good reasons for their actions (Allport, 1982).

This is exemplified by this nurse's narrative in Kelly (1998)

N1 …a patient has a large decubitus ulcer. Nutrition is a very important thing. Without it there is no improvement. Three of these are total feeding. A round of meds to be given at noon and - someone is being discharged and you have to stand there and try to feed these patients and you end up sending back a tray - some of the trays two-thirds full-someone should have stood there and fed those people. They needed that. They needed that more than they needed the medicine you just gave them but I know that if I didn't give the medicine and it wasn't signed off there would be holy hell to pay. While if I send back a tray that is almost full nobody is going to bother. It is wrong, but there is no other way (cited in Kelly, p. 1139).

In this instance the nurse has learnt to rationalise her prioritisation of giving medications over feeding patients, a dilemma paralleled in my own facticity.

It can be seen that the construct/concept of 'care' is full of contradictions, as further exemplified by this nurse in Bolton's paper (2000) who argues that nurses' work is emotionally complex and is better understood by applying a

combination of Hochscild's concepts (1983) and the concept of 'emotion work as a gift' in addition to emotional labour:

Staff N

> …what we do…is not recognized as anything special – it's just something that we do. But could you do what we do? There are not a lot of people who could. You have to really, truly care and yet at the same time be able to cope with caring too much and remain professional. If that's not a skill I don't know what is (Staff nurse, 1997, cited in Bolton, 2000, p. 585).

The contradictory notion of 'caring' is also exemplified by this psychiatric nurse in Johns (2002):

Psychiatric N

> [n]ursing is far from my expectations, my personal practice is not what I want; it is confined by so many limitations. All my idealism forced to the recesses of my mind, never perhaps to be realised…to change the face of something so massive at what cost to myself? At what worth to others?…the routine continues, the relentless routines...I need to reshape what I do, because it swallows me like a whale…I am not complacent about the issues that affect my feelings about my job, but maybe I am worn down (cited in Johns, 2002, p. 174).

Rationalising one's change of values is vital to resolving moral distress and personal crisis. While there is a need to revise one's self-concept, there are also ways to gain self-respect. Many construct a professional identity, which means incorporating within the self the image of self as viewed through the eyes of the team. Because preserving moral integrity involves such self-protective strategies,

inevitably self and identity are changed by this process (Kelly, 1998). Goffman (1961) illustrates how such moulding of a person's identity occurs. Goffman's work focused on the notion that each person's life can be viewed as a 'moral career'. He suggests that each moral career has two sides. Internally it involves how persons see themselves, how they experience their identities, and the motivation that influences them. Externally, it involves the influence of social groups and the existence of hierarchical systems and organisations. Maintaining moral careers involves changes in how persons view themselves and their criteria for judging themselves and others (Gergen, 1971). This concept has been clearly related to nursing by Smith (1992), who observes in relation to one nurse's story:

> She recognises that, as a nurse, she is expected to be happy rather than cross and to manage to and cope with extremes of feelings… She learns through 'trial and error' to 'switch off' and 'forget about work' when she gets home. But is this is through surface acting to the point that she can no longer remain involved with patients other than at a superficial level, at the risk of becoming detached and alienated. Or can she learn through experience and systematic training to recognise her feelings and to remain therapeutically involved both for herself and her patients (Smith, 1992, cited in Henderson, 2001, p. 132).

In the context of gerontic nursing practice, caring as an attitude and activity is critical. Moral caring requires a quality of care that touches the human spirit and promotes health and growth in both patients and nurses. Tennant (1999) suggests that perhaps the challenge for student nurses and their teachers is to recognise that caring, healing and nurture can be perceived not as an end in themselves, but

as instrumental to achieving health gains. From this position, professional nurses may articulate their value to society.

TRANSITION PROCESS AND GERONTIC NURSING PRACTICE

While the previous segment addressed entrance into the culture of gerontic nursing in terms of 'status passage' and 'sense making' (Bradby, 1990a, 1990b; Glaser Strauss, 1971; Kramer, 1974; Louis, 1980), this segment more specifically explores the closely aligned concepts of 'transition process', 'culture shock' and 'reality shock' (Greenwood, 1993; Kelly, 1992, 1996, 1998; Murphy, 1990, 1998). It closely parallels the older person's transition to old age as discussed in chapter 2. According to Selder (1989) the main properties of any transition process include; fear of helplessness and of being unable to manage one's life situation, not recognising one's former self, and feeling different from others. Such a transition process is indicated when a person's reality is being disrupted. The process is influenced by different factors among which the most important are; the individual appraisal of the meaning of the transition, expectations for the future, and level of knowledge and ability to meet the demands of the situation (Barba & Selder, 1995; Schumacher & Meleis, 1994). In order to achieve a healthy and successful transition, the individual needs to redefine the meaning of the transition, and obtain knowledge about the process of adapting and expectations. The goal is to eliminate uncertainty in order to create a new reality and a sense of control (Murphy, 1990; Schumacher *et al*., 1999).

Again, when I read this data, I am acutely aware of how useful it would have been to me personally all those years ago when I first embarked on a gerontic nursing career. At that time I had no knowledge about culture and culture shock,

and so blamed myself for what I felt to be my shortcomings in adapting. Such issues will be pursued in greater depth in chapter 7. Some of this moral distress is also exemplified by other colleagues, for instance, this graduate nurse's narrative relaying the experience of being a new graduate, and cited in Kelly's (1998) study of nurses' perceived adaptations to the 'real world' of hospital nursing:

> …it is just the global newness…it is kind of overwhelming. You are new to the setting, new to all the technical skills and new to the personalities. It is very difficult to hold yourself together and function in those early months. It is just kind of an overwhelming plunge, I think. Not everyone survives it (cited in Kelly, 1998, p.1137).

According to McDowell and Forsyth (1990), in their study to investigate job satisfaction of nurses and clues to nursing shortages, new practitioners encounter 'reality shock' primarily as a result of staffing levels which do not enable nurses to provide the level of care they expected. In a similar vein, Kelly (1998) sought to ascertain what graduate nurses perceived as major influences on their moral and ethical roles in the three years following graduation. Moral integrity was the basic psychological process that explained their adaptation. Although Kelly's study (1998) focused on undergraduate students making the transition to registered nurse status in the acute care sector, based on my experiences in aged healthcare, the data is transferable to situations such as I encountered back in 1973 and which are still evident today. For example, I have witnessed on many occasions the obvious difficulties encountered by quite often highly experienced registered nurses in acute care nursing when they are transferred to long-term care wards, especially dementia-specific units or gerontic rehabilitation wards.

Additionally, this transition anxiety process in gerontic nursing is ongoing in this healthcare discipline. I find that each time I am required to work in a different sub-specialty of gerontic nursing, such as dementia care, I am faced with similar anxieties to those I encountered in 1973 and those I witness others encountering on a daily basis. I am certain that the knowledge gained from research such as Kelly's (1998) facilitates adaptive potential. This viewpoint will be promoted in chapter 7.

Fortunately I was able to 'make sense' of my gerontic nursing reality in 1973, mainly due to support received from my family and friends. Not only did I become accustomed to the feelings, sights, sounds and smells associated with caring for elderly clients, but I actually came to love working with them, as exemplified by my reflective narrative (recorded in my methodological log):

Reflection on practice

> I grew to love working in this facility. It was like belonging to one huge family. I wondered how I could have felt so negative, or believed that the residents all looked the same. As I became involved in the personal lives of these elderly folk, their families and their loved ones, I began to appreciate the uniqueness of working in this specialty.

'Making sense' of the reality of gerontic nursing work is also exemplified in both Moyle *et al*.'s and Carter and Phillip's studies.

RN 1

> It's the most all-round nursing that I have ever done. It encompasses everything and is so rewarding when you sense that you have made a difference in the day of a resident (cited in Moyle *et al*., 2003, p.172).

RN 2

> I love my oldies. I consider they deserve the very best nursing care in every way (cited in Carter & Phillips, 1987, p.50).

RN 3

> I find great satisfaction working with old people and…some count the days until I come back (cited in Carter & Phillips, 1987, p.50).

Reflection on practice

> Such narrative, based on reflection on practice in gerontic nursing offers much transformative potential. I still learn and pass on information by recounting the many stories occurring on a daily basis in my everyday practice. For example, the magic of sneaking out of the ward with Mary (one of my favourite demented elders) to purchase huge bags of lollies from the kiosk and then devouring most of them in the garden before returning to the ward. The frustration of returning from lunch break to the dementia unit to discover that some of the clients have been busy moving furniture out into the garden and are now gleefully 'surfing' on the bedside tables. Or the hilarity of finding Bob (also a favoured demented elder in long-term care) happily urinating into all the sterile dressing bins in the treatment room. One could go on for ages, and nurses often do when they meet socially. It is the sharing of these stories that in some way sustains and informs us as gerontic nurses.

MODELS AND GERONTIC NURSING PRACTICE

Jackson *et al.* (2001) assert that models of care shape the way nurses work and the way care is delivered, and have a critical role in determining nursing actions and outcomes. Any radical change to gerontic nursing and aged healthcare in general will require the power bases of medicine and administration cultures to be challenged (Street, 1992, 1995). McCormack and Ford (1999) argue that:

> …[e]nsuring effective person-centered care with older people is a complex issue for nurses and is fraught with difficulties, [and that] [t]he health, social care and nursing services offered to older people today are influenced not only by issues such as societal perceptions, but also by the way in which the services have developed (McCormack & Ford, 1999, p. 42).

It has been argued (Agrich, 1993; Jackson *et al*., 2001) that many of the traditional perceptions and patterns or models of care for gerontic nursing do not derive from older people themselves, and are not intrinsic to nursing older people. Aspects such as chronic underfunding, inferior care environments, inadequate equipment, low staffing levels, lack of appropriate educational preparation, lack of professional support, low priority given to the service, and general perceptions of older clients as inferior in some way, have profoundly influenced the way in which many, including health and social care professionals, think about nursing older people.

If, as Kuhn (1970, 1995) believes, science, and thus nursing science, is cyclical in nature, consisting of periods of normal science (such as the current situation), and revolution (future science), such radical change may be possible. It requires

gerontic nurses to apply the principles that lead to new discoveries in caring for elderly people with long-term health problems.

Models of caring

As has been seen, the concept/construct of 'care' is often contradictory in nature, particularly so in long-term care of elderly clients (Aiken *et al*., 2001; Baker, 1985; Barker, Reynolds & Ward, (1995); Benner, Tanner & Chesla, 1996; Boykin & Schoenhofer, 1993; Gattuso & Bevan, 2000; Woodward, 1997). Nurses *are* caring, but in many cases without recognising the consequences of this type of care, or even that optional ways of caring exist (Boykin & Schoenhofer, 1991). Many staff employed to provide care for elderly people have no formal nurse education to draw upon and draw on their mothering experiences to inform their practice. Conversely, of those who do have a nursing qualification, many were schooled in the medical model and have not recognised the inappropriateness of this model to care for older people. James (1989) discusses the gendered nature of emotional labour as enacted within healthcare settings and the way in which caring work gets constructed as 'naturally female', deriving naturally from women's position and work within the family, and therefore devalued as a commodity:

N1 I still think nursing is seen as women's work. A lot of doctors – their attitude…a bit backwards in their way of thinking (cited in Henderson, 2001, p.134).

Additionally, the invisibility of the older person's association with family care means it has ambivalent status. While the ideological values of family care may be attractive, the low status and lack of acknowledged transferability of the skills

means these values do not fit effectively with professional status (James, 1992). Gattuso and Bevan (2000) examine emotional work within the predominantly female environment of aged care nursing, as discussed in chapter two. They identify the phenomenon of the blurring of public and private women's experiences and the maternal model of care. Their findings demonstrate the high levels of stress experienced by staff related to emotional labour and to the conflicts around the erosion of care standards. Phenomena such as dual caring, conflicts, insider-outsider roles and transference are revealed in their narratives. Many women in the focus group interviews conducted by the researchers released long-suppressed feelings of anger or in terms of frustration and grief.

This viewpoint is exemplified by Nola's (a personal care attendant) narrative:

Nola …I just go up there and sit around all afternoon with a group around a table and laugh, and have fun while we pretend that we are doing embroidery and craft. It is me getting that mother thing that I missed all my life and I know it. I go up there and I am the beloved daughter of all these lovely old ladies and they give me affection and I give it back (cited in Gattuso & Bevan, 2000, p.896).

In this instance, Gattuso and Bevan (2000) posit that Nola's personal investment in relationships with those in her care puts these relationships at risk since they are based on unconscious psychological processes such as transference. Such processes take little account of the nurse as person and expects a standard of care based on the assumption that caring is natural, in the same way that mothering is normal. Such a dual caring issue brings into sharper focus dilemmas around caring, such as conflict between caring roles or being an insider with expert

knowledge and an outsider of a care system (such as a relative of a resident). If these conflicts go unrecognised and unsuppressed, or the emotions they evoke remain outside awareness, both the nurse and the recipient of her care are damaged. However, the emotional labour and energy needed to sustain self is considerable. This issue is further addressed in chapter 7.

The acute/chronic illness dialectic

As previously established in earlier chapters, traditional gerontic nursing practice is in need of change if it is to progress as a specialty within the science of nursing. One force compelling such change is the growing 'tensions' between views of acute and chronic illness (Burggraf & Barry, 1995, 1998; Easton, 1999; Nolan, 1997, 1999; Nolan *et al*., 1997; Temmink *et al*., 2000; Woog, 1992). Traditionally, acute and chronic illness have been seen as requiring radically different approaches within gerontic nursing care. Yet there is no sharp dividing line between what is acute and what is chronic illness. According to Easton (1999) this growing dilemma can have but one satisfactory outcome: the change in gerontic nurses' approach to holistic care of elderly clients.

A second problem arises from the essential tension between gerontic and rehabilitation nursing. Easton (1999) asserts that through rehabilitation nursing the emphasis will move from just 'recovery' to 'recovery of abilities', accentuating the positive and adaptation to any limitations. Easton (1999) further asserts that nursing's methods and procedures must reflect that rehabilitation is at the core of, and the prevailing framework for, all gerontic nursing. She adds that this can only occur as nurses become educated about the process of rehabilitation. Hopefully, it could be that over time, as this idea is developed, a shift will occur

and a new paradigm will emerge. However, a barrier to such innovation may lie with gerontic nurses themselves. While they acknowledge the need for such changes, they remain reluctant to diverge from the comfort circle of the current gerontic nursing medical model paradigm of care.

Best caring models need to be developed in gerontic nursing practice based on humanistic principles and holistic practice, for example, primary nursing models that encourage negotiated care, and emphasise wellness, greater client autonomy and independent decision-making, and are associated with not only higher job satisfaction but also with better outcomes (Benner *et al*., 1996). Without the advantages of appropriate education, role models and support measures to resist everyday ageism and reconstruct caring practice, it can only be expected that 'caring' will unwittingly be devalued and dehumanised. Informed care will not occur while increased demands are met with decreased services. These issues will be further explored and synthesised in chapter 7 and recommendations for future gerontic nursing practice suggested.

GERONTIC NURSING NARRATIVITY

The final element in this chapter addresses narrativity and gerontic nursing. Narrative, in a general context, has already been addressed on several occasions, as it is a key theoretical and methodological framework underpinning this thesis. However, in the context of this chapter, gerontic nursing narratives may be defined as the combination of beliefs that surround important nursing symbols, myths and rituals by unfolding the 'reality shock' of reflection (Buchanan, 1997). Narrative is ideological, as it facilitates reflexivity, hope and connectedness. It uses the fabrication of images and the processes of representations to persuade us

that gerontic nurses are who and what they are because that is what they should be. As a theoretical framework for this thesis, narrative opposes the logico-scientific mode of thought by linking science with history, literature and everyday life. The study of narrative reflects the increased reflexivity that categorises gerontic nursing practice. Theories such as 'the primacy of caring' (Benner & Wrubel, 1989) and 'nursing as caring' (Benner *et al*., 1996; Boykin & Schoenhofer, 1991)) suggest also that narrative is beginning to assume a role of theory development within gerontic nursing science, which of course leads to the narrative's application as a research method/methodology for this thesis (as discussed in chapter 3). In a caring-healing context in gerontic practice, narrative facilitates the ontological shift from the dominant medical model of aged healthcare to a theoretical, caring-healing approach, which has been in the margins (Baker & Diekelmann, 1994). My personal viewpoint is that one of narrative's most valuable contribution to ageing, gerontic nursing practice and education is its transformative potential: as by facilitating the sharing of realities and experiences (whether they be in ageing, gerontic nursing or gerontic nurse education), transformations are facilitated. I extend on this viewpoint in the context of gerontic nurse education in the next chapter.

SUMMARY

The chapter began with the 'epiphany' that actually spawned this thesis. Such was the moral distress suffered when I first entered the gerontic nursing specialty as a registered nurse, that even thirty years later it still remains a vivid memory. By analysing this experience in the context of theories and constructs discussed throughout the thesis, further 'sense making' has eventuated. I have developed a

much deeper understanding of the complexity of caring for elderly clients and the interrelationship between so many socio-economic and political factors. Such understanding will guide and enlighten my future, both as an ageing individual and as a continuing aged healthcare professional.

It was interesting to compare and contrast some of the Australian (and other) studies undertaken to ascertain factors related to job satisfaction and dissatisfaction and staff shortages in aged healthcare. While there doesn't seem to be any magical answers, an understanding of such factors assists in future staff planning. Of particular interest is that little seems to have changed in gerontic nursing over the past fifty years, as exemplified by my own reflections. According to Kuhn (1995) this will create the domino change effect required to solve many of gerontic nursing's current dilemmas.

CHAPTER SIX - AGEING CONSTRUCTS: IMPACT ON GERONTIC NURSE EDUCATION

INTRODUCTION – EDUCATIONAL TENSIONS

The ontological foundations of gerontic nursing's knowledge and praxis are critiqued and parameters for future development examined; this is facilitated by the processes of reflexivity, narrative analysis and dialectic thinking. This discussion is offered as a way of challenging current assumptions about gerontic nurse education and its epistemological base. Some relevant aspects of the other two domains of this project – ageing and gerontic nurse education – will also necessarily be addressed.

Prior to exploring the educational domain of this thesis in the context of its conceptual framework (that is, ageism, emotionality, transition process and models), I review the major findings about educational issues identified in the literature review.

Previously presented key issues enumerated

1 One thing seems certain: the existing scientific paradigm of technical rationality on which gerontic nursing is built, is no longer adequate to meet the needs of practising nurses (Bowen et al, 2000; Nazarko, 1997a, 1997b; Spitzer, 1998a, 1998b).

2 We are at the end of healthcare as we know it, and the end of gerontic nursing as we know it (Nazarko, 1997a, 1997b; Spitzer, 1998a, 1998b).

3 The theory/practice gap remains the most fundamental issue currently facing nursing practice (and especially gerontic nursing practice), since, if the profession cannot be certain that theory is reliably and accurately translated into practice, then it cannot be certain of anything (McAllister, 1999; Palmer *et al.*, 1994; Phillips *et al.*, 1993; White *et al.*, 1993).

4 What is unique about nursing (and gerontic nursing)? It's the process rather than the outcome, a highly skilled and specialised activity which unites practice, research and education in the indivisible whole of nursing praxis (Bowen *et al.*, 2000)

5 Gerontic nurse education must prepare students for meeting health systems of the future, not the past. (Nazarko, 1995; 1997a, 1997b, 1998).

6 Growth in technology has changed the nature of care of the elderly and about this care teaching and learning (O'Berski *et al.*, 1999; Nazarko, 1998; Spitzer, 1998a, 1998b). The use of computers in healthcare use are limited only by imagination (Felton, 2000; Lindeman, 2000).

Gerontic nursing knowledge

What is gerontic nursing knowledge? As with nursing knowledge in general, gerontic nursing knowledge has a unique epistemology, defined as both the facts and experiences known by a person or a group of people (Apple, 1993). Antrobus (1997) considers such nursing knowledge to be constructed from reflecting upon experiences of nursing with the purpose of enabling the nurse to understand and learn through lived experience. Then as a consequence action

can be undertaken towards developing increasing effectiveness within what is understood to be desirable practice (Johns, 1995). Such action requires a high level of personal involvement, and has at its essence reflexivity. Gerontic nursing knowledge, then, is created by the process of reflection as a dynamic integration and construction of the empirical, clinical and personal, in the context of the activity of doing.

Theorising gerontic nursing education

The adoption of a medical science model has in the past limited gerontic nursing science to restrictive thinking related to empirical knowledge as the primary way of knowing, thus rejecting gerontic nursing's diverse and whole ways of knowing and being. Such emphasis on empirical and behaviourist science eclipsed and silenced gerontic nursing's values, philosophy and caring ethos from its natural prominence and place in the health system. There remains a need for a new context for gerontic nursing education, a need to establish education policies that acknowledge and plan for projected demographic and economic shifts (Barron, 1999; Kanitsaki & Johnstone, 2002; Porter-O'Grady, 2003b). Through analytical and critical reflection the gerontic nursing profession can examine the ontological and ethical foundations of knowledge and praxis in gerontic nursing education and practice, and examine parameters for knowledge development in the future (Allen, 2001). There also remains an urgent need to prepare gerontic nurse specialists adequately for the complex role of caring for older people (Nazarko, 1995). McCormack and Ford (1999) posit three themes underpinning such a role: role definitions and gerontic specialism, the social/medical themes which address the shift towards a social model of care, and the psychological

health/mental theme which represents the need for greater integration of skills and knowledge. Further, the authors assert that in contrast to the generalist, the practice behaviours of the specialised nurse are directly attributable to their knowledge base. This knowledge is a synthesis of propositional knowledge and practices.

Worldviews for gerontic nursing knowledge development

In a clinical context, Gorin (1998) identifies the main directions, dilemmas and challenges facing gerontic nurse practitioners in the future: the demographic shift to ageing; concern for social justice; the growth and expansion of managed care organisations; continued move away from hospitals and institutions to community; integration with complementary and alternative medical approaches; accountability and performance (evidence) based care; increasing costs resulting from technology explosion; and values for the practice of health promotion.

In a similar vein, Kulbrok *et al.*, 1999) postulate three worldviews in which nursing can be formed and parameters examined for knowledge development for the future:

1 *The mechanistic-community health nursing science worldview.* Nursing practice in this context would be focused on the restoration of individual human agency in illness and health.

2 *The orgasmic world view,* emphasising organic interrelationships, partnerships and interactions, and

3 *The developmental-contextual worldview* where emphasis is on describing and understanding patterns and forms of phenomena. Change is inherent in such a system. The focus is on empowerment of a common mutual potential for health and wellbeing. Kulbrok *et al*., (1999) herald this worldview as the potential overarching framework for what nursing could be in this new millennium.

Consistent with the views of these authors, questions underpinning this research project focus on issues of how we as gerontic nurses acquire and operationalising such a worldview of elder care. I have come to accept that positive outcomes are reliant on conceptual debate and challenge within the gerontic nursing profession about the purpose of gerontic nursing and its epistemological base, which has not, so far been evident. My personal goal is that research such as this project may contribute in some small way to this change.

Education and the changing role of gerontic nurses

Nursing education has reached an exciting stage and has the potential to value practice-based learning. We need to establish equal partnerships with practice and experiment with different teaching and practice modalities (Conway-Welch, 1996; Fagerberg *et al.,* 2000; Jorgenson-Huston & Fox, 1990). Nurses need to progress through three stages: awareness, reflection and development. Such education needs to be learner-focused and based on learner-centred constructivist and sociocultural philosophies and theories to guide students as they construct their understanding of professional nursing practice. The learning community needs to support such learners through interactive relationship or cognitive apprenticeships as they acquire the skills, values and roles of the professional

(Lee *et al.,* 1999). This approach prepares the student for the real world, is problem-based, and furthers new approaches to practice. Such innovative educational programs would focus on the learner and their special needs. Content would be based on role orientation (as opposed to task orientation), creative thinking, and problem solving skills. Such skills and learning would be acquired through access to a range of educational resources. The Internet and emerging collaborative learning tools will enable new ways of teaching and learning in networked communities characterised by group communication, place and time independence, multimedia, and computer-mediated messaging. However, the reality is that gerontic nurse education on the whole still operates in an illness and disease-oriented paradigm. Behavioural competencies are still in vogue and student nurses are trained to demonstrate them (Hartrick, 1999; Romyn, 2001). There needs to be a major shift in the underlying philosophy and practice of nurse academics. This requires a construction of a unique epistemology of empirical, clinical and personal ways of knowing, the conceptualisation of gerontic nursing knowledge. Some progress has been made in this direction and innovations such as those identified in QUT's *Principles Paper* (2004) offer some insight into how such change can be effected. Chapter 7 of this thesis also offers a model of care in which new educational endeavours and approaches which are underpinned by postmodernist narrative learning theories may herald such new conceptualisations.

Curriculum implications

Such innovation have an impact on gerontic nursing education curriculum evaluation, and according to some researchers (Bayliss *et al.*, 1999; Hockey,

1997; Mann & Reece, 2000; Parker *et al.,* 1999) critical analysis of curriculum such as that espoused in the *Principles Paper* (QUT, 2004) will need to pursue issues such as:

1 To what extent does the curriculum reflect the realities of the changing world of aged healthcare and gerontic nursing practice?

2 Are our graduates and employers of our graduates satisfied with their preparation and readiness for the world of work? If not, why not?

3 To what extent do we collaborate with a range of aged healthcare clinical practice settings?

4 How do we provide for students' and stakeholders' participation in curriculum development and evaluation?

5 What proportion of our clinical learning experiences should take place in ambulatory and community-based settings?

6 How effective are we in collaborating in our clinical practice?

Contributory factors for gerontic clinical practice change

Many factors have contributed to the impetus for clinical change. Bond and Holland (1998) espouse the following:

- broad organisational change;
- policy directives;
- concerns about accountability;
- improving standards;
- philosophy of care, empowerment, partnership;

- education, maintaining competence, reflective practice;
- concern abut practice health;
- prevention of burnout;
- development of therapeutic interventions, and
- self-awareness.

It is evident then that tensions have arisen in the gerontic nursing profession in the past in relation to the extent to which its recruits can be prepared for gerontic nursing professional practice and the extent to which this constitutes education or training. Many researchers (Davies, Slack & Laker & Philip, 1999; Mezey & Fulmer, 1999; Robertson *et al*., 1999; Skiba, 1997; Stevens & Crouch, 1995) have asserted that educationally gerontic nurses have been poorly equipped to cope with the multi-faceted health problems of the elderly, leading to a sense of frustration, powerlessness, and poor quality of care. The following is exemplified by such nurse interviewees' narratives:

RN There should be more chances to upgrade geriatric skills, i.e. weekend seminars (cited in Carter & Philips, 1987, p. 50).

Or these undergraduate student nurses' statements:

SN1 I work in a nursing home and can't see much expansion of your general medical knowledge, procedures etc (cited in Happell & Brooker, 2001, p.16).

SN2 I don't believe it would offer as much of a challenge as acute areas (cited in Happell & Brooker, 2001, p. 16).

Or on a more positive note by this enrolled nurse:

EN I enjoy the work and now that I have done a lot of training in dementia I really like working here. I feel I can relate to people with dementia (cited in Moyle *et al*., 2003, p. 172).

In an Australian context, studies such as those carried out by Queensland Health (1999) indicate that few nurses working in this area pursue relevant professional development, and that the education focus on the nursing needs of older clients in regional care facilities was minimal. Beck (1995) linked this educational deficit with society's ingrained and traditional values and images of nurses working in this specialty. More recently, Nay and Pearson (2001) point out that this century promises yet another global nursing workforce shortage, and that the debate on who should be nurses and how they should be educationally prepared, still rages, after 150 years. They believe that if gerontic nurse education is to fulfil its obligation to advancing aged healthcare and remain relevant; it must be responsive to changing healthcare needs in the broader society. Tensions pertaining to the legitimate role of various levels of aged healthcare workers in the context of education have also been previously addressed. Of concern has been the proliferation and domination of the sector by untrained workers at the expense of jobs for trained personnel such as registered and enrolled nurses. Much of this is influenced by an economic rationalist approach endemic in healthcare in general, and aged healthcare in particular. The AIHW (2000) established that clinicians in gerontic nursing constitute 14.3% of the workforce, but these numbers are rapidly declining. With the ongoing deregulation in the aged healthcare industry, the numbers of qualified nurses in these areas will have further decreased significantly. Recruiting and retaining sufficient qualified

nurses in aged care constitutes a major challenge to quality care outcomes (Commonwealth of Australia, 2001; Commonwealth Department of Health and Aged Care, 2000; Latrobe University, 2001; Queensland Health Ministerial Taskforce, 1999).

The impact of deregulation in aged healthcare is reflected in nurses' narratives in many recent studies undertaken to explore why nurses may experience job dissatisfaction in aged healthcare. For instance Moyle *et al*., (2003) identified that job dissatisfaction is linked to working with unskilled and inappropriately trained staff as shown by this narrative:

> **EN** Dissatisfaction is more related to who you work with than the resident. You could be working with someone who you don't think should be here or who is doing the wrong thing and you don't necessarily have a good day (cited in Moyle *et al*. (2003, p 172).

Dialectically gerontic nurse educational tensions are also evident in society's perceptions of gerontic nursing practice and education. On the one hand, society acknowledges the contributions of gerontic nurses, but on the other hand, operates from an outdated ideology (Hallam, 2000; James. 1989), whereby it greatly undervalues them (Hallam, 2001; Schroeder, Trehearne & Ward, 2000). Offsetting this somewhat negative ideological representation, other researchers (Boykin & Schoenhofer, 1991; Clandidin & Connelley, 1987; Diekelman, 2001; hooks, 1994; Cash, Brooker, Penney, Reinbold & Strangio, 1997) posit that narrative pedagogy may be a useful transformative nursing education approach to enable nurses to explore such ideological questions that underpin their everyday practice. I have certainly found this to be the case in my own gerontic nurse education experiences.

Certainly it is evident that tensions abound in relation to the extent gerontic nurses can be prepared for professional practice (Duffy & Anne-Scott, 1998; Gifford & Edwards, 1994; Glass & Todd-Atkinson, 1999; Tishman, 1993). It is also evident that relatively little is known about teaching and learning in the gerontic nursing workplace, or how experience is utilised to become 'expert'. Benner (1984) draws on the work of Dreyfus (1972), who developed the 'Dreyfus Model of Skill Acquisition' and undertook work in the 1970s on how United States Airforce Pilots develop their skills, to conceptualise the way nurses learn in the workplace and develop from 'novices', through being 'advanced beginners', 'becoming competent', then 'proficient' before possibly achieving 'expert' status. Major features of Benner's work (1982) address cognitive learning and the abilities learners develop to transfer learning to different situations. Some researchers (Bevis & Murray, 1990; Burgiere, 1999; Diekelmann, 1988; Hanson & Waters, 1991; Luggene, Travis & Meiner, 1998) are concerned with the limited scope of gerontic content in nurse education programs, and a general ambivalence on the part of nurse educators. Travis and Duer (1999) posit that much of the curriculum in gerontic nurse education still focuses on institutional settings and prepares basic practitioners for a world that is quickly disappearing.

AGEISM AND GERONTIC NURSE EDUCATION

Ageist attitudes in gerontic nursing have been validated in previous chapters and now further exemplified in nurse narratives' such as the following:

N1 The general public think nursing the elderly is degrading work. Residents can be rude and ungrateful, treating you like slaves. Co-workers can be unhelpful. There is never enough time to do things properly and talk to the residents. You can become irritable; get a headache, become unmotivated and accident-prone. You rush around and suffer from exhaustion. Staffing levels are bad and the only feedback we get is negative. There is no support...Feelings I have are frustration, guilt, grief, resentment, anger and helplessness. Feelings are suppressed because of the culture of the work environment. You can't acknowledge your feelings when you are having a 'bad day' and you can't provide quality of care. You feel isolated and unable to vocalize opposition to certain policies (cited in Gattuso & Bevan, 2000, p.893).

Such attitudes also emerged in my own research (Brooker, 1999) as a lecturer and course developer in a graduate diploma in gerontic nurse education program when I interviewed ten rural elders to ascertain their thoughts pertaining to 'the reconceptualisation of ageing'. These elderly people were invited to suggest ways of helping aged healthcare professionals to change their often negative attitudes to ageing or to facilitate more positive attitudes to caring for elderly clients. Some of this dialogue is included to further exemplify the misunderstanding and misinterpretation of the complex role of nurses in aged healthcare.

Brooker (1999)

> We are meeting today to talk about nursing's negative attitudes towards ageing and caring for elderly people. How do we change this? One way is to gather stories about the real image of ageing

from older people themselves. This type of learning/teaching seems most appropriate for nursing.

Do you think the quality of life of elderly people in rural areas is getting better/worse/or the same?

I1 For anyone sick, they get better attention when they finally get it, but if they're not seriously ill, there's not much help available. Sick people don't get near the same care from college/university nurses – it has deteriorated markedly. These nurses might know all about drugs etc, but as far as sympathetic care etc, forget it. These students are programmed for high technology. When you try to address nurses, they are not really interested. We need nurses to actually value nursing again.

Brooker

Do you think that nursing needs a new approach?

I2 There is a need to constantly evaluate where we are going…there needs to be more interactions with people getting services and those giving…we need to think about how to go forward in the best possible way.

I3 I think there's a need to enthuse students about caring for elderly people…maybe the power achievers in your courses should not be concentrating on oldies. The top people go for technology, but the others have a place in the sun. From my experience in running a Nursing Home and Hostel for thirty years, my observations are that those people working in these places are very special. They have huge hearts. They may not have huge minds, but they know what the residents need.

I1 Yes! I agree. Nurses caring for the elderly need more humanness; we don't need academics for this task.

I3 Perhaps we need two levels, the lower caring level and the higher level which informs policy, research etc. You don't need high quality people looking after elders. They just want to be loved and cared for.

Brooker

Is the image of nursing a problem? Perhaps while doing the low level tasks, the skilled nurse is also doing the higher level tasks of assessment, planning etc. They may be sorting out what's average and what's pathology. And all the time they will be monitoring and reporting.

I3 Yes! I agree with all this, but you still don't need high academic programs for working with these people. You need teaching of course, but it has to be selective.

I2 Hang on! I really have difficulty with these lower levels. I really don't like that John. The skills of caring for elderly people are very special, not less, just different, they shouldn't be considered as lower.

I3 I'm not saying they should be unqualified, but they need different levels of skills and knowledge. Those who believe themselves to be too superior to get their hands dirty in this way, well we don't need nor want them near us. We need more empathy and less ambition.

I1 In the old days they had trainees and nursing aides. My feelings are that we need knowledgeable academics, but for creature comforts for nursing, nursing aides are much better at the human quality of looking after nursing care. Sisters and doctors can look after the medical tasks.

Reflection on practice

I must say that I was quite amazed at these comments. I had thought that these senior citizens, who were the pillars of this rural society, would have more contemporary views pertaining to gerontic nurse education. Instead, their comments more resembled the outdated ideological tensions previously discussed, whereby while they acknowledge the contributions of gerontic nurses; they fail (or chose to fail) to acknowledge the complexity associated with modern aged healthcare. They consider it to simply require 'tender loving care'. Obviously, much work is still required to overcome ageist attitudes in society in general, as well as in gerontic nursing practice.

In chapter 7, I explore some of these future possibilities for gerontic nursing education.

EMOTIONALITY AND GERONTIC NURSE EDUCATION

I have established that understanding the emotional demands of caring for elderly clients may be one of the most important steps towards retaining these highly valuable, skilled and knowledgeable aged healthcare workers (Behrens, 1998; Gattuso & Bevan, 2000; Lee *et al*., 1996; Goldman, 1995; Kaliath & Gillespie, 1999). Unfortunately, research indicates that gerontic nurse education has failed to address such emotional requirements for the work gerontic nurses do (Henderson, 2001). One of the most constant themes arising from Henderson's study (2001) involved the nurses' views of the correct balance between regarding

emotional engagement and detachment in the pursuit of excellence in their practice. This skill was not one that nurses had been formally exposed to in their professional education. Many expressed professional disappointment in this failure of nurse education to address the emotional requirements of their work as exemplified in these nurses' narratives:

N1 To be quite honest, what we got in college was management this and management that, how to manage time, how to manage resources, how to manage money…I've learnt nearly everything on the wards. From other people's knowledge, other staff nurses and in just talking to your patients (cited in Henderson, 2001, p.134).

N2 I was trained very much that you just got on with it…You weren't suited to nursing if you couldn't - you know. Externally I spent a lot of time covering up emotions (cited in Henderson, 2001, p. 134).

There is considerable evidence that nurse education is increasingly emphasising self-awareness on the part of the nurse as well as increased understanding of the patient as a whole person with emotional needs which influence physical ones (Manson, Backer & Georges, 1991; Malterud, 1993). Yet from these nurses' accounts, they are not receiving the message during their education. Henderson (2001) concludes that:

> [a]s much attention needs to be given to the emotional components of the preparation and support of those in caring work as is given to the theoretical and skill component. Clearly, emotional labor and emotional engagement or detachment is under-theorized in relation to caring work in general (Henderson, 2001, p.137).

Other researchers (Kelly, 1996; Kramer, 1985; Speedling, Ahmadi & Kuhn-Weisman, 1981) have also identified such emotional aspects of nursing as being problematic, especially for new graduate nurses, or those making transitions to new fields of nursing. While organisational and professional support in terms of collegiality or mentoring are known to ameliorate emotionality, there is still little evidence of these supportive mechanisms in practice. Again this is exemplified by a nurse narrative in Henderson's study (2001):

N1 But at the end of the day you know, the hours that you have to put in…nobody could care less about you, they just push you to the limit (cited in Henderson, 2001, p.134).

And as stated by Henderson (2001) herself:

> [t]hey [nurses] generally also felt professionally ignored and unappreciated by their employers and by other healthcare professionals within the workplace (Henderson, 2001, p.134).

TRANSITION PROCESS AND GERONTIC NURSE EDUCATION

This discussion of the 'transition process' overlaps the previous sub-construct of 'emotionality'. Both clearly indicate the critical need for appropriate and continuing educational programs to address emotional aspects associated with gerontic nursing practice, and to facilitate the 'sense making' required to achieve a successful transition to gerontic nursing practice.

This need is clearly exemplified by Kelly (1998):

> Nursing students, especially, are intensely aware of the discrepancy between what they experience in hospital practice and what they are taught in schools of nursing…Melia (1987) found that students coped with this discrepancy through

> rationalization and compartmentalization…come to terms with 'two versions of nursing' each with its own standards and rules…rationalizing that they are just passing through (cited in Kelly, 1998, p.1135).

According to Selder (1989) the main principles of any transition process include; fear of helplessness and being unable to manage one's own life situations, not recognising one's former self, and feeling different from others. Surveys reveal that new graduates are keenly aware that they need much support in making the transition from new graduate to experienced nurse. Yet, as multiple studies show, the real world experience of the new graduate is extremely traumatic (Burton & Burton, 1982; Kersten & Johnson, 1992). A further example is provided by Hamel (1990), who studied the transition of student to practising nurse using an ethnocultural method. The purpose of her study was to understand the influence of the hospital subculture on the socialisation of the neophyte. She believed that a new graduate's entry into nursing practice is typified by fear of failure, fear of total responsibility, and fear of making mistakes. In a similar vein, other researchers (Brief, Aldag, Van Snell & Melone, 1979; Kramer, 1985; McCloskey & McCain, 1987; Oechesle & Landry, 1987; Speedling, Ahmadi & Kuhn-Weisssman, 1981) conclude that new graduate nurses experience severe job stress. They cite exacerbating factors in such stress as: lack of confidence, unrealistic self and clinical staff expectations, role conflict and role ambiguity; value conflict, and lack of support. Huy (1999) asserts that the social climate into which new graduates enter is of great significance. If the above factors are not heeded and attempts made to ameliorate their impact on nurses, emotional exhaustion and burnout can result.

It can be seen that while gerontic nurse leaders have the challenge of turning workplaces into dynamic and engaging learning environments by guiding care workers through the maze of concepts and ideas emerging in the clinical workplace, little research has been undertaken to understand ways in which knowledge of ageing is produced and reproduced. Gerontic nursing knowledge therefore still embraces rigid perceptions about ageing and embraces notions about dependency, autonomy and other non-rational forms of imagery. More positively, the process of reconceptualising work and learning is already evident in some aged healthcare organisations, where new employees are encouraged and assisted to extend their educational capacities in learning through their work. One such strategy is the Clinical Information Support System (McDowell *et al.*, 1984; O'Brien, 2001). This system utilises modern technology and information systems to provide an 'electronic' climate in which teachers/mentors/preceptors become strategists and establish a climate of sorority and fraternity, of equality and scholarly seeking. They raise questions and issues, and dialogue with nurse students and new graduates so that they become partners in the continuing education process (Bevis & Watson, 1993; Mastrian & McGongile, 1999; O'Brien, 2001).

Characteristics of clinical support systems

Some researchers (Abdullah *et al.*, 1997; O'Brien, 2001) have identified characteristics associated with clinical support systems. These include:

1 In the rapidly changing aged healthcare system with its increased reliance on information technology, gerontic nurses need to keep their knowledge and skills up to date, know how to search for and access evidence, and

apply and adapt clinical knowledge to the individual's needs. These systems help gerontic nurses in achieving such objectives.

2 Help gerontic nurses to identify and define their information needs by incorporating these needs into data elements and structures that can be used in the design of computerised databases.

3 Provide cues to enhance gerontic nursing practice and optimise elder client care outcomes.

4 Assimilate practice and research findings to guide gerontic nurses in day-to-day practice.

5 Access to information on clinical areas ensuring clinicians do not to have to visit a library or other resources to gather data.

6 Links also to professional colleagues and evidence-based best practice guidelines.

As much of the process is reliant on information technology (IT), it is useful to build on previous discussions of this technology in the context of gerontic nursing education. This of course requires computer literacy on the part of gerontic nurse practitioners, which may or may not be a tool highly valued by this cohort of people. In fact, computer literacy acquisition may create anxiety for some, a humourously espoused by Thede (1999):

> My great-great grandfather rode a horse, but was afraid of a train.
> My great-grandfather rode a train, but was afraid to drive a car.
> My grandfather drove a car, but was afraid to fly.
> My father flew in an airlane, but is afraid of computers.
> I use a computer, but am afraid to ride a horse (Thede, 1999, p. 8).

So! Let us explore IT in the context of this segment.

Information Technology

Advanced forms of technology and modern communications have transformed the fundamentals of daily living, and allowed for people to interact in new ways (Spitzer, 1998a). The increased power of computerised and telecommunications systems in daily life have enabled the rapid transfer of knowledge across the globe (Spitzer, 1998a). In terms of health information, the existing knowledge in medicine, gerontic nursing and elder health can be opened up for use by a wide range of clientele. Such technological capacity transcends the limits of space and time, meaning that even the most rural and remote communities can be drawn into the global network (Cooper, 1998; Hepburn-Smith, 1999). Older people themselves will be able to learn about health and the practice of health promotion from computer technology that makes data readily accessible. Such learning and relearning may make the difference between human fulfilment and desperation. There will be the potential for civic networking (Coleman, 1988) which will involve the public use of community technology for community development, civic participation and social service development, and policy debate about issues of ageing, preventive health measure, homecare, and arts and recreation (Cooper, 1999; McCormack & Ford, 1999). There will be a need for new parameters, and expansion of public information about aged healthcare systems,

and an involvement of the elderly public in what health means for ageing communities (O'Neil, 1999). The continuing expansion of computerised and innovative technologies and the clients' ability to access relevant health data will turn data management in the healthcare system into a critical element in the future (Spitzer, 1998b). Such conditions will require aged healthcare professionals to carefully examine the fit of their services with the demands of their clients.

Computers and 'E' learning will provide aged healthcare workers with tools to develop multidisciplinary electronic knowledge bases and to extend their memories and analytical skills. Some researchers (Bevis & Watson, 1989; Mann & Reece, 2000) assert that if computers are used appropriately in nurse education, it will free educators to focus on curriculum goals and help students become critical thinkers, more responsible to societal needs, more caring and compassionate, and more insightful into ethical and moral issues associated with healthcare. This is indeed a worthwhile outcome for gerontic nursing and aged healthcare in general.

MODELS AND GERONTIC NURSE EDUCATION

Postindustrial learning in the workplace

The nature of gerontic nursing work is changing, with knowledge being recognised increasingly as the primary resource, giving rise to unprecedented demands for learning (Allee, 1997; Allen, 1990). Many researchers (Bowen *et al*., 2000; Diekelmann, 1988, 2003; Jeglin-Stoddard & de Natalie, 2000; Jorgenson-Huston & Fox, 1998; Mann & Reece, 2000) consider that the challenge for nurse education will be to design curricula that will address

healthcare needs of the future. Nowhere is this more important than in the ever-changing aged healthcare system. Weik (2000) believes there will be two alternative pathways for nurses to take: that of being the 'doer' or that of being the 'thinker'.

The skills required for these roles differ considerably. For instance, the nurse as 'doer' will use computer technology to undertake all assessment, planning and evaluation of client care; implementation of detailed plans will be carried out by highly skilled technicians; all clients will be critically ill and so people skills will not be needed; pharmacists will manage medication regimes through central lines; chaplains will manage family matters and engineers will manage the computers; there will be some nurses for home care, but the family will prefer technicians because they will be able to do the same skills and are more friendly (Weik's sentiments, not mine).

Conversely, as 'thinker', nurses will lead all health initiatives and be advanced in the practice of assisting clients to maintain optimal health. They will have advanced skills in computer analysis and therapeutic reasoning; hospital and home care will be provided by nurses based on critical thinking and problem solving; most will be educated to master's level; focus will be on critical thinking, creative problem solving, compassionate caring, computer technology and effective teaching strategies; nurses will be seen as policy experts and advocates for good health for all, and nursing education will challenge students to reach their highest level of self-actualisation (Weik, 2000).

Further to these assertions, Weik (2000) explores the changes in healthcare and the shift in education from task to role orientation. She believes the emerging paradigm will include the following elements and personnel: collaborative, independent practice undertaken in communities; managers of care; problem solving, decision making, change agents and educators, researchers and leaders. Other researchers (Bayliss *et al*., 1999; Hockey, 1997; Parker *et al*., 1999) have studied curriculum evaluative implications associated with such changes. They consider that any critical analysis of future nursing (including gerontic nursing) curricula will pursue such issues as:

1 To what extent does our curriculum reflect the realities of the changing world of healthcare and nursing practice?

2 Are our graduates and employers of our graduates satisfied with their preparation and readiness for the world of work?' 'If not, why not'?

3 To what extent do we collaborate with a range of clinical practice settings?'

4 How do we provide for their participation in curriculum development and evaluation?

5 What proportion of our clinical learning experiences take place in ambulatory and community-based settings?

6 How effective are we in collaborating with our clinical partners?

Underpinning such tensions is the complex question of appropriate learning models to achieve desired outcomes.

Learning theories and gerontic nursing models

The gerontic nursing practice of professionals must be informed by relevant theories in order to provide high quality care. Gerontic nursing education therefore should enable the development of the relevant knowledge and skills at all levels to meet this demand (Bruner, 1966; Mallik, 1998; Marks-Maran, 1999). Some of these learning theories and strategies have been alluded to in previous chapters, but are now pursued in the context of this segment.

Medical model

Both Clarke (1999) and Rolfe (1996) state that nursing education, until recently, has been aligned with the medical model. This is dominated by following reductionist and robotic tasks that take nurses away from much of the people oriented praxis they desire (Hodge, 1993; Marks-Maran, 1999; Northway, 1997). More recently nurses have tried to develop practice that is individualistic, holistic and therapeutic (Carper, 1978; Watson, 1990).

Nursing process

Throughout this thesis much mention has been made about the dominant rationalist and scientific paradigm that has dominated gerontic nursing practice. This has correlated with the medical, custodial, disease-oriented, geriatric model of care that has dominated practice. In terms of gerontic nurse education,

curricula underpinned by this learning and practice model focuses on curing diseases and fixing body parts. An extension of the learning model has been the nursing process, which is still in vogue in many gerontic nurse education programs today. This model was developed in nursing in an attempt to bring order to nurse decision-making. It never worked, especially in gerontic nurse education, as its disease focus neglected elderly peoples' adaptive characteristics such as resilience, hardiness. The nursing process reflects the Newtonian era of breaking the whole into separate parts. The complex phenomenon of sick elderly people is thus analysed problem by problem. Furthermore, each problem is broken into smaller parts of aetiology and symptoms, thereby limiting engagement with the complexities of gerontic nursing practice.

Marks-Maran (1999), in her paper critiquing the nursing process as a model for nursing practice, suggests that its failure is due to the dialectical reality that the nursing process requires nurses to think in a linear fashion, whereas the real world of nursing practice is chaotic. Additionally, 'cause' and 'effect' are not proportional. In reality, nurses make decisions in random, sometimes intuitive, ways. The world of client care is not linear and therefore a linear and orderly framework for explaining it never worked. Marks-Maran (1999) suggests that a postmodernist approach to nurse education extends an invitation to explore totally new ways of thinking and working as teacher. I have certainly found this to be the case, particularly in the application of narrative pedagogy in a postmodern context. Such endeavours are exemplified later in this chapter.

Humanist educational theory

Many theorists (Dewey, 1915; Freire, 1972, 1985; Knowles, 1975, 1990; Rogers, 1956, 1961, 1983; Purdy, 1997) challenge the individuality of the humanist perspective. They recognise the ideology and social control of education in securing the reproduction of power relationships. In the context of gerontic nursing practice, the humanist ideology compromises the need to produce safe practitioners and in fact operates as a form of social control and supports a competency model. I take a stance similar to these theorists, believing that gerontic nursing needs to break with individualism and develop a collective ideology. Neither competency-based nor humanist process models recognise the social and collective nature of gerontic nursing practice and both enforce individualism. Change does not come from individualism; it comes as a result of collective consultation, cooperation and action. Consequently the humanist process model of education may survive in gerontic nursing education precisely because it offers no real threat to the ideology of the free market. If there is no change, gerontic nursing will keep serving the needs of a socio-economic system built on the single principle of unrestrained competition.

Mezirow's transformative theory

Mezirow (1981) postulated that through perspective transformation and increased professional competence, enhanced care could be promoted. Hartrick (1999), when arguing for a revolution in nursing education supports Mezirow's transformative learning concept, believing it to involve change in consciousness. Other authors (Bevis & Watson, 1993; Diekelmann, 1988; Hartrick, 1999) support this concept by stating that such a change in consciousness involves an

enhanced level of awareness of one's beliefs and experiences, and a critique of the assumptions underlying them. It leads to a realisation of one's choices to replace an old perspective, or styles of old, with new.

Work-based learning

Discourses in industry work have long held the belief that there are many processes that socialise people at work, yet very little is known about the social effects of post-industrial work (Billet, 2001; Candy & Matthews, 1998; Garrick, 1998). Identities are shaped within new waves of communication ensembles such as learning organisations, self-directed teams, empowerment strategies and quality circles. These identities are both symbolic and practical tools of communication in many post-industrial workplaces, including aged healthcare environments and can be described as discursive practices. To examine the effects of these practices, Garrick (1998) draws on Foucault's (1989) theorisations of power. This theory enables the unmasking of ways in which employees can be seduced by corporate reward or punishment systems. It can be argued that contemporary reward/punishment systems often entails a hidden agenda. DuGay (1996) asserts that there is always much more to learning than that which is directly observed or stated. In a similar vein, Garrick (1998) asserts that the manifested curriculum is always accompanied by the hidden curriculum of work that socialises and shapes workers.

The shaping of workers' identities requires compliance with corporate objectives and directions, but a compliance that involves subjects making choices and decisions about their place in the new corporate culture. This discussion closely parallels much of the previous discussion of gerontic nurses' transition to

practice, reality and culture shock, status passage and finally, sense making in order to survive in the aged healthcare work environment. However, nurse educators' viewpoints may differ, as exemplified by Crow (2003):

> Why have I got a problem with WBL [work-based learning]? My instinct is that this model indicates that nursing education has gone around in a full circle (Crow, 2003, p. 79). …Why do I feel a sense of doom-personal and professionally? What is going to happen to the nursing profession now? Are we being railroaded in the pressure to meet the government and industry needs, but losing our professionalism? What is the nursing profession's understanding of professionalism? (Crow, 2003, p. 80) …[G]etting the WBL right, that is, getting the balance right between on-the-job and off-the-job components…could [be] a valuable resource in the drive to recruit [and retain] nurses. In all this though, I have a concern. It seems to me that the Commonwealth Government is still not completely in-step with the needs of the healthcare industry…. Where does it go from here? I want to see nursing progress professionally as well as see sick and elderly individuals in this country of ours receive the highest quality nursing care as and when they need it (Crow, 2003, p. 82).

As the work-based learning approach becomes more predominant in aged healthcare, gerontic nurse educators need to accept the challenge. Work-based learning in gerontic nurse education can become a vital basis for equal partnership between service providers and educators, and ameliorate the so-called 'theory-practice gap' so commonly referred to in nursing.

Competency-based learning

There has been a move over the last two decades to measure the outcome of education by means of competencies. Nursing has particularly been involved with this controversial debate. Many of the debates have been about the definition and language. Supporters of competency-based education emphasise the capacity a person has to 'do' and well as to 'know'.

Competency-based learning has emerged as an approach to workplace learning and an answer to the 'training' needs of aged healthcare workers in this era of deregulation (Boud, 1998; Boud & Garrick, 1999; Phillips, Schostak, Bedford & Robinson, 1993; Skippington, 2002). While regarded by some as visionary, others, including myself, view it as a tool of administration, of behaviourism in disguise, and no more than an mechanistic, task-oriented system to serve an economic rationalist paradigm (Hartrick, 1999). Many critics (e.g. Ramsey, Franklin & Ramsey, 2000; Usher *et al*., 1997) believe that competency-based learning will not improve learning. In a teaching context, Bevis (1993) characterises this approach as an oppressive 'banking' concept in which the teacher assumes responsibility for imparting knowledge to the student, who in turn assumes the role of the passive recipient, a mind numbing, authoritarian relationship. Competency fails to recognise experience that can only be seen through cultural prisms, and as culture is a cental tenet in this thesis, competency-based learning is dismissed as being not appropriate to underpin gerontic nurse education.

'Competency' itself is an overused and ill-defined word with many practitioners having different meanings for the concept. According to Swendsen and Boss (1985):

> [c]ompetency is more than knowledge and skill. Values, critical thinking, clinical judgement, formulation of attitudes and integration of theory for the humanities and sciences into the nursing role are also important (Swendsen & Boss, 1985, p. 8).

Some researchers (Boud & Garrick, 2000; Ramsey *et al*., 2000; Skippington, 2002; Usher *et al*., 1997) consider that competencies provide a prescriptive and managerial solution, a new human capital package that can be delivered by educational establishments and work settings, and monitored by bureaucrats according to criteria that stress the importance of meaning and outcomes, uniformity and an instrumental definition of education. Enterprises tend to take a short-term view and regard staff development and continuing education as a cost rather than an investment.

Behavioural/outcomes-based learning

This model is closely aligned to competency-based education. The notion of competence is concerned with the knowledge, skills and personal qualities, which are required for particular employment purposes. The model of education is also behavioural learning outcomes-based, rather than input-based and directly relates to employment requirements. It is this focus on behavioural outcomes within a competency approach, which has been a source of intense criticism for purist educationalists who argue that learning and assessing in occupational

competency tend to be mechanistic. Complex roles are reduced to individual functions and therefore individuals seek to complete tasks in a highly reductionist way. Such educational approaches are ignore the complexity of the real world and do not account for the roles of professional judgement and intelligent performing. In the context of gerontic nurse education, competency based and behavioural/outcomes based education assumes the competences/learning objectives are easily identifiable yet the nature of skills in gerontic nursing has remained largely indeterminable.

Problem-based learning

Bechtel, Davidhizar and Bradshaw (1999) address the shifts in nurse education to a process that promotes higher-level thinking and clinical judgement. In the 1990s I found this model of learning to be useful in teaching/facilitating both undergraduate and postgraduate gerontic nurse education. However, it required considerable resources to develop and deliver, and many teachers and students did not favour it, preferring the medical model with its nursing process.

Ever increasing changes in healthcare delivery coupled with diminishing resources within nurse education, have led to a need to rethink and re-design approaches to teaching and learning in nurse education. The goal of nurse education is to facilitate the transition of knowledge from the classroom to a variety of clinical experiences (Bowers & McCarthy, 1993) within a framework of social responsibility (Mayo, 1996). Whatever educational philosophy is utilised to facilitate learning, the ability to solve problems remains a critical phenomenon. Bechtel *et al*. (1999) suggest an alternative approach to either competency-based or problem-based learning through a merging of the two.

They assert that by such an endeavour, a higher level of learning may be achieved, which will result in a more expert clinician. They further add that as well as the ability to solve problems, nurses require skill competency. In other words, both critical thinking and mechanical skills must be incorporated into a dynamic learning environment.

This then leads me to present learning models that would seem to be appropriate to underpin gerontic nurse education.

Lifelong learning/continuing education

It is evident that changes in demographics and public policy pose challenges for the delivery of services to older people. The future practice base will be shaped by education, which will need to remain relevant through continuing education for all gerontic nursing personnel (Gifford & Edwards, 1994; Glass & Todd-Atkinson, 1999). This continuing education will have to be skilfully and regularly delivered and properly accredited. In particular, the residential aged care system faces increasing pressures for providing better and more efficient facilities. Maintaining quality of care is highly dependent on continuing professional education which will; enable better practice through the acquisition of specialist knowledge, deal with ageism in gerontic nursing practice, develop and maintain competency across a wide professional spectrum, and provide an understanding of recent professional issues. Such learning organisations will be skilled at creating, acquiring and transforming knowledge, and modifying its behaviour to reflect new knowledge and insights (Garvin, 1993). A North American analysis of the continuing education needs of nurses working in nursing homes identified six major learning needs of gerontic nursing, and within

each of these six areas, a further fifty specified educational needs. Major learning needs included; the ageing process, nursing interventions, nursing process, management of elderly people with specified clinical problems, professional issues, and managerial and supervisory skills.

Reflection on/in practice

The concepts of 'reflection' and 'reflexivity' have already been addressed in some depth in previous chapters. For example in chapter 3 they were identified as methods to underpin the data collection process of this thesis. Reflection has become an important component in encouraging gerontic nurse practitioners to experience and learn from their world of practice (Johns, 2002; Wilkinson, 1999). Much of the data for this thesis emerges from such a reflective approach (mine and others). Reflection helps in thinking about what we understand and then analysing it. Gerontic nursing knowledge may be constructed from reflecting upon experiences of gerontic nursing practice, with the purpose of enabling gerontic nurses to access, understand and learn through lived experiences; then as a consequence they can undertake action toward developing practice. Learning through reflection is a process of enlightenment, empowerment and emancipation. Perry and Moss (1989) note that one of the aims of emancipatory curriculum is to "initiate and develop in students a process of self-reflective inquiry which leads to transformative action". However, while reflective practice has been encouraged for student nurses, some researchers (e.g. Johns & Freshwater, 1998) caution that in reality reflection only comes with maturity, and few students have sufficient experience to reflect on their experiences in depth.

Reflection may also be perceived as a dialectic process whereby higher order knowledge is gained through the effort to reconcile lower elements of knowledge. The reflective approach to learning is implicitly critical, in contrast with the instrumental approach to learning that encourages gerontic nurses to adopt a non-critical stance which denies gerontic nurse practitioners the need or opportunity to articulate their own beliefs and values about gerontic nursing. Such reflection and reflexivity have technical and intellectual dimensions. Suggestions for implementing such techniques in gerontic nurse education in the future will be promulgated in chapter 7.

Critical reflection

Critical reflection builds another quality onto the process of reflection, in that it seeks to locate the reflection within the broader theoretical framework, with a view to testing out both the theory and the object of reflection. It was developed as an alternative theory, which although incorporating the elements of positivism and hermeneutics, went further by adding the third dimension of emancipation. Several authors (Clarke, 1993; Ray, 1993; Wilson-Thomas, 1995) consider that by using critical reflection in nursing practice one can uncover the structures that support unjust social systems.

NARRATIVE PEDAGOGY

Narrativity and gerontic nurse education

Narrative has always been a path to knowledge in nursing care. In an educational context, Diekelmann (2001) posits that narrative pedagogy may be described as a research-based, innovative alternative for reforming nurse education, and states:

> Narrative Pedagogy is a new approach to schooling, learning, and teaching…such preparatory thinking and comportment points toward reforming nursing education (Diekelmann, 2001, p. 69).

Narrative pedagogy is also an excellent way of knowing emotional literacy, which, based on the centrality of 'emotionality' to ageing, gerontic nursing practice and gerontic nurse education, makes it of critical significance to this thesis. Researchers such as Geanellos (1996), Sandelowski (1991) and Stryker (1996) state that narrative pedagogy is especially useful in the search for shared meaning in the gerontic nursing profession, for example in sharing the complex and emotive issues of disillusionment, death and suffering. It offers the opportunity to share and value one another's contributions, to critique our experiences and transform our lives by liberating us from the processes that distort learning. Such an understanding frees us for the self-reflexive inquiry required to develop a critical consciousness. As a transition process it offers transition from a medical model approach to learning to a caring-healing approach, a new frontier where there is transferred knowledge and construction of practice. Additionally, by utilising the reality shock of reflection, narrative facilitates the reflexive spiral of being and becoming, and thus opposes the

logico-scientific mode of thought, which still dominates much of gerontic nurse education.

Narrative pedagogy offers us all (academics, students, clinicians) the opportunity to participate in risk taking, being vulnerable, sharing and valuing one another's contributions, critiquing our experiences and understanding, thus transforming our lives by liberating us from the processes that distort communication (Cash *et al*., 1997). Such an understanding frees us for the self-reflexive inquiry required to develop a critical consciousness. However, it needs to operate on the ideology of learning from experience through experience. Thus the profession demands that gerontic nurses involve themselves in an ongoing quest for professional development and self-awareness. This requires an interpretive approach, a deeper understanding to gerontic nurse education, whereby students are equipped with skills of lifelong learning and the ability to change.

Narrative pedagogy and my facticity

I have been fortunate to personally apply narrative pedagogy to most of my teaching in nurse education. I exemplify this with two experiences encountered in the late 1990s and early 2000s.

Reflection on practice

> In the late 1990s I was privileged to teach second-year undergraduate nursing students the subject of 'Nursing Ethics'. The tutorial sessions for this subject were powerful, as we shared experiences pertaining to ethical dilemmas in nursing practice. As these students commonly worked (on a part-time basis) in aged care facilities to pay for their educational expenses, many of these dilemmas involved

elderly clients. Unfortunately, many similar dilemmas have caused extreme moral distress, and students were grateful for the opportunity to discuss these issues in a nurturing, non-threatening environment. Initially, I set the scene for these tutorial sessions by providing a powerful and appropriate narrative from Bishop and Scudder (1997, pp. 63-65), the 'Midori Moment'. This narrative reflects a nurse's thoughts as she cares for a dying client. It captures her reflective thoughts when taking a dying lady for a walk in the hospital to see the city lights from one of the hospital windows.

Midori

"She [the dying patient] gathered her energy and asked me to help her to wash up and take a walk. As we stood together at the mirrored basin, I saw the reflection of her small contorted body. She stood less than five feet tall – her spinal column curved to the right, an adaptation her body had made over the years, allowing her to breathe more easily. I reached for the warm, soapy washcloth and gently scrubbed her back. I could feel Midori beginning to relax as water cleansed her body. Glancing at her reflection in the mirror, I saw a woman who suddenly looked so frail and helpless. Her body was straining, using every means to survive.

The hospital world is an enormous building; overgrown monster-towers of steel and concrete with endless labyrinths or hallways and people scurrying in every direction. There is one place of solace however, where a large window overlooks the city. During the day, it is like any other window, offering a view of the city's architecture, traffic, pedestrians, and an occasional helicopter. At night, however, it becomes a magical opening into the darkness where a thousand lights come alive.

I suggested to Midori that we take a walk to the window as the sun was beginning to set. Her eyes lit up when she saw the view.

"How beautiful!" she sighed.
I put my arm around her, holding her close, protecting her. I knew that this was one place Midori could leave her illness behind.

"I just hope to go home and spend a few weeks with my family and friends".

I held her tighter.

"You know" she said, "these last two days have been the most important days of my life. I am grateful that you have helped me through them".

I left the hospital that night overwhelmed by the impact this woman had made on my life.

She helped me to see nursing from a different perspective. We all get caught up in daily routine - giving drugs, changing linens, charting. After six years in nursing, I suddenly realised what it really meant to be a nurse (Bishop & Scudder, 1996, pp. 63-65).

Reflection on practice

Students were then invited to share their thoughts on this story, and particularly to reflect on their nursing experiences to identify a 'Midori Moment' that they may have encountered. As the Coordinator of this subject, I found such narrative pedagogy to be a powerful tool to facilitate the learning outcomes for this subject. It enabled students to be aware of

the ethos of nursing that continues to sustain behaviour and values and to engage and enter authentically into caring relationships focused on fostering the patients' well-being.

The second experience emanates from a paper I presented at a nurse education conference at Alice Springs (1996) in association with four other nurse colleagues. This paper was consequently published (Cash *et al*., 1997). The paper is written around one of the team member's (Wendy) nursing reflective journal entries, relaying her clinical experience in caring for an eighty-year-old gentleman we called 'George'. Wendy's narrative of this moving experience was presented in the form of a play reading where "a conversation about practice stories between the different aspects of the nurse's self is depicted" (Cash *et al*, 1997, p. 246).

In the context of this thesis, I present my reflective narrative (taken from my Methodological Log, 1998) recalling my experience in this conference presentation.

We five fly out in high spirits (despite the slight hitch encountered when one of our crew realises they haven't got their ticket). As soon as we arrive at the scheduled motel, we get straight into rehearsal mode, checking out the conference facilities to ensure that all is compatible. Our session is scheduled very early in the conference program. All too soon the moment of reckoning arrives and we're 'on' to the haunting and soul stirring sounds of didgeridoos and large screen images of the Australian outback. I'm feeling VERY nervous as (from our stage vantage point) I look out at the sea of faces in front of me - all nursing colleagues. There's this hush and the lights are dimmed. A spotlight focuses on our youngest actor who is to relive a poignant and powerful nursing experience by recalling and retelling a journal entry. The rest of us are to the other side of the stage, representing 'the multiple selves' of our young clinical teacher as she tells

her story. The story unfolds – as we are all (audience and actors) transported along with her into this clinical environment. Handover is happening, and the star (the patient) of this clinical encounter is revealed – we are to be involved in the care of an elderly gentleman, George, (80 years of age) who had a Triple-A repair and is quite sick and not doing very well (visually represented by slides on the huge screen at the back of the stage. While handover is occurring, George has managed to pull out his nasogastric tube, despite the fact that his hands are shackled firmly to the chair. Reinserting this tube will be Wendy's first task for the day, although an unpleasant reality for all concerned (Wendy, George, family and other nursing staff). Wendy successfully, although reluctantly, reinserts the tube. However, this traumatic experience is to be repeated shortly as George again manages to dislodge this tube and flings it on to the floor. How could this happen, when he is shackled? How did he manage such a feat? Now what? No one wants to repeat the procedure yet again, but all know that the surgeon will demand this to happen. What a dilemma! The situation begins to illuminate some of the competing claims underpinning nurses' moral agency. The audience are now fully engrossed in this experience and some are mopping their eyes with tissues as they are all too familiar with such events. As George becomes increasingly distressed (along with his family), Wendy takes a tea break.

What should she do? Why does she feel so powerless and so morally distressed?

The short break away from the situation has strengthened her resolve to ring the surgeon on return to the ward and question the need for yet a further reinsertion of the dreaded naso-gastric tube. Luck's in as the surgeon is not

on call, and the doctor filling in for him agrees to try leaving the tube out and trying George on sips of water.

Wendy is elated as exemplified:

> [l]eaving the shackles off had done something to my nursing: I was me again! Mr George and I began to communicate; I could feel the flow of warmth that I was used to (Wendy in Cash *et al*., 1997, p. 251).

However, the permanent ward staff explain that the tube will be ordered to be reinserted on the next day when the surgeon returns and envy Wendy, who will be back at the university by then and will not be involved.

Wendy leaves the ward with "a vision of an unrestrained man sleeping peacefully" (Cash *et al*., 1997, p. 251), but for how long?

At the first opportunity Wendy revisits the ward and finds an empty bed where George had previously been.

Knowing what the outcomes would have been she still questions staff as to the events, only to have her fears confirmed in that George had died in a most traumatised way (hemorrhage) shortly after her shift had ended.

Emotions are running high in the audience, this of course reinforced by powerful stage (music, visual, etc) effects. Many are openly sobbing, and we (actors) are also finding it difficult to remain emotionally functional, especially

Wendy, who is reliving this experience through the relating of her journal entry. She states that:

> [t]here is still a great sense of injustice to think that this man, so strong for all of his 80 years, met a death so traumatized. Perhaps his ultimate control was in his death because, despite the interventions, he died. But did he do so because of them? Was he left with death as the only way to freedom? Was his strength and energy sapped with the fight? I need to stop here as I am beginning to go in circles and its very painful. I haven't the time to cry. There is a meeting on. Is this what happens to nurses? They move on to something else, another deadline that has to be met (Wendy in Cash *et al*., 1997, p. 253).

The lights dim as we all (audience and us) share this precious thread of collegiality, but the terminal pain is almost too much.

Some minutes later, a more composed group ponders the power of this clinical nursing narrative, a shared reality. We continue to ask ourselves, 'How do we shape a future that is less oppressive and consistent with values of equity, justice and democracy?' 'Is this the practice of freedom for which we are aiming'?

SUMMARY

This chapter critiqued the ontological foundations of gerontic nursing knowledge and praxis and examined parameters for future development. It was established that past and present forms of gerontic nurse education have not been, and are still not, appropriate or adequate to equip the gerontic nurse for his/her continually changing role. Many nursing students have expressed their disappointment and disillusionment with an educational preparation that does not parallel the 'real world' encountered at the nursing coalface. Gerontic nurses have also been vocal in their disappointment with the nursing profession's, and society's, attitude towards their nursing contribution, believing it to be greatly misunderstood, undervalued and equated simply with the 'tender loving care' rhetoric. Support from leaders and management is not forthcoming, and workloads continue to increase. Many actually relate narratives depicting deep moral distress encountered when entering the nursing profession, especially the gerontic nursing specialty. Many relate that they do not cope, are forced to lower their own standards and not live up to their own expectations, this causing considerable heartache, and in some instances resulting in them leaving the profession altogether.

It is also apparent that past (and many present) teaching and learning models are not appropriate to facilitate the type or depth of learning required by the modern gerontic nurse practitioner. While rhetoric would indicate that the old behavioural objective type of education curriculum is in the past, the reality is that it may simply have been replaced by a different version, that is behaviourism in disguise associated with learning and teaching modes such as those which are

competency-based or focused. Additionally, while it has been shown that the nursing process never worked, especially in gerontic nurse education, it is still in vogue in some educational organisations and curricula.

However, on a brighter note, some educational researchers, such as Baker and Diekelmann (1994) and Diekelmann (2001), have shown that narrative pedagogy may be the learning model for this new millennium. It would appear to be particularly appropriate for such emotionally charged education as that associated with gerontic nurse education.

It seems that it is time now to reflect and think about gerontic nursing and to let go of old ideas and practices. It is time to consider how gerontic nursing might be anchored in relation to its historical and epistemological roots, to find new ways to make gerontic nursing knowledge transparent and transferable to others, to endeavour to synthesise the thesis and antithesis, and in so doing, derive a higher, more complex understanding of gerontic nursing practice (Porter-O'Grady, 2001a).

CHAPTER SEVEN - FUTURE DIRECTIONS AND SUGGESTIONS

INTRODUCTION

Chapter 7 presents future directions and suggestions emanating from a synthesis of thesis and antithesis that emerge from this research study, highlighting the ways a new postmodernist theoretical story of ageing and aged healthcare may be conceptualised by opening up the way in which gerontic nursing practice and education are viewed and practised. The chapter will first review major tensions identified in previous chapters before offering my proposed model for gerontic nursing, the GCDU.

New roles for gerontic nurses

At the beginning of the third millennium we are at the advent of a new time for ageing and health services. This will result in new roles for gerontic nurses and require a reconceptialisation of gerontic nurse education. Questions in relation to this development include: 'Will gerontic nurses welcome these changes?' 'Will industry encourage/support such change?' 'Will socioeconomic factors such as economic rationalism impact on the advancement of gerontic nurses roles?' 'Will there be sufficient numbers of personnel interested in pursuing a career in gerontic nursing?'

The thesis generated five major tensions: meaning of life and ageing; rehabilitation as a new model of aged healthcare, workforce planning in aged healthcare, elder health in the future, gerontic nursing practice, and education shifts. Each of these tensions is outlined below.

Meaning of life and ageing

This was seen to be a philosophic question of concern and identified as a significant factor in health and wellbeing in later years. As such, it is considered that pursuit towards meaning in life (particularly in terms of maintaining a 'caring connectedness') should be integral to any model of gerontic nursing practice, particularly for those clients placed in long-term care. Such an approach will yield understanding how older people feel about themselves and how feeling old creates for them a new reality and sense of control.

Rehabilitation – a new model of aged healthcare?

There needs to be a new way in which rehabilitation for older people is conceptualised and practised. The ultimate aim should focus around improving the individual quality of life in any way, no matter how small, in relation to not only physical health, but also to emotional and spiritual wellbeing. A distinct lack of clarity about the nurse's role in such a rehabilitative approach was identified, necessitating a realistic appraisal of the knowledge and skills required to deliver 'expert' care. There also needs to be consideration given to how this can be meaningfully incorporated into gerontic nursing education programs and models of care.

Workforce planning in aged healthcare

The achievement of high standards of care for elderly clients is dependent on the ability to attract quality, motivated and interested staff who consider elder care to be a viable and worthy nursing field. The reality (current and future) indicates

the continued national and global shortages of such personnel. Gerontic nurses are facing unprecedented pressures to do more with less, and productivity has risen phenomenally over the past decade as a consequence. It seems that the current caring paradigm does not ensure the existence of the gerontic nursing profession in the future. It becomes imperative to improve the attractiveness of the aged care sector for care professionals, as well as addressing training, career progression and other issues such as workloads and remuneration; these of course are heavily influenced by economic rationalism and deregulation. In the context of the long-term care of older adults, an important consideration is job satisfaction for nursing staff in order to maintain optimal productivity levels and quality care outcomes. For example, keeping abreast of how the changing healthcare environment affects nurses' job satisfaction is an important policy issue, particularly if the retention of gerontic nursing staff is to be improved.

Elder health in the future

Again, many questions have been generated around the complex issues surrounding future health needs of elderly clients. A major challenge identified is the increased costs of care to treat the growing volumes of ageing patients. Such demand on healthcare workers, particularly gerontic nurses, will keep staff turnover rates high. Additional stress will be exerted on remaining staff to adapt to technology and empowered clientele. The overwhelming involvement of expensive technological innovations in the aged healthcare system, and the increasing demands for increased quality from knowledgeable clients, mean that aged healthcare systems will always suffer from a mismatch between what is planned and what really happens. The increased interaction between ageing,

technology and consumerism will force policy makers to make difficult decisions. Newer communication techniques and strategies will fully track clients wherever they may be along the continuum of care and allocate services based on their specific needs at these points. This process will cause gerontic nurses to move from primarily procedural activities to relational, educational and care management activities.

Gerontic nursing practice and education shifts

There will be a new context for practice, a need for different service models and a society facing changes it may not be prepared to address. Resources will need to be reallocated to educate the workforce to deal with empowered consumers and new technology. Categories of specialities will become increasingly important to the viability of the service organisation. Consumers will want more and will not want to pay for it. Ethical dilemmas will proliferate. It seems that elderly consumers will need two things from gerontic nurses during the next two decades: education and care management across the life continuum. Further research will be required to capture underlying facts that allow elders to adapt successfully to old age and these need to be reflected in gerontic nurse education programs and in models of gerontic nursing care.

New postmodernist theoretical stories of ageing and aged healthcare

A postmodernist position is of direct relevance to nurses who make decisions based on best evidence and have misgivings about whose authority is invested in the nursing profession. I adopt an 'ironist' postmodern position to planning and implementing future aged healthcare. In so doing, I reject those who are *in*

authority (i.e. having power) in favour of those who *are* an authority (i.e. having knowledge). This stance will be a key factor underpinning my promulgated theoretical framework for an idealistic GCDU in generating discussion pertaining to leadership and managerial roles. Of course, there is the likelihood of this not being a popular stance with many management structures existing in the current aged healthcare culture. Restructuring has resulted in staff downsizing and erosion of work practices. Gerontic nurses feel devalued and dissatisfied with such cultures that do not promote diversity, creativity, empowerment or liberation. Rather such cultures focus on conformity, 'power over', authoritarianism, economic rationalism, competitiveness, and lack of educational opportunities for all. However, a postmodernist narrative methodological approach to nursing care in GCDUs provides a voice for those who are silenced and in the margins (identified as both elderly clients and gerontic nurses). It makes ageing visible, fosters hope and connectedness among marginalised people, and educates those who wish to become allies in liberation struggles.

Opening the way for reconceptualising how gerontic nursing practice is viewed and practised.

There is an urgent need to redirect management philosophy towards more democratic and participative organisations, with an acknowledgement of the vital importance of a workforce experiences job satisfaction, is encouraged to be responsible, and to use initiative and be self-directed. Explanations of internalised powerlessness and oppression (both for elderly clients and gerontic nurses) are vital. Any radical change to gerontic nursing and aged healthcare in general will require the power bases of medicine and administration culture to be challenged.

Models of gerontic nurse education in a post-industrial context

Major tensions centre around the legitimate role of various levels of aged healthcare workers. In a post-industrial context, goals of gerontic nurse education will move from simply the conveyance of instrumental knowledge (that needed to get the job done) to knowledge that enlightens and empowers. Of particular concern has been the proliferation and domination of the sector by untrained workers at the expense of jobs for trained personnel such as registered and enrolled nurses. This trend towards personal care assistants is influenced by an economic rationalist position endemic in healthcare in general, and aged healthcare in particular. It is also evident that relatively little is known about teaching and learning in the gerontic nursing workplace, or how experience is utilised to become 'expert'. Gerontic nursing leaders will have the challenge of turning working in aged care into dynamic and engaging learning environments by guiding gerontic nurses through the maze of concepts and ideas emerging in the clinical workforce.

Despite my scepticism, it would seem that indicates that work-based learning in gerontic nurse education *can* become a vital element in forming a basis for equal partnership between service providers and educationalists, and so ameliorate the so-called 'theory-practice' gap so commonly referred to in any nursing practice. Favoured teaching-learning models could include: problem-based learning, lifelong learning, reflection on/in practice, and narrative learning. A new lifelong learning culture for all 'care' staff in long-term care facilities for elders will play a major role in breaking the cycle of marginalisation and disadvantage in delivering increased economic security, and an ability to respond to change for individuals and enterprises. One challenge will be to create adaptive, creative,

equitable and interested, participatory productive environments and to encourage learning communities and a learning culture in collaboration with other partners. Critical analysis of gerontic nursing curricula will pursue such issues as 'To what extent does the curriculum reflect the realities of the changing world of aged healthcare practice and gerontic nursing?' and 'Are gerontic nurse graduates and employers satisfied with their preparation and readiness for the world of work?' The gerontic nursing profession will demand that gerontic nurses involve themselves in an ongoing quest for professional development and self-awareness. This will require an interpretive approach, a deeper understanding to gerontic nurse education, in which students are equipped with skills of lifelong learning and the ability to change.

This discussion foregrounds the following analysis and synthesis of these elements in the context of my idealistic GCDU for long-term care of elders.

GERONTIC CLINICAL DEVELOPMENT UNITS (GCDUs)

As stated in earlier chapters, GCDUs are clinical units where gerontic nurses (and allied aged healthcare workers) strive assiduously to develop client-focused and research-based practice through the conscious and deliberate development of their own reflective, clinical and research skills (Christian & Norman, 1998; Gerrish, 1999; Gerrish & Ferguson, 2000; Greenwood, 2000; Steaban, Fudge, Leutgens & Wells, 2003; Tang & Titler, 2003; Titler, Steelman & Goode, 2001).

What are the primary aims of a GCDU?

The primary aim of a GCDU is to bring about improvements in clinical practice and enhance outcomes for elderly clients and gerontic nurses. Improvement in aged care practice is achieved through utilising and conducting research and quality improvement initiatives. Such units successfully integrate practice, research and education. They support aged care workers to develop aged care practice by providing education and research resources. This allows the formation of crucial links between clinical and academic domains. They celebrate elderly people as deserving the highest quality of standards of care and also provide the highest quality education to staff that aims for quality care in the best possible working environment. GCDUs strive to provide excellence through three strategies: by providing client-centred care based on systematic needs assessments and promoting elderly autonomy and empowerment by developing aged care workers who are creative, questioning and autonomous within the healthcare team and optimising the quality of care by reorganising aged healthcare workers' roles and functions; and by implementing evidence of evaluative-based practice (Christian & Norman, 1998; Gerrish, 1999; Gerrish & Ferguson, 2000; Greenwood, 2000; Steaban *et al*., 2003; Tang & Titler, 2003; Titler *et al*., 2001).

What aged care standards apply in GCDUs?

GCDUs would implement general standards of care as promulgated under the Aged Care Act (1997) by the Standard's Accreditation Agency and incorporate those put forward throughout this thesis by researchers (for example, Greenwood & Parsons, 2003a & b; O'Hara, Duvanich Foss & Wells, 2003; Robinson *et al*.,

2003; Steaban *et al*., 2003). They include: a GCDU is a defined practice setting led by advanced practice gerontic nurses who act as consultants and change agents for the aged healthcare team; it is a place where all staff welcome change; the GCDU uses its philosophy to determine the conceptual framework for organising aged healthcare practice, including the incorporation of decentralised decision-making with client and staff empowerment; staff are developed utilising individual professional development programs; it develops an inquiry-based approach to aged healthcare practice and evaluates the impact of practice development on the client, staff and the host organisation and informs the appropriate authority; it has a defined plan of action within a strategic plan for renewed practice, which includes the process of disseminating evaluative practice; and it collaborates and consults with the multidisciplinary team to achieve client-centred care.

Having identified philosophic elements of a GCDU, the discussion now focuses around issues previously outlined and so proceeds under similar headings: new roles for gerontic nurses; meaning of life and ageing; rehabilitation – a new model of aged healthcare; workforce planning in aged healthcare; elder health in the future; gerontic nursing practice and education shifts; and models of gerontic nurse education in a post-industrial context.

GCDUs and new roles for gerontic nurses

National trends provide gerontic nurse leaders with a unique opportunity to develop innovative strategies to place gerontic nurses in a positive position in the marketplace, but the challenge will be to attract and retain the brightest and best recruits and to promote, support, recognise and reward such excellence. These

gerontic nurses (envisaged to be RNs) will be supported to advance through Benner's (1984) four levels of competence: novice, competent, proficient, and expert (Steaban *et al*., 2003). Level one novice will undertake only basic gerontic nursing skills and carry out plans of elder care which are guided by the GCDU's policies, procedures and standards. The second level gerontic nurse uses systematic approaches to their work. They will be able to make independent decisions guided by experience as well as policies and standards. Level three will have an in-depth knowledge of gerontic nursing practice, focussing on analysis of problems and solutions and clinical leadership roles. The fourth level gerontic nurse functions from an intuitive approach, providing skilled, innovative elder care. They will be seen to be change agents.

It will be imperative that managers and leaders (mangers being people who cope with *complexity*, whereas leaders are people who cope with *change*) of the GCDU provide a clear expectation for the role and work of each level as well as support systems that steer them closer to both their personal visions and those of the unit (Porter-O'Grady, 2003a&b; Robinson *et al*., 2003; Steaban *et al*., 2003). Job descriptions, expected behaviour and evaluation tools need to be clearly stated. All RNs will need to understand and embrace these centrally expected, defined and measured outcomes. The importance of strong and committed leadership at all levels will be critical in transforming gerontic nursing practice associated with such role changes.

A major problem encountered at this stage may be associated with gerontic nurses' adherence to pre-learnt nursing activities, when demand (as determined by their role) is changing. Attachment to old rituals and routines impede gerontic

nurses' ability to engage in embracing fundamental changes in their practice. Nurses practising around outmoded beliefs and value systems tend to defend the old model of care and see change as a threat. They get caught in an endless cycle of frustration and recidivism, which may ultimately lead to redundancy. This transition stage may be accompanied by feelings of loss of meaning in their work, as everything that was once normal and part of the ritual and routine of their daily practice seems to be quickly dissipating. They may become overwhelmed and decide to leave the position or the profession. It will be the task of the GCDU's leaders to identity such moral stress and rekindle their passion. This difficult process is well exemplified by Porter-O'Grady (2003b) who asserts that:

> [c]reating the milieu, contesting historical attachments, embracing and creating new models of service, and engaging practitioners in their own change are central activities of clinical leadership today. Although it is a daunting task, the future of nursing practice depends on the nurse leader's willingness to engage it (Porter O-Grady, 2003b, p. 178).

GCDUs and meaning of life and ageing

When exploring ontological aspects of ageing, that is, the lived experiences of growing old, both good and bad, it was seen that such experiences shape who people are, and in a healthcare context, how they regard their health and what they will seek from healthcare. Understanding such viewpoints is seen to be a pre-requisite when the goal is to give individual care and make personally suited interventions based on the older person's needs rather than on their chronological age. An enhanced understanding of how older people experience ageing was seen to assist in redefining the value of aged healthcare. The age-old quest to

identify the 'meaning of life' will continue; resulting in enhanced understanding by both elderly clients and their carers and subsequently an enhanced ability to assist older people to make successful transitions to old age.

GCDUs and rehabilitation – a new model of aged healthcare?

Aged healthcare within a GCDU will have a strong focus on restorative, rehabilitative and preventative measures. Much of the future content for gerontic nursing services will be life management and community-based care, and providing a framework for assisting the predominantly ageing society in adaptive, development and service needs in much more mobile and decentralised settings. Care of the older adult, who may have long-term chronic illnesses (mental or physical), cannot be adequately given in long-term care facilities apart from the principles and concepts of gerontic rehabilitation (Easton, 1999). The gerontic nurse will be encouraged to value the older adult with a long-term health alteration as a holistic being who perpetually interacts with, and is influenced by, the internal and external environment. The emphasis will be on health maintenance, promotion of as much self-care as possible, and prevention of further complications and functional decline. Practical strategies will include such things as; improving nutritional status, maintaining and promoting skin integrity, mobility, establishing bowel and bladder patterns, and enhancing sensory perception. Gerontic nursing actions associated with commonly encountered diagnoses in older adults such as stroke, spinal cord injury, neurological disorders, orthopaedic problems and mental health alterations such as dementia, will be managed in the context of maintaining function and minimising further decline. Rehabilitation in this context is a lifelong process in which the client works together with the family, the rehabilitation team and

society to achieve optimum levels of functioning as a holistic person, with the goals of preventing secondary complications, fostering maximum independence, maintaining dignity and promoting quality of life (Easton, 1999). The gerontic rehabilitation nurse is able to build rapport with their elderly clients and family members and help to promote a positive self-image through goal achievement (Easton, 1999). Emphasis is on adaptation, not just recovery. The process of gerontic rehabilitation helps elders adjust or adapt to life-altering situations, without giving false hope of total recovery. Gerontic rehabilitation programs offer hope and an optimistic outlook for the future to those whose lives have been devastated by a life-altering condition. Easton (1999) asserts that the concepts of rehabilitation gerontic nursing stand as an example of the beginning of new theories emerging from the old; teaching that the elderly are to be valued throughout their entire life span and that independence can and should be maintained for as long as possible. This would be an underpinning philosophy of my idealistic GCDU.

GCDUs and workforce planning in aged healthcare

Dramatically changing times have given aged care leaders a more demanding and vital role to play in aged healthcare. They need a clear vision of the direction of change and skills in identifying and responding to change (Porter-O'Grady, 2003b). Changes in the power equation in the delivery of aged healthcare services are associated with the user's ability to obtain the same data as providers. This situation requires both changing the structure of the services delivery and the context of practice. GCDU leaders must transfer their own attachment and energy to the staff, engaging them as co-creators and committing them to the broader task of actively creating new futures (Porter- O'Grady,

2003a&b). Organisational change associated with the development of GCDUs can have detrimental effects on gerontic nurses' job satisfaction. For example, restructuring may result in downsizing or revision of work practices which may lead to staff feeling devalued, powerless and disillusioned.

Research services (as aspired to in such a unit) present special workforce planning challenges. Though research in a care facility such as a GCDU requires unparalleled levels of skilled nursing care, the staff mix is quite different to that found in hospitals and other healthcare settings, often with markedly fewer RNs, and most direct care provided by assistants in nursing, or to a lesser extent, enrolled nurses (Jackson & Raftos, 1997). The literature has already hinted at some tensions in defining the staff mix for such a facility. For example, Nazarko (1997a) discusses issues relating to job security prospects and professional advancement and a belief that profits of the organisation will be put ahead of client needs. Skilled RNs may be vulnerable to being deemed redundant because of perceived increased costs associated with their employment.

Other factors contributing to job satisfaction may centre around such issues as; violence and occupational injury (Erickson & Williams-Evans, 2000); feeling un-supported and under–recognised, and dislike of management styles, emotional fatigue, lack of career progression, pay issues, workload, and workplace relationships (Aiken *et al*., 2001; Larrabee *et al.,* 2003; Shields & Ward, 2000). Mueller (2003) suggests some strategies to ameliorate these problems. They include; attractive workplace environments, the opportunity to work with other gerontic nurses who are clinically competent, supportive nurse managers and supervisors, the giving of gerontic nurses' control over their own nursing

practice, adequately and appropriately skilled nursing staff. and use of technology to minimise time spent on paperwork. In a similar vein, Larrabee *et al*. (2003) argue that nurses are more likely to stay in work when they view themselves as having more control of their practice, adequate autonomy, good collaboration, adequate staff, and view their chief nurse as having power in the organisation. Organisational empowerment is the product of employee interaction with the organisation's structures of information, support, resources and opportunities that enable the employee to develop further and be more effective in the organisation (Larabee *et al*., 2003). It would seem that psychological empowerment is the strongest predictor of nurse job satisfaction; therefore there is a need to create and maintain a work milieu in which participative management thrives. In the context of increased technology, Porter-O'Grady (2003b) cautions that as the pace of technology accelerates, it will be increasingly less viable for organisations (including GCDUs) to continue to employ the growing myriad of technical specialists required to apply this technology. What will be required is a shift in how people are managed, which in turn requires different skills, such as; high levels of interactive skills, the ability to obtain compliance, build worker relationships, problem solve, manage conflict, and obtain possible work outcomes. Many more shared decision- making models will emerge to address needs of workers to control their own practice. A higher level of performance proficiency in the worker will need to be exemplified by increasing the focus on efficiency, economies of scale and work effectiveness.

The removal of nonessential, extraneous and reductionist tasks and functions will be a critical element of sound work design. Porter- O'Grady (2003a) further asserts a need for 'goodness of fit' between the activities of various knowledge

workers or specialities, who will require high levels of relational leadership. They recommend an organisational culture based on the emotional intelligence work of Goldman (1997), wherein everyone shares the impact of emotions of any one member of the team, and staff take a clear emotional cue from leaders. Such relationships require the leader to communicate effectively with others in a way that anticipates, and when necessary disarms, the potential for conflict. This type of leader supports the power of humour, kindness, communication and availability to others in a way that creates a context of including and caring (as opposed to much of the emotionality associated with environmental and cultural aspects promulgated in previous chapters of this research). Larrabee *et al*. (2003, p. 110) state that "[a]ll of this comes in the context of emotional and professional congruence that fits well within the framework of a new age for effective sustainability".

GCDUs and elder health in the future

Much of this topic has already been covered in previous chapters where it was clearly established much more flexible elder care arrangements will emerge in the future. For instance, the hospital sector will cooperate with aged care organisations to provide all their care services within the aged care facility. There will also be increased demands from elderly clients to receive healthcare in their own homes, resulting in new roles for aged healthcare professionals. In the context of elder healthcare systems, it was established (Bowen *et al*., 2000; Clarke & Croft, 1998; Falk-Rafael, 1996; Schwartz, 1998) that changes in the future will include such factors as; orientation towards health, with greater emphasis on prevention and wellness; a population perspective; intensive use of information; a focus on the consumer; knowledge of treatment outcomes;

constrained resources; coordination of services; reconsideration of human values; and expectations of accountability and growing independence. More recently, other researchers (Porter-O'Grady, 2003a; Robinson *et al*., 2003) identify signs of a pattern of change that gives a glimpse of the direction of change in aged healthcare systems. Some of their observations include the following: healthcare is moving from residency-based delivery models to mobility-based practices as medical therapies become more portable, less invasive and requiring less treatment and recovery time; staff shortages of all kinds will continue to contribute to the stress of providing services and scheduling and assigning staff to meet the demands of a changing aged population and shifting therapeutic environment; the behaviour of the aged care worker is changing from an 'institutional mode' to a 'mobility' model of work; and the pace of technology creates a demand in process and procedure that changes faster than providers can cope. A major challenge identified with such health needs is the soaring prices to be paid to treat the growing volumes of demanding ageing patients.

GCDUs and gerontic nursing practice and education shifts

The previous dialogue leads to such questions as: 'What sort of gerontic nurse will be required in the future to meet these projected elder health needs?' and 'How will such personnel be educated for their changing role?'

Knowledge is the single major value the worker now brings to the workplace and that knowledge is increasingly portable. Because the workplace has a greater need for knowledge than the knowledge worker has for the workplace, there will be tensions between the worker and the organisation. Additionally, Porter-

O'Grady (2003a) states that there is a critical shortage of such knowledge workers, which has led to growth in outsourcing of knowledge work. McCormic and Gieselhart (1996) assert that elderly consumers will need two things from gerontic nurses during the next two decades: education and care management across the life continuum. This will prompt gerontic nursing to move from primarily procedural activities to relational, educational and care management activities. Institutions will cease to be the major option for treatment and client management. Healthcare communities, group residences and progressive service systems will emerge as the main thrust for special health services, adjusted by both age and demand. As the Human Genome Project finishes its work, whole new concepts of treatment and therapeutic management at the cellular level will emerge as the foundation for clinical treatment. The successful residential care facilities of the future will be those that pay attention to the constant search for information needed to guide gerontic nurse practice with change as a result. Other researchers (Hickey, Ouimette & Venegoni, 2000; Joy, Carter, & Smith, 2000; Popejoy, Rantz, Conn & Wipke-Tevis, Grando & Porter, 2000; Porter-O'Grady, 2001;Valanis, 1995; McBride, 1999) believe that gerontic nurses will begin to see their work differently, and play a dominant role in improving and transforming aged healthcare practice. In an educational context, gerontic nurses have been poorly equipped to cope with the multi-faceted health problems of the elderly, with much of this education still focusing on an illness and disease-oriented paradigm. Inadequate and inappropriate gerontic nurse education does not to prepare nurses emotionally or intellectually for their changing role.

Furthermore, there is a lack of credible gerontic nurse practice and research and limited coverage of gerontic nurse education in current nurse education programs. There is a focus on competency-based learning which may be perceived as 'a child of economic rationalism', i.e. a type of administrative behaviourism in disguise, a mechanistic, task-oriented system to serve an economic rationalist paradigm (Jackson *et al*., 2003). Steaban *et al*. (2003) caution against the idea of the continued separation of gerontic nurse practice from research and scholarship. The consequences of this separation are dire, meaning research in gerontic nursing, especially in long-term care facilities, remains unknown territory for many nurses.

Gerontic nurses of the future will also require skills in critical thinking, biological sciences, computer literacy, informatics for evidence-based practice, clinical reasoning, financial management, outcomes management, and interdisciplinary practice (Hickey *et al*., 2000; Lipman & Deitrich, 1997). Gerontic nurse education will be seen as a process rather than an outcome, and gerontic nursing practice will be seen to be a highly skilled and specialised activity, which unites practice, research and education in the indivisible whole of nursing praxis. Gerrish and Ferguson (2000) indicate that the role that education can play in supporting such practice decisions, as GCDUs appears underdeveloped.

GCDUs and models of gerontic nurse education

Gerontic nurse leaders of the future have the challenge of turning workplaces into dynamic and engaging learning environments by guiding care workers through the maze of concepts and ideas emerging in the clinical workplace. One of the strategies identified was a move to reconceptualise gerontic nurses as 'thinkers'

as opposed to ‘doers’. In this context, they would be seen to lead all health initiatives and be advanced in the practice of assisting elders to maintain optimal health. They would require advanced skills in computer analysis and therapeutic reasoning. Care would be based on critical thinking and problem solving, and most RNs would be educated to master’s level (Weik, 2000). One method for attaining such goals is Clinical Information Support Systems, a strategy to underpin educational philosophy in my ideal GCDU. Such a system would utilise modern technology and information systems to provide an ‘E’ climate in which teachers, mentors and preceptors become strategists and establish a climate of sorority and fraternity; of equality and scholarly seeking. These Clinical Information Support Systems would provide links to professional colleagues and evidence-based practice guidelines; make expert knowledge available to all participants; assimilate practice and research findings to guide the gerontic nurses in day-to-day practice; help gerontic nurses identify and define information needs; and transfer information into data elements and structures that can be used in the design of computerised databases. The educator’s role in this process would be to facilitate discovery, inquiry and learning. Such professional learning support systems will provide a good learning experience for staff and students and one in which they master new knowledge and skills, critically examine assumptions and beliefs, and engage in invigorating, collaborative quests for wisdom and personal holistic development.

Gerontic nurse education is at an exciting time and has the potential to value practice- based learning, especially within such units as GCDUs. We need to establish equal partnerships with other practice and educational establishments and experiment with different teaching and practice modalities. Gerontic nurses

in this educational context would progress through three stages: awareness, reflection and development. Such education would be learner-focused and based on sociocultural philosophy and theories to guide students and staff as they construct their understanding of professional gerontic nursing practice. The learning community (internal and external to the GCDU) would need to support such learners through social interactive relationships (cognitive apprenticeships) as they acquire the skills, values and roles of the 'gerontic nurse expert'. Learning would be lifelong and ensure the development of gerontic nurses who remain intellectually alive in an environment of ambiguity and change. Such learning support is necessary as a defence against feelings of disorientation, disillusionment and burnout; as a framework for clarifying our human values; as a way of developing social relationships; as a means of providing skill rehearsal and access for appropriate role models in the workplace; and as a device for evaluating and disseminating best practice in aged heathcare.

CONCLUSION

The challenge for gerontic nursing will be to create a new type of practice for the services offered by professional nurses. It will be a period of great experimentation and flexibility. Success will depend on progressing partnerships in which there are reciprocal transfers of knowledge and a growing ability to achieve sustainable systems.

Porter-O'Grady (2003b) provides an excellent conclusive statement, exemplifying my stance eloquently:

> [T]he wonderful thing about the times we are in is that no one is sure of anything. In emerging clinical models of care, everything is in motion and subject to evaluation. The leader should be encouraged by the fact that few know enough about the sum of the future to impede well-constructed attempts at engaging it, there is enough creativity in any new model design that taking any action is infinitely better than undertaking none. The future is uncertain enough that sufficient creative error is embedded in almost any activity undertaken to address it. If anything, this gives broad permission to risk creating new models of care. The leader stands to lose less in the attempt than in doing nothing at all (Porter-O'Grady, 2003b, p. 176).

POST THESIS REFLECTIONS

My epiphany

One of the most significant outcomes for the researcher was the realisation that the epiphanic experience as outlined in the beginning of this thesis, truly *did* represent a new beginning for me from a distinctive and past identity. The opportunity to voice my opinions based on both experience and literature, not only in narrative form, but also schematically and pictorially *did* provide substance for searching, struggling, feeling, asserting, yielding, facing and choosing a direction that continues to challenge my direction and enhance realisation of potentialities.

Research methodology

It has also been gratifying to find that interpretive biography has lived up to its reputation in its ability to underpin a study which is characterised by complexity, uncertainty, instability, uniqueness and value conflicts.

It has enabled me to explore how my own experiences might inform the production of gerontic nursing knowledge and to study the relationship of facts and incidents, of themes and currents, and of social and professional issues that have influenced past events and continue to influence the present and future. It assisted in the search for the 'why' and 'how' of the research questions, not just the 'what'. Perhaps more importantly, it has given me voice (via narrative), which has enabled the identification of submerged realities and the 'unfolding of the reality shock of reflection'.

The limitations identified as being characteristic of this methodology were also applicable, that is, getting the methodology accepted as a bona fide and credible research methodology (this taking from 1996 to1998 to achieve); the

realisation of the complexity of this seemingly easy research option; the risk of self-disclosure as required in such narrative; and the difficulty defending its disciplinary value. However, the stated difficulty of applying the research outcomes to nursing did not eventuate. On the contrary, I believe this has been achieved most successfully.

Will this biographic study be highly regarded? Only time, and the valued opinions of you, the readers, will tell. However, it was a joy not to feel overly constrained by the rules, there being no lists of best criteria to apply, or universal targets to which to turn. This aspect was truly empowering and enabled ample scope to develop creative and scholarly ways of conducting and reporting my findings.

Where to for the future?

So! While Australian gerontic nursing remains a threatened species in the current economic rationalist climate, the future looks more promising. From my perspective, it is clear that skilled gerontic nurses *will* become key components in the refigured and redesigned aged healthcare delivery system, and *will* transform practice; it's just a matter of imagining a different future and then going about creating it.

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APPENDIX ONE

Schematic representation of analytic framework for the three domains: gerontic nursing practice, ageing, gerontic nurse education

Chapter 4 – Ageing constructs

General concepts of ageing culture

i) The ageing process and the paradox of cohesion through diversity (a synergistic relationship of reciprocity and change)
ii) Ageing – biological conditions embedded and modified by social/cultural contexts
iii) Image/ontology of ageing (the collapse of a coherent framework for meaning in old age is a pressing cultural and social problem) – image captured in powerful general metaphors – creates pictures/words that drive policy
iv) Being old/feeling old (being old does not necessarily equate with being old)
v) Understanding the culture of ageing facilitates a move beyond a rationalist view of ageing to a more expansive, comprehensive, personal, existential perspective

Dialectically

i) Negative pessimistic view of ageing – old people depicted as useless drains on the energies of the young – defeatist attitude towards care – 'nothing can be done') versus Positive optimistic view – romantic, modernist view of old people as responsible for the quality of their own old age = positive healthcare context – aggressive surgical/medical approach)

ii) Negative – fear of anonymity within a homogenous culture versus Positive – heterogeneity – there is considerable psychological/physiological variation between elderly people depending on culture and other social/political factors

Ageing constructs - culture sub-sets

Ageism

i) Defined - Discrimination of elderly on grounds of age alone (stereotypical assumptions – damage individual potential)

ii) Ageism and difference – the ability to identify what is the same and what is different is crucial for survival – all need to belong, be part of a social group within society. The politics of difference, difference and identity

iii) Ageism and marginalisation – a dangerous form of oppression which means exclusion of elderly people from useful participation in life

iv) Ageism and resilience – a dynamic process influenced by protective factors that serve to modify the effects of adversity

v) The lived experience of ageing – the concept of 'being', feeling out of control, desire for authenticity

Dialectically

i) Oppression – marginalisation, exploitation, cultural imperialism/invisibility versus resilience – a process whereby people bounce back form adversity and go on with their lives. Parallels hardiness, determination, tenacity and fortitude. Characterized by: equanimity, self-reliance, existential aloneness and meaningfulness

ii) Sameness – ageing is not homogeneous – it is structured and systematic in equalities – there are frequent exclusions versus difference – the ability to identify what is the same and what is different is crucial for survival of the species – all need to belong and be part of a social group within society

Emotionality

i) Feeling old/being old – not recognizing one's former self, feeling different from others

ii) Ageing and self-punishment – elderly people internalize the cultural experiences of society and engage in self-punishment = isolation, loneliness, institutionalisation.

Dialectically

i) Feeling old – feeling old is not necessarily synonymous with chronological age, more to do with physical/mental changes = feeling/being different, reduced self-esteem, disempowered, vulnerable, disengaged, detached, powerless, often reflects loss of a person's capacity to maintain independent life. Versus being old – not feeling old = meaning making, redefines meaning of life/ageing, has positive expectations of the future, being true to oneself. Authenticity, creativity, empowered. Opposes stereotypes and negative images of ageing in order to preserve their dignity (e.g. life review)

Transition Process

i) Feeling old/being old – disrupted reality – concerns of being institutionalised, lack of choice, lack of control, helplessness

ii) By gaining knowledge of elderly people's strategies of being old but not feeling old, may facilitate the adaptive potential of the gerontic nurse practitioner

Dialectically

i) Unsuccessful transition – disrupted reality, disequilibrium, ageing becomes a vicious circle of uncertainty, vulnerability, anxiety, fear, insecurity, feeling out of control, confusion about one's identity, self-care deficits, manipulative behaviour, isolation, invisibility versus Successful transition – equates with being old, but not feeling old – redefines meaning of life/ageing (use of narratives), obtains knowledge about the processes of adapting, recognises own potential, caring connectedness

Models of Ageing

i) Deficit model of ageing – a negative, pathological focus – ageing as a disability
ii) Resilience (as previously)
iii) Protective factors (knowledge/understanding of ageing process, create a new reality and sense of control)

Dialectically

i) Deficit model of disability – positions the older person, or their disability, as the sole cause of disability or lack of ability versus caring connectedness

Ageing – narrative

Narrative gerontology

i) Existential/ontological image of human beings as story tellers/listeners – social constructions used to create identity and establish coherence and continuity = new meanings to experiences of temporality and personal actions = potential to generate knowledge/learning about ageing

Dialectically

i) Makes visible the variety, contingency and inventiveness in each/all efforts or present life, versus resists the temptation to put it all together into an analytically consistent, comprehensive framework, privileging certain voices and silencing others

Chapter 5 – Ageing constructs – impact on gerontic nursing practice

General concepts

i) Culture – defined
ii) Productive diversity
iii) Agents of power

Dialectically

i) Sameness (post-Fordism) versus diversity (synergy, reciprocity, change, pluralism)
ii) Singular corporate culture versus permeable boundaries
iii) Conflict resolution versus productive dissonance
iv) Self-directed teams versus overlapping, fluid tasks for work groups

General concepts - specific to gerontic nursing practice

i) Unprecedented global change
   i) Technological innovation
   ii) Cognitive dissonance (psychological morbidity)
   iii) Outdated ideology
   iv) Job satisfaction/dissatisfaction
      a. workplace flexibility
      b. inappropriately skilled staff
      c. long-term setting as a workplace of convenience
      d. staffing levels
      e. staff skill mix
      f. teamwork
      g. support/learning environment
      h. authoritarianism
      i. powerlessness and self-alienation
      j. oppression and gerontic nursing practice
   v) Changing gerontic nursing practice culture
      a) challenge negative assumptions/stereotypes
      b) defining practice
      c) outdated ideology

Dialectically

i) Marginalisation versus inclusion
ii) Disempowerment versus empowerment
iii) Poor (negative) image (ageing as disability, medical model/acute disease model as dominant paradigm – institutionalization, oppression, powerlessness, self-alienation) versus good (positive) image (valuing of staff, creative work practices)
iv) Low job satisfaction – as above) versus high job satisfaction (support systems, workplace flexibility, lifelong learning, autonomous decision-making)

Gerontic nursing practice culture sub-sets

Ageism

i) Gerontophobia – (discrimination, stigmatization, oppression, poor image)
ii) Ageing as disability (oppression, marginalization. sociopolitically constructed)
iii) Economic rationalism/fundamentalism (autistic choice-receivers, deregulation)

Dialectically

i) Defeatist attitude approach to aged healthcare versus optimistic, humanistic, rehabilitative approach
ii) Deregulation – untrained or inappropriately trained aged healthcare worker (custodial, curative, routinised, ritualistic, institutionalised practice) versus gerontic nurse specialist (ownership, accountability, responsibility)

Emotionality

i) Feeling old/being old – not recognizing one's former self, feeling different from others

ii) Ageing and self-punishment – elderly people internalise the cultural experiences of society and engage in self-punishment = isolation, loneliness, institutionalisation.

Dialectically

ii) Feeling old – feeling old is not necessarily synonymous with chronological age, more to do with physical/mental changes = feeling/being different, reduced self-esteem, disempowered, vulnerable, disengaged, detached, powerless, often reflects loss of a person's capacity to maintain independent life. Versus being old – not feeling old = meaning making, redefines meaning of life/ageing, has positive expectations of the future, being true to oneself. Authenticity, creativity, empowered. Opposes stereotypes and negative images of ageing in order to preserve their dignity (e.g. life review)

Transition Process

i) Reality shock (accompanied by high levels of emotional responses)
ii) Preserving moral integrity (six stages – vulnerability, getting through the day, coping with moral distress, alienation from self, coping with lost ideals, integration of the non-professional concept)
iii) Moral agency – (power of decision and action)
iv) Support systems (to cope with high stress levels – lack of confidence, self-expectations, unrealistic expectations by clinical staff, role conflict, role ambiguity, value conflict)
v) Status passage
vi) Sense/meaning making

Dialectically

i) Reality/culture shock (as above) versus status passage/sense making (preserving moral integrity, moral agency, support systems

Models

i) Models of caring – the contradictions (stated 'good' care versus reality of care – authoritarian model – depersonalised care - lack of choice, loss of identity, powerlessness, devaluing, dehumanising, 'power over'
i) Biomedicalisation/routine geriatric style of aged healthcare
ii) Resilience and authoritarian models of gerontic nursing practice
iii) Acute disease model
    a) The acute/chronic illness dialect
v) Therapeutic caring presence and gerontic nursing practice ethics
iv) Power and caring
    a) Dual caring – maternal model of care

Dialectically

i) Authoritarian model of care (as above, 'politicisation' of caring) versus resilience – five themes – equanimity, self-reliance, existential aloneness, perseverance, meaningfulness, facilitates transformation of negative events into personal growth and opportunities within authoritarian, inflexible organization)
ii) Acute illness/disease model (dominant medical model, pathological methodology) versus gerontic rehabilitative nursing role – holistic practice - therapeutic caring presence, e.g. 'primary nursing model' (wellness, increased autonomy, independent decision-making)

Gerontic nursing practice – narrative

General concepts

i) Existential-ontological image of human behaviour = meaning making of life experiences
ii) Broad epistemology – teleological – indicates possibilities for future action – connects theory with experience, daily practice with knowledge

Concepts specific to gerontic nursing practice

i) ideology
ii) caring-healing
iii) emotionality
iv) empowerment
v) liberation
vi) theoretical framework
vii) transformative

Chapter 6 – Ageing constructs – impact on gerontic nurse education

General concepts of gerontic nurse education's culture

i) Outdated gerontic nurse education ideology
ii) Ontological foundations to gerontic nursing knowledge/praxis
iii) Increased power of computerised and telecommunication systems
iv) Gerontic nurse education tensions
v) Reconceptualising gerontic nurse education
vi) Chronic illness, rehabilitation and gerontic nurse education
vii) Quality care and continuing education

Dialectically

i) Negative outdated gerontic nurse education ideology – illness/disease focus/paradigm versus Positive – responsive to changing aged healthcare needs
ii) Negative rationalist/fundamentalist approach = technical, rationalist paradigm = deconstruction of gerontic nursing practice and education. Versus positive role of gerontic nurse practitioner enlightened by new educative caring paradigm

Gerontic nurse education culture sub-sets

Ageism

i) Demographic considerations
ii) Image/attitude issues
ii) Poor image = reduced job satisfaction = compromised standards of care
iii) Recruitment/retention issues
iv) Failure of gerontic nurse education to address aspects of ageism and emotional requirements for the work they do
v) Education/training issues e.g. sameness/conformability (instrumental knowledge) versus Knowledge that is empowering/enlightening

Dialectically

i) Negative image (oppressive, kind, custodial care) = view that there's not much to learn versus positive image – humanistic, therapeutic-caring, reflective = resilience
ii) Education (enlightening/empowering) versus training (instrumental knowledge)

Emotionality

i) Outdated ideology – poor understanding of emotional work of gerontic nurse practitioners
ii) Gerontic nurse education curriculum issues e.g. emotional aspects of role not covered in gerontic nurse education curriculum
iii) Gerontic nurse practitioner's professionally ignored and unappreciated by employers and other aged healthcare professionals in the workplace
iv) Support-collegiality

Dialectically

i) Negative pathological/theoretical understanding of the role emotional labour plays in student gerontic nursing learning/caring = emotional detachment versus emotional literacy
ii) Emotional detachment versus emotional literacy

Transition Process

i) Changed ideology – learning from experience through experience = remains emotionally/therapeutically involved = lifelong learning
ii) Development of a learning culture – supports gerontic nurse students through maze of concerns/ideas which have emerged in the clinical workplace
iii) Gerontic nurse leaders – have challenge of turning working environment into a dynamic/engaging learning environment
iv) Gerontic nurse education needs to focus on loosening up rigid perceptions about old age
v) The changing contexts of aged healthcare practice = unprecedented demands for learning

Dialectically

vi) Negative – reality/culture shock versus Positive – status passage/support = sense making= moral integrity = a new frontier and transferred knowledge and construction of practice

Models

i) The economic imperative - behavioural approach (CBL) to education – task-oriented system to serve economic rationalist/fundamentalist paradigm
ii) Training = narrow promotion of 'culture capital' = losses of dignity and sense of self-worth. Innovation framed by singular compliance seeking struggles and techniques, including the language of empowerment
iii) Medical/behavioural model (including nursing process) approach to learning – focuses on curing diseases/fixing body parts – reductionist/robotic. Nursing process – an extension of the medical model – developed in an attempt to bring order to nurse decision-making – lacks potential to mobilise change within complexity
iv) Human capital theory – i.e. the productive capacities of human beings – learning is a holistic experience – socially/culturally constructed
v) Work-based learning – creation of learning environments
vi) Competency-based learning – behavioural model in disguise = mechanistic, task-oriented system to serve an economic rationalist paradigm. NB May also have positive conations if it incorporates the ideology of professional judgment – called the integrated or holistic approach to competency
vii) Problem-based learning
viii) Lifelong learning

Dialectically

i) Training (instrumental knowledge/socially distributed knowledge) – aligned with government and economy, and social impetus versus education (quest for knowledge)
ii) 'Doer' versus 'thinker'
iii) Medical behavioural model = conservative, reductionist, mechanistic approach (caring-healing approach in the margins) versus Interpretive/emancipatory approach = reflexivity = students develop a process of self-reflective inquiry = transformative action. Additionally, gerontic nurse students equipped with skills of lifelong learning and ability to respond to change – parallel act of meaning-making (narrative pedagogy)

Gerontic Nurse Education Narrativity

i. Reconceptualisation of gerontic nurse education – revealed through storytelling (narrative) = changing role of gerontic nurse specialist = reflexive, humanistic approach

ii. Facilitates emotional literacy – gerontic nurses share stories/narratives – gradually accrue to become a culture, commonsense and folklore = gerontic nurse education theories/knowledge

iii. Liberation narratives – narratives are concerned with the marginality of the caregiver's/student's voice in a highly technical, cure-oriented system. Narratives of liberation depict gerontic nurses finding their voice (i.e. liberation narratives include many stories about breaking free of biases/misunderstandings that limit caring practice whatever the source of inhibition, e.g. timidity, fear of risk, fear of disclosing vulnerability, fear of intimacy and responsibility, avoidance of suffering, need of openness and tyranny of rules/procedures

APPENDIX TWO

This diagram represents the interrelated nature of the three domains of ageing, gerontic nursing practice and education, within each of which are the four interrelated, and often diametrically opposed, cultural elements of ageism, emotionality, transition process and models. Offsetting this 'chaos' are the protective and positive *narrative factors* of; ideology, continuity', reconceptualisation, transformation, liberation, emotionality, theoretical framework, and caring-healing.

The interrelated nature of ageing, gerontic nursing practice and education