UNIVERSITY OF WINCHESTER

An exploration of health professionals' learning about ageing, old age and older patients: a biographical-narrative-interpretative study

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DECLARATIONS

No portion of the work referred to in the Thesis has been submitted in support of an application for another degree or qualification of this or any other university or other institute of learning.

I confirm that this Thesis is entirely my own work.

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ABSTRACT

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ABSTRACT

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Health professionals work increasingly with patients who are older, and who are likely to have multiple long-term conditions. A significant proportion of the patients are considered to be frail and/or vulnerable.

This small study of two nurses, two occupational therapists and one medical practitioner, explores how health professionals — learn about ageing, old age and working with older patients. Using a biographical narrative method for data collection, and taking a hermeneutic approach to the interpretation of the data, the data provides insight into the subjective experiences of the participants, and the deeper meanings the participants associated with their experience.

The data show that learning to work with older people is linked to the learner's biography, and is a multi-layered and individualised process which takes place in an organisational, as well as a wider societal and historical context. The learning biography of each of the participants is unique, and links to the individual's personal and professional experiences, life events, and the choices they made; as well as to the wider context in which they worked and lived. The participants developed different forms of knowledge during their professional and personal life, throughout their life course; including propositional knowledge, as well as their values, beliefs, perceptions about older people and their patients. The data also reveal some of the emotions experienced by the participants, and the

development of less tangible qualities such attitudes, curiosity, aspiration, compassion and hope.

Learning can be informal and formal, intentional and unintentional. This study also includes reflections about the position of the researcher and their relationship with the data in a study like this.

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1 Chapter 1: Introduction

The first chapter gives an overview of the thesis. The chapter sets the scene for the study, and maps out the structure of the overall thesis and gives a brief overview of each individual chapter.

1.1 Background to the study

As the population is ageing, health professionals will care for an increasing number of older patients (Cornwell 2012). The focus of this qualitative study is on health professionals, and specifically how they develop their knowledge about ageing, old age and to work with older patients throughout their lives and career. Generally, health professionals develop their professional knowledge throughout their careers, through working towards accredited qualifications, participating in a variety of learning opportunities, and through professional practice and personal experience.

The interest in this study originates from my work as an occupational therapist and researcher, my work with older patients and as a lecturer in healthcare, and the conversations I had with students, colleagues and patients. Working with older people used not to be, and still is not, perceived to be desirable work; and it is often not seen as a good career choice for students and health professionals (Cornwell 2012).

Older patients' healthcare needs can be different from those of younger adults. The approach in acute care, where the main goal is to "cure" the patient, is not well-suited to older patients with long term conditions, as they are more likely to have complex health and social care needs because of co-morbidities, frailty, and impairments (Cornwell 2012). The average age of hospital patients is now over 80 (Cornwell 2012), but concern has been expressed about the preparedness of healthcare professionals to work with older patients and *"the system continues to treat older patients as a surprise, at best, or unwelcome, at worst"* (Royal College of Physicians 2012,p3)

Reports such as the Francis report have expressed concern about the preparation of health professionals working with an increasing number of older patients, their

knowledge base, and the relationship between the patients and the healthcare workers (Francis 2013).

There are challenges around how best to provide healthcare for older people, particularly those with complex needs (Goodwin, Dixon et al. 2014). Working with older patients can be complex, and is governed by uncertainty. Old age is not an entity because ageing is individual, diverse and universal; and a physical, psychological and social process: older people are not a homogenous group (Bond, Peace et al. 2007). Professionals' learning about ageing, old age, and working with older patients is likely to be multi-layered and multidimensional.

Their work with older patients and knowledge about ageing, old age and working with older patients will be influenced by a range of factors including educational, individual, and wider societal factors. Health professionals bring professional and personal knowledge to their practice, and develop their knowledge in and through practice, and through the interaction with their patients (Fish and Coles 1998, Binnie and Titchen 1999, Titchen, McGinley et al. 2004, Bengston, Putney et al. 2005). The relationship between the older patient and the health professional is key to the care. The beliefs, perceptions and values which the health professional brings to the relationship with the older person will shape the care of the older patient (McCormack 2003, Nolan, Davies et al. 2004, Nolan, Brown et al. 2006).

1.2 Research problem and Hypothesis

Studies of professionals' learning and development of practice have shown that only part of their knowledge health professionals apply in practice will be learned explicitly. Much will have been learned implicitly, not necessarily consciously reflected or learned (Fish and Coles 1998, Eraut 2000, Eraut 2004, Coles 2013). In healthcare, professional knowledge and knowing is developed through day to day experience in practice as well as through formal learning such as participating in courses. The learning also will be shaped by the organisational context and work culture of the work setting. The different dimensions of learning – the biographical, cognitive, emotional, and organisational – play a role when learning and in the meaning the health professionals attach to their learning. Different forms of knowledge and knowing such as technical knowledge, tacit and personal

knowledge which includes perceptions, beliefs and values such as for example societal attitudes towards older people will be blended in practice (Higgs and Titchen 2001a). Work with older patients is characterised by complexity and uncertainty, and there is an absence of a unifying theory of ageing and old age (Bengston, Putney et al. 2005).Knowledge about old age originates from different disciplines e.g. psychology, physiology, and sociology. This means there is not necessarily a stable or prescribed framework for health professionals to develop their knowledge from.

A professional's knowledge, propositional, knowledge in action or practice, and personal knowledge continuously changes throughout their working life; and it changes with the interactions with patients (Higgs and Titchen 2001a). Existing knowledge will be interpreted and adapted for the individual patient, and the specific clinical context (McCarthy 2003, Fish and Coles 2005), and will be *"embodied and embedded in the actions of the practitioner"* (Ewing and Smith 2001 p23), and is not easily articulated (Benner 1984, Benner, Hughes et al. 2008). Part of the knowledge will be unique to each health professional. Each person will bring their individual biography to their work; their own subjective experiences of ageing and old age.

Learning is multi-dimensional and involves the whole person; and learning takes place when meaning is attached to experience. Exploring healthcare professionals' learning biographically does not separate the cognitive, emotional, organisational and social dimensions on learning, no separating the learning experiences from the wider context.

1.3 Methodology

Learning involves the whole person; and healthcare professionals draw on professional and personal knowledge in practice, knowledge they acquire through experience, informal and formal learning. The development of professional knowledge and knowing is life-long and complex, contextual, situated, and biographical (Higgs and Titchen 2001a, Jarvis 2009, Coles 2013). I was therefore searching for a methodology which would allow me to focus on the subjective

experiences of healthcare professionals, and the meaning they attach to their experiences, while also capturing the complexity of learning about old age.

For the above reasons, this is a qualitative study. It sits within the framework of life-long and biographical learning, and is theoretically underpinned by interpretative phenomenology and symbolic interactionism focusing on the subjective experience of the healthcare professionals, and the meanings they attach to those experiences. The specific method chosen for this study is the biographical-narrative-interpretative method (BNIM) developed by Rosenthal and Schütze (Schütze 1983, Rosenthal 2006) in Germany, and brought to the UK by Wengraf and Chamberlayne (Chamberlayne, Bornat et al. 2000).The method of data collection are individual interviews, which are analysed in depth and interpreted so individual cases can be constructed.

1.4 Justification for the Research

Learning is lifelong, multi-layered, and encompasses internal and external processes. In the UK, the education and professional development of healthcare professionals is also formalised and regulated, but much of the learning happens informally in practice.

Little is known about the acquisition of knowledge about ageing, old age and older patients throughout the life and career of healthcare professionals. Existing research gives insight into how professional knowledge and knowing is developed, or how healthcare professionals develop knowledge at specific points of their career. This study explores learning biographies. The exploration of what and how healthcare professionals learn about ageing, old age and working with older patients throughout their lives and careers can deepen the understanding of the interconnections between the biographical, professional and personal, the formal and informal learning. This understanding can assist the creation of educational initiatives and professional development opportunities for healthcare professionals and students which are meaningful and relevant to them and their practice.

Research into healthcare professionals' biographical learning is limited, and research about the biographical learning of healthcare professionals about ageing,

old age and working with older patients is lacking. Through exploring the subjectivities of the participants, the research aims to understand the concerns of the healthcare professionals, and to capture the interconnections of formal, informal and personal learning and the biography of the participant. It aims to increase the understanding of *what* healthcare professionals learn about ageing, old age and working with older people and *the meaning* they attach to their learning.

1.5 Brief overview of each of the chapters

1.5.1 Chapter two: Review of the literature

The narrative literature reviews concepts and research relevant to inform the research question.

The literature review has been broken down into two sections: concepts relating to ageing and old age, and older patients within the healthcare system; and learning and development of knowledge in healthcare**.** It includes adult learning theories, biographical learning and socialisation and more specific literature relating to the development of professional knowledge.

The search for literature continued throughout the course of the studies, and was iterative. The literature included comes from different sources including books, book chapter and reports, and opinion pieces as well as research articles. Some of the literature was identified through systematic searches of relevant data bases, but also through reference lists. Only literature published in English was included in the initial literature search, although some relevant literature in German was subsequently identified and included.

Very few articles were found on biographical learning of healthcare professionals, none of those related to the learning of ageing, old age or working with older patients.

1.5.2 Chapter three: Methodology and method

This is a qualitative study based on interpretative phenomenology and symbolic interactionism focusing on subjective experience and meaning.

The Biographic- Narrative- Interpretative Method (BNIM) was chosen for data collection. BNIM is a specific method to interview, and gives a structure to the analysis of the data. The process of detailed and in depth hermeneutic analysis of the interviews was developed by Rosenthal (Rosenthal 1995, Rosenthal and Fischer-Rosenthal 2004), Schütze (Schütze 1983), and Oevermann (Oevermann, Allert et al. 1987) in Germany. The analysis of the interview includes the life history and the told life story, as well as analysis of the transcribed text, and microanalysis of a sections of the interview. Each case is reconstructed, and the cases are compared and contrasted. BNIM has been adopted and taught in the UK by Wengraf and Chamberlayne, among others (Chamberlayne, Bornat et al. 2000, Wengraf 2004, Miller 2005).

1.5.3 Chapter four: Personal story

The critical reflections on my own position as a researcher became more prominent over the course of the study, to understand the intersubjectivity between the participant and the researcher. In this chapter identifies my position in the research study. I reflect on my own biography, experiences of older people, my professional work, as well how my own experience of a life threating illness influenced my understanding of care, ageing, and illness.

1.5.4 Chapter Five: Presentation and analysis of the data

Five individual case studies – of two nurses, one occupational therapist and one occupational therapy student, and one medical practitioner, a geriatrician are presented. The presentation of each individual case is based on the step by step analysis developed for the biographic-narrative interpretative method (BNIM).

Each of the cases gives insight into the learning, what and how the participants learned about working with older patients throughout their lives. This is followed by the researcher's reflection about the case study.

The second part of the chapter presents the common themes of the interviews which emerged from the analysis. This chapter was written with each of the case in mind, and identifies some common themes which emerged during the analysis, and which are pertinent to the research questions, in more detail.

The summary of the analysis draws on the findings of the individual cases and contrasting and comparing of the cases and the thematic analysis.

1.5.5 Chapter Six: Discussion

The strength and limitations of the methodology and the method are being discussed, and the specific challenges of being a reflexive qualitative researcher.

The findings are discussed drawing on the methodological underpinnings of this study as well as gerontological, and adult and professional learning theories and empirical studies. the insights gained from the individual each case study is taken into consideration as well as the commonalities and differences identified during the contrasting and comparison of the case studies and the common themes which emerged. The findings are discussed considering the micro, meso and macro factors, the social. organisational and historical context in which the narratives are embedded. The discussion has been structured in different headings such as biography and learning, learning to work with older patients, and includes subheadings of the findings which were specifically identified in the findings.

1.5.6 Chapter Seven: Conclusions and implications

This chapter gives an overview of the conclusion from the study and why understanding the individual biography of the health professional can be significant when thinking about how health professionals learn about old age ageing and working with older patients. The recommendations point towards what can be taken from the study to develop learning opportunities for healthcare professionals throughout their careers as well as recommendations for further research and evaluation of learning.

1.6 Aims and research questions of the project

The main aim of the research is to:

Explore the learning of healthcare professionals about ageing, old age and working with older patients throughout their lives and careers.

The 3 sub-aims are to:

1. Explore the subjective experiences of the healthcare professionals' learning about ageing, old age and working with older patients throughout their life and career, and to identify the meaning they attach to those experiences
2. Explore the development of propositional, personal and craft knowledge
3. Gain insight into the connection between the biographical, and formal and informal learning

The research questions are:

> How do healthcare professionals develop knowledge about ageing and working with older patients throughout their lives and careers?
>
> How does the biography of the learner and formal and informal learning opportunities shape the development of knowledge about ageing and old age?
>
> How do the experiences of the individual and the context shape the learning of the healthcare professional?

1.7 Conclusion for the introduction chapter

Drawing on theories of adult and professional learning, as well as theories of ageing, the focus of this study is how healthcare professionals learn about ageing and working with older patients through formal and informal learning opportunities throughout their lives. Using BNIM, the study explores the individual learning biographies of five healthcare professionals and how they learn to work with older patients. It explores the interaction between the individual and the wider context in which the learning takes place, and how healthcare professionals make meaning of their work with older patients. It explores the

interaction between professional and personal learning within the context of work and wider social structures, and the meaning the individuals attach to their learning. Developing a deeper understanding of how healthcare professionals learn about ageing, old age and older patients throughout their careers can help to develop learning initiatives.

2 Chapter 2: Literature review

2.1 Introduction to literature review

This study sets out to explore how healthcare professionals learn about ageing, old age, and working with older patients throughout their lives and careers. One of the difficulties of the study like this is that the potential literature derives from different fields, and includes literature relating to ageing, old age and older patients as well as adult and work-based learning theories and specific literature relating to education and professional development of health professionals. The literature presented therefore needed to be selected carefully, to give an overview of some of the concepts and topics relevant to give information how health professionals learn about ageing and old age. A mind map was used to help explore which topics to include and how to structure the review (see section 9.1 on page 269 in the appendix).

The literature review is broadly organised into two sections. The first section is on ageing; the second section on learning. The field of gerontology is very broad. It is an interdisciplinary field drawing on a wide range of theoretical perspectives, and includes biological, molecular, physical, psychological and sociological perspectives. The first part of the review gives an overview of the concepts of ageing, old age, and the care of older patients. Some of the key concepts have been identified through engaging with the literature and identifying topics considered pertinent to this study, focusing on how old age can be understood, the relationship between old age and disease, and healthcare.

The second part of the review relates to the learning of healthcare professionals who care for older patients. The literature review includes an overview of how professional knowledge and practice and professional learning can be understood. Adult learning theories, as well as the concept of biographical learning, are explored in more detail because they are pertinent to how the study has been conceptualised.

2.2 Approach to the literature review

A narrative style of literature review was chosen, with the aim being to highlight some of the wider debate around professional education and preparing healthcare professionals for working with older patients.

The search for literature has been iterative as well as systematic. The review was organised conceptually, using concepts which relate to the research topics. These were extended and after the analysis of the data and once emerging themes had been identified. Books, and book chapters, reports, opinion pieces and research articles were included into the review if they contributed to understanding of the research questions. Some systematic searching of databases has been carried out over time. This study is interested in the experience and meaning-making of healthcare professionals, rather than how they learn a specific technical skill: articles which focused on how health professionals acquire specific technical skills were excluded. Many of the included articles are qualitative studies or used combined approaches to their research approach. The systematic searching was limited to the field of healthcare and specifically medicine, nursing, occupational therapy, and physiotherapy. Additional relevant articles were identified through reference lists, or found by chance. Only articles published in English were included in the search The Eric,PsychINFO and PubMed databases were searched (last searched in August 2017) for biographical learning of healthcare students or professionals in relation to age, ageing, and working with older patients using the keywords including *"biography"*, *"biographical"*, *"healthcare"*, *"nurses"*, "learning", *"doctors"*, *"physician"*, *"nurses"*, *"older", geriatrics"*, and *"elderly"*. No additional studies were identified through this search.

The literature addressed in this review consists of different components which relate to understanding how healthcare professionals acquire and develop knowledge about working with older patients. The review will highlight some theories of biographical learning, social learning (communities of practice), some specifics around learning about older people in healthcare, and how ageing and old age are understood.

Some of the literature can be applied to adults' learning, and to the development of professional learning in healthcare and other fields. Research studies which specifically address how healthcare students and professionals learn about ageing, old age and working with older patients have been reviewed as they address the topic about learning to work with older people specifically. The articles described were considered to be relevant to this study and to give insight into the research question.

2.3 Ageing and old age

How people age varies greatly between individuals (Bond, Peace et al. 2007). An 85-year-old person can be physiologically fitter than, for example, a 65-year-old. Ageing causes bodily changes: some of these changes affect almost everyone, such as becoming long-sighted in mid-life; while other physical changes differ from person to person (Bengston, Putney et al. 2005). An individual's ageing process is influenced by endogenous and exogenous factors such as life style, nutrition, social status, activity levels, and stress, meaning that individuals age at different rates (Johnson 2005). The ageing process is universal, individual, and diverse. Ageing is multifactorial: it is a physical, cellular, psychological and social process. Changes in ageing are not linear, and they differ between individuals (Kirkwood 2001).

Every person ages biologically once they reach adulthood, and definitions – e.g. of when old age starts, or terms such as *"older person"* – are not straightforward. The difficulty in defining the boundaries of old age reflects its diverse, individual nature; and the way in which it involves both physical and psychological changes while, at the same time, also being a social and cultural construct (Degnen 2007, Phillipson and Baars 2007). Adding to the difficulties of conceptualising old age is that, although many older people will maintain high levels of independence and participation, biologically there is a complex relationship between ageing and disease, and cellular changes over time mean that the risk of developing serious diseases such as heart disease, stroke and cancer increases with age (Kirkwood 2001, Gjonca and Marmot 2005).

To categorize a person by their chronological age is arbitrary in many ways, but it is common to do so for pragmatic and policy reasons such as setting out criteria relating to retirement or entitlement to benefits or care. In the UK, the National Service Framework, which sets out standards for care of older people, defines an older person as being 65 years and older (Department of Health 2001, World Health Organization 2011). The specific societal context influences some of the official cut off points. The increasing life expectancy of populations, for example, can shape how old age is perceived and understood. Old age can be seen as a social construction, and ideas about old age have changed over time; and with changing societal and economic changes, they will continue to change (Phillipson 2013b). The move from a welfare state to a more individualised society or risk society has transformed old age *"towards a more fluid and unstable landscape surrounding the latter part of the life course"*, where the status of older people in society is not clearly defined (Phillipson 2013a p81). Older people's experiences of living within society are influenced by the ways in which old age and ageing are socially and culturally constructed, and attitudes towards old age. Ageist attitudes also impact on how older people are cared for (Twigg 2006).

Potentially, everyone who is not already old will become old in the future. But many people, even gerontologists who study old age, distance themselves from older people, taking a stance of *them and us* (Andrews 2014). De Beauvoir, describing the experience of her own ageing and that of her mother, comments that the tendency is to think of that ageing and old age happens to others, and can be a surprise (De Beauvoir 1996). Ageing is often stigmatised in society, which may explain why individuals tend to distance themselves from older people (Bytheway 2007, Andrews 2014). Individuals project their own fear of illness and decline and their own death on the older person, identifying them as *the other,* and separate (Twigg 2006).

> *"For most of the population, the old, in particular the very old, are 'other'. Everyone is, or has been, young. We have known the condition from the inside. In contrast, no one "has been" old in the past tense. Older people are ripe targets for stereotyping. This may underpin a resentment that questions the very point of being old"* (Tallis 1999).

Physically, ageing is a process of bodily changes and transformation, but not necessarily of illness. Illness differs from old age (Tallis 1999). As people age they

will adapt and integrate a new understanding of their changing bodies. But, for people who are not old themselves, it takes imagination to understand what it likes to be old and very old:

> *"So our present embodied selves are not only different from what they once were, but also different from they will be"* (Andrews 2014 p15).

The fluidity of boundaries between the different stages of life such as adulthood and old age is demonstrated by the recent changes of the official retirement age in the UK (Fullfact.org 2017), which is linked to the fact it is predicted that the proportion of people living longer after reaching 65 years of age is going to increase (Office for National Statistics (ONS) 2013). In contrast, in some African countries, where the average life expectancy is still lower than in the UK, old age might be defined as starting at 50 or 55 (World Health Organization 2002).

The British sociologist Haslett described old age as two distinct phases, the *"third age"* and the *"fourth age"* (Laslett 1996). The third age is a phase of fulfilment and active participation where individuals are often relatively free of work and family commitments combined with good physical and psychological health. It is the concept of the third age which has influenced policies of encouraging people to work towards *"successful ageing"* and *"an active old age"*. Being active in old age increases the chance of having a good old age (Baltes and Baltes 1990). The differentiation between the third and fourth age is not a chronological difference but a differentiation in the qualities of life (Twigg 2006).

Laslett's fourth age or phase of life is the phase of dependency and death. Some individuals will die without ever having to experience decline and dependency; however the Berlin study shows that a substantial proportion of 85 years old or older, will be in what can be described the fourth age as their psychological and physical wellness declines (Smith 2000, Baltes and Mayer 2001). The study found that the oldest old showed an increased prevalence of frailty, and they had to deal with challenges such as diminishing autonomy, and a diminished sense of identity (Baltes and Smith 2003). However, disease does not necessarily mean that the older person feels disabled or unhappy. In a study carried put in Newcastle in which 1042 people born in 1921 were recruited, it was found that at the age of 85, the participants were identified as having high measurable prevalence of

disease and impairment, but despite this many of the participants self-rated their health and level of disability optimistically (Collerton, Davies et al. 2009). This indicates that older people themselves adapt to changes in their lives. However, disease and disability can have an impact on the social life of the people concerned. Older people who suffer ill-health and frailty are at greater risk of loneliness than older people of the same age who are in good health. According to a recent survey by the Office for National Statistics, self-reported loneliness is higher in people over 80 years of age, but over 60 percent of people of that age did not self-report being lonely (Thomas 2017). The prevalent culture – and how old age is viewed – impacts on older people, social policy and healthcare, and can influence the status of older people in society (Quadagno, Keene et al. 2005). Twigg sees that old age and death in Western society has become medicalised, where the developmental aspect of ageing is overlooked and unacknowledged, and as a consequence has become devoid of meaning (Twigg 2006).

Compartmentalising old age into distinct phases such as *"old"* and *"old old"* or third and fourth age might be an oversimplification. Studies which focus on the subjective experience of older people show that the transition between the third and the fourth age might not be as clear cut as has been suggested. A study of frail older people identified that they were simultaneously living between the third and the fourth age, where they were experiencing losses, but also where they *"work actively to retain anchorage in this state of imbalance between loss and continuity"* (Nicholson, Meyer et al. 2012, p1432). Old age, especially the time when an older person is close to death and in cultures where youth and a healthy body is highly valued, is often described as a time of decline. But it can also be a time of development rather than decline, as it is often seen a time of gaining a new understanding of life and accompanying life satisfaction (Tornstam 1997, Tornstam 2011).

Increasingly, health professionals are likely to work with and care for older people as they are more likely to need to use of health and social care. The fact that health professionals are increasingly working with older patients has a profound effects on the work of doctors and other healthcare workers (Oakley, Pattinson et al. 2014). The age of patients seen in acute hospitals is increasing (Cornwell 2012).

Maben et al identified the patient and staff experience on acute medical wards when working with older patients and the challenges they faced *"i.e. the complexity of acute care needs combined with requirements for personal and psychological care"* (Maben, Adams et al. 2012, pp 86-7). Older people who need healthcare can have very differing needs from younger patients (Gjonca and Marmot 2005).

The older patients that health professionals are caring for are not a homogenous group. Because of the diversity of ageing, a proportion of older people who are patients will be in a phase of their lives where they experience increasing dependence, illness, disability and frailty and will need specialist geriatric care. Some of the patients will need end of life care. Other patients might need treatment but remain able to return to good health and function (Bachmann, Finger et al. 2010). Older patients will be seen in different specialities throughout the health services, and only a smaller proportion will be seen in services which specialise in the care of the older person (British Geriatrics Society and Royal College of General Practitioners 2015).

Geriatric medicine emerged as a speciality in the 60's and 70's. At the time it was perceived in the UK as a Cinderella service (Grimley Evans 1997). The Royal College of Physicians (London) defines geriatric medicine as addressing the *"clinical, preventative, remedial and social aspects of illness of old age"* (British Geriatrics Society 2010). A report by the King's Fund identified the following ten components within the spectrum of care for older people, reflecting the diverse needs of older patients and the wide remit of the care of older people found in the health service (Oliver, Foot et al. 2014, page vi):

- *"Healthy, active ageing and supporting independence,*
- *"living well with simple or stable long-term conditions,*
- *"living well with complex co-morbidities, dementia and frailty,*
- *"rapid support close to home in times of crisis,*
- *"good acute hospital care when needed,*
- *"good discharge planning and post-discharge support,*
- *"good rehabilitation and re-ablement after acute illness or injury,*
- *"high-quality nursing and residential care for those who need it,*
- *"choice, control and support towards the end of life;*
- *integration to provide person-centred co-ordinated care".*

In healthcare settings, it can be difficult to meet the needs of older people who have multiple medical conditions and complex needs, older patients who are considered frail, or who are not likely to recover, and patients who are physically, socially and psychologically vulnerable. Reports like the Francis report, and by the King's Fund and British Geriatrics Society, addressed specifically the care of frail older people with complex needs: patients, who are the most vulnerable when being treated in hospital or the community (Cornwell 2012, Francis 2013, Conroy, Hawkins et al. 2016). Ageism may be an underlying factor in the negative ways older people are being cared for and the need to improve attitudes towards older people were part of the standards set out in the National service framework for older people (Department of Health 2001). The healthcare system and older people themselves will have ageist attitudes meaning an older person might not seek medical help or being denied certain services or care (Twigg 2006). With an increasing ageing population, more of the older patients will have complex needs**,** but hospital care is not organised so that it serves the needs of those patients, and health professionals are not prepared for working with those patients (Cornwell 2012). Those are also the patients who are most likely to be stigmatised in healthcare and wider society where active, successful and healthy ageing is promoted and valued (Tallis 1999, Biggs, Phillipson et al. 2006, Oliver 2017).

2.4 Learning about ageing and old age

2.4.1 Professional knowledge

In the UK, doctors, nurses and allied health professionals must show that they have completed an accredited course leading to a recognised qualification. Many will gain additional qualifications over the course of their working lives, to increase their expertise, to become a specialist, or to develop and maintain specific skills. qualified health professionals such as medical practitioners, nurses, occupational therapists and must comply with regulatory bodies such as the General Medical Council (GMC) for medical doctors, or the Nursing and Midwifery Council (NMC) for nurses and midwives or the health and care professions council (HCPC) for allied health professionals to be admitted and stay on their register which is a pre-requisite to be allowed to practice. The regulatory bodies also set

the requirements for health professionals' continuing professional development and revalidation.

One of the difficulties in researching how health professionals learn is that they draw on a wide range of knowledge in their practice. The body of knowledge around ageing and old age and medicine of old age is expansive, and developing and changing. The question of how health professionals learn is linked to the questions *"what is professional practice?"* and *"what is professional knowledge?"*. This in turn influences how to advance the education and professional development of nurses, doctors and occupational therapists, is how to prepare students and professionals to work in practice with patients. Defining what constitutes professional knowledge is not easy because the definition of knowledge will depend on the theoretical perspective of whoever answers the question.

In healthcare, professional knowledge is not a single entity, but has different components which are interwoven with each other. It can be difficult to research and identify the nature of professional knowledge or how it is constructed (Atkinson 1995). Fish and Coles advocate that in medicine there needs to be closer analysis of *"practice epistemology of medicine"* (Fish and Coles 2005 p128). The analysis of what knowledge doctors used in practice is relevant to curriculum design and developing the development of practice knowledge (Fish and Coles 2005). The analysis of what professional knowledge is varies between the professions. For example, the work of Benner, Higgs and Titchen has provided insight into how nurses draw on different forms of knowledge in practice, and the work of Mattingly into how occupational therapists draw on and build information about patients in occupational therapy (Mattingly and Fleming 1994, Higgs and Titchen 2001b, Higgs, Andresen et al. 2004, Benner, Hughes et al. 2008, Higgs, Fish et al. 2010).

Understanding how professional knowledge is used in practice is complex because it involves the synergy of different forms of knowledge coming from a range of external and internal sources. The health professional will have knowledge about the individual patients, profession specific theoretical knowledge, the know-how of practice, insights into the uncertainties associated with illness and treatment

outcomes, cumulative experiences, moral and ethical knowledge and considerations, and personal and cultural knowledge (Schon 1983, Titchen, McGinley et al. 2004, Coles 2013). How professional knowledge and knowing in practice are understood shapes healthcare professionals' education and continuing professional development. The terms found in the literature to describe different forms of professional practice knowledge include propositional knowledge, procedural knowledge, tacit knowledge, craft knowledge, personal knowledge and professional artistry and wisdom. Distinctions between the different forms of knowledge originate from the distinction between propositional, procedural and practical knowledge (Coles 2004, Fish and Coles 2005).

Theoretical or scientific knowledge – also called propositional knowledge, for example understanding anatomical details of the body or research evidence published in journals and text books – is the type of knowledge which can be made explicit, and is easy to share. As part of gaining a professional qualification, healthcare students will have participated in learning opportunities, including the acquisition of relevant theoretical or propositional knowledge, based on the assumption that theoretical knowledge and practice are linked, and that professionals translate theory into practice, and that healthcare students and new practitioners learn to apply theoretical knowledge in practice (Fish and Coles 1998).

The need to apply scientific and technical knowledge – to treat patients using available scientific evidence, for example – has been has been increasing over the last 20 years; and the emergence of evidence-based medicine has been instrumental in the development of medicine and other healthcare professions (Sackett, Rosenberg et al. 1996). Technical scientific knowledge is considered an essential component of professional knowledge in healthcare, because it is knowledge that it can improve the quality of care and outcomes for the patients (Sackett, Rosenberg et al. 1996), for example knowing how to minimise the risk of disability when a patient has had a stroke (National Institute for Health and Care Excellence (NICE) 2008). Consideration of this knowledge can be part of the decision making about care and treatment, and is part of professional judgement

(Jones 1996). However existing research evidence is not always easily translated into clinical practice. Evidence changes over time: scientific knowledge is always in changing as new research findings are emerges. For example, in the care of older patients there has been new knowledge regarding e.g. the causes and treatments of dementia, and the definitions and features of frailty (British Geriatrics Society and Royal College of General Practitioners 2015).

The strong focus on scientific technical knowledge in medicine has also been criticised as being not relevant for many patients, especially patients who have multiple medical conditions and where the available evidence does not necessarily fit the patient, or an age group. This can especially be the case when working with older patients, where the existing evidence does not apply to the age of an older population (Greenhalgh, Howick et al. 2014, Mooijaart, Broekhuizen et al. 2015).

Propositional knowledge is often learned through more formal learning opportunities such as attending courses and lectures, finding research evidence, or learning technical skills (Richardson 1999). Propositional knowledge can be profession specific, is often made explicit in the curriculum what students have to know as well as in the practice guidelines clinicians use to make decisions. It is an essential part of practice, but it is only part of the knowledge which health professionals draw on in their day to day practice.

Much of the knowledge in practice is implicit and includes tacit knowledge. Tacit knowledge, a term commonly attributed to Polyani can also be described as the *"know how"* type of knowledge: the knowledge which is learned through experience and practice and doing (Polanyi 1958, Blackler 1995, Polyani 2009). It can relate to the *know-how* of practice, and can include the health professional's personal knowledge including attitudes, values, beliefs and perceptions. Tacit knowledge is often pre-reflected and semi-conscious knowledge, and includes values and beliefs held by the practitioner. It can be acquired through socialisation, and can be learned in a personal as well as in a professional context, but will be present in practice (Blackler 1995, Epstein 1999, Richardson 1999).

Epstein describes how, in medical practice, explicit and tacit and personal knowledge inform clinical judgement, but the tacit and personal dimension are often overlooked:

> *"Seasoned practitioners also apply to their practice a large body of knowledge, skills, values and experiences that are not explicitly stated by or known to them"* (Epstein 1999, p834).

Understanding professional knowledge in healthcare is complex, and it is difficult to describe how knowledge comes together in practice. Formal education in healthcare can have a strong focus on propositional knowledge which can be taught and assessed. But other forms of knowledge are often less visible, and can stay unacknowledged.

Higgs and Titchen (1995) identify three different types of professional knowledge shaping the practice of health professional. The knowledge includes propositional knowledge, professional craft knowledge – knowledge which integrates theory and practice and is used every day in action, the know-how of practice – and personal knowledge. In practice, the health professional blends and enmeshes knowledge. Professional craft knowledge will blend with tacit knowledge and knowledge the professional will have of their patient or client and with the accumulated knowledge of their previous experience (Higgs and Titchen 1995, Titchen, McGinley et al. 2004).

Higgs and Titchen highlight the role of personal knowledge, knowledge gained through life experience, also includes a person's cultural knowledge in nursing practice (Higgs and Titchen 1995). Personal knowledge is significant in healthcare because it shapes practice, it involves the whole person; and health professionals bring their whole being to the interaction with the patient (Higgs and Titchen 2001a, Jarvis 2009). Eraut (2000) discusses the role of personal knowledge in practice, however differs from the understanding of Higgs and Titchen (Higgs and Titchen 1995). Personal knowledge is *"what individual persons brings to situations that enables them to think, interact and perform"* and can include propositional knowledge (Eraut 2007 p406). Eraut refers to personal knowledge as the cognitive resource. While Jarvis, Titchen and Higgs see personal knowledge as involving the whole being, Eraut explicitly integrates propositional knowledge into personal

knowledge, avoiding the separation of propositional and personal knowledge(Eraut 2000).

The theoretical understanding of what constitutes practice knowledge in healthcare is evolving. Because of the holistic, complex and dynamic nature of practice, knowledge in practice, theories of practice knowledge will assist in the understanding but are unlikely to give an absolute insight because practice knowledge will also be related to a specific context. The relationship between practice and the development of practice, learning formally and informally, and the construction of professional knowledge are interlinked and not easily researched.

In pre-qualification training healthcare students will acquire theoretical, scientific and professional knowledge, with the expectation that they will be able to apply that knowledge in practice. But there is a gap between what nursing students are taught at University and what they find in nursing practice (Maben, Latter et al. 2006). The relationship between theory and practice has also been identified as problematic for newly qualified occupational therapists (Steward 1996). Professional practice is defined by complexity and uncertainty (Schön 1987). Working with older patients is challenging, because the needs of many older patients are complex (McCormack 2005a).

The assumption that, in healthcare, theory is applied to practice, is seen as a misconception. The relationship between theory and practice and how professional knowledge is constructed has been researched and developed by, for example, Schön, Fish, Coles, Higgs and Titchen, Higgs et al, and Eraut (Schön 1987, Fish and Coles 1998, Eraut 2000, Higgs and Titchen 2001b, Eraut 2004, Higgs, Andresen et al. 2004, Eraut 2009b). Fish and Coles (1998) distinguish between two different approaches to understanding practice. One is a techno-rational approach which breaks practice into components, and emphasises evidence-based practice, where the actions of the practitioners are prescribed by the existing research evidence rather than relying on the clinician's professional judgement, and the role of the practitioner is seen as delivering a service (Fish and Coles 2005). But theory and practice cannot be separated, but continuously inform each other. *"You can only understand your practice by appreciating the*

theory that, for you, underpins it, and you can only understand the theory basis of your practice by appreciating its concrete expressions in your own practice" (Coles 2004).

Practice is seen as professional artistry rather than a highly structured process where the professional follows a step to step approach to problem solve or draw deliberately on one form of knowledge. With increasing expertise health professionals develop what has been described as professional artistry.

> *"Professional artistry is evident in those moments of highly effective or beautiful practice which, when witnessed, may seem inexplicable or even magical. It involves a complex blending of what the professional knows (in diverse ways), senses (in the here and now and in terms of possibilities) and is capable of."* (Frost and Titchen 2010).

In professional artistry, the professional draws together different forms of knowledge , taking into account moral and ethical considerations, the patient and the wider context, rather than following a pre-prescribed route to problem solve or make decisions, the professional uses what appears to be intuition and creativity to respond clinical scenarios and its uncertainties in practice (Coles 2004 , Finlay 2008). Schön sees reflection in action as part of professional artistry (Schön 1987).

Healthcare practitioners draw on a wide range of knowledge in their practice. The relationships between practice and the development of practice, learning formally and informally, and the construction of professional knowledge are interlinked and not easy to research. In healthcare, the creation or development of professional knowledge is closely linked to practice.

There are barriers to applying explicit knowledge such as evidence-based knowledge to practice. Formal and informal learning and personal knowledge overlap and can become indistinguishable on reflection (Titchen, McGinley et al. 2004). The development of professional knowledge can be understood in different ways. Habermas, a critical theorist, links knowledge to daily life. He differentiates between technical or analytical empirical knowledge, practical knowledge which is related to understanding, and emancipatory knowledge which is linked to self- reflection and transformation of the individual, culture and society (Ritzer and Goodman 2003). Habermas' differentiation of knowledge indicates that not all knowledge is learned through reflection. Much knowledge is

learned in and through practice. Pre-reflexive knowledge in practice is what Polyani described as the tacit and personal knowledge which is difficult to articulate and describe (Polyani 2009). It is that knowledge and knowing in practice predates reflexive theoretical knowledge. Reflection, and analysis only comes into play when there is a breakdown in practice (Nicolini, Gherardi et al. 2003).

Working, in practice, means learning to deal with the uncertainties and complexities of practice (Schon 1983, Coles 2013). Evidence based practice, and basing treatment decision on scientific evidence can be too narrow and not meet the needs of the individual patient. Scientific evidence does not address the uncertainties, or the ethical and moral decisions healthcare involves (Coles 2013). The rigidity of evidence based medicine has been questioned and may actually prevent the patient being treated with their needs in mind (Greenhalgh, Howick et al. 2014). In medicine and other healthcare professions other methods of knowledge and knowing are essential in practice.

There is variation in how scientific evidence is used throughout the different healthcare professions. Medicine has a strong culture of evidence-based practice, but in occupational therapy relevant available evidence is scarce, and its acceptance in clinical practice is more recent (College of Occupational Therapy 2014). There has been an increased integration of evidence-based treatment and interventions in practice via, for example, the use of clinical guidelines, and the integration of teaching on evidence-based practice into the professional curriculum (Jones 1996, Rycroft‐Malone 2004).

The assumption that scientific technical knowledge such as evidence-based guidelines can be applied to practice easily is problematic because of the relationship between different forms of knowledge and the relationship between theory and practice in healthcare (Slawson and Shaughnessy 2005). Fish and Coles (1998) highlight that theory is not applied to practice, and reverse the assumption that evidence can be applied to practice, arguing instead that theory emerges from practice. Higgs, Andresen et al. (2004) propose a model which links the construction of knowledge and theory and practice. According to their model, the elements of practice knowledge include propositional knowledge, procedural

knowledge, artistic and ethical knowledge, wisdom and reflection, reasoning and judgement, metacognition and intuition; and these are all connected and intertwined with each other. Titchen, McGinley et al (2004) refer to the blending of the different types of knowledge such as self-knowledge; intellectual, emotional and personal knowledge which is integrated with the professional knowledge base(Titchen, McGinley et al. 2004). The development of self-awareness and personal development of health professionals is an essential component of practice development, they refer to the blending of the different types of knowledge such as self-knowledge; intellectual, emotional and personal knowledge which is integrated with the professional knowledge base. The development of self-awareness and personal development of health professionals is an essential component of practice development (Higgs and Titchen 2001b).

But the emotional aspects of learning are often overlooked. Howatson-Jones, having researched nurses' biographical learning, states:

> *"It appears from this that emotional aspects of learning and reflection on self as learner remain secondary to achieve learning in the workplace… The professional subject, it seems is viewed as disembodied from the personal and as having limited agency in or ownership of their learning."* (Howatson-Jones, Thurgate et al. 2013 p3)

The necessity to consider emotions as part of learning of medical students has also been identified by Helmich and Shapiro (Shapiro 2011, Helmich, Bolhuis et al. 2012). Helmich identified different response patterns of emotions medical students experienced when caring for patients (Helmich, Bolhuis et al. 2012).

Doctors and other health professionals are exposed to illness and death. Their emotional responses are linked to how they experience their practice, how they position themselves to their patients, and to their professional identity. This in turn will impact on their practice.

With increasing expertise, the practitioner is able to blend professional artistry, so they can respond to the constantly changing demands and interactions; the messiness and uncertainties of practice. Professional artistry allows the healthcare professional to respond to the challenges and uncertainties in their clinical practice with skill, critical judgement, and wisdom (Fish and Coles 1998, Higgs and Titchen 2001a). Professional artistry is part of what constitutes practice. It is the part of practice which is informed by tacit knowledge, knowledge which

cannot be easily expressed yet is evident in practice, but because of the practitioner is not necessarily conscious of that knowledge, find it difficult to explain. Layers of knowledge, rather than one form of knowledge, are at the crux of practice. De Crossart and Fish (2005), looking at the work of surgeons, developed a multi-layered and interwoven model of professional knowledge involving fourteen components of different types of knowledge The layers of knowledge inform the decisions and judgements healthcare professional make.

In a study of occupational therapists, Mattingly investigated their knowledge and reasoning in their clinical practice (Mattingly 1991). The study showed that they drew on different forms of knowledge to help them to reason and to find solutions with or for patient's problems. Mattingly describes two different ways in which occupational therapists discussed patients at case conferences. One was what Mattingly describes as the *"chart talk"*, where the biomedical details relating to the patient were discussed. The second form of discussion took the form of storytelling, focusing on the individual patients and their experience of their illness. The use of storytelling and narrative reasoning was used by the therapists to focus on patients' needs, and when interacting and problem solving with their patients. Occupational therapists' reasoning differs from that of a doctor working towards establishing a diagnosis. The occupational therapists' reasoning involves a much more phenomenological understanding of the patients experience and how they make meaning of their illness or disability (Mattingly 1991). It was a core element of their practice (Mattingly and Fleming 1994). The therapists try to understand the beliefs and values and motivations of the patient to establish a collaborative relationship with the patient.

> *"Narrative thinking especially guides therapists when they treat the phenomenological body; that is, when they are concerned with their patients' illness experience and how the disability is affecting their lives."* (Mattingly 1991 p1004).

The work highlights some of the different types of reasoning in occupational therapy, and how it is used by therapists in practice, and reflects how some of the values of occupational therapy are enmeshed into reasoning.

2.4.2 Values and beliefs in practice

Values and beliefs underpin professional practice. They are part of professional knowledge, and influence the care provided to patients (Higgs and Titchen 2001b, Fish and Coles 2005, Tadd, Hillman et al. 2011). Some of the values which health professionals aim to adhere to, such as treating patients with respect and dignity, are made explicit in published codes of conduct published by the professional bodies. For example, the UK code of conduct for occupational therapists states:

> *"You should enable individuals to preserve their individuality, self-respect, dignity, privacy, autonomy and integrity* (College of Occupational Therapists 2015 S3.2.1, p16).

Making special reference to vulnerable people states, it continues:

> *"Vulnerable people should be treated with dignity and respect as equal members of society, entitled to enjoy the same rights and privileges as any one of us would expect"* (College of Occupational Therapists 2015 S3.2.3, p16).

The first item in the code for nurses and midwifes states:

> *Treat people as individuals and uphold their dignity* (Nursing and Miwifery Council (NMC) 2015 S1, p4).

The British Geriatrics Society and King's Fund highlight values such as treating older patients with respect and dignity and giving them choice (British Geriatrics Society 2009, Oliver, Foot et al. 2014).

The Francis report identified that patients were treated with a lack of dignity, with serious consequences on the lives of the patients and their families and friends, and in some cases leading to neglect and poor treatment or even the death of patients, especially of frail and vulnerable older patients (Francis 2013).

It can be difficult to identify exactly how practice is shaped by the values and beliefs of the healthcare professional. Treating patients with dignity makes a difference to the patient which is often palpable. The factors contributing to dignity in care include treating the patient as a person, respectful communication, avoiding physical exposure, and valuing the patient as well as creating spaces which make dignified care possible.

It is often easier to identify episodes of care where values were not implemented in practice, and give example of undignified care:

> *"Values and beliefs are visible but not necessarily easily identified in practice. As much of the empirical literature notes, it is often far easier to relate experiences of indignity or present examples of undignified care than experiences of dignity and dignified care"* (Tadd, Hillman et al. 2011 p50).

Values and experience are part of what shapes professional practice (Fish and Coles 1998, Fish and Coles 2005). The values of person-centred care differ from those of task-focused care. The theoretical development of person-centred care emphasises the values which are at its foundation. Person-centred care is underpinned by a respecting the autonomy of the patient.

"The role of the patient centred nurse is to be there, offering personal and technical expertise, while enabling the patient to follow the path of their own choosing and in their own way." (McCormack 2005b page 615)

Although some of the values driving patient care in healthcare are made explicit, an individual health professional or team's values can be part of their tacit and personal knowledge, and not something the individual is aware of. Not all the values will be adopted consciously, but are absorbed through osmosis and socialisation, becoming part of tacit and personal knowledge (Tadd, Hillman et al. 2011). An individual can bring values to their practice which have often been adopted during socialisation earlier in life, as well as the values absorbed over the course of professional education and through practice (Jarvis 2001, Giddens and Sutton 2013). A study of mental health nurses showed that some of the values they held were developed prior to their initial training, although some values were also developed over the course of professional training. The values held by a health professional do not only impact on patient care, but also on job satisfaction and attrition (Stacey, Johnston et al. 2011). A recent report suggests that this remains the case, and that attrition rates may be an increasing problem (Nursing and Miwifery Council (NMC) 2017).

Drawing on critical theory of the Frankfurt School, Manley and McCormack (2003) conclude that it is emancipatory knowledge, involving self-awareness and empowerment, that leads to change in practice in nursing. Technical and practical knowledge is essential in practice, but these types of knowledge do not

necessarily help to change practice. However practical and technical knowledge generated through scientific methods can lead to innovation and fundamental changes in practice, and in how patients are treated. Scientific knowledge has always been considered important for the development of medical practice (Moule and Goodman 2013).Theories of transformative learning and practice development focus on the role of the learner at changing practice rather than scientific theories alone bringing change to practice. Because clinicians develop practice, it is the health professional who in the process of learning, who is at the core of change and needs to increase their understanding of themselves, their attitudes and beliefs, leading to changes (Mezirow 2000, Manley and McCormack 2003, Jarvis 2009). However, learners can be neglected, especially in healthcare.

In the care of older patients, the significance of values of the health professional and the organisation have been identified as having a significant impact on the care older patients receive. In practice patients and carers will know when they have received care underpinned by positive value. Care which lack of positive values in practice were identified in public reports like the mid Staffordshire inquiry. The Francis report identified that patients were treated with a lack of dignity, a values which is identified in professional standards of doctors, nurses and allied health professionals leading to neglect and poor treatment of patients (Francis 2013).

2.4.3 Learning and biography

Healthcare professionals are adult learners. Adult learning theories will assist the understanding how health professional learn and develop knowledge throughout their career.

Knowles theorised that adults learn differently from children that focused on the idea that the adult learner needs certain conditions for learning. Adult learner are self-directed, participating actively in their learning (Knowles 1990, Knowles, Holton et al. 1998). Adult learning is based on the concept of experiential learning. Dewey theorised that individual learn from experience and build on those experience. But just having experiences is not enough unless the experience is reflected upon:

> *"We do not learn from experience, we learn from reflecting on experiences"* (Dewey 1997 (original publication 1938), p20).

Illeris (2009) provides a map of how learning theorists have answered this question, beginning with the assertion that learning consists of the learner interacting with the external environment and the learner interpreting and dealing with external information internally. Illeris's theoretical map also highlights dimensions or domains of learning: knowledge, understanding, skills; motivation, emotion, volition; and interaction. In addition learning starts with the body (Illeris 2009, Jarvis 2009).

The individual might learn through experience and build on the experience. In healthcare, a professional can accumulate experience through practice, but building up experience does not necessarily develop and change their practice. The learning leading to transformation is more complex, and occurs when certain conditions are fulfilled. Mezirow identifies the conditions leading to transformative learning:

> *"Learning occurs in one of four ways by elaborating existing frames of reference, by learning new frames of reference, by transforming points of view, or by transforming habits of the mind". (Mezirow 2000 p19).*

Jarvis (2007) expands the understanding of transformative learning by linking learning to the learner's biography. Learning through experience can be transformative if the thoughts, actions and emotions of the learner are changed ,

and the learner connect their experiences and perceptions to their biography(Jarvis 2007). Learning is an individual process, but it needs to be considered that the learner learns in a wider context of their lives and is embedded in social circumstances.

Sociocultural theories of learning, such as the theory developed by Lave and Wenger (1991), see learning as a social practice and as how the learner becomes a member of a community of practice. In their research Lave and Wenger studied how individuals became a tailor, or a midwife. Learning is more than acquiring knowledge: learning is situated. The learner adopts values and beliefs, becomes socialised and becomes part of a community. In later publication they defined Communities of practice as *"groups of people who share a concern, a set of problems, or a passion for a topic, and who deepen their knowledge and expertise in an area by interacting on an ongoing basis"* (Wenger, McDermott et al. 2002 p4). Initially the learner is a newcomer and is at the periphery of the community. Over time the learner moves from the periphery to the centre of practice and becomes gradually a full member of that community of practice.

The learner does not only learn a trade or skills, but the learner is absorbed into the culture and absorbs the community's culture. The development of an identity is central to learning, but learning also includes technical learning and skills. Not all learning will, necessarily, be intentional. The learner's knowledge changes through the involvement of the community. With the arrival of a newcomer to the community, both the newcomer and community will change. The newcomer changes as they become part of the community of practice, and at the same time by becoming part of the community the newcomer will encourage the existing community to review their practice (Lave and Wenger 1991).

In healthcare, communities of practice have been promoted to enhance knowledge and practice (Nicolini, Scarbrough et al. 2016). Teams, clinical settings or professional groups can be understood as communities of practice. A student or practitioner can belong to several different communities of practice, and can be connected to a specific profession, an interdisciplinary team or a specific location, each having different tasks, roles and cultures within the wider healthcare system. Teams, professional groups, or wards can be considered to be

communities of practice. An individual health care professional can be a member of multiple communities, the different communities having variable expectations and cultures and roles (Hall 2005). Even within a clearly defined community of practice, individuals can be part of different communities of practice, and might not always share the same behaviours and values, or ways of knowing and practicing of every community of practice. The care of older patients is often given by a multidisciplinary team where the health professional will be part of various teams, for example, a physiotherapist might be working on various wards, and be part of a wider physiotherapy team. Different health professionals caring for an older patient will have different roles in the care and rehabilitation of older patients (Department of Health 2001). Differences in the attitudes, values and beliefs held by the different team members can be a barrier to collaborative inter-professional working and learning (Sargeant 2009). In practice, each health professional will have to negotiate the individual, professional and organisational differences. Learning is a sociocultural process as well as an individual process. Learning at pre- and post-qualification level is a social process but make demands on the individual health professional, and therefore can also be understood an individual process. Each learner needs to learn how to be a member of different communities of practice, and has to absorb the knowledge and culture of different communities (Yanow 2014).

In the context of educational frameworks such as lifelong learning policies, adult education, workplace learning and learning in and through practice and continuing professional development, there has been an interest in understanding the educational experiences and opportunities of the individual throughout their life course, and the connection between the individual biography and learning. Even if education and professional development is not formalised, individuals make choices – including educational choices – throughout their lives. These choices are significant. The choices an individual makes at different life stages about their education and career will influence the shape of the individual's subsequent life (Beck 1992, Bauman 2000). Learning is linked to the individual biography and the subjective experience of the learner, but is also linked to societal conditions and changes.

The concept of biographical learning can help us to understand the learning of health professionals over the course of their lives. In the UK, the need for health professionals to demonstrate continuing professional development requires them to formalise some of the learning throughout their career. Learning can take place through formal learning in institutions and through accreditation. Although learning in healthcare is often informal and unintentional, and not necessarily planned, it may be formalised through the requirement to keep professional portfolios.

The definition of biographical learning by Alheit and Dausien portrays the learner as having a degree of agency and autonomy. They define biographical learning as:

> *"…a self-willed, 'autopoietic' accomplishment on the part of active subjects, in which they reflexively 'organise' their experience in such a way that they also generate personal coherence, identity, a meaning to their life history and a communicable, socially viable lifeworld perspective for guiding their actions"* (Alheit & Dausien 2002, p.17).

Through reflection, the learner creates coherence of their biography and life experiences. The learner becomes being able to direct their choices and action, rather than following existing traditions and pre-determined structures. Their definition highlights the individual's active engagement with their learning, and the connection between the individual biography and making meaning. The learner attaches meaning to their experiences.

The study of biographical learning encompasses the individual, the internal and external factors. It focuses on the individual learner and their stories and experiences, but is not understood as an exclusively individual process. The individual learning biography also reflects the wider social structures in which the learner and the learning is embedded. Understanding the individual story of a learner makes it possible:

> *"……to comprehend education and learning both as individual identity work and as a 'formation' of collective processes and social relations; in other words to link stories and structures."* (Alheit 2005a p5)

Adult learning theories describe learning as being multifaceted, encompassing more than the cognitive components of learning. It *"includes the cognitive and reflexive dimensions of learning as much as the emotional, embodied, pre-reflexive and non-cognitive aspects of everyday learning processes and practices"* (Tedder

and Biesta 2007, p2). The adult learning theory proposed by Jarvis (2009), who sees learning as a process of becoming a person in society, involves the whole person. Jarvis describes adult learning as holistic and complex: it does not take place in a linear fashion, but the different ways of learning interact with each other, creating a web of learning. When the learner makes meaning of their experience, the learning becomes part of the learner's biography and in turn the learning changes that biography. Compared to Alheit, Jarvis emphasises the individual in the learning process including the inner processes of learning, however he also sees the learner embedded in a social context.

Perception, memory and biography are connected. Perceptions of an experience or an event and the memories of experiences are individual:

> *"perception of the situation is largely determined by individual biography and it is therefore subjective and individual."* (Jarvis 1995 p67).

One advantage of this insight into individuals' learning biographies – which encompasses the temporal aspects of learning, learning over the life course of an individual – is that it allows a holistic view of learning over time and allows one to understand how the learner understands, organises, and constructs meaning from their learning experiences (Alheit and Dausein 2002). Learning is an individual process and can be personal, but at the same time a social process. Alheit, like Lave and Wenger, sees learning not exclusively as an individual process, but as something that takes place through interaction with others, and which is socially structured (Lave and Wenger 1991, Alheit 2009). This view of learning is supported by theories of symbolic interactionism: learning takes place through interaction and the interpretation of the interaction with others (Blumer 1992). It is an internal as well as an outward process, a social act. The learner is a social actor (Alheit 2009).

There are intrinsic tensions when considering the position of the learner, and the connection between biography and learning. Individuals can be understood to have varying degrees of agency in how they live their lives and organise their learning. Alheit and Dausien coined the term *"biographicity"* to describe how individual can *"redesign again and again from scratch the contours of our life within the specific context in which we(have to) spend it, and that we experience*

these contexts as shapeable and designable" (Alheit 2009 p125). In the definition of biographicity, the learner is seen as being reflexive, and creating coherence of their learning experiences throughout life. An individual's learning is structured, implicitly or explicitly through their biography. Learning takes place within the individual, and the individual integrates their learning with their past experiences and their biography.

But the relationship between action, reflection and action is not always clear. Reflection is not always part of learning. Individuals do not always reflect on their actions or events. *"In some cases, learning (new action patterns) may result from an individual reflecting on his or her previous ways (biographies) of dealing with certain situations; in other cases, adaptations are simply added to an ongoing biography without much reflection. This implies that biographical learning is as diverse as learning"* (Hallqvist 2014 p39). On the one hand, the learner can be seen as a self-reflexive and active learner who creates coherence of their experiences and manages transitions, change and opportunities; on the other hand, they can be seen as more passive, where much of the learning is unintentional and not necessarily reflected upon. Individuals need to give meaning to their experiences, but might do so long after the event; meaning might never be attached to an experience. Schön (1987) differentiates between reflection in action, where a practitioner reacts to a situation in practice, and reflection on action. Reflection on action takes place after the incidence of an event. However, in Kolb's learning cycle, the first step of learning is learning through experience, health practitioners can draw on what has been learned previously without necessarily reflecting on the most recent event or situation (Kolb 1984). But the learning is likely to be less effective when the experience is not reflected upon (Moon 1990).

The learning process often starts when the learner experiences a sense of disjuncture: when an individual has to deal with change or respond to new situations. Jarvis (2007) describes a point of disjuncture when there is a feeling of unease, a mismatch between the expectation of what is going to happen and the actual experience. These feelings are more likely to be experienced in phases of change. In healthcare, the transition from being a student to being a qualified

professional is recognised as a period of change and adaptation and has been recognised as being challenging (Maben, Latter et al. 2006, Maben, Adams et al. 2012). Transitions are phases of change and learning, when individuals have to deal with new demands, work cultures and developing new knowledge. The individual might benefit from extra support at that time: some of the transitions can be anticipated. Reflecting on experience is one way to acquire knowledge. Health professionals learn in and through practice: this learning is not necessarily intentional or reflected upon, nor has the learner the opportunity to create coherence of the experience of learning, but it still adds to their experience.

In workplaces, such as in clinical practice, the focus of learning on competence and skills may be necessary, but to focus exclusively on how individuals become competent or acquire skills at the workplace is to take a restrictive view of learning. In healthcare, learning takes place in specific contexts and is situated, and what is learned in one context might not necessarily be easily transferred into another context (Eraut 2004, Pimmer, Pachler et al. 2013). There has been a shift towards the assessment and measurement of competence in healthcare education (Fish and Coles 2005). Eraut (2009a), discussing work-based learning, advocates for a more holistic understanding of learning, and going beyond the focus on competence. Focusing on competence in the workplace is restrictive, does not take into account the individual's lifelong learning, and neglects the emotional aspects of learning. Individuals develop throughout life, and through different parts of their life, not only through work.

West researched the biographical learning of students in higher education, and professionals such as doctors and teachers. Learners' biographies can be viewed from a variety of theoretical perspectives and opens up the understanding of learning. Alheit's research on learning biographies was viewed from a sociological perspective. West examined the learning biographies psychodynamic theories but still connecting learner to the social context in which learning takes place (West 1996, West 2009). West concludes that professional and personal learning are not separate, and advocates that the exploration of biography and autobiographical reflection can be part of professional learning.

West highlights the link between how practice is understood and the development of educational initiatives or strategies:

> *"Under the mantra of evidence-based practice, harder more quantitative 'scientific' and 'objective' evidence may be privileged, rather than what is more personal, subjective and challenging. In this paper, in challenging some of these trends, and as a contribution to the debate about professional knowledge, I suggest that auto/biographical forms of reflexive learning, can offer a rich way of thinking about professional lifelong learning,….."* (West 2009)

In biographical learning research, viewing the learning of an individual from different theoretical perspectives, such as sociological-, life course- or psychodynamic theories can complement each other, and can deepen the understanding how learning takes place.

Studies of healthcare workers' biographical learning are scarce. Howatson-Jones (2011) explores the use of the individual biographies in learning through setting up a space within a nursing programme, where nursing students are given the space to explore their own biographies. Howatson-Jones used questions to ask the students about their life stories. They were given written transcripts of the interviews for further reflection. This gave the nurses the opportunity to change, reflect upon, and add to the original interview, and to enter into a dialogue with the researcher. Understanding their biographies allowed them to develop a new understanding of themselves, and they felt it enhanced their professional practice and person-centred care. *"Personal spaces are rich sources of learning but seem to be irrelevant to professional life"* (Howatson-Jones, Thurgate et al. 2013 p8). There is a link between the personal and the professional: the context of a work environment matters to the individual nurse, but the personal is not given space in pressurised work environments. This time pressure is experienced by the individual as a *"process of rupture"* (Howatson-Jones 2011).

Research studies of biographical learning in healthcare are rare, but in addition to academic research, literary writing can add to the understanding of the connection between learning, biography and being a health professional. Autobiographical writing, not necessarily with an academic audience in mind, such as *"Do no harm. Stories of life, death and brain surgery"* can give insights into (in this example) the learning throughout life and the career of a doctor. After retiring from the NHS, Marsh (2014) writes about his life as a brain surgeon,

looking back over his career. He recalls the circumstances which led to the decision to becoming a brain surgeon, his experience of learning to become a surgeon, and being a senior doctor, training and mentoring junior staff. The book gives insight into the subjective experiences of being a doctor in a big teaching hospital, and the writing brings out into the open what is often hidden but part of practice: some of the attitudes, feelings, fears, motivations, and the uncertainties, ethical and moral dilemmas of medical practice. The liveliness of his writing conveys with honesty some of the less visible components of practice such the emotions he felt, but did not show or discuss with his colleagues or patients. The stories he tells have a coherence, and yet describe the uncertainties, messiness and complexities and at times the turmoil of clinical practice.

2.4.4 Learning and socialisation

Viewing learning as a lifelong process integrates the process of socialisation over the life course. Socialisation is a process which starts in childhood, and continues throughout life (Giddens and Sutton 2013). Through socialisation, individuals become part of a group and a culture. Socialisation takes place throughout the life course: in early in life primary socialisation takes place mainly through the family; and secondary socialisation continues through education, peer groups, and work place, for example. (Jarvis, Holford et al. 2003, Giddens and Sutton 2013). Jarvis (1983) describes learning as a social act. Although individuals learn unintentionally and at pre-conscious level throughout life, learning is both an internal and external process as people learn to develop a sense of self through interaction with others (Mead 1967, Jarvis 1983).

Professional socialisation takes place during initial training and throughout someone's career. It influences how professionals carry out and perceive work, and is part of professional development and identity (Jarvis 1983, Giddens 1991). When considering the learning of health professionals throughout life, socialisation is part of their personal learning and professional education and development. Mead and Blumer, who developed the theory of symbolic interactionism, see learning which happens through the interactions with others and when the individual interprets and attaches meaning to the sensations, interactions and their experiences (Mead 1967, Jarvis 1987, Blumer 1992, Jarvis

2007). The social structures, for example the organisation, or educational institution the individual is embedded in, are reflected in the individual's learning (Jarvis 1987). Lave and Wenger see learning as a social cultural activity: the individual learner is socialised through to becoming a member in a community of practice, and through social interaction with members of that community (Lave and Wenger 1991). Bourdieu theorised the link between agency, structure, and socialisation through what the concept of *habitus*. Habitus is linked to people's actions and practices in daily life. Habitus is formed during the socialisation process, through internalising values and beliefs of a culture, which will affect the person's actions and thoughts (Bourdieu 1977). Learning is a cultural and social process, and each learner is socialised into many groups and subgroups. Norbert Elias rejects the dichotomy of the individual and society: the individual and society cannot be separated, as one influences the other (Elias and Schröter 2001).

The socialisation of healthcare students and professionals is a tacit and often unspoken part of their education during undergraduate training. It is part of what is sometimes called "the hidden curriculum". The book "*Making of doctors"*, is based on an anthropological study of students at a London medical school in the 1980s. The medical students were followed over the course of their studies, and the observations describe how, over time they became members of the medical profession. This included learning to speak what is considered the right language, adopting behaviours which are acceptable within the hierarchy of the medical profession, and developing attitudes towards their work (Sinclair and Toulis 1997). The socialisation of medical students takes place throughout their training, and shapes their professional identity and career choices. Socialisation is seen as an important of learning in professions such as nursing, physiotherapy, and occupational therapy: Students and practitioners internalise professional values and beliefs, some of which are not necessarily made explicit or articulated, and acquire skills and develop an implicit understanding of rules which are shared throughout healthcare or can be specific to a professional and professional identity (Richardson 1999, Dahlgren, Richardson et al. 2004, Lindquist 2006).

In healthcare, students are traditionally socialised into their professional groups, often working alongside each other and in interprofessional teams. Lindquist

(2006), in her study of physiotherapists, described the socialisation in their study as a process of osmosis. Healthcare professionals develop their professional identity, adopt values, attitudes, skills and knowledge during their professional education and practice and learn how to become members of their profession (Clouder 2003, Lindquist, Engardt et al. 2006). Socialisation can be profession specific but also include interprofessional socialisation, where students learn to work interprofessionally in practice (Khalili, Orchard et al. 2013). Socialisation can be seen as a passive process, but can also be seen as a more interactive process where the student or healthcare professionals is not merely a passive person in the process and adopts values and beliefs unconsciously, but rather is a person who interacts and reflects with their environment.

Clouder (2003) studied the socialisation of occupational therapy students. She found that that socialisation is not necessarily a passive process. Drawing theoretically on social constructivism and the work of Berger and Luckman (1967), the analysis of the data is based on the concept that socialisation is dialectical. It is a process between the individual and society, where the newcomer enters *"the social world of a profession and predominantly through face to face interaction with others , establish[es] what it means to be a professional"* (Clouder 2003 p216). During this process students change, gradually developing their professional identity. The students are not completely passive, but have some agency in their development. The students are subtly modelled through their interactions in practice, but Clouder's findings also show that the students position themselves, considering their options in the socialisation process, the values and beliefs they encounter and question their profession. The process of socialisation is neither completely passive nor unconscious. It is possible that the nuances of socialisation, if it is an active or passive process and the degree of agency a student will express, will depend on many factors, including the professional and other context specific as well as individual factors. Socialisation can have positive and negative outcomes for the individual, and the development of professional identity and practice. It can lead to good or poor quality care, and can motivate and demotivate a healthcare professional (Dinmohammadi 2013).

2.4.5 Learning to work with older patients

The preparedness of healthcare workers to care for with an increasingly older population has been highlighted, and how the needs to an older patient population can be met. In nursing in the UK, gerontological nursing is not recognised as a speciality in its own right. Even when it is part of the undergraduate curriculum its interpretation and the way in which it is integrated into the curriculum varies (McCormack 2005a). Unless they work in paediatrics or obstetrics or a young person service, for most health professionals who work in hospital or the community, a proportion of their patients will be older patients. An argument can, therefore, be made that all health professional should have some preparation to work with older patients.

All medical schools in the UK were asked, in surveys in 2008 and again in 2013, to identify what was taught about older people in their formal curriculum. The responses to the survey in 2013 show that there has been an increase in teaching about old age within the undergraduate medical curriculum since 2008. The topics identified within the curriculum focused largely on scientific knowledge such medical conditions which tend to affect older people (Gordon, Blundell et al. 2014). The survey's findings provide an overview of the topics taught at the different medical schools, but did not investigate the students' experience of the teaching, their recall of what had been taught, or look at the development of professional knowledge outside propositional knowledge.

Oakley, Pattinson et al. (2014) extend the discussion of what and how to teach medical students that is specific to the care of older people. Acknowledging that there always will be competition as to what subjects and topics to include in a crowded undergraduate medical curriculum, using expert consultation and consensus techniques, the researchers established a list of topics medical students need to learn about older people. The consensus was that conditions commonly found in cohorts of older patients such as stroke, falls, and incontinence should be included in the medical curriculum. But the researchers are also clear that learning about old age and older patients goes beyond teaching propositional knowledge. Because working with older patients is often viewed negatively by many medical students, the learning about older people needs to go

beyond learning scientific and technical knowledge, but needs to include the development of positive attitudes towards older people as well as praxis knowledge. This in turn will influence the perceptions students have of working with older people and will influence motivations of future doctors to give good care to older patients (Oakley, Pattinson et al. 2014). Biggs (1993) had previously highlighted the significance of the relationship between the older patient and the health professional and concluded that this relationship is not very well explored, and this more recent discussion shows that the relationship between older patients and younger healthcare students and professionals is still an issue in terms of motivation, status and care of the older patients.

Studies of nursing students have not only focused on identifying the content of the curriculum, but also on how the material is best placed within the curriculum for students to learn. In a Canadian study of a nursing students it was found that integrating teaching about older people into the undergraduate curriculum rather than having a standalone course, might have positive effects. The study of 119 nurses showed that integrating teaching and clinical experience about older adults lead to improvements in students' knowledge and beliefs (Baumbusch, Dahlke et al. 2012). The study relied on self-reported increase of knowledge. It is not clear how the authors defined knowledge in this study; but it seems to include components of tacit knowledge such as the beliefs.

Person-centred care has been identified as being at the core of good quality care of older patients. The National Service Framework for older people sets out standards for the care of older people specifying person-centred care as one of the standards (Department of Health 2001). Person-centred care moves away from the idea that the patient is a passive recipient of care and respects that individuals can make their own decisions (McCormack 2003)The prerequisites for person-centred care in the nursing care of older people is that that the nurses are competent in giving care and have communication skills and self-knowledge, including are clear about their own values and beliefs, and how these can impact on the decisions they make *"…before we can help others we need to have insight into how we function as a person"* (McCormack and McCance 2006 p475). Values, beliefs and attitudes towards older patients, and personal knowledge can

influence the motivation of students and staff to want to work with older patients. They can also influence their motivation to develop their knowledge, and ultimately influence the quality of care and patient experience.

Attitudes of students and qualified health professionals towards older people have been shown to impact on patient care (Rybarczyk, Haut et al. 2001). Studies of staff working in different healthcare settings give insight into the reasons why some health professionals find it more difficult to work with older patients.

The link between attitudes and age bias and treatment and care of older patients were investigated in an American study of rehabilitation professionals (Rybarczyk, Haut et al. 2001). This study combined quantitative and qualitative data, and although it is set in an American healthcare system, it gives detailed insight into the attitudes of rehabilitation professionals and especially what underpins the negative attitudes of the rehabilitation professionals towards some of their older patients. The study included 974 participants with different professional backgrounds including nursing, physiotherapy and occupational therapy. The study included responses to case study vignettes, as well as the completion of attitudes scales. It was found that the age of the patient influenced the attitudes and the perceptions the rehabilitation professionals had of the patient. Rehabilitation professionals were biased against older patients, especially when assessing the patients for the potential for rehabilitation or predicting if they could return home. The study identified the characteristics of the patients the health professionals found it most difficult to work with. They were most biased when the patient was perceived as being non-compliant with treatment, or being depressed. The age of the patient was a significant factor. Older patients were seen as less desirable to work with than younger patients, possibly due the fact that they were more difficult to work with. Older patients whose needs are the most complex, and different from other patients', are perceived as difficult possibly because the professionals found it more difficult to respond to their needs. It is likely that older patients with the most complex needs do not receive the treatment they need because of the negative bias of the health professionals. The authors hypothesise that it is possible that the attitudes of the participants in this study reflect wider societal attitudes found in America or that the lack of

education about older people contribute to the negative bias rehabilitation professionals have towards older patients. Although this is an American study, similar issues have been identified in the UK where negative attitudes towards older people in society can also be found in healthcare setting, and this raises the concern how prepared health professionals are to work with older patients with complex needs (Cornwell 2012, Abrams, Swift et al. 2015).

Work setting can influence attitudes staff and students have towards working with older patients. Higgens, Riet et al. (2007) researched the attitudes of nurses working on an acute ward in Australia. Acute ward patients need more intense medical attention in comparison to a rehabilitation environment where patients tend to be medically stable. The nurses working on the acute wards were interviewed in depth. The authors identified specific factors which led to negative attitudes towards older patients. Nurses preferred to work with patients who had less complex needs and had medical problems that could be cured, and they felt that they lacked specialist knowledge to care for older patients. The wider negative attitudes towards older patient in society might be partly reflected in the healthcare setting. Older patients are more likely to have long term conditions which might be improved but not cured. This contributes to the complexities often identified in the care of older patients.

As more health professionals work with older patients, studies have investigated how to prepare students to work with increasingly older patient populations and how to foster positive attitudes towards older patients. McLafferty studies the influence of tutors and senior nurses in practice on nursing students, as well as the exposure of nursing students to older patients during the time of their pre-qualification studies can influence the motivations and attitudes of nursing students to work with older patients. The messages given to students can influence nursing students' attitudes towards older patients: experienced staff conveying negative attitudes about older people, and highlighting mainly the negative aspects of ageing such as declining physical and cognitive abilities of older people, can lead to negative attitudes towards older people in nursing students (McLafferty and Morrison 2004, McLafferty 2005).

Westmoreland, Counsell et al. (2009) studied interventions which foster positive attitudes towards older people in first and second medical students in the USA. Having contact with healthy older people (in this study the older people were a council of elders, and doing some reflective writing about their encounter with older people was found to improve attitudes of medical students towards older people immediately after having contact. However, the study did not follow up the students to evaluate if the positive attitudes persisted. The contact the students had was with healthy older adults rather than patients in hospital who needed medical attention. The older people who participated in this initiative could potentially differ from older people future doctors encounter in healthcare services. Older people are a diverse group and as the McLafferty's study shows, it can be important to foster positive perceptions of older people, and add to the development of a holistic picture about ageing and old age and older people.

The AGEIN project was a big study researching the attitudes and experience of qualified nurses and nursing students over three years by the university of Sheffield (English National Board for Nursing 2002). The research methods included surveys and focus groups in four different nursing school. It was found that student nurses had positive attitudes towards older patients, but that students were off put by care of the older patients in practice. One of the problems was that student nurses who work in care of older people are often exposed to poor environments, and this contributes to students developing negative attitudes towards working with older people. (Nolan, Brown et al. 2006). As a result of this study, Nolan et al developed the senses framework to create an environment which fosters motivation and positive relationships between healthcare workers and older patients. Working in an enriched environment where patients, family and carers and staff and students feel safe and valued and there is a sense of continuity, made a difference attitudes and motivations of student nurses working with older patients (Nolan, Brown et al. 2006).

2.4.6 Relationship between health professionals and patients

The relationship between health professionals and patients is seen as being at the core of professional practice in healthcare and is related to quality of care and patient experience (Kitson, Marshall et al. 2013, Seale 2016). Reflection, self-

awareness, knowing being able to take different stances have been linked to the ability to establish a therapeutic relationship with the older patients (McCormack and McCance 2006).

The national service framework for older people emphasises the importance of person-centred care (Department of Health 2001). In occupational therapy working in a client centred way has been a core professional value (Law, Baptiste et al. 1995, Ripat, Wener et al. 2014). There is no clear definition of the concept of person- or client-centred care. It is based partially on concepts proposed by Carl Rogers: each person is seen as an unique human being with their own experiences, beliefs and preferences and the relationship with a client is based on empathy and unconditional positive regard (Rogers 1951). The Health Foundation identified four principles of person-centred care (Health Foundation 2014):

1. *"Affording people dignity, compassion and respect.*
2. *"Offering coordinated care, support or treatment.*
3. *"Offering personalised care, support or treatment.*
4. *"Supporting people to recognise and develop their own strengths and abilities to enable them to live an independent and fulfilling life.(Health Foundation 2014)"*

A study of occupational therapy students traced the development of client-centred attitudes during their university course. By the end of their studies, the students had internalised client-centred attitudes through the university course as well as inter-professional practice through reflection and engagement with the factors which facilitated or prevented them from being client-centred in practice (Ripat, Wener et al. 2014).

However, person-centred care focusing on the individual independence and autonomy has been criticised for not being appropriate for older person's care where it is more appropriate to focus on personhood and interdependence (Nolan, Davies et al. 2004). The concept of personhood gained prominence in dementia care and was proposed by Kitwood in developing dementia mapping. It is a concept developed by the philosopher Buber in the publication *Ich und Du* (translated in English as *I and Thou*) (Kitwood 1990, Buber 1995, Kitwood 1997). The person is understood to develop their identity through their relationship with their environment, and with people within the environment. This idea has been integrated the thinking about the care of the older person.

In relationship-centred care, personhood is understood within the context of the relationship between patient and a health professional. Nolan, Brown et al. (2006) developed a framework for nurses of relationship-centred care called *"senses framework"*(Nolan, Brown et al. 2006). In relationship-centred care both the health professional and the patient are seen in the wider context. The health professionals' roles, affect and emotions that the health professionals also *"benefits from serving the patient"* (Beach, Inui et al. 2006 pS4), and that the relationship is guided by an ethical and moral component. Health professionals have a genuine relationship with the patient which beyond their role, and have a commitment to the relationship (Beach, Inui et al. 2006).

In both person–centred care and relationship-centred care it is acknowledges that the relationship between patient and health professionals – especially in the care of older people – is a significant aspect of the therapeutic relationship. In relationship-centred care, Iles uses the term *"covenantal care"*: in the interaction, the values and expectation of both parties matter and are taken into account (Beach, Inui et al. 2006, Iles 2011). Patients with long-term health problems, and many older patients seeking healthcare will have multiple chronic conditions, and are especially looking for a relationship with the health professionals. Both the patient and the health professional attach meaning to the relationship. Rather than seeing the health professional as the one who is giving e.g. their skill, time and expertise, the healthcare worker gives and receives in their interaction with the patients (Iles 2011). The emotional self-awareness of the health professionals is crucial. A small phenomenological study of three occupational therapists confirmed that relationship-building with clients is *"inherently meaningful and valued by Occupational therapists"* and considered by the Occupational therapists intricate to their practice and part of professional artistry (Williams and Patterson 2009).

2.5 Conclusion for literature review

Because of the demographic changes, there is a need to prepare health professionals care for an increasing number of older patients. Older people who seek healthcare are likely to have complex and long-term conditions. The older patients that professionals care for are a diverse group of persons: some older

patients will have complex physical, social and psychological needs; and some will be considered frail and vulnerable. In the light of an ageing population, the changing and increasing complexities and uncertainties that health professionals have to deal with in practice, and the multi-faceted nature of professional knowledge, it is important to increase the understanding of how to prepare health professionals acquire and develop their knowledge about ageing, old age and working with older patients.

Concern has been expressed that the students and staff are not well prepared to meet the needs of older patients (Goodwin, Dixon et al. 2014).

The ways in which health professionals learn about ageing, old age and working with older patients are related to our understanding of professional knowledge and practice. Health professionals draw on a wide range of knowledge including scientific and theoretical knowledge as well as procedural or practice knowledge, including tacit knowledge, and their attitudes, values and beliefs. Adult learning theories – including biographical learning theories and practice and work-based learning theories – can inform our understanding of how health professional learn to work with older patients. These theories address learning holistically; and exploring learning biographically addresses learning over the course of time, linking the individual's learning to their biography.

Health professionals working in the UK will have studied towards an accredited professional qualification, but learning and the development of practice will continue throughout their careers. In practice health professionals draw on different forms of knowledge and knowing, integrating and blending various forms of knowledge. Some of the knowledge is acquired formally, but some of it will be acquired unintentionally and informally, through primary and professional socialisation, life experience, professional training and education, and through working practice, and some of the knowledge will not be necessarily easily articulated. The different forms of knowledge and knowing shape the care of the patient, the interactions between health professionals and their patients as well as the clinical decision making.

Learning is complex and multi-layered. Individuals learn through their interaction with others and their environment. Individuals learn by attaching meaning to their

experiences and linking experiences to their biography. Researching the phenomena of learning, the understanding of the subjective experiences of the learner in this study health professionals, can be a rich source to explore learning as it can encompass formal and informal learning, cognitive, emotional, and personal, public and interactive components of their learning. There is a scarcity of research about biographical learning of healthcare professionals and no studies could be identified of the biographical learning of healthcare students or professionals in relation to ageing, old age and working with older patients.

3 Chapter 3: Method and methodology

3.1 Introduction

In this chapter, the choice of methodology and method will be explained. The research aims to understand how health professionals learn about ageing, old age and working with older patients throughout their lives and careers. In this chapter the assumptions as well as theoretical foundations will be discussed, the biographical-narrative-interpretative method (BNIM) will be explained, and the ethical framework will be considered.

3.2 Justification for the methodology

The personal assumptions I brought to the research process were influenced by my work as an occupational therapist. In occupational therapy people are seen as psychosocial beings, as individuals with their own values, preferences and wishes, but whose lives are embedded into social networks and wider society. The purpose of occupational therapy is to enable individuals to live a life which is meaningful to them, and understanding how people make sense of their lives when they become ill and disabled and what motivates them is a significant part of the work.

The exploration of the literature presented in the previous chapter has revealed how the concepts which are at the core of this study - ageing, old age, and the development of professional knowledge and learning to work with older patient-, are complex, multi-layered and relates to relates to knowledge about the lifespan and life-long learning. The temporal element of learning, gaining insight into how health professionals learn throughout their lives and careers, rather than at a specific point in time, became an important consideration the study. Health professionals learn and develop their practice throughout their career, with the development of values beliefs and assumption about ageing and old age being related to the wider social and cultural environment.

Adult learning theories for example by Jarvis and Alheit, emphasise the connection between the individual biography of the learner and learning, and the significance of the context in which their learning takes place. Exploring and

understanding the biography of the learner can give insight into learning about ageing, learning is not only as an individual process but also social process, and therefore gaining insight into the conditions in which learning takes place deepens the understanding how health professionals learn.

Adult learning theories have emphasised the multi-layered character of learning, involving the whole person, involving cognitive, sensory, physical, psychological processes. Learning can be understood as a meaning making process, where the individual creates meaning of their experiences through linking new experiences to previous experiences, as well as making meaning of their experiences through the interaction with others.

Health professionals not only develop propositional knowledge about ageing and old age, but also learn and develop knowledge which is not always explicitly articulated such as values, attitudes, beliefs and perceptions about older patients which becomes part of their tacit and personal knowledge. Some of that knowledge will be adopted, often unconsciously through primary and professional socialisation, and will be influenced by the wider social and cultural understanding about ageing and old age.

Considering how health professionals learn about old age and older people, the reviewed literature makes it apparent that old age can be understood from a multitude of theoretical perspectives, and therefore the knowledge health professionals apply in practice is not easily identified, boundaried or defined. Existing research highlights that educating healthcare students about old age – for example, what students are expected to learn for example at undergraduate level – is poorly defined and disputed (Gordon, Blundell et al. 2014). Oakley, Pattinson et al (2014) highlight that motivation, values and attitudes are part of what matters in the education of medical students and student nurses, and motivations, values and attitudes are in turn influenced by experience in practice (McLafferty and Morrison 2004, McLafferty 2005, Brown, Nolan et al. 2008).

Learning and developing knowledge how to work with older patients is not straightforward. Researching learning about old age and working with older patients, it seemed to be particularly relevant to be open to emerging

information, as well as being open to the fact that learning can take place through different modes of learning, and can take place in professional and personal life.

The theoretical underpinning for this project therefore needs to inform how as a researcher it is possible to understand how health professionals make meaning about their work with older patients, and capture the relationship between experience, meaning making and learning, and help to gain insight into the complexity of learning. The methodology and method also needs to accommodate the understanding that knowledge of health professionals is subjective, that learning can be explicit and implicit, and that learning is not always a conscious process. Life-long learning is likely to be diverse, and will vary between individuals, and that it is developed in a range of contexts such as through participation in formal learning opportunities as well as through practice and personal experiences. For those reasons the methodology needs to assist the researcher to be open to diverse experiences and views, to gain in depth understanding of the subjectivities of the participant and guide the researcher how to connect to the experience of the participant rather than looking for pre-determined categories.

Erben, writing about researching biography and education, makes reference to the necessity to, on the one hand to, comprehend the specificity of the individual who is being researched, and on the other hand the conditions of the individual's life (Erben 1998). Learning takes place in a context. Learning is not always an explicit or conscious act. Health professionals develop their knowledge in and through practice as well as through participating in formal learning opportunities, therefore the definition of learning in this study needs to encompass an understanding of learning which includes formal, informal learning opportunities, and learning which takes place explicitly and implicitly through socialisation, and can capture the multi-layered and intricate nature of learning throughout the life and career of a health professional as well as the different forms of professional knowledge, some of the knowledge which cannot easily made explicit.

Learning is lifelong, and professional knowledge develops through working in practice over time, therefore a biographical research approach was taken. Biographical research is a wide field.

3.3 Biographical research methods

Biographical research is an umbrella term embracing different approaches to studying the lives of individuals, a group, or an organisation. It can include different methods such as oral history, life history, life story, and biographical-narrative research. Biographical research lends itself to studies crossing disciplinary boundaries e.g. psychology, education, health care and the life course. The different biographical methods draw on different methodologies, and its methods can include both qualitative and quantitative strategies for data collection.

A biographical approach to research does not draw on one theory, but on a combination of theories and research approaches. Biographical educational research is a wide field and can include surveys, the measurement of motivation and attitudes as well as interpretative research approaches. However surveys for example need, by their nature, to limit their focus to aspects which have been identified by the researcher before the data are collected, and therefore do not capture the complexity and nuances of people's lives or concerns; and the data do not allow for gaining a deeper understanding of the subjective experiences or how these experiences are interpreted by an individual (Chamberlayne, Bornat et al. 2000, Alheit 2009). Surveys do not capture the individual in the social context and milieu in which a health professional lives and works.

Doing biographical interview different research strategies can be used such as narrative interviews, semi structured and focused problem-centred interviews. I considered using the problem-centred interview developed by Witzel (2000), which is a structured biographical interviewing technique where the main questions are prepared by the researcher, and the answers given by the participant will be followed up by in depth interviewing strategies (Witzel 2000). One of the advantages of the problem-centred interviews is that there is some uniformity in the questions asked across each interview, but overall the initial questions are determined by the decisions of the researcher.

Narrative approaches to interviews are open to the agenda of the participant as they allow the participants to tell their story. The formation of identity, of

becoming and being the understanding of the other, are a cornerstone of the biographical narrative approach (Rosenthal 2006). The Chicago school was significant in developing biographical research. A 1927 study by Thomas and Znachieki, which gathered data of Polish peasants who had migrated to the USA, and analysed the changes individuals and the migrant community made over time, is often quoted as being influential in the development of a biographical approach to research (Thomas, Znaniecki et al. 1984, Thomas, Znaniecki et al. 1996).

Biographical research approaches have become increasingly popular in social science research. Biographical research can draw on different theoretical underpinnings. Biographical research approaches can focus exclusively on the subjectivities of the individual or a group of people, or on the other end of the spectrum focus on researching objective verifiable facts. How the biography of an individual is presented or represented also will vary, and include the interpretative approaches where the interaction between the researcher and the researched is being understood as significant in the construction of the data.

Oral life history focuses on participants giving an account of a time or historical event with the aim to give a voice to marginalised individuals or groups of people. Researching the life history of people includes the examination of the objective evidence for example external evidence such as official or personal of a person's life and historical records relating to events of the time. However, in this study, gaining insight into historical events is not the main focus.

Another biographical approach to research is autobiography. Autobiography focuses on how stories are generated, and the interpretation of data. The research includes exploration of the way in which the biographies of the researcher and the research participant relate to each other, and how biographies are co-constructed (Merrill and West 2009). This was initially not my main concern, however during the research process I became increasingly aware about how the relationship with the participant and researcher, and the interview data became a significant component in the analysis of the data. (This is elaborated further in section 6.2.1.1 on page 205.)

Different biographical research approaches used in social science are not necessarily exclusive of each other, they can be used in combination with each other such as interviews in combination of researching historical official and/or personal documentation available.

The research aims and questions shape the research approach. The literature is sparse in answering how health professionals learn about ageing, old age and older patients over time and throughout their lives and careers. Asking the questions “how” rather than “what” and “why”, a qualitative approach to research was considered appropriate. A quantitative approach lends itself to research questions which aim to answer specific and predetermined questions.

While some of the factors which influence the motivation to work with older people have been investigated, for example the attitudes of health care students working with older people (McLafferty and Morrison 2004, Mandy, Lucas et al. 2007, Liu, While et al. 2012, Kydd and Wild 2013) and how clinical experience might influence the motivation to work with older patients (Williams, Anderson et al. 2007, Westmoreland, Counsell et al. 2009), and some of the factors which might influence the motivation of student nurses to work with older patients, relatively little is known about how people learn formally and informally about old age and working with older patients throughout their lives and careers.

Being aware of the complexity of professional learning, and specifically learning about ageing and working with older patients, and the limited research about the biographical learning of healthcare professionals, various options for research were considered.

In contrast, interpretative biographical research aims to capture the complexity of the lives of the participants, and takes an open stance, allowing themes which are significant to the participant to emerge. It allows one to explore the participants’ perspective, and their subjective experiences within the wider context. Qualitative research is useful to investigate issues in depth and to explore topics which are not very well understood (Punch 1998). For these reasons a qualitative research approach has been adopted for this study.

3.4 Qualitative research

The origins of qualitative research can be found in the interpretative sociology of Max Weber. One of the underlying assumptions in qualitative research is that humans assign meaning to actions which will influence their behaviour.

Weber used the German term *"verstehen"*, which is commonly translated into English as *"empathetic understanding"*. Empathetic understanding of the participant's subjectivities allows the researcher to understand the meaning the subject attributes to the actions or words, and also allows them to understand some of the wider cultural context (Ritzer and Goodman 2003). *"Interpretive methodology is directed at understanding phenomenon from an individual's perspective investigating interaction among individuals as well as the historical and cultural contexts which people inhabit"* (Creswell 2009 p. 8).

Examples of qualitative methodology include: case studies; phenomenology; hermeneutics; and ethnography (Flick 2014a).

3.5 Understanding the individual and learning in the context of psycho-social theories

One of the positions I adopted in this research is that people live an inner and outer world, the psychological and sociological are interconnected. The writing of sociologists Beck and Baumann, the structuration theory of Giddens, the theoretical understanding of Bourdieu's habitus, and Archer's understanding of micro and macro sociology allows to understand the interaction between society, structure and the individual (Bourdieu 1977, Beck 1992, Bauman 2000, Bauman 2001, Giddens 2001, Archer 2003). Historical, cultural and demographic changes in late modernity mean that society is becoming increasingly individualised: the individual biography takes on an increased importance in the shaping of the career and, for healthcare professionals, learning takes place throughout their working life, through life-long socialisation, formal learning and informal learning.

According to Giddens, socialisation is a process which starts in childhood and continues throughout life (Giddens and Sutton 2013). It is the process through which people acquire values, attitudes and beliefs. Through socialisation,

individuals become part of a group and a culture. Professional socialisation influences how professionals carry out and perceive work (Jarvis 1983). Bourdieu (1977) theorised the link between agency, structure, and socialisation through the concept of *habitus*. Habitus bridges the gap between the sociological and psychological interpretations of actions. Habitus subconsciously directs people's actions and practices in daily life. It is formed during the socialisation process through internalising values and beliefs which are subconscious in nature, and create and affect the person's actions and thoughts.

3.6 The importance of meaning making and the theory of symbolic interactionism

Learning involves meaning making. The theory of symbolic interactionism gives insight into how individuals make meaning of their experiences and actions. Experience and learning are closely intertwined. Individuals learn through making meaning of their experiences (Jarvis 2009). Healthcare professionals have varied experiences of ageing and older people through their own ageing, their professional practice and personal experiences

The attachment of meaning to experience is not only an internal process, but theories by Mead and Blumer and their theory of symbolic interactionism, as well the writings of Dilthey connect experience, meaning attribution, action and biography (Mead 1967, Blumer 1969, Blumer 1992). For Dilthey, making meaning is an essential part of human nature as humans draw on their experiences and to create coherence in their lives. The meaning individuals attach to their experiences influences their actions and this will in turn influence their biography and the choices they make.

Blumer highlights the role of the individual in meaning making. The meaning individuals attach to an action is not inherent in the action itself, but to the way in which a person interprets and attaches meaning to an action or interaction. Actions are carried out based on the meaning they have for the individual. Meanings can change over time, as the meanings which have been attributed to experiences or actions are re-interpreted and transformed in the light of new events or situations (Blumer 1992). Some of the subjective meaning of action can

be understood through the understanding that human action is meaningful, and that the creation of meaning is based on interaction between individuals and the interpretations of individuals (Schwandt 1999).

Meaning-making is a continuous process. The individual makes meaning of their experiences, but interpretations of the experience are constructed – not only individually but with others – during the course of social interactions. Shared meanings and understanding are developed through interaction with others (Mead 1967).

3.7 Understanding the experience of others

This research seeks to explore the complexity and the multi-layered nature of professional experience and learning, examine learning without drawing tight boundaries or breaking it up into components or separate dimension, as well as examining learning as a lifelong process. I was searching for research theories which avoided the separation of the individual from the context in which learning takes place, a theory which was psychosocial in its nature, rather than based on exclusive sociological or psychological theories for example and gives insight how as a researcher we can understand the subjective experience of others, their thinking and emotions. This in turn led me the theories of phenomenology and hermeneutics, and philosophies concerning how, as social sciences researchers, the experience of others can be understood.

3.8 Phenomenology

Phenomenology stems from the work of philosophers such Husserl and Heidegger, and has been changed and developed over the years by the theories of others such as Merleau-Ponty and his theories of embodiment (Merleau-Ponty 2002). The phenomenology literature is broad, and many philosophers have contributed to the development of phenomenology. Phenomenology is a philosophy as well as a research approach.

Phenomenological research is used where the focus is on studying the experiences of day to day life, to gain deeper insight into the experience of illness, education and psychology, Give examples here Phenomenological research aims

to illuminate and describe the *"human experience in and of the world"* as it is experienced (Moran and Mooney 2002, p1). Experience *"is fundamental, always already given, something which every exploration of reality or mental processes must start"* (Alvesson and Skoldberg 2009, p94).

Doing phenomenological research means as a researcher adopting what can be described as an approach of the research which allows to understand the experience of the participants or the phenomena which is being researched. Koob describes phenomenology as a way of adopting a research position to see what is being shown, to see it from the position of the research participant: the researcher takes an open stance, aim to understand the participant's experience. Phenomenological research aims to gain an in-depth understanding of a person's feelings, opinions, perceptions, and the context of a person's life (Koob 2008). Phenomenology, and especially the work of Alfred Schütz, focuses on providing an understanding of the life-world (*Lebenswelt*), the day to day life of the subject (Ritzer and Goodman 2003).

Phenomenology studies the phenomena to which people are attaching meaning. It aims to give a thick and rich description of the concrete and lived experience, to provide a holistic representation of the experience, and to describe the participant's life-world. Phenomenological research ask question about the experience and what the experience means (Finlay 2009a).

Learning is complex, and as Jarvis describes like a web. Learning in medical education means that a lot of what is learned is beneath the surface what is visible, accredited or easily recorded. How old age and ageing can be understood can vary widely, and can be influenced by societal factors such as attitudes towards older patients and expectation and individual experiences of older people in society. This is one of the reasons – and an important reason – why phenomenology is an appropriate approach for a study like this. Phenomenological research approaches allows one to capture the ambiguity and uncertainty of day to day lives, rather than separating the phenomenon described into separate components, and is suitable to study identity, self-hood, embodiment, temporality, mood and atmosphere (Ashworth 2003). The understanding of old age is complex and multi-layered, and the needs of older

patients are complex, and multi-layered, Woking with older patients involves learning to work within a broad spectrum of demands in practice. These characteristics make a phenomenological approach appropriate for a study like this one.

Crotty critiques the current field of phenomenology research for overemphasising the study of the subjective experience, rather than the elucidation of the phenomena the participants make sense of; but the phenomena and the subjective experiences will not always be easily separated (Crotty 1996). The researcher might examine the data through different lenses, which assists with the description and the illumination of the life world of the participant

Healthcare professionals learn at pre- and post-qualification levels through varied learning and teaching approaches, and their learning continues in practice throughout their career. Phenomenological research lends itself to researching professional practice as it is concerned with everyday living, and learning through practice (van Manen 2007). It allows one to understand the fullness and complexity of professional practice and learning in practice. In healthcare, the relationship and integration between theoretical knowledge and practice: knowing is complex and subtle (Coles 2013).

Gadamer questions the concept that theory and practice are separate entities (Gadamer 1990). People are part of the world through their actions, their relations. While reflections are understood to be part of learning, not all experience is reflected upon in day to day life. In daily life much experience is pre-reflected experience (Heidegger 2001). Once experience is reflected, and the individual becomes more aware and conscious of the experience it changes and becomes different from the pre-reflective consciousness of the experience

3.8.1 Hermeneutics – the art of interpretation

The assumptions that understanding the experience of the other as a researcher and being able to present the experience of the other to the outside world is an assumption which I started to question.

Initially my assumption was that phenomenological research gives participants a voice, but I quickly became doubtful that this was possible as at least two persons

– the participant and the researcher – interact with each other during the research process. I moved towards understanding the study as an interpretative, hermeneutical phenomenological study, rather than a purely phenomenological study, drawing on the ideas of Heidegger, Dilthey, and Gadamer about interpretative research or hermeneutics.

Hermeneutics is the art of interpretation. It has its origins in the study of the bible, and its focus is on the interpretation of text and language. According to Heidegger, as humans, being part of the world allows us to understand shared meanings and values (Heidegger 2001). The ontological understanding of hermeneutics is that the researcher aims to understand the participant's lifeworld (Heidegger 2001). During this process, both the participant and the researcher contribute to the understanding of the social world, "co-constructing" knowledge together (Cohen and Crabtree 2008)

To understand the participant's lifeworld, the researcher immerses themself and engages with the data using their empathy (Gadamer 1990). The researcher enters the hermeneutic circle. During the interpretation of the text, the reader oscillates between understanding parts of the text, and integrating that understanding into the understanding the text as a whole, gaining new insights (Schwandt 2003, Kinsella 2006).

> *"From the beginning, the main theme in hermeneutics has been that the meaning of a part can only be understood if it is related to the whole"* (Alvesson and Skoldberg 2009).

In interpretative phenomenology, understanding the life word of the participants, and the immersion and engagement with the interview text cannot be a neutral process but entails the researcher's subjectivities as they try to deepen their understanding of the text (Finlay 2009b). The intersubjectivity between the researcher and the participant and data acknowledges that It involves the researcher as a person: their cognition, emotions and imagination. The researcher tries to put themself into the participant's place and, during the interpretation of the text, brings their own questions, assumptions, feelings and thoughts to the text. As a result, the interpretation of the text and its meaning is shaped by what the researcher brings with them. (Todres and Wheeler 2001, Kinsella 2006). Park goes as far as saying that:

> *"the knower and the known thus participate in the process of knowing, in which what they bring to the encounter merges together"* (references quoted on p 36 in Clarke. Hoggett quote is by Park 2001 page 83 (Alexandrov 2009, Clarke and Hoggett 2009).

3.8.2 In summary

Sociological and psychosocial theories explain the reasons why the biography of an individual matters, and how choices, life events and agency influence the life course. Phenomenological research sets out to understand phenomena and subjective experience and the life world of an individual through empathetic

understanding. But the research process also is an act of interpretation. The data are co-constructed between the participant and the researcher.

3.9 From methodology to method – the qualitative research interview

Aiming to understand the meaning healthcare professionals attach to their experiences I decided to carry out qualitative interviews. Qualitative interviews provide insight into a person's subjective experiences, and also into the social worlds in which the individual is embedded (Silverman 2006). Qualitative research interview methods encompass a variety of approaches to interviewing, including interviews using structured and semi-structured, focused, conversational, interactive, or narrative interviews. Although a qualitative interview is often open ended and may appear to be conversational in style, it nevertheless differs from a day to day conversation. The qualitative interview aims to gain understanding of the participant's subjective experience, and the participant is understood to actively construct meaning during the interview (Holstein and Gubrium 1995). The data created during the interview do not exclusively reflect the experience and knowledge of the participant; it is during the interview that knowledge is co-constructed through conversation and social interaction, that knowledge and meaning is produced between two people (Kvale and Brinkmann 2009).

Collecting narratives of participants is an important part of biographical research. The divergences in the discussion around narrative research centre around how narratives are constructed, and between seeing narratives as constructions of the individual or of the social and cultural context in which the narratives are constructed. Squire (Squire 2008) additionally distinguishes between forms of narrative research, the narrative is being events based where the representation of the event stays constant over time and does not change significantly when it is being told another time , experienced based where the narrative might change over time , however *"what is shared across both event and experience-centred narrative research, that there are assumed to be individual, internal representations of phenomenon- events, thoughts and feelings, -to which narrative gives external expression"*, (Andrews, Squire et al. 2008, p5). The third form of narrative research has a focus on the co-construction of the narrative. In

the discourse of narrative research, it is accepted that it is the individual thinking and feeling which emerges from the narratives is a significant feature. Wengraf highlights that the assumption is that the narrative reflects the inner and the outer world, *"of conscious concerns and also of unconscious cultural, societal and individual presuppositions and processes"* (Wengraf 2008, p1). In educational biographical narratives Alheit, for example, emphasises that the biographical narrative makes the social context which shapes the learning of an individual visible which is significant for the understanding of learning as social learning theories accentuate that the individual learns with others and within a social context (Alheit 2005b).

Narratives are mainly text based, but not all biographical research is based exclusively on text-based data. The discourse in biographical research reveals that researchers also include images, documents, films into building up a patchwork of sources for biographical analysis, or advocate the combination of the collection of text based accounts with other research approaches such as ethnography (Roberts 2005).

Considering the topic, and that learning about ageing and old age is professional and personal, because ageing is universal, and every person will experience their own ageing and that of people close to them. At the same time learning about ageing and old age is also situated in a wider societal and cultural context, and for healthcare professionals in the context of their work and professional learning. For these reasons, an interpretative biographical research approach where the personal as well as the professional could emerge, where it is acknowledged that the past can influence the present and might influence the future.

3.10 Research procedures: Biographical Narrative Interpretive Method– a specific method within the field of biographical research

I became aware of the biographical narrative interpretative method (BNIM) when, by pure coincidence, a friend gave me an educational research article about adult learning by Alheit in German. At the time I was studying for a Master's degree in teaching and learning. All of the students on the course were working in further and higher education with a wide range of professional and life experience. It was a combination of circumstances as well as being immersed in studying myself at the time, which sparked my interest in biographical educational research methods. As a result of reading Alheit's article, I searched for more information in English on the connection between learning and biography. Reading Erben's book on Biography and Education, I felt immediately an affinity with the approach to research included in the book, realising that biographical narratives and the method of analysis are a powerful way to gain in depth understanding of the experience of the research participants, and the structure and techniques to analyse the accounts helps to understand the meaning the participant attached to their experiences.

Having become interested in in this research approach, I attended a five-day BNIM training course with Tom Wengraf and Prue Chamberlayne in London to learn more about the method, as well as and a master class on BNIM with Kip Jones at Bournemouth University. Attending the two workshops gave me an understanding of the structure of the interviews and practice how to develop research questions, developed my ability to listen over the course of the interview and how to carry out the analysis of the interviews. Additionally, I attended a workshop for health and social care professionals in Frankfurt with Oevermann how to analyse interview data using objective hermeneutics. The workshop was in German. Participants bring material from their practice for analysis, and spent time analysing the material which was mainly text based, but also included visual materials.

BNIM focuses on the experience of the person, and is holistic in nature in so far that it understands the participant holistically within the context of their lives,

rather than trying to research selected components of a person's life. It lends itself, therefore, particularly to research which aims to understand the interaction between the inner and the outer world. Because professional practice is often shaped by one the one hand the individual health professional and what they bring to their practice as individuals, as well as organisational and societal factors in which care of an older person is situated.

Biographical narrative interpretative interviewing is a method of biographical research which sits within the framework of interpretative phenomenology, symbolic interactionism and the theories of Gestalt psychology. The method is influenced by the phenomenologist Husserl and his ideas around experience, memory and reconstruction of experience, but is also influenced by other theories such as hermeneutics – the understanding of the interpretation of text, and intersubjectivity. Gestalt psychology – especially the notion that component is part of a whole (Gurwitsch 1979), in case of BNIM sections of an interview are understood being part of the whole interview – is essential in the way the interview has been developed and how the data are analysed.

BMIN as an interviewing method was developed by social scientists Rosenthal, Fischer-Rosenthal, and Oevermann in Germany (Oevermann, Allert et al. 1987, Rosenthal 1995, Rosenthal and Fischer-Rosenthal 2004). The method draws on a range of disciplines for the interpretation of the interviews especially psychological, sociological, biological, educational and historical knowledge and theories. The method and the structure of the interview is significantly influenced by the work of the German sociologist Fritz Schütze and his work on the narrative interview (Schütze 1983). Schütze drew on the work of Anselm and Strauss and grounded theory. Schütze developed the theoretical understanding of the narrative interview and its analysis and how the narrator makes sense of their lives. Asking participants to tell their life story, Schütze observed three constraints which drive a narrative interview. Firstly, the constraint to condense the narrative. For the narrator it is impossible to tell everything, so the narrator will select events and stories to share in the interview. The selection of what is being told is relevant to the narrator and relates to their life structure. Secondly, the constraint to go into detail. This is linked to the first constraint. Once the narrator has

mentioned an event, they will feel compelled to go into more detail. Thirdly the narrator will feel compelled to close a story. The constraints bring to the forefront the biographical the external conditions of the narrator's life and the internal responses of the narrator.

In the UK, this method has been adopted as the "The Biographical -Narrative-Interpretive Method (BNIM)" by Wengraf, and Chamberlayne (Chamberlayne, Bornat et al. 2000, Wengraf 2004), and has been used in wide range of projects in the UK such as by Kip Jones and identity and the informal care role, Margaret Volante in understanding professional practice of nurses and health visitors and the work of Caroline Nicholson on the experiences of frail older people (Jones 2001, Volante 2005, Nicholson 2009b). The justification from a sociological perspective for this interview method is linked to the individualisation theories of Beck and Baumann (Bauman 2000, Bauman 2001, Beck and Beck-Gernsheim 2001). As the lives of individuals are less structured and pre-determined , the ways in which people experience the interplay between the individual and society has led to the acceptance of research methods focusing on the individual which can give both subjective perspectives and insight into the social and cultural processes (Roberts 2002).

BNIM is a powerful method to gain insight into how internal and external structures influence and shape the lives of individuals. BNIM differs from other research methods which have a strong biographical component such as life history or oral history research interviews in so far as BNIM has a strong focus on the account the individual gives about their life, rather than focusing on the objective and verifiable data such as chronological data (Miller 2000). In this study the researcher is interested in uncovering through the life story how the participant makes meaning of their experiences of old age and their work with older patients over time. The participant is understood as an actor in a social context, and the interpretation of the text has an emphasis latent meaning, the meaning the participant attaches consciously or unconsciously to these experiences (Chamberlayne and King 2000). The life story of a participants allows the identification of the changes and transformations which takes place during the participant's life. How the participant talks about changes and

transformations in their lives helps one to understand the experiences of the participant and the context in which they took place. Changes and transformations give insight and help the researcher.

> *"to understand and explain social and psychological phenomena we have to reconstruct their genesis – the process of their creation, reproduction and transformation." (Rosenthal 2006 p49).*

During the interview, participants will give a description of their life experiences. The accounts and stories participants will tell about their lives are understood not to be independent from each other, but are inextricably linked. The inner life of the individual is understood to be linked to an outer life. There is a link between a person's action and their subjective experiences. In order to understand a person's actions, it is necessary to find out about their subjective experiences, and in order to understand these actions and experiences, the researcher needs to interpret them in the context of the person's life. (Rosenthal 2006).

3.11 The temporal element in the biographical

An important characteristic of any biographical research is the time element. A biographical approach sets out to explore the life of a person over time. During the analysis of the interviews, a distinction is made between two elements: the *lived life history* – the chronological events of a person's life; and the *told life story* as narrated by the participant. Life history and life story are understood in their own unique sequences. This allows the researcher to identify changes, developments and transition and turning points throughout the individual's life course.

At the time of the interview the participant will select – consciously or unconsciously – aspects of their lives to talk about. By asking the participant to retell their life, the participant is understood to remember life events selectively (Miller 2000) , and one part of the interview is understood to be related to other parts of the account. The interview can only capture the story of an individual and how they tell the story at a point in time. The participant might tell their story differently at another time. However, the element of temporality, and the ability to identify developments and turning points in the life of the participant will help to understand the experience feelings and perceptions of the individual.

Healthcare professionals will have diverse educational and career histories, and are likely to have made choices about their education and careers at certain points in their lives, where they have made transitions which will influence their life trajectory (Gallacher, Ingram et al. 2009). The educational choices and their learning will be driven to various degrees by the individual; but these choices can also be incidental, and can be initiated by others or by the person themselves. Formal and informal learning, reflection, and pre-reflexive knowledge are part of learning. Many learning processes occur implicitly throughout life, each one is not necessarily reflected on, yet they make up the person's biographical knowledge about themselves (Alheit 2005a). Consideration of the transitions and turning points in individuals' lives can allow us to gain insight into factors which motivate and enable the healthcare professionals to learn about working with older patients.

3.12 The narrative component of interview

The human being is a story telling animal (MacIntyre 2007). Narrative inquiry develops descriptions and interpretations of phenomena from the perspective of the participant and the researcher, and does not start off with theoretical assumptions, but starts off with an interest in a phenomenon (Mattingly 1991). The term narrative in research does not have a clear definition and meaning but Polkinghorne describes it as:

> *"any prosaic discourse, that is, any text that consists of complete sentences linked into a coherent and integrated statement" (Polkinghorne 1995 p6).*

In biographical narrative research, the participant tells their story, and coherence is not always given as the participant might attempt to clarify or find an explanation for their experiences. Their account is understood as a narrative construction rather than the objective truth (Bar-on and Gilad 1994). The construction of the told story is determined by the participant's experiences, how the interviewee sees himself or herself, and interprets their own actions and the actions of others. Hollway and Jefferson refer to the concept of free association in an interview, and take the psychodynamic standpoint that the narrative as told by the participant are not driven only by the conscious, but more by the unconscious motivations and associations (Hollway and Jefferson 2000). Each narrative

interview is unique, it can contain stories, but also reflections or generalisations, and the different characteristics of the text will give different qualities to each interview.

3.13 The structure of the interview

There are three stages to the interview.

The interview starts off with a question from the researcher. The question is loosely worded, and constructed in such a way that it allows themes to emerge which are relevant to the participant, rather than following the agenda of the researcher (Breckner and Rupp 2002).

Rosenthal discusses the advantages about having a completely open question, so the narrative of the participant is not directed by the research agenda. However, she also acknowledges that an open-ended question without specifying the topic is not always possible (Rosenthal 1995). In this study, the participants had seen the information sheet, and thus had some understanding that the topic of the study and that the study is related to healthcare professionals working with older people, and learning, and this knowledge framed their thinking.

With the opening question, the aim was to keep the question as open as possible within the framework of the study.

With the initial question of the interview, I tried to stay as close as possible to the following wording:

> *"To start off, ok, it is really all about you. All I know about you is that you are an Occupational therapist (nurse/doctor), basically, and I just wanted to ask you how did you get to that point of your work life where you are now. Talk about whatever comes into your mind."*

In the first part of the interview, the researcher aims not to interrupt the participant but, rather, to wait until the initial narration is finished. Interruption, such as asking questions, will disrupt the *Gestalt* of the interview, the Gestalt being important because it expresses the participant's concern (Wengraf 2004). But I was aware that I encouraged the participants to talk through body language and utterances. The researcher takes notes of the narrative whilst the participant is speaking.

The length of the initial narration of the participants varied. Only when the participant has finished the initial narration will the researcher move on to the second part of the interview. In one of the interviews, the start of the interview was slow, it is not easy for every person to start talking freely at the beginning of the interview. Silence can be psychologically challenging for both the participant and the researcher. The temptation for the researcher is to break the silence and start asking questions. Looking back at the transcript of the one interview, I wonder if starting to ask questions could have been delayed, but each interview is a real-life situation with its own social dynamic.

Before proceeding to the second part of the interview, the researcher and participant have a break. During this time, the researcher will identify themes from the notes written during the initial narration of the participant, and the topics raised by the participant. and will decide which of the themes to follow up further. The researcher uses questions to encourage the participant to expand what they have said, as well as asking them for specific stories or events.

TEXT BOX 1: EXAMPLE OF NOTES WRITTEN CONCURRENTLY DURING THE INTERVIEW

Start of the initial narrative

- Thinking about knowledge of ageing
- How did I get to work with older people
- intermediate care team
- master's degree
- Why did I like them (older people)
- worked as a volunteer with older people at age of 14
- Nurse training – combination of gerontology and midwifery. Enjoyed both
- medicine very much interesting
- if someone gets better
- went straight into midwifery. two ends of the spectrum
- medicine in the middle (reference to age (not that interesting))
- when I had my own children, went to work in nursing home
- District nursing -fitted with family. was a lovely job
- ENB -introduction to elderly care
- UTI (Urinary tract infection) in older people, multipathology/ more skills needed
- rarely as simple as just treating UTI.

In this interview the researcher decided to focus on the work with older people when she was 14 years old, by summarising the start of the initial section of the narrative and then asking about her experience working as a volunteer.

> *"You talked about knowledge and ageing, and how you got to work with older people and how you got into intermediate care, and you went back through some of your nurse training and you did a master's and why you liked working with older people. you thought about why did I work with older people and you mentioned that when you were fourteen that you used to volunteer looking after older people. You said that you took people's teeth out. What sort of experience was that for you, you were fourteen and, I assume, still at school?"*

In the third part of the interview, the interviewer uses a topic guide and asks questions relating to the research aims if necessary. Here the questions follow

more the researcher's agenda and cover any areas questions or topics which have not be raised during the first or second part of the interview, but are considered relevant to answer the research questions.

3.14 Eliciting stories

Within the narrative stories about specific events or situations are told. One of the features of the BNIM is that the researcher will try to elicit stories from the participant (Wengraf 2004).The researcher will ask the participant to tell stories e.g. about their work, as stories give an accounts what actually happened and individuals will talk about their experiences in a storied form (Polkinghorne 1995, Hollway and Jefferson 2013b).

Narration and story are sometimes used interchangeably; however, there are distinguishing features. A story has a beginning (often a description of a situation); actions, and events which change the situation or where there is a development of increasing tensions and sensations; and a resolution or ending to the story. A story has therefore a connecting structure between the different elements (Polkinghorne 1995). Stories are often told as they assist to make sense of events which have taken place in a person's life or the life of an organisation. The significance of a plot according to Polkinghorne is that:

> *"the plot functions to transform a chronicle or listing of events into a schematic whole by highlighting and recognizing the contribution that certain elements make to the whole" (Polkinghorne 1988, pp18-19)*

Healthcare professionals talking about their work with patients will have their own stories about their work with older patients, and they will narrate how they experience their patients' old age and illness, and how they make meaning of their work.

When trying to elicit stories, the type of question asked helps to shift the focus from general statements to specific situations. Small stories are significant in helping to understand the participants' meaning, values, and so forth.

For example, one of the participants was talking about learning to become a nurse and having to accept responsibilities, dealing with the death of a patient the first

time. I wanted to find out more the experience of witnessing the death of a patient

Interviewer: *"Did you feel, because did you feel a death is in a way significant?"* The participant then proceeded to tell a story about for the first time looking after a patient who was dying.

Another participant was talking in general term about feeling sad when working with older people, the question asked aims to prompt the participant to talk about a specific scenario.

Interviewer: *"Can you remember the situation, is there any situation you can describe, that sense of sadness when you felt that emotionally it was really difficult."*

Not all the stories told during the interviews were elicited through asking questions. Participants also told stories spontaneously. One of the participants told a story which was a significant learning experience, when I was thinking that the interview was close to the end, and was about to close the interview, rather than trying to elicit a story.

Interviewer: *"OK, interesting. Is there anything else you want to tell me about, it is very interesting what you are saying?"*

The participant then proceeds to tell me about the death of one of her patient and why she felt some responsibility for the patient dying,

3.15 Sampling for participants

3.15.1 The case study approach

The BNIM uses a case study approach. (Rosenthal 1995, Wengraf 2004). Yin recommends a case study approach when trying to answer research questions starting with 'how' or 'why,' if the contextual factors are relevant to the study, and if you do not manipulate the behaviour of those involved in the study. Case studies allow one to gain deep insight into a case (Yin 2009). Examples of how case studies can be used for learning and increasing scientific knowledge can be found in medicine. Traditionally medicine has used case studies to observe, learn

from and develop new understanding of practice. In practice doctors and other health care professionals develop expertise from cases, learning from cases has been a part of healthcare education, and has led to the development and integration of problem-based learning. An example where the description leads to a greater understanding of disease is Alzheimer's disease: Alois Alzheimer recognised that the deterioration of one of his patients was due to symptoms which could be distinguished from other diseases recognised at the time, and this case study led to the recognition of Alzheimer's dementia (Shampo, Kyle et al. 2013).

The advantage of case study approach in researching professional learning is that it captures the context of work of the individual cases (Flyvbjerg 2006). The concreteness of a case study in oral history and biographical research gives insight into the experiences of the participants, as it explores the real-life situations in detail and nuances. Each case is analysed and presented individually.

3.15.2 Identification of cases

The researcher needs to consider what a case study is in relation to their research and define what is a case. A "case" can be an individual, a team, or an organisation. The process of defining the boundaries of a case is analogous to the process of setting exclusion and inclusion criteria in a quantitative study. The exclusion and inclusion criteria are not set in stone, but were reviewed after each interview How case studies are selected for the research interview will be critical. Since case studies focus on the individual and aim to capture context rich information (Wengraf 2001), individual cases are chosen for their validity, rather than for their generalizability. This effort to gain in-depth and deeper knowledge is considered more useful than attempting to generalise (Flyvbjerg 2006).

In this study, "cases" are the individual participants; however, when contrasting and comparing cases, a case might be defined as, for example, individuals belonging to the same professional groups or participants who have different levels of experience working with older patients.

One of the criticisms of case studies is the question of research from case studies be generalised. Generalisability is not necessarily an aim for the qualitative

researcher but in qualitative research it is more important to gain in depth insight in the life events of an individual.

> *".....but formal generalization is overvalued as a source of scientific development, whereas "the force of example" is underestimated" (Flyvbjerg 2006 p228).*

3.15.3Sampling for case studies

When sampling participants for a qualitative study, the recruitment of participants should have characteristics relevant to the phenomena being studied. The aim is to recruit information rich cases which allow gathering in depth and rich data. In qualitative research, it can be difficult to predict with certainty who the potential participants will be at the beginning of the project. The sampling strategy was specified at the beginning of the study, but needed to have a degree of flexibility throughout the recruitment and data collection phase. The emerging data can expose themes which are unexpected but significant in answering the research questions which might influence the choice whom to recruit next. In the initial sampling strategy, the need for flexibility must be taken into account to allow the research to be responsive to emerging themes. To be open and responsive to emerging themes requires the researcher to approach the data with an open mind.

I was aware that having worked in healthcare and education makes having an open mind harder when researching other health professionals. Experience and exposure to the literature potentially mean that the researcher seeks to confirm their existing knowledge. Reflecting on my own assumptions, and recognising the theories and research which has influenced the development of the study helped me to identify possible preconceptions.

The researcher's immersion into the data, listening to the interviews several times, as well as the process of transcription, approaching the interviews with an open stance, oscillating between immersion and standing back from the interviews assists the reflection on the background knowledge which can influence the responsiveness to the data. Connecting with the data, with the aim of understanding the participant's experience – a deep engagement with the data through active listening to the interviews, and at the same time noting my responses to the data while listening and transcribing – helped me to separate the

data from my own responses, thereby letting the themes of the interview come to the foreground.

When conceptualising the study, the review of existing literature helped to the development of the project. However, some of the literature was not reviewed until after the data collection and analysis. Additionally, after considering the initial analysis of each interview, the recruitment strategy and criteria for the recruitment of the next participant was reviewed and discussed with the supervision team, with the aim to recruit for variation. But specifying some criteria protects the researcher from the tendency to search for data which fits their own conceptions unless a convenience sample is used (Fielding and Fielding 1986). Criteria are specified for sampling in qualitative research studies, unless convenience sample is use. Clear criteria increase the credibility of qualitative data (Patton 2002, Silverman 2006).

I adopted a purposeful and theoretical sampling strategy with the aim to sample for information rich cases. Purposeful sampling means to recruit

> *"information rich cases are those which one can learn a great deal about issues of central importance to the purpose of the research, …" (Patton 1990 p169).*

Theoretical sampling is influenced by the literature and the researcher's experience, criteria will be developed for recruiting participants. (Glaser, Strauss et al. 1968).

For this study for example the theoretical knowledge of ageing and the lifespan points towards recruiting healthcare professionals from different age groups as age will have impact on the experience of ageing, and professional learning theories points towards recruiting participants with different levels of experience. In qualitative research, the recruitment strategy maintains flexibility as the data are analysed and the researcher might look for contrasting cases.

There were generational differences in terms of pre-qualification education for the participants in this study. Two of the retired participants had not participated in university education until later in their career as until the introduction of project 2000 the education of nurses took place in hospital based nursing school (Fulbrook, Rolfe et al. 2000). The prequalification education for occupational therapists started to move in the Universities in the late seventies (Mayers and

Olsen-Wells 2016). Medical education has been always degree based. Generational differences affect educational experiences (Field 2011).

Initially the criteria for recruitment were that the participants were qualified healthcare professionals with a nursing, OT, Physiotherapist or medical background or studying for one of those qualifications. After each interview, criteria for recruitment were considered and specified.

TABLE 1: DETAILS ABOUT THE RESEARCH PARTICIPANTS

Professional background	**Experience with older patients**	**Work status**	**Time of initial professional qualification**
Nurse	Yes	Retired	Qualified late sixties
Nurse with Master's degree	Yes	Retired	Qualified late sixties
OT	Yes	Working full time rotational post	One year since qualified at time of interview
OT student	Yes	At the end of second year of training	Working towards OT qualification
Geriatrician medical degree with specialisation	Yes	Working	Qualified in the eighties

The first interview was with a nurse who was retired but had a special interest in the care of older people but had worked with different age groups as it was likely having had many years of experience

Following the interviews with two retired nurses, the aim was to recruit participant with a different professional background who were at the beginning of their career.

The fifth participant was working as a consultant geriatrician, and differs from the other participants that that he had to make an explicit choice to study and specialise in geriatric medicine and that he was male.

3.15.4 Data analysis

3.15.5 Immersion and Transcription of the interviews (data analysis)

In qualitative interviews immersion into the interviews is part of gaining understanding of the interviews.

I listened to the interviews before the transcribing, being aware of the tone of voice of the participant and indicating changes of tone in the interviews.

Four interviews for the individual cases were transcribed verbatim. Transcription is part of the data analysis, and is itself an interpretative act as decisions how to describe the interview need to be made (Bailey 2008).Transcription will depend on the methodology and method chosen for the study. In this study, the transcription needs to be detailed and accurate enough to capture meaning.

Initially I tried to describe all the utterances. The first interview contained more utterances, and incomplete sentences than the other interviews. Initially I transcribed the utterances but when reading the text for further analysis, I found that they were distracting and did not necessarily add to the understanding of the meaning of the text. The following interviews I did not transcribe utterances.

In all interviews Incomplete or grammatical incorrect sentences were transcribed as spoken. In spoken language, it is always clear where sentence starts and finished, especially in the longer sections of the narrative. Listening to these specific sections often several times helped to gain a better understanding of what the participant was saying. Commas and full stops were inserted to the transcript, in order to make the text manageable, and to clarify the meaning of sentences. It is at these points, where the researcher needs to make a decision about the interpretation of the text.

If there were long pauses (longer than this was indicated in the interview, or where there was obvious expression of an emotion (such as laughter) that this was indicated in the text.

Additionally, I followed the steps of the listening guide, a relational voice-centred method to analyse qualitative research interviews, and to understand the

different voices in the interview. The listening guide involves fours steps, it means listening and reading the transcript of the text several times and create an "I-poem" for each of the cases. It assists to understand the tone and the nuances of the interview. The process also includes noting the spontaneous responses of the researcher to the text, aiding the reflexivity of the research process. (Gilligan, Spencer et al. 2006)

3.15.6Building of individual cases

In BNIM, the interpretation of the data follows a step by step structure, with the aim of avoiding the fragmentation of the data through establishing the biography of the individual and the reconstruction of individual cases.

The emphasis is to keep the whole case in mind, rather than breaking the interview into components too early (Breckner and Rupp 2002). Biographical narrative interviewing aims to gain access to the deeper structures and latent meanings, the life story of the individual is analysed and interpreted within the context of their lives.

This research aims to capture the subjective views and experiences of the healthcare professionals about their work and how they learn about ageing, old age, and work with older people. The researcher selects a theoretical stance or different theoretical stances through which to view the data. The theoretical stance taken will depend on the research aims and the background of the researcher. In this study, for example, the theoretical perspectives will be in line with theories of life-long professional learning and the development of professional knowledge, life course theories and theories of ageing. The researcher, being conscious of the theoretical lenses they take, must be at the same time to maintain openness to non- expected themes emerging from the data.

In BNIM, the interview and the analysis of the data identify the gestalt of the person's life story through both the way the interview is carried out and, later, when the data are analysed. The concept of gestalt is based on theories of human perception, specifically Gestalt psychology. The person looking at a phenomena

maintains the whole in their mind without breaking it into smaller components, and recognises that components are always part of a whole (Gurwitsch 1979).

3.15.6.1 Sequence and temporality.

An important characteristic of biographical research is the temporal element, of exploring the life of a person over time. During the analysis of the biographical narrative, a distinction is made between the two elements: the lived life history – the chronological event of a person's life; and the told life story as narrated by the participant. Life history and life story are understood in their own unique sequences. This allows the researcher to identify changes, developments and transitions, and turning points throughout the life course.

At the time of the interview, the participant will select- consciously or unconsciously aspects of their lives and events to talk about (Miller 2000) . One part of the interview is understood to be related to other parts of the account. The ability to identify change and turning points helps to understand the subjective experience, feelings and perceptions of the participant. Health professionals are likely to have made choices about their educations and careers at certain points in their lives, which will influence their career and life trajectory (Gallacher, Ingram et al. 2009). Some of those choices might be incidental, be initiated by others or by the person themselves. Many learning processes occur implicitly throughout life, not all learning is reflected upon, yet they make up the person's biographical knowledge about themselves (Alheit 2005a) .

3.16 The case reconstruction

The biographical case reconstruction of an interview follows a sequence of steps. The precise description of the steps, and the number, varies from publication to publication, as authors conflate or subdivide the processes. Rosenthal has proposed two different versions (Rosenthal 1995, p216, 2006, p54); and Wengraf has proposed as many as ten steps (2008). In this study a sequence proposed by Rosenthal (2006, p54) was used:

1. Analysis of the biographical data
2. Text and thematic field analysis (structure of self-presentation; reconstruction of the life story; narrated life
3. Reconstruction of the life history (lived life as experienced)
4. Microanalysis of individual text segments
5. Contrastive comparison of life history and life story
6. Contrastive comparison of several cases

3.16.1 Step one of the analysis: analysis of the biographical data

The first step of the analysis is establishing the chronological and more objective biographical data from the interview. The interview is unlikely to presented by the participant in chronological order. (Rosenthal 2006) makes the important distinction between the lived life history and the told life story as told by the participant.

To establish the life history of the participant, life events are identified and put in chronological order. This allows to researcher to consider the social cultural and historical context of the person's life. Rosenthal (2005) advocates drawing, for this part of the analysis, on other materials such as material from archives, written documents, if necessary for example to verify data or understand the time in which an event took place. This also allows the researcher to identify if it is necessary to clarify more details about the identified events in a second interview. To understand the context of the participant's education and working life better I have, for example, drawn on articles about the history of geriatric medicine in the UK, and nursing education in the 60s (Grimley Evans 1997).

Looking at the chronological outline of the life history, hypotheses are then generated about the life of the participant without taking into consideration the account the participant might have given in the interview.

TABLE 2 EXAMPLE OF FIRST PART OF SEQUENTIAL ANALYSIS BIOGRAPHICAL DATA FROM ONE INTERVIEW

Facts from the interview, in chronological order, and further questions they raise for the researcher (not necessarily put to the interviewee).

Chronological data –Participant: Elicia
Date? Born to parents of mixed backgrounds, one had South American background
• *Not clear from the interview data if both parents were from a South American background, but mother spoke Portuguese.*
• *has siblings? Mentions a sister once.*
• *Was she born in the UK or did she immigrate with her parents later?*
• *Was it difficult in the UK to be a child of parents of mixed background? Her childhood was in the 50's or 60's when racism was not uncommon*
2 to 11 years old –The participant spent 75% of the time in hospital as a patient
• *early experience of being a patient,*
• *Experience of interventions and pain?*
• *Difficulty of keeping up with school?*
• *Could this a motivation for wanting to help others?*
• *Could this mean never wanting to have anything to do with hospital*
At Age 5 –the participant knew that she wanted to become a nurse
• *Was that early career choice influenced by her hospital stay?*
• *Did she have role models?*
• *Did she stick with the career choice made at five?*
• *did she regret this choice?)*
Age 5 - death of her grandmother
• *Early experience of death in the family*
• *Was she close to her grandmother, did this experience impact on her?*
(The rest of the life events from this participant's interview are not included here, but the whole life history was analysed in this way – this extract is used to illustrate the process)

3.16.2Step two of the analysis: text and thematic field analysis

The second part of the analysis focuses on the structure of the narrated life as told by the participant or their life story. The focus of this stage of the analysis is on understanding the self- presentation of the participant, how they tell their life story. The assumption is that self-presentation is not always intentionally controlled consciously (Hollway and Jefferson 2013a).

The second part of the analysis is done in two stages. Sequencing the interview into sections allows to understand the flow of the interview told by the participant. Here the researcher focuses their attention on the content of the interview. The text is analysed and sequenced for change of topic, or

At the same time the researcher identifies the manner in which a topic is talked about. The researcher identifies for each sequence of the text, if the participant uses descriptions, puts forward an argumentation or tells a specific story. Within the same section of the text, descriptions and argumentation might be used. Making the differentiation between argumentation, description and story is slow, but increases the understanding of how the participants use language and how the participants presents themselves. For example, does the participant tell a story of a specific event or interaction with a patient, or give a generalised description of their work and their role? Sequencing the interview, identifying points of change, either of content or how the participant talks, aids one to understand meaning found in the text.

This helps one to understand how the participants talks about work or an aspect of their lives themselves. The stories are particularly powerful as they can give insight into how the participants navigate inconsistencies, tensions, difficulties in the context of their lives (Bamberg and Georgakopoulou 2008), and this study navigates the complexities of their work with older patients.

The sequencing also helps the researcher to reflect on the interaction of researcher and participant during the course of the interview, where the interruption of the interview, or the follow up questions will have shaped the interview. I recorded my spontaneous reaction and emotional responses or questions.

Once the interview is divided into sequences, each of the sequences is considered and hypotheses are generated how the events recounted might have been experienced by the participant. The hypotheses are refined as further sequences are being looked at. It is at this stage of the analysis, that the researcher will need to bracket their knowledge of the whole interview as hypothesises are generated.

Text box 2 below gives an example of part of the sequencing of one of the interviews.

TEXT BOX 2: SEQUENCING OF INTERVIEW WITH PARTICIPANT ELICIA - EXAMPLE (PART)

- Opening of interview initiated by researcher
- Start of participant's narrative
- Retired now
- Nurse for 40 years
- Description of her role: Specialist in older people and stroke care
- Description of work role senior matron
- Management of nursing homes
- Detailed explanation of the different components of the job, including training of other staff, responsibility for delivery of care, ensure that care given to patients is individualised and personal. Description and argumentation
- Change of job to working for a housing association. who was buying nursing homes.
- After couple of years, left to work in teaching hospital responsibilities for five wards including a stroke ward and continuing care wards. (this *was her last job before retirement*)
- Job in teaching hospital included the responsibility managing big budget and 300 staff
- Expression of how she feels about her work: Passionate about older people and how they are treated.

Full example is provided in appendix 9.2.1on page 270.

3.16.3 Steps three of the analysis: Reconstruction of the life history

In this part of the analysis the life history is compared with the told life story. The hypotheses and questions generated in the first step of the analysis and the chronological order of the life history are verified or rejected by examining how the participant talked about life events, and how they represented themselves. The participant will not necessarily have talked about all the life events in depth. This process gives insight into the participant's perspective of pat events. During the analysis sections of the text for microanalysis are identified.

3.16.4 Step four of the analysis: Microanalysis of individual text segments

A significant section of the text is chosen for the microanalysis. The microanalysis involves going through a section of the text slowly word by word.

The beginning and the end of the interview can be significant, a section of the interview which is particularly significant to the research aims, which is difficult to understand. The microanalysis helps to gain a deeper understanding of some of the text, and helps to understand the key aspects of the interview.

Text box 3 on page 97 provides an example of the microanalysis of one of the transcripts.

TEXT BOX 3: MICROANALYSIS OF THE TRANSCRIPTS – EXAMPLE

Participant's words in **bold**; researchers thoughts in *italics*.

A: And I think that, but I think this can be sometimes just a very black and white view *(does she consider the view as rigid, she uses the word black and white does she consider that there are other views? She does not seem to agree with the view?)*

and I hate to say it medical view of looking at age. *(Does she consider that the medical view differs from other views?*

I think from a therapy point of view (*from a therapy point of view. She identifies her position from a professional point of view- she calls it a therapy view/implies that she might consider that other therapists have a similar view, but that this might differ from the view of other healthcare professionals* **it does not matter what age you are** (*age does not matter*?*)*

…as a matter of fact, it does not matter what condition you got, *(here she makes reference to the medical condition of the patient, that does not matter either- in effect she says ag**e*** and medical condition does not matter? *Does she imply that the medical condition of the patient does not matter at all? Will she refine that statement, perhaps look at different medical conditions? Does she make exceptions to the rule?)*

…it's looking actually what you can do (*here Anna emphasis what matters from her perspective is what the patient can do*).

A: I had, I particularly remember one 92-year-old patient I had (*recalls a specific patient she came across professionally) she mentions the age, but does the age of the patient matter to her? Does the age of the patient impact on the function, something she has identified as being crucial? Will the story confirm her previous statement that only functions matter? Will she modify her previous statement?)*

and she was more mobile and independent *(describes what the patient can do and then continues to compare it to patients she has seen who are over 30 years younger than the patient she is talking about)* **than some 60 years old than I see. So, for me age realistically it does come into it, it has to, but for me it is not the be and end all how I would approach someone,** *(here she modifies or adds extra thoughts to her thoughts on whether or not age matters, or if she would or should consider the age of the patients. She concedes that age might matter, but it is not the most important factor how she approaches a patient).*

You have to take it into consideration because realistically you are not expecting the same from a 90-year-old who lives on their own than a 55-year-old who lives with their wife/husband. (*Does she think that social circumstances make a difference? Does it make a difference to her as a therapist and the way she works?)*

But I certainly would not approach someone: you are 85 well it is time, *(here she highlights that she would put her assumptions aside. I think here she makes reference to an earlier part of the interview where she explains that some people make the assumption that an 85-year-old patient goes into a home***)**

but I think I depends very much what speciality you work in and how the team approaches. (*highlights that the approach taken will depend to a degree on context of speciality of the team as well as the team itself**; will she go into more detail how the teams differ? Does she agree with the different approaches? Does it cause her conflict?)***

3.16.5 Step five of the analysis: contrastive comparison of life history and life story

Once the first four steps are completed, the lived life history (the chronological order of events) and told life story (the life as narrated) are compared.

It is at this stage that the researcher compares the chronological and the narrated life story with some of the following question in mind. “Why did the person tell the story like this? What does this tell me about the research I’m carrying out?”. It is at this point that the researcher reconstructs the case. The reconstruction allows exploring and understanding the interrelationship between the individual, subjective and the structures the individual is embedded in.

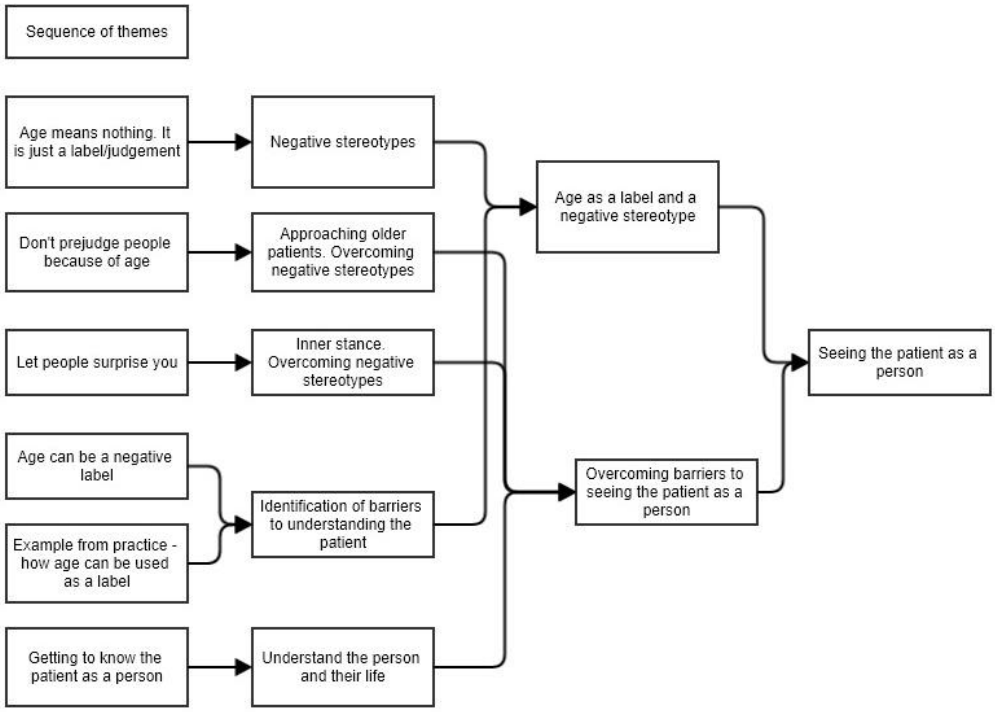
3.16.6 Step six: comparing and contrasting the cases

Once all cases are reconstructed individually, the comparing of and contrasting between the cases will take place. One of principles of BNIM is that the researcher always maintains the whole case study in mind during the analysis of the data and when comparing cases. While the drawing out of commonalities and differences of the themes found across interviews assists one to understand each case study as a whole, as well to gain understanding of the differences and commonalities between the case studies. It is a qualitative process: it assists the deeper understanding of details and nuances of the cases, and of how individuals represent themselves. For this part of the analysis, Riessman’s consideration of case study research and narrative inquiry is relevant. A case study approach does not necessarily exclude the development of categories as used in grounded theories, categories being *“theoretical concepts and observations about general processes”* (Riessman 2011, p311). For this part of the analysis I also drew on qualitative research analysis described by Punch (1998).

When identifying differences and commonalities, concepts from the themes identified during the sequencing of the interview text were identified, and sections of the text which were pertinent to the research topic were compared across the interviews. When developing concepts, there is an increasing degree of abstraction which allows comparison between the cases and sections of the

interviews (Punch 1998). Figure 1 below shows the abstraction process for a section of an interview text.

FIGURE 1: PARTICIPANT 4 (ANNA). SEQUENCE OF THEMES: SEEING THE PATIENT AS A PERSON



Starting initially with a description of a text section, the themes identified during the sequencing of the interview text are conceptualised. The comparing and contrasting of the case studies is a reiterative process. The process involves going backwards and forwards between the interview text, the themes and the developing concepts, ensuring that the developing concepts are derived and grounded in the data. Development the themes presented in the findings – such as “seeing the patient as a person”, ”giving choice to the patient”, and “the values shaping the relationship” (see section 5.3.7 on page 184) – involved comparing the themes identified in the sequencing of the interview text, and the concepts developed from those themes. The developed concepts are compared between the cases, initially starting with comparing two of the cases, then moving to the other cases. This process led to another level abstraction and concept development. During the abstraction process, the developing concepts were continuously checked with the interview text to ensure that the concepts maintain their connection with the data.

3.17 Hypothesis generation during the analysis of the data.

To gain insight into the experience of the participant, hypotheses are generated about the meaning for each of the sequences of the text.

The case construction is helped by the abduction procedure as described by Peirce in 1903 (Reichertz 2004). In BNIM, the process of abduction is used to verify the generated hypothesis, especially sections of the transcribed text which are difficult to understand or carry an element of surprise when reading the text.

Abduction is one form of reasoning used in research, as well as in daily life, to solve problems, and to generate or test hypotheses. Other forms of reasoning are deduction and induction. Deductive reasoning a form of logic. In deductive reasoning, a hypothesis is established, usually based on a theory, and a systematic process of known procedures is used to test the hypothesis.

Inductive reasoning is used to explore fragments of information or data. It is a form of reasoning where a person makes predictions of specific information. A researcher will generate hypotheses rather than test a hypothesis like in deductive reasoning. The inference will be based on what is known from the past. Inductive reasoning searches for an explanation of a phenomena by using generalisations often based on observations in daily life. So, for example, if it has been found in previous studies that student nurses do not like to work with older people, it can lead to the generalisation that all student nurses do not like to work with older patients. One of the limitations of inductions is that predictions however are not always true. Generalisation might not cover all scenarios, especially where the premises differ the generalisation might not be applicable. For example, when researching learning, the contexts in which learning takes place might not be comparable. Generalisations do not take into account individuals who might be described as different or as outliers. For those reasons, a researcher might find that inductive reasoning can lead to misleading conclusions.

Abductive reasoning is a form of logical inference, and is also described as a thought process which can be explained as *"the inference to the best explanation"* (Douven 2017, S1). Abductions starts like inductive reasoning with the

observation of phenomena. The evidence available to generate hypothesis is often incomplete. In BNIM this will be sections of the text, especially sections where the reader is in doubt or uncertain about its meaning. The hypotheses generated aim to give the best explanation of the phenomena observed.

Generating hypotheses helps one to understand the text of the interview. It is a way of asking questions about the text and generating hypotheses for explanations. According to Oevermann it allows one to understand the individual's subjective meaning and sense making and how individuals create internal coherence (Oevermann, Allert et al. 1980). While the hypothesis generated need to be close to the text, at the same time Pierce (as represented in Reicherts) specified the conditions for abductive reasoning as letting the mind wander as there often can be an element of surprise when arriving at an insight, abduction can be a creative process. When the hypotheses have been generated, the researcher moves along the text to look for evidence to confirm or reject the hypothesis. It is only when moving along the text, that the hypotheses can be confirmed or disregarded.

Rosenthal (1995), Wengraf (2004), and Hollway and Jefferson (2000) recommend generating hypotheses with a group of other researchers or persons who are not necessarily experts in the field and can contribute a wide range of perspective to the data analysis. Group analysis assists the researcher to overcome the blind spots blind spots they might have. Hollway refers to the *"defended self"*: the researcher might defend themselves against the parts of the interview which the researcher finds difficult to acknowledge, and the group analysis can help the researcher to process difficult emotions evoked by the data.

In this study, I did not share the interview data with a group partly due to logistical reasons. I found that this poses some difficulties when studying independently for a PhD. I did not consider at the time that the option of carrying out the group analysis using email or teleconferencing even retrospectively this might have been an option worthwhile exploring. At the beginning of the project and when I chose the method, I did anticipate organising a group for data analysis as recommended in the BNIM guide. However, I did not anticipate the difficulties of organising a group to come together and to physically meet in a location. I

made some attempts to organise this by contacting some potential group members. But at the time of the analysis I found the difficulties of organising this overwhelming.

Obstacles I encountered included the following.

Firstly, identifying a space to meet in was very difficult. At the time of the data analysis I was employed part-time, but I was working from home and had no facilities to book a room through my work place.

As a long-distance PhD student, travelling to the University can take up to two hours each way. Again, this proved to be an obstacle when considering arranging a meeting there, and I struggled to identify people from different backgrounds to be part of a group meeting at the University. The travel time to the University for the potential group members would have meant a considerable commitment in terms of travel, time and expenses. Meeting in my home was not an easy option as I share the living spaces with others, and there were issues around privacy and finding a space where where confidentiality could be ensured, and about offering hospitality to people especially to people who might have to travel from afar.

Secondly at the time of the data analysis, I was getting physically and emotionally easily overtired, and working part- time as well as doing the PhD, I found pacing myself was difficult. As a consequence, I lived in relative isolation, and as I'm writing this, I realise that for a few years I did not invite anyone into my home.

Not using group analysis was, at the time, dictated by circumstances, rather than as a rejection of the idea or not seeing it as part of BNIM. I highlight that the fact that I have not used a group as a shortcoming and limitation of the study in the discussion.

Having attended two workshops on objective hermeneutics led by Oevermann using the process of abduction for text analysis. Oevermann recommends staying as close to the text as possible when generating hypotheses, not to hypothesise wildly, and not to generate more than three hypotheses for a section of the text. The consequences of each of the hypotheses and if they are true, are considered. Once the hypotheses are generated, the reader moves on to the next sequences

of the text, where the hypothesis is confirmed or refuted using the text of the interview (Rosenthal 1995, Rosenthal 2006).

3.18 How does the method of analysis allow the researcher to identify meaning?

Meaning can be identified through the BNIM interview technique and analysis.

Both the interview structure and the methods used for analysis help the researcher to gain understanding of the deeper meanings the participant attaches to the accounts and stories over the course of the interview.

Meaning is revealed through the following:

To start the interview, Schütze and Rosenthal both argue for asking a very open question to encourage the initial narrative (Schütze 1983, Rosenthal 2006). This means that the participant is free to tell what they talk about in the interview. As Schütze discusses in his article, the narrative interview, the openness of the interview means that the participant will present themes in a sequence which is relevant and meaningful to them. Starting the interview with an open question, the participants will make a choice what they will talk about, -an individual will not recall all details of their lives - selecting from a range of alternatives themes available to them. Schütze identifies this as the first constraint of the narrative interview. Rosenthal draws on Gestalt psychology explaining why an individual will recall certain events of their lives. Events of the past are recalled because they have a significance with the present, the theme of a past event has a connection with a current theme in the individual's life (Rosenthal 1995). Because the interview is not rehearsed, it is a planned but at the same time spontaneous interaction between the participant and the researcher, the decision what the participant will chose to talk in the interview and how the participant represents themselves, is not always directed exclusively by conscious or deliberate thought.

The telling of past events can evoke other memories, and can be associated with the recall of emotions experienced at the time. The thematic field analysis will show if the participant might break off a theme during the interview and where the participant might not have wanted to go into more detail. Not all events recalled during the interview will be remembered as coherent stories, especially if

they involve a degree of trauma, but some will may be presented as fragments (Rosenthal 1995). During the analysis, paying attention to the manner in which an event is recalled, will also contribute to the understanding of meaning.

A biographical narrative interview is in itself a space for reflection. The participant will because of the nature of the interview do some biographical work over the course of the interview, where the participants reflecting on life events will articulate some of the feelings and beliefs which are part of tacit knowledge, the values and beliefs perceptions which underpin professional practice in healthcare. Tacit knowledge often hard to articulate, but reflection can be an opportunity to let it rise to consciousness, and some of the values, beliefs, perceptions underpinning the life story will become more visible. In an interview, the participant will make at times new connections between events and life stories. The interview itself is a biographical work in process.

Through the process of analysing the interview text the first step is to establish the life history of the participant, for example ordering from the interview data a chronological order of events and history. It is at this point that the researcher might ask questions about the life history, considering the choices the participant has made, and identifying turning points in their lives. It is through this process of analysis, asking questions about those choices and turning points, and the consideration what other choices the participant might have made as well as putting forward hypothesis the reasons the choices were made, that the potential meanings become apparent. The first step of the analysis is connected to the second step of analysis, the thematic field analysis, where the interview is sequenced into themes, this is the life story as told by the participant (see section 3.16 on page 91). It is during this stage of the process that the researcher can also identify the parts of the life history which the participant has not elaborated on. It is during the second part of the analysis that the researcher can find some of the answers to the hypothesis generated about the life history of the participant. By comparing the life history and the told life that the researcher comes closer to what meaning the participant has made of life events, and gains insight how the biographical processes, and what values and beliefs shaped the participant's biography, and influenced the choices they made. Additionally, the micro analysis

of sections of the text, where abductive reasoning is used to generate hypothesis for small fragments of the text, which also helps the researcher closer to the meaning of the text.

The analysis of the data shows the individual subjective experience as well as the wider context in which the experience takes place. This allows in the analysis to gain insight into the deeper meanings, for example to distinguish where the participant took positioned themselves in relation to the more collective attitudes, beliefs.

Identifying points of transitions turning points and crisis in the life of the participant. These are often points where the participant experiences difficulties, tensions, conflict with others and the outer world. It is often at those points that also the inner world of the participant, their thoughts, feelings, beliefs, perceptions become clearer. Through the generation of hypothesis for these sections of the text, asking questions about the experience of the participant and how turning points might have impacted on other aspects of their life, the researcher can come closer to understand the participants experience, feelings, values.

3.19 Quality of qualitative research

Qualitative research can have a high degree of validity. Research using a small sample size may not aim to be generalised; indeed, the importance in qualitative research is to gain deep insight and to capture the complexity of the lived experience, to understand the human experience, and to give rich accounts of the data, acknowledging that there will be multiple realities (Cohen and Crabtree 2008).

Guba and Lincoln have developed the concepts of credibility, transferability and confirmability, and dependability to assess the quality of research (Lincoln and Guba 1985):

- Credibility, confidence in the 'truth' of the findings
- Transferability, showing that the findings have applicability in other contexts. In qualitative data the findings cannot be generalised to a wider population, but taking into account the context and specific situation, they might be transferable to similar scenarios.
- Dependability: the research findings cannot be repeated like in a quantitative research project. Having an audit trail, field notes, recordings increase the dependability of the findings, as they demonstrate what has been done and the changes made.
- Confirmability: the data were recorded and transcribed and when writing each case reconstruction, the researcher attempts to represent the voice of the participant. Also, as a researcher, I tried to make transparent how some of the data were interpreted, my responses to the data.

D. Ethical considerations

3.19.1Ethical considerations for the study

A researcher needs to practice in an ethical manner and within a legal framework relating to data protection, privacy laws and confidentiality. These ethical considerations are an essential part of the agreement between the participant and the researcher. Ethical research guidelines for educational research by BERA's are guiding the project.

The study has been approved by the Research committee of the University of Winchester. As part of this process an information sheet about the study (appendix “9.4 Information sheets for potential participants” on page 279) as well as the consent form (appendix 9.2 on page 270) which each participant is asked to sign before the interview has been approved.

The following ethical issues issue were considered: Voluntary participation and Informed consent, maintaining privacy and confidentiality of the participants, and potential harm caused by the project.

3.19.2 Voluntary participation and informed consent

The principle of informed consent means that potential participants must be given information about the study, so they can decide if they want to participate in the research. To participate voluntarily in the study, potential participants must not feel coerced, pressurised, or threatened if they decide not to enter into the study.

Potential participants for the study were approached with the understanding that participation in the study is entirely voluntary, and that the participant can withdraw their participation at any stage of the study.

Potential participants were sent an information sheet and a consent form prior to the interview, so they could consider the study and can meaningfully make the decision if they want to participate in the study and give them an understanding what is involved in the data collection, the presentation and writing up of the data.

3.19.3 Challenges of informed consent and voluntary participation

Both the issue of voluntary participation and informed consent can present challenges in qualitative research.

The issue voluntary participation can be complex in qualitative research, as the identification of potential participants means that the researcher will need to find out some information about the person. In this study, I had to clarify the professional qualification and have some indication of level of professional experience.

Early in the process of recruitment, when considering approaching potential participants, the researcher enters a social relationship with the potential participant. This relationship might be directly between potential participant and researcher, or indirectly through a third party. In two cases, potential participants were “recommended” by acquaintances as potentially suitable for participation.

In order to establish contact, some exchange of information about the project, the participant and the researcher takes place in a relatively informal manner.

Apart from written information the participants informed consent, the participants were also given the opportunity to clarify any questions before the interview.

One of the difficulties with open-ended interviews, where the participant rather than the researcher sets the agenda, is unpredictability of the course of each of the interviews as the participants reflects on their experiences, emotions, and events.

As a researcher, it is hard to be sure before the interview how exactly the data will be presented. The hermeneutic analysis means that the researcher searches for deeper meaning in the data, some of which might not be fully conscious to the participants themselves. During the analysis, the researcher will make decisions about how to present the data over a period. It is at this point of the project, where the question of control and ownership of the data becomes most pertinent. Having attended a course on BNIM and hermeneutic analysis, I was aware that the custom is not to share the data with the participant, unlike in other forms of qualitative research especially feminist research and action research.

As a researcher using hermeneutic interpretation for the first time, I was only partially aware of detail of analysis and interpretation of the data, of how the cases emerged during the process of analysis, and of how intimate it would feel to present and write up the individual cases.

3.19.4 Confidentiality, anonymity and privacy

According to the Data Protection Act (1998), the participant has the right to privacy and confidentiality. Recruiting participants from one or two healthcare teams was considered, but decided against, and to maintain confidentiality individuals were recruited individually and not through their workplace. Recruiting from one or two teams would make it impossible to maintain the anonymity of the participants.

During the transcription, the data were anonymised including names, names of workplaces and locations. The data were kept in a secure place. Personal information such as the participants' contact details were stored separately from the interview data.

Despite the anonymisation of identifiable details, it can be a problem to present the data in such a way so the participant cannot be identified, and it is very likely that the participants will be able to identify themselves in the study.

The researcher aimed to choose the data for publication with care and sensitivity. The data could be anonymised sufficiently, but would this not have been possible to anonymise the data to protect the confidentiality and privacy, the data would have been either been excluded from publication, or additional consent for publication will be sought from the participant.

3.19.5 Potential harm

The researcher must consider the potential burden of the research upon the participant. Reflecting about their past or current life events might bring back difficult and painful emotions which can be distressing. The risk of distress is greater in the second and third part of the interview, where the researcher takes a more active role asking questions to gain a deeper understanding of what is being said. For the participant, it might be difficult to negotiate how much information to reveal during the interview, however healthcare professionals tend to be skilled to manage the interaction with others. For the researcher, it can be difficult to judge the degree of questioning acceptable to the participants. I felt that my role was to be sensitive to the boundaries of the participant, these are

often “negotiated” non- verbally, through body language, eye contact, or the use of the voice.

3.20 The relationship between interviewer and interviewee.

A qualitative interview depends on the relationship between the researcher and the participant, the interviewer needs to build rapport and trust between the participant and themselves.

The interaction between the researcher and the participant starts before meeting each other. I had met three of the participants in person before arranging the interviews, and two participants I met for the first time for the interview. The interviews were arranged through face to face contact, e-mail, or telephone interactions before the start interview.

From the researcher’s point of view, the aim is to develop communication, rapport and trust between participant and potential interviewee. Even written and verbal consent is sought for every interview, it is often at an early stage of the relationship before starting the interview, that implicit and explicit agreements about consent as well as expectations, roles, trust and confidence, and boundaries between researcher and participant as well as the practicalities of the interview.

Once the researcher and the participant meet for the interview, the first minutes of an interview are significant. “The subject will want to have a grasp of the interviewer before they allow themselves to talk freely, exposing their experiences and feelings to a stranger” (Kvale 1996 p128). Having read the information and consent form, the participant brings their own assumptions about the interview to the interview. The information sheet gives the focus of the topic, and the participant is likely to have thought about the interview beforehand. This can have disadvantages that like one of the participants in this study was trying to anticipate what I wanted to know. Initially was concerned about that this would limit the narrative in the interview. But my concerns were unfounded. The data were rich, and the analysis of the data revealed the concerns of the participant.

3.21 Boundaries in the relationship

In any type of research, ethical issues such as informed consent and the relationship between the participant and the researcher are bound together. Interviews which do not rely on closed questions or a tightly prescribed protocol are unpredictable in their course. The boundaries between the researcher and the participant will vary and be fluid. In biographical narrative interviews, the role of the interviewer is associated to a degree with openness and uncertainty as the researcher deliberately avoids setting the agenda for the interview. Informed consent will therefore depend on the participants understanding the nature of the interview, and managing the information they give in the interview. The participant will make decisions during the interview what to reveal.

Because the participants were healthcare professionals, my assumptions were that they would be trained to protect the confidentiality of their patients and workplace, and likely to be skilled at drawing internal boundaries about the degree of disclosure. Healthcare professionals have learned, as part of their professional training, to manage difficult feelings and to be non- judgemental. Before the interview, I was concerned that the healthcare professionals would not be willing to share their concerns. The skill of the researcher is to manage contradicting demands, on the one hand respect the boundaries set by the participant, to create a feeling of space which allows the participant to be relaxed and open, to listen actively and with empathy and to indicate to the participants that they are understood, and on the other hand to make decisions about the appropriateness to push for information. Each of the participants is different and each interview situation unique. The researcher will need to be responsive to the participant. There were places in the interviews, where I deliberately decided not to probe as asking more questions might have been perceived as too intrusive. In qualitative research too manage the relationship with the participant a deliberate process, but not a completely rational one, it relies on intuition and the interpretation of language, and body language.

An unstructured interview demands openness and flexibility from the researcher. In biographical-narrative research there is little structure to rely on. Many decisions are made during the interview, while the participant is talking. The

researcher requires high level active listening skills, to do this while at the same time adopting a passive stance, so as not to disturb the flow of the narrative. Listening to the interviews during the analysis, it is easy to see lost moments and opportunities missed by asking questions too early or not asking questions at all. One of the pitfalls for a researcher familiar with the topic is that it creates a feeling of recognition, and may lead to an overidentification with the participant's experience, which may not allow enough room for the participant to open up.

3.22 Being a reflexive researcher

Being reflective is an integral part of being a qualitative researcher, and fieldwork means engaging in a process of discovery of self (Guba 2003). In qualitative research reflexivity of the researcher involves reflecting critically on the self as a researcher throughout the whole research process. Reflexivity entails self-awareness and being conscious of the whole research process from choosing and refining the methodological approach to being aware of values, beliefs, and thoughts, and making the personal, professional, and cultural background of the researcher and what they bring to the data explicit (Plummer 2001, Todres and Wheeler 2001).

Maintaining reflexivity during the qualitative interviews can be particularly difficult, as the interviews are open in their nature. The flow of the interview is governed by two people and might throw up surprises, difficult feelings and makes cognitive and emotional demands on the researcher.

The feelings and thoughts that might be evoked by the interactions and environments in the field can depend on previous experiences, sensitivities and anticipation of themes which are discussed. These responses might be only come to consciousness after the interview when writing field notes, transcribing or analysing the interviews. After each of the interviews I wrote field notes as soon as possible. Listening and transcribing is a helpful tool to learn about one's own responses to the interviews. Before starting to transcribe the interviews, I made free-flowing notes listening to the recordings, and examined the interaction between the participant and me, specifically those where I felt I had cut the answer of the participant short by moving on to another question. The increased

understanding of the interaction between the researcher and the participant, and understanding how it affects the flow of the interview, can impact on the next interview (Wengraf 2001).

Being a reflexive researcher and empathetic listener has been more difficult than I imagined at the beginning of the project. Talking about old age, illness and death are difficult topics to research. It can be a challenge to disentangle the emotions of the participant and the researcher, because of the semi-conscious and unconscious nature of the emotional responses. Before starting the data collections, never having carried out interpretative phenomenological research, I had not anticipated the intensity of data analysis. Returning frequently to the text or the recording of the interviews, it felt like I was living with the participant for the time I analysed the interview. The interaction between the researcher, participant and the data is influenced by the openness of the researcher. Crotty invites researchers to *"open ourselves to the phenomenon as the object of our immediate experience"* (Crotty 1996 p278).

Reflecting on the interaction between participant, the data and myself became, at times, a difficult and emotionally painful process; a process which I was not always sure if I could hold and contain. In the early stages of data analysis, I felt my perspective was constantly shifting. I had become sensitised to the question about growing old, and I was looking at the data with the lens of a healthcare professionals as well as a patient. Both the participant and the researcher are sentient beings. The boundaries between the researcher and the participant can be porous as the biographies of the researcher and participant meet (Hollway and Jefferson 2013b). The intersubjectivity feels messy and chaotic at times. The researcher can use the awareness of their emotional responses to gain a deeper understanding of the data and to make more explicit how meaning and knowledge are co-constructed between the participant and the researcher.

3.23 Writing and interpretation

The writing of the data findings is where the co-construction of meaning and k9nowledge is most obvious, the writing is driven by the data themselves, and the lens of the researcher and the interpretation of the data. The individual case

reconstruction is the summary of hours of analysis. The case reconstruction aims to present a case, to give insight into the life of a participant, and highlight events, stories and details which are significant to the research question. During the writing, the aim was to stay close to the data, using some of the language the participant used, constantly comparing the text of the interview with my writing. The selection of the data presented will be dependent on the lens adopted, and a deliberate selection of what aspects of the interview to bring to the forefront of the writing (Rosenthal 1995, Rosenthal and Fischer-Rosenthal 2004, Rosenthal 2006).

Choosing the words to tell the life story of the participant means describing, characterising, establishing a picture or an atmosphere, interpreting the context and what the participant said, to capture the flow of somebody's life, highlights changes, dilemmas, and transitions. It means oscillating between the whole and the detail, and linking the detail to the whole.

Throughout writing the case reconstruction, the question *"have I presented what the person said and means, is there a circle of evidence?"* meant always going from interview data to rechecking the writing, to going back to the data. At the same time, I used reflective notes to understand my own responses to the interview, and the field notes gave insight into my initial reactions to the interview. These notes are useful to understand my own beliefs and assumptions, and consider how they influenced my writing. Writing is always an interpretation partly because it uses language to represent somebody else's experience.

3.24 Conclusion (whole chapter)

Methodology and method underpin the whole project, its development, and the method for the data collection, analysis and interpretation. The focus of this project is the description of the phenomenon of how health professionals learning and development of knowledge about ageing old age and working with older patients. This is a small study using a case study approach and using a well described method, BNIM, to collect and analyse the data in addition to using the listening guide to enrich the understanding of the data. Or add another dimension to understand the data.

Ethical considerations of carrying out qualitative interviews with a small number of participants were considered before and during the process. The reflection on the intersubjectivities of this research is a crucial part of the data analysis, and it adds to the credibility of how the data will be presented. For this reason, I presented a personal story in the next chapter, to increase the transparency of the interpretation of the data.

4 Chapter 4: Personal story

4.1 Introduction

In interpretative phenomenology, the researcher reflects on their own position, assumptions and experiences. The aim is to access and understand the participant's world and their subjectivity.

> *"Access is both dependent on, and complicated by, the researcher's own conceptions which are required in order to make sense of that other personal world through a process of interpretative activity…"* (Smith, Flowers et al. 1997 , p70).

But In a study like this, the researcher will attempt to understand and interpret the text of the interview. The interpretation will be guided by, the research aims and questions, as well as looking at the data through selected theoretical lenses relevant to the topic, and intellectual understanding, as well as the experience, beliefs and assumptions, emotions, the researcher brings to the activity.

Being reflexive about the intersubjectivities was always and important component of the research process and adds to the transparency of the research process. From early in the research, as I was considering the theoretical underpinnings of the research, I have been aware that my position as a researcher, my beliefs, assumptions and experiences will influence the research process, and will be significant during interviewing and the interpretation of the data.

Working with my own subjectivities has changed through the course of the study. When developing the proposal of the study, it was the combination of my professional background as an occupational therapist, researcher and educator, and the experiences I had over many years of practice, as well as the theoretical of ageing and the life course, which motivated me to drive the study forward and were at the root of my thinking.

However, I had not envisaged at the beginning of the study how self-reflexivity would become increasingly important over the course of the study.

Exploring the intersubjectivity between the participant, data and researcher became significant part of data collection and data analysis.

During the interview, the analysis and the interpretation of the interview and writing, the life worlds of the participant and the researcher become intertwined – at least in places. Understanding the data is an iterative process leading to a deeper and different understanding of the text at each step, the interrelationship between the researcher and the data. The writing of the data emerges from this relationship.

One of the challenges of qualitative research, is it to make the research processes transparent. Some of my professional and personal experiences and their influence on the research became a profound part of doing this work, as those reflections were part of the internal conversations I had with the data. Those reflections rely on conscious or unconscious selection of pictures about my life and their translation into words, which reflect some of these experiences.

4.2 The origins of the project

My professional work as an occupational therapist and my work as a researcher and lecturer as well as my personal experiences are a profound influence on the study When I was thinking about doing a PhD, I worked as a lecturer at a school of nursing and midwifery. At the time, I felt strongly embedded in clinical and educational practice. Having worked for over 15 years clinically as an occupational therapist earlier in my career, I became a researcher and lecturer initially teaching occupational therapy, and later other healthcare students, being an occupational therapist always stayed part of my identity.

Early in my career, I worked in different locations and variety of clinical settings for example general hospitals, in patients' homes, on spinal injury and stroke units, and on specialist elderly care wards. A substantial proportion of my work was with older patients. The care and rehabilitation of the older patient gradually became over time the focus of my career. I liked working with older people, but I realised that in term of healthcare it was not seen as a prestigious speciality (Grimley Evans 1997). However, my own perception of old age at the time was that it is as an interesting phase of life, and that to become old was something positive.

I feel my grandmother was in so many ways a positive role model. Growing up in southern Germany, I saw my paternal and maternal grandparents frequently at weekends. My paternal grandmother had nine siblings; the youngest is in 2017 still alive, and has reached her 100th birthday. I always felt close to my paternal grandmother, and after I moved to the UK she was the first person I phoned as soon as I arrived in Germany. My grandmother could be described an example of a person who had aged successfully. At the time, I did not think of her in those terms, not until I developed an academic interest in ageing teaching occupational therapy students. My grandmother took an interest in life and other people until the day she died. I always felt, and still feel, that she was a very good role model for how to age well, and she influenced my attitudes to ageing. Ageing was part of life, and not something to be feared. But working as an occupational therapist, I became aware that not every person had a good old age, I encountered many patients for whom old age was difficult because of illness, poverty and isolation. I started to realise that not everyone was lucky enough to be able to age well, supported and in good health.

I developed an interest in ageing and working with older patients over the course of my career. As a student, I was allocated two placements on a geriatric ward. At the time, I feared that the lack of variety of experience would limit job opportunities post-qualification. My first occupational therapy post was on a spinal injury unit, followed by a rotational post in a general hospital. Part of the rotation included working on a geriatric rehabilitation ward and day hospital. It was only after that experience, that I felt working in geriatrics was interesting and enjoyable, however I wanted to develop my interest in neurology, and worked in a specialist stroke unit. Moving to a geriatric rehabilitation ward, I was shocked about the poor environment and noticed the lack of training opportunities.

After I had a family, and moving to different places because of family commitments, I worked part time, and took on posts on acute wards, mental health, orthopaedics and dementia care. Many of the patients I saw were older patients. My feelings about the years I worked with older patients are ambivalent, changeable and full of contradictions. I found the work difficult, emotionally and physically draining at times, but also interesting, stimulating and challenging. I felt

the work was perceived as low status and did not get the recognition it deserved. External factors such as the physical setting or the team made a difference. I remember being moved to work in a geriatric hospital, a place feared by many patients, because it had been a workhouse in the past. The physical environment was unsuitable, often depressing and difficult to work in. But I knew it did not have to be like this, because the experience contrasted with previous posts in a purpose-built unit, where I was part of a multi-disciplinary team.

When I started to consider a study proposal, a conversation with a colleague came to mind.

At the end of the working day, I asked my colleague *"How do you cope when one of your patient dies?"* I felt sad, because two of my patients had died unexpectedly during the day. One of those patients had been supposed to be discharged home: I had done a home visit with her just a few days previously. The conversation stayed brief, and I remember thinking how difficult it was to discuss the topic of death and the emotions.

After working as a clinician and researcher, I became a senior lecturer in occupational therapy. It was there that I had conversations with occupational therapy students – and later with nursing students who had been on placement and returned to University. Teaching about the rehabilitation of older people, some students told me that they did not want to work with older people, and that only "losers" ended up working with older people.

Exploring with the students the topic of old age and their experiences of working with older patients, it became apparent that the students themselves were hoping to be fit, fulfilled and happy in old age. Their own aspirations and hopes for their own old age seemed to be in stark contrast to the lives of the patients they worked with. They described working with patients who were struggling with deteriorating health, social isolation, and lack of support. Some of the students were clear that they would not work with older patients once qualified.

The origins of the study were certainly being embedded in the practice of, preparing students to go into practice, as well as being in practice myself. When I started the PhD, I felt that I was very much embedded in practice. This was my

original position when I developed the idea for this project: I saw myself as a healthcare practitioner somehow turned academic (Stenhouse 1975)), who was going to interview other healthcare professionals – people who were in fact colleagues – about their work. I became aware that this could, on the one hand, give insight into the participant's experience; while it could also present a danger with boundaries, assumptions and over-identification (Hirsch 2000).

4.3 Rupture in the project and the development or immersion into another perspective

However, two to three years into the PhD project, the diagnosis of a serious illness threw me off course and changed the way I viewed this study. I had reached the point where I felt ready to start to interview participants. However unexpectedly and what felt like overnight, I found myself being a cancer patient, I found myself "on the other side of the fence". It is said that health professionals who become patients often only then start to understand what it means being a patient (Tomlison 2014). I felt that my life as I knew it had changed overnight.

Months of treatment demanded a lot of my energy and focus. I was unable to work during that time. The commitment and rhythm of hospital visits meant that my life rotated around my immediate family and living within the physical boundaries imposed by the treatment. Post-treatment, I tried to return to my PhD study, but did not find it easy. I felt I was living without a safety net. Walking away from the hospital, I was conscious that there are no guarantees in cancer treatment, nobody knows if the treatment has worked and if I was in remission. Time, age, life expectancy, and uncertainty have taken on different meanings.

Yet the expectation is to return to day to day life and to some normality. Although it looked from the outside like I was returning to my previous life, I had to learn to live with my new life, to find an inner place where I could find hope, live in the moment and feel alive.

As I wrote in my reflective diary at the time:

> *"Being diagnosed and treated for cancer feels like landing in a new world. But the old world does not go away. I inhabit my old world and the new world simultaneously. The new world feels unfair and harsh at times. Like arriving in a new country, I had to familiarise myself with the contours of an unknown landscape, learn a new language,*

and experiment".

Concepts I had discussed with my students were now a reality in my life. As an occupational therapist, I tried to understand patients' experiences. Being treated with dignity, respect, kindness and in a person-centred way took on a new meaning for me.

It was a few months after completing hospital treatment, when I interviewed the first participant, and started the transcription. I was surprised by the strength of my visceral responses to some sections of the interview. I became aware that despite our different professional backgrounds, I felt a degree of identification with the first participant – a retired nurse with a strong interest in older patients. But I found sections of the interview more emotionally unsettling than I had anticipated: I was now looking and listening to the interview through the lens of being a patient.

While I did not want my diagnosis of cancer to define me as a person, the experience of being a patient with a life-threatening illness was very raw, not something I could ignore or suppress; and it influenced how I related to the data. Studying the data, I felt I had lost something. I still understood the data from the perspective of my professional experience and my understanding about older patients, but reading the text through the lens of being patient was forceful and felt a less safe position.

Making the decision to return to the PhD, I had anticipated finding it difficult, but I had not anticipated how difficult it seemed to connect to anything I had thought before I became a patient. Slowly and gradually over months and years, I could feel a connection again. But this took time. I could not articulate what I was feeling or thinking.

> *"I try to connect my old world with the new world, sometimes with a sense of desperation, I want to close the gap, heal the rupture. To heal I have made and am making changes, to let go of the painful parts of the old life, so I can move on and live the life I love, the life I have now, and build on the best parts of the life I had before."* (Reflective diary entry).

I suddenly found the topic of the study emotionally difficult. I was talking with healthcare professionals about their older patients, about illness and death, when my deepest fear is that I will not be allowed to reach retirement age, and there is

always the question how long I will be in reasonable health. I never quite believed that I would grow as old as my grandmother, but somehow expected to get to what I considered a reasonable old age. Now I find it difficult to make any long-term plans. But these are topics which are difficult to talk about.

> *"It is life changing yet so difficult to have any conversation about it. The signals point towards silence and getting on with life. Yet having been given a cancer diagnosis is part of who I am today. It does not exclusively define me, but like being left handed, being a mother or a foreigner, it is part of my identity, my day to day life." (Reflective* diary entry.)

There were days where I felt I was about to fall over. The realisation that the staff at the hospital had done everything they could, but the fact that nobody could tell me if the treatment had worked made me fearful, feel out of control, and on my own. In the land of probabilities, only time will have the answers. It seemed I was standing on one side of a gorge: I could not see easily how I could get back to the other side, to my previous life, my thoughts and feelings. I was highly motivated to return to the PhD work, and I did return to it, but it took me a long time to connect to the work I had done before my cancer diagnosis. Trying to return to life meant learning to live with waves of emotions. Embodying the knowledge of the uncertainty of life, an acute sense of my own mortality was and is interwoven every day with hope and deep gratitude for being allowed to live.

I found that doing academic work and adjusting to being a patient did not sit easily together. Trying to create coherence was difficult. Talking about being a cancer patient and finding the right language is awkward. It seemed impossible to get the grammar right when talking about cancer. I'm never sure what tense to choose when talking, because having been treated for cancer includes the past, present and future.

> *"The experience of continuity and inner coherence is called into question, perhaps becoming invalid altogether. Illness can be experienced as a more or less external event that has intruded upon an ongoing life process." (Hydén 1997) page 53*

The after-effects of treatment gradually lessened over time, but I had lost confidence. When I was doing my first two interviews, I was not sure how I would cope. There were new sensitivities to deal with. Words like "*patient"* and "*older patient"* were no longer neutral terms. I felt young and old at the same time. An illness like cancer forces you to review your life.

The expansion of the patient perspective in my own life was confusing. In some ways, it was enriching; but it meant a lot of confusion internally. Emotionally I was unsure how I could cope with the interviews – and indeed, once I had done the interview, how I could cope the analysis. My own narrative was at the time what Frank describes as *chaos narrative* rather than restitution or quest narrative, a narrative which is often associated with serious illness. – is difficult to articulate (Frank 1995).Looking at it now, perhaps I was worried that I would not understand the participants' experience of their work with older patients easily and at the time being too unsure about my own emotional responses to the narratives of the participants. The researcher needs to have empathy for the experiences of the participants. Empathy, or *Einfühlung*, to use the German word, helps us to understand the subjectivities of the research participants, but strong emotional responses by the researcher may prevent empathetic listening, so the phenomenological researcher cannot to take the necessary passive and receptive stance; cannot adopt the stance of *Gelassenheit* (Crotty 1996).

But awareness of, and reflections on the researcher's emotional responses are integral part to a study like this, and can be also harnessed to clarify the researcher's voice in the research, and to create boundaries and distance between the participant's narrative and the narrative of the researcher, and to be clearer where the narratives meet (Trahar 2009). In this study and because of the timing of the data collection and analysis and the need to orientate myself in my circumstances, to interact with the experience of my own illness and the consequences of the illness meant that the exploration of the relationship and the interaction between the data and me took considerable energy.

4.4 Conclusion

Considering my own perceptions experiences and emotional responses was important to identifying some of my own shifting perspectives in relation to the data. Hearing the participants' stories takes openness, and an awareness of my own stance as a researcher. Rupture in my own life unsettled me; but new perspectives can enrich as well as hinder. Exploring my own position in the project could be interpreted as navel gazing; as too self-absorbed. Indeed, the easier option would have been to be silent. However, I felt that I needed to clarify my own position to increase the transparency of the analysis and interpretation of the data, and the stance from which I hear the participants' stories.

5 Chapter 5: Findings

5.1 Introduction

The findings presented give insight into the research questions. The findings are presented in two sections: the individual case reconstructions (vertical analysis) and the thematic analysis (horizontal analysis). Each individual case study gives insight into the life and the career of the individual and their learning about ageing, old age and working with older patients over time. Each case can stand in its own right.

The second part of the findings emerged from the comparing and contrasting of the individual cases after each case has been reconstructed. The analysis was done keeping each of the cases holistically in mind. The contrasting of cases leads to the identification of commonalities and differences between the cases and common themes found in all the interviews. This helps one to gain a detailed and nuanced understanding of the cases, and the common themes found in the individual case studies.

5.2 Case studies

In the first section five individual cases are presented: Ruth, Elicia, Anna, Zoe, and Michael. The names of the participants, hospitals and locations have been changed.

The reconstruction and representation of each individual case is at the heart of the BNIM. It focuses on the participant's life, and tries to capture the participant's self-presentation of their life in the wider social context in which it was and is lived. The reconstruction is an interpretative process. It builds on the analysis of life history and the life story as told by the participant, and on the identification of the meaning found in the text. Each case tries to show the movement throughout the life of the participant: the transitions, choices, changes, points of crisis, and their personal and professional development.

In the representation, I tried to stay close to the text using the participants words as far as possible.

Each of cases is presented in the following sequence:

1. The essence of the case, which is based on the abstraction of the case reconstruction.
2. Background information and context of the interview
3. The reconstruction of the case: the life and career of the participant
4. My reflections on the case – to increase the transparency of the co-construction of the material.

5.2.1 Ruth

5.2.1.1 The essence of the case

Ruth's narrative tells the story of what it meant to learn look after others early on in her life, and how this led to her having a strong identity as a nurse, dedicated to care for others – especially older patients – throughout a long career in nursing. Her knowledge about older patients, and the way she understood her role as a nurse, coupled with her values – the values by which she wanted to practice – did not sit comfortably with the expectations of the organisations she worked for, eventually leading to burn out.

Ruth kept her curiosity and willingness to learn about older patients throughout her career, extending her theoretical understanding. What she wanted to do most as a nurse, was to look after patients, doing for them what mattered to them most.

At the end of the interview Ruth says:

> *"I feel like I was 20 years too late, on a bike in a small community doing things as people wanted them done, that would have been my role."*

5.2.1.2 Background information to the interview

I contacted Ruth after meeting her through an acquaintance. She volunteered to participate in the interview after having been sent the information sheet. I interviewed her a few weeks after first meeting her. I knew that she has worked as a nurse and had an interest in gerontology. She asked me to come to her house and she was very welcoming. The interview took place in her kitchen. She was relaxed, and was happy to talk with me about her studies and work.

5.2.1.3 The reconstruction of the case: Ruth's life and career story

At the time of the interview, Ruth is in her late fifties or early sixties and retired.

5.2.1.3.1 LOOKING AFTER OTHERS

Ruth is the oldest of three siblings. From about the age of 10 years, she had some caring responsibilities within her family. She talks about that she looked after her two younger siblings, a brother and a sister, while her mother was out at work. Between the ages of 10 to 14, she also looked after her grandmother after school. Her grandmother had heart disease, and lived in the same household, and then in accommodation close by. Looking after others was part of Ruth's life when she was growing up. Ruth emphasised that caring for her grandmother did not involve personal care like washing or bathing. Looking after others was something which was expected in her family, and normal. She describes herself as *"a looker after"* rather than *"being looked after"*.

Ruth did not just look after others in hospital. She started to volunteer for the League of Friends at a local hospital, at the age of 14, being the youngest volunteer there at the time. This seemed not to have been a conscious or explicit choice. *"No idea how or why this"*. As a young volunteer, she enjoyed being with older patients, but she did not like every one of them.

At around the age of 15, while still was at school, she started to consider her long-term career options. Initially she considered an artistic or craft career; but after talking to friends and the school careers counsellor, she also considered nursery nursing, because it is a qualification which can be taken anywhere in the world. She decided to train as a nurse. It is not quite clear from the narration why exactly she chose nursing over, for example, becoming a nursery nurse. However, some motivations emerged for training to become a nurse: a nursing qualification opens doors, and it would allow her to specialise in children's nursing.

Looking after others is not only a theme of her growing up but remains a theme throughout her career as a nurse, as she aims to be available for others, and to look after others, her patients and their families.

5.2.1.3.2 LEARNING TO BECOME A NURSE: TO LIVE AND BREATHE NURSING

Ruth started nursing training just before her 18th birthday. She mentioned that she had met her husband prior to starting her training. She had to choose between two options for her training: to study either a combination of midwifery and gerontology, or of community and psychiatry nursing. She chose the combination of midwifery and gerontology because, as she says, the beginning and the end of life have a lot in common and appeal to her.

She talked animatedly about her training. Having moved away from home, she lived in a nurse's home for three years: living with other student nurses was crucial for her learning and becoming a nurse.

Living with other students in the nursing home was an important source of learning and support to her. She found that talking with her peers at the end of the day meant that she was learning, not only through her own experience, but also from the experience of others. Nursing became her life:

> *"We did not really revise very much but it was our life, you lived it and breathed it, and you did nothing but talk about it."*

She talked about her training as something enjoyable and interesting. As a third-year student, she took the opportunity to teach first and second year students, organising impromptu tutorials on the wards.

She recalled how she accepted responsibilities during the course of her training, and highlighted that nursing students who trained more recently do not have to take on as much responsibility as she had then. She reflects on the importance of dealing *"with many firsts: – first death, first time taking blood*" as all these experiences make you who you are as a nurse in the long term. She told a story about dealing with a patient's death for the first time. Being on a night shift with another student, she took charge of looking after a dying patient. Hinting that the elderly patient did not have an easy death, she looked after the patient in her last hours, as well as the laying out of the body after death had occurred. She recalls not feel particularly affected by the death of the patient.

Any support she received after the event came from the other students, rather than from senior nurses or doctors. The relationship with more senior staff was distant – apart, she remembered, from one supportive senior nurse on the elderly ward.

Talking with her fellow nursing students allowed her to work through and rationalise her experiences. She looked at all these experiences as something necessary and positive; as what made her a nurse.

5.2.1.3.3 FROM BEING A MIDWIFE TO LOOKING AFTER OLDER PATIENTS, LEARNING TO BE LIKE SHERLOCK HOLMES

After three years, when Ruth was about 21, she qualified. Having studied midwifery and gerontology during her training she worked in both fields *"as you do"*. The initial years post-qualification involved significant changes in her personal and work life: she married and became a mother, and she changed jobs several times during those years.

She did not give a lot of detail of her work, but she worked as a midwife and then as a staff nurse in a cottage hospital. She mentioned that she the glow of midwifery started to wear off somehow after she had her own children:

> *"I began to think, after I had my own children, midwifery and the novelty wore off in midwifery."*

So she decided to work in a nursing home for two nights a week for two months because, unlike in the NHS, she could work part-time. She did not refer to the age of the residents, but working in a nursing home motivated her to go back to general nursing.

Years of frequent changes were followed by a phase of stability in her career. From her job in a nursing home, she moved to be a District Nurse working evening shifts, a post she enjoyed:

> *"so, with a young family, and it was a nice way, it was such a lovely job in those days."*

She also attended an ENB (English national board*]* course in the care of older people. The course sparked an interest in older people and formed some of her understanding of working with older patients (*"it really opened my eyes"* (page4)). She learned how many older patients have multiple medical conditions, and how this makes caring for them more complex, and requires an ongoing relationship with them. She describes how working with older people requires the mindset of a Sherlock Holmes: it is essential to give such patients the right treatment and care as, because of the patient's age, there are no second chances.

5.2.1.3.4 THE JOYS AND CHALLENGES OF BEING A DISTRICT NURSE

In the 1980's, national changes to the way in which nurses were graded affected Ruth's ability to progress in her career. The introduction of this new grading system meant she could not promoted to Sister. This left her in an unfavourable position compared to nurses who had less experience but had the necessary qualifications. To enable her to apply for more senior posts, she studied for a District Nurse qualification when her children started school. This allowed her to become a Sister and work as a district nurse in a busy suburban district for eight to nine years while her sons were growing up.

Ruth worked with adult patients, including older patients, in their own homes. There were many changes to her job over time. In the 80s, AIDS was an emerging disease, and some of her patients were early AIDS patients. Other patients had terminal cancer: she describes their situation as ghastly.

> *"……because I was in charge I go from one to the other, one of them was a young lad with a brain tumour, and I remember somebody else was just diagnosed that weekend it was all ghastly"* (page 5).

Her workload meant that she was busy, and this meant having, metaphorically, to put a mask on as she stepped into a patient's house, to appear unhurried.

Many of the older patients she cared for had chronic diseases. She saw her role as being a professional friend, giving them a lot of her time, in some cases replacing family for them. It was demanding, but she describes her relationship with the older patients as that of mutual concern, and it allowed her to find a sense of normality in her working day.

Within the boundaries of her workload, she saw her role as being patient focused, doing jobs which were important to the patient – for example, ensuring that patients had food in the house when they came home from hospital or hoovering. But over time the nature of her job changed from being patient centred to becoming more task orientated. Working in a task orientated way was not how Ruth wanted to practice. Other managerial changes increased the pressure on her to change her practice, including having to discharge patients from her care rather than being available and provide continuity of care, and making it more difficult for the patients to cope.

> *"…it went against my whole ethos of what I was doing really ….and to have continuity of care is, I think, really important."*

She also had increasing responsibilities for providing support for new staff, as she had been in her post for a long time, and was familiar with the area and set up. The combination of these factors led to a deterioration of how she felt about her job, and this eventually impacted on her wellbeing. With hindsight, she realised that she had become burnt out, although at the time she might not have described it as such. She also reflected on working in an interdisciplinary way with other professionals and nurses

5.2.1.3.5 SHALL I STAY BEING A NURSE?

The new ways of working and the other demands led to a crisis in Ruth's career. She left the post she had been in for quite a few years. She kept contact with her colleagues. She recalls that she realised that she needed to learn how create and keep clear boundaries between work and home, but she did not find that easy, even after she left her post. It was during this time that she considered starting another career. She explored the idea of starting something different from nursing. But she had a very strong identity as a nurse which made it impossible for her to give it up. Having started nursing a few weeks before her 18th birthday, being a nurse was her identity, her soul.

> *"I should have thought this is an opportunity for a lovely new career, but when you go into nursing a month before your 18th birthday and the whole world is, is part of you part of your soul really".*

She did not start a new career, but decided to continue nursing.

Searching for other nursing jobs, she worked in jobs for shorter periods of times, frequently changing jobs, but she maintained her focus on working with older patients. She worked as an agency nurse, but found this unsatisfactory, being unsuited to just filling in for others and not having responsibilities. A chance meeting when she went on course led her to take on *"hospital at home"* nursing in an intermediate care setting. Initially she did this on a temporary basis, but eventually this became a more permanent job. Initially she liked the work, but over time her post in intermediate care became increasingly managerial and she left. She did not like being in the office instead of being with patients; it does not suit her as she is a doer, she likes working with patients rather than being in an office.

She pursues her academic interest in the care of older people and studies for a Master's degree in Nursing. She finds studying with other nurses from different specialities, especially from psychiatric background, enriching, because it opens up a new understanding of her work with older patients. Before her retirement she worked in various jobs in elderly care, and project work.

5.2.1.4 Reflections on Ruth's interview

Ruth's story, I felt, was a story reflecting some of the tensions of professional autonomy, the personal qualities healthcare professionals bring to work, and organisational change.

I was struck by the strength of my own emotions when I started to analyse the interview.

I liked Ruth: she was clearly a very committed, caring, and giving person, with a genuine and long-lasting interest in the care of older patients. Ruth's account indicated that she gave a lot of her time to the older patients who needed her. But in giving so much to others – to her family and patients – she neglected to protect herself. In retrospect, she realised that this contributed to her burn out. Her difficulties seem to have been compounded by the way in which the role of nursing changed over time, and as the role she wanted for herself as a nurse stopped matching the organisational expectations of her role.

I was struck how early in her life she learned to care for others. She accepted a caring role within her family early on because that what was expected of her: it is likely that she was not very conscious of the responsibility she had while she was growing up. Her description of herself as *"a looker after than being looked after"* is powerful. Her early identification with seeing herself as someone who cares for others seemed to have influenced how she saw her role as a nurse later in life.

In the narrative, she highlights the tensions created by of having to learn how to draw boundaries between her work and home life. I wondered if having a caring role early in life compelled her to take on a lot professionally later, but as a researcher I felt it impossible and inappropriate to ask that question.

Managing workloads and the demands of caring for others is a tension which is not just Ruth's experience. When I was analysing the interview, I felt a sense of anger

on her behalf, partly because there seemed to be very little support for her to manage the demands of her work. It is not clear, from the interview, if other people tried to protect her from becoming burnt out.

As a researcher, being aware of the feelings the interview evokes in us allows us to search for and understand the participant's emotions. Strong emotions in the researcher can be confusing. Acknowledging my emotions, I tried to stand back and understand Ruth's experience. Reading and listening to sections of the interview several times, I realised that the feelings of anger were my feelings rather than her feelings. She certainly did not express anger or resentment in the interview, but seemed to accept the situation.

Her strong identity as a nurse, which she developed early on, made her very committed to her work, but made it more difficult when the organisation started to expect nurses to work in a more task orientated way, in which she could give less of herself. But organisations seem to find it difficult to see the person in the healthcare professional at times.

Ruth seemed to have a lot of knowledge and experience in looking after older people. She seemed to have a genuine interest in older patients. But a combination of pressures made it almost impossible for her to sustain her work as a nurse. Her narrative contains the story of constant balancing: of giving and taking within the patient/healthcare professional relationship; and of doing the best for the patient, creating a trusting relationship and understanding patients' needs, creating emotional and physical closeness, while at the same time maintaining a professional distance. While Ruth's story is unique, many healthcare professionals find this balancing difficult. This balancing act is something which does not come naturally to everyone; and changing work environments means that many healthcare professionals have to work on it throughout their careers. Ruth's narrative demonstrates some of the pain that occurs when maintaining the balances becomes impossible, and illuminates the interconnectedness between personal and professional identity

5.2.2 Elicia

5.2.2.1 I'm not afraid to be counted

Elicia had a nursing career that lasted for over 40 years. She dedicated a lot of her career to increase standard of care and developing good practice, especially improving the care of older patients. She never gave up. Witnessing poor practice motivated her to improve it. She was not afraid to be counted.

She is confident about her contribution to the care of older people. Her practice is underpinned values, some which she adopted early in her life. Occasionally her values – such as dignity, respect and person-centeredness – and her aspirations to improve the care for older patients were not shared by others in the organisations leading to conflict and turbulence which threatened her career. But Elicia stood by her values and beliefs, and worked hard to be in a position to shape and change care for the better. In her last post before retirement she gained recognition for her work on local and national level.

5.2.2.2 Background information to the interview

At the time of the interview Elicia has been retired for 4 years. She talks about some of her professional experiences of being a nurse, manager, leader, teacher, and change agent; as well as about some of her personal experiences of being a daughter, grand-daughter, wife and mother. When I interviewed her, it was the second time I had met her, having been introduced to her a few weeks before the interview by a mutual acquaintance. She asked me to come to her house for the interview. She came across as confident and determined when she was telling her story.

5.2.2.3 The reconstruction of the case: Elicia's life and career story

5.2.2.3.1 DEVELOPING VALUES DIFFERENT FROM THOSE AROUND ME

Elicia grew up in the UK as the child of immigrant parents from South America. She was socialised into the culture of her parental origins. The family have strong values and beliefs about the care of older people, and dying and death. Those values and beliefs stayed with her throughout her life and became part of her professional values as a nurse.

Very early in life she experienced what it is like to be a patient. Between the ages of 2 and 11, she spent about 75% of her time being a patient in hospital. She recalls being treated well, and has the memory of only one bad experience when a nurse did not explain to her what was going to happen. She says this experience always stayed with her.

At 5 years of age she knew that she wanted to become a nurse. It was around this time, that her grandmother died suddenly and unexpectedly whilst at her family's house. Elicia recalls how, at the time, she was holding her dying grandmother's hand. Telling about her grandmother's death, allows her to elaborate on the beliefs she holds about death. Being present at her grandmother's death, was not alarming to her, because as she explains in her culture, death is not seen as something frightening but is accepted part of life.

> *"In our culture, we are not afraid of death we encourage the family to lay out and the family come and pay their respect".*

She felt that her acceptance and lack of fear of death differ from the beliefs in British Society.

Spending long spells in hospital during her childhood meant that she was late gaining her school qualification. She became a nursing cadet at the age of 16 whilst completing school. In 1965, she started three years of nursing training. From the interview, it is not clear if the training was a significant time for her. She does not go into any detail about her training, where it was, what it involved or how she felt about it, apart from giving a list of the clinical settings she worked in during her training. She did not work with older people very much during her training.

5.2.2.3.2 LEARNING FROM FAILURE

After the completion of her training, she got a job on a geriatric ward. She gives her judgement about the care she observed. She did not consider the care the patients received there as good or acceptable. She recalls thinking at the time, that there must be another way to treat older patients. She found the experience quite unsettling and the experience motivated her to improve the care of older patients.

Near the end of the interview she tells a powerful story in some detail about learning and failure, and this story differs in content from the rest of the interview which focuses on the challenges of improving the care of older people. The story is about not always successful, but had also failed on occasions. She tells a story how a patient on a geriatric ward when she was caring for him died.

> *"…so the very first patient I saw die, died if I'm really honest because of my ignorance."*

She feels responsible for the patient's death.

She describes the pride she felt to wear a nurses' uniform when recently qualified. She recalls that she had been sent after handover to look after a patient, carry out some routine tasks, but when she was with the patient, she did not recognise that the patient was displaying serious signs and symptoms. He had a cardiac arrest whilst she was looking after him. She blames her lack of knowledge, understanding and experience, which prevented her seeking help and possibly saving the patient's life. It is not clear if the patient could have been saved even if she recognised the symptoms immediately; but resuscitation could have been attempted. She accepts responsibility for not calling for help, and interprets her lack of recognition of the seriousness of the situation and lack of action as a time as a failure.

She sees this story as changing her practice, especially in relation to staff she was working with

> *"…and I thought when I have a ward I always say do you understand, is there anything you didn't understand about a patient."*

Elicia identified the need to apply theory to practice, something which was not part of her initial training, and was something she only became aware of subsequently in her career when working as a health visitor.

5.2.2.3.3 SEARCHING FOR SOMETHING ELSE

She moves on to train as a cancer nurse, but does not work in that speciality afterwards. She has mixed feelings about nursing cancer patients; she found it enjoyable, but emotionally very draining. She highlights that it involved witnessing a lot of difficult scenarios adding but does not talk in detail about her experiences.

She views the cancer nurse training as having been valuable to her overall experience. When, later in the interview, she talks about dealing with dying patients, she explains that the time of cancer nursing contributed to her ability to deal with death.

> *"…but the other part may be that people do not like how to cope with the terminal end, certainly doing cancer nursing taught me how to do that, even I come from a culture where death is not seen as the end, I recognise that other cultures they find it difficult to cope with especially in British culture where they do not talk about death."*

5.2.2.3.4 A TIME OF TURBULENCE, AND STANDING BY WHAT SHE BELIEVES IN

Elicia decided that she wanted to increase her experience of general nursing. She works on a renal ward for a few months in a big hospital, and then moves to work in care of the elderly in the same hospital. In the early seventies, geriatric medicine was an emerging speciality and generally seen as a Cinderella service.

Many of her patients came from urban socially deprived areas. She makes it clear that she did not accept the culture of care on the ward she worked on. It was considered sufficient for a patient to be able to move between chair, commode and bed. She decided to change the culture of low expectations and institutionalisation, by trying to create an environment resembling normality. She had aspirations for the patients: she aimed to increase their level of mobility and independence, and to prepare the patients to return home to a better quality of life. She attempted to implement practical changes which would make a difference to the patients, such as having the patients eat at a dining table.

Her approach was not supported by the medical consultant of the ward, who believed that she was fostering unrealistic expectations in the patients. Elicia

herself felt that the patients were not enabled to fulfil their potential. This led to disagreements between Elicia and the consultant not being able to resolve the differences and not being able to see how she could move forward, Elicia decided to leave her post. The conflict reflects the hierarchical structure found in many hospitals, and the power relationship between doctors and nurses. At the time, Elicia was a relatively junior nurse challenging prevalent attitudes. But Elicia could see that, with the consultant's opposition, she would not be able implement the changes she wanted to make.

This would not be the only time in her career that Elicia would be in conflict with senior colleagues about the care she aspired to give to her patients.

5.2.2.3.5 CHANGE, CONFLICT AND STABILITY

After leaving her job, Elicia worked in health visiting. Health visiting, at that time meant she was looking after the whole family: all the generations of a family.

It was at around this time that she married and had a child. To accommodate her new domestic circumstances, she worked part time for a period.

But, missing general nursing, she eventually decided to take on a temporary nursing post in a private hospital as her husband took on domestic responsibilities. After working at the hospital for a few months, she was asked to become deputy matron, a position of influence, where she could introduce changes to practice. She had a wide remit of responsibilities. She describes her role at the hospital as being a change agent, developing staff and, the hospital having been behind the times, bringing the care up to current standards. She stayed in the post for 10 years

She moves to be a matron at another private hospital. She was made redundant after being in the post 3 to 4 years. She explains the reasons for the redundancy. The first reason was that they paid her too much, and then adds that once again she had disagreements with medical directors about patient care. Recognising a repeat of the previous conflict with a consultant, she says:

> *"Again, I upset one of the consultants."*

But she knows that the conflict arose for the right reasons. She stood by her beliefs and principles, she put the needs of the patients first, and this has put her into trouble.

Elicia tells the story of being made redundant as a matter of fact, with no self-pity, or hurt, and without giving a sense of the crisis she might have felt at the time.

Listening to her, I wonder if the situation had been difficult for her; but Elicia does not dwell or expand on the tensions or the impact her redundancy might have had on her personally or professionally, but focuses on what she had contributed during her time at the hospital. She is confident about what she had achieved. She feels that she had made a positive contribution to the hospital. Working at the hospital, she had improved practice and the organisational culture. She has fulfilled her role being a change agent.

"…again, I was a change agent in the other hospital I was a change agent right…"

After leaving this job she went to work in a variety of roles, expanding her experience, but she does not seem to be able to settle into jobs for very long and her career did not seem to have a focus. She works an infection control nurse, a dental nurse, and in a role overseeing staff training for a care agency. But in the wider context of her career, Elicia she sees those nursing jobs as adding valuable experiences and knowledge.

5.2.2.3.5.1 CHANGE AGENT /LEADER AND ADVOCATE FOR OLDER PEOPLE'S CARE

Following this series of short-term jobs, she became a matron for several nursing homes, putting her into a role of manager, leadership and decision maker. Her responsibilities are varied, included overseeing policy decisions, financial management, staff training and care delivery. She then moved to a post commissioning nursing homes. The posts in the nursing home allowed her to develop a recognised leadership role in older people's care.

By the mid-eighties, Elicia had built up a considerable amount of professional experience. She returned to formal studies to complete a nursing degree. She was around 45 years of age at the time.

She tells me the name of the institutions where she studied for her degree. She does not give much detail about her degree course: neither about the content, how she experienced being a student at an academic institution, nor how it linked to her experience as a nurse. The very brief reference she makes to the course, could indicate a lack of enjoyment or that the course lacked relevance and meaning for her.

It is in the context of talking about studying for her degree, that she emphasises that throughout her career she always paid attentions to her continuing professional development, she has an extensive CPD folder: she kept herself up to date throughout her working life.

After completing the degree, she started to work as a hospital matron, this was her last job before her retirement. This was the job in which her accumulated experience and dedication to the care of patients come together, where she could implement and role model some of values she held throughout her career in her practice as well, where she feels successful.

The post brought with it a lot of responsibilities, challenges and tensions, as well as recognition, satisfaction, and support from others. She was in charge of five wards, including stroke care, care of the elderly and long-term wards. She found stroke care particularly interesting.

The job was demanding and, she spends long hours at work. She had to fulfil many roles: dealing with complaints; managing, developing and training staff; as well as providing direct patient care for part of her working week. Providing direct patient care was an important aspect of her job, being part of her professional identity, it allowed her to be a nurse looking after older patients, working along the other nursing staff; and it gave her insight what was going on the ward, and allowed her to role model the care she wanted for older patients. She had the influence and the position to be able to implement good care:

> *"That is an expectation of the role must do practice with the nurses otherwise nobody tells you what is going on, and it is there that I learned about some bad practice and because I had experience of such a wide range. "*

She describes how nursing patients and role modelling good practice, and challenging staff was part of how she taught and developed staff.

The post had many challenges. She tells a story about dealing with a complaint on one of her wards. The story gives insight into how Elicia challenged the actions of one of the members of staff.

Elicia had been aware that one of the patients was dying. The patient's son had stayed at his mother's bedside for many hours. After the patient had died, the son complained to Elicia, that the nurse on duty had not responded to him when he sought advice and support just after his mother had passed away. Following the son's complaint, Elicia challenged the nurse concerned for not treating him with empathy. She asked the nurse to put himself or herself into the shoes of the son who just had lost his mother. She clearly believed that the nurse had not been sensitive to the needs of the son and had failed to support him adequately.

5.2.2.3.6 VALUES AND KNOWLEDGE ABOUT OLDER PATIENT

Talking about her work, she explains some of her values that underpinned her work with older patients, and the values she tried to pass values she tried to develop in the staff she was responsible for. Her view, at the time of the interview, was that we do not have the right people leading care of older people. Nursing older people is heavy and demanding work.

Nurses need to understand the effect of ageing on people: the process of ageing; the effects of institutionalisation; the effects of loss of independence; and that people are just not only old, but that they have a history. Nurses need to be able to see the different roles the patient has and had in life, the patient's biography; and to be able to relate to the person when they are doing nursing tasks.

Considering her own ageing, and how older people are seen in society she sees that older people are seen as a nuisance in society; but she contrasts this to her own attitudes.

> *"But I think it is a wonderful privilege looking after older people."*

She takes this further: it is not merely a choice, but a duty: the duty to provide a high standard of care for people throughout their life.

It was also during that time that she talked at conferences and was invited to sit on local and national committees to develop the care of older patients. She influenced care on a wider level.

5.2.2.4 Reflections on Elicia's case

The values Elicia worked by run like a thread through the narrative. The values of dignity and respect, two concepts she highlighted several times during the interviews.

Respect and dignity are terms which are widely used and understood. It is hard to articulate how to practise with respect and dignity. Professional guidance often seems to include example of what is considered good practice; but giving examples, whilst helpful, can only act as a crude guide, as practice is complex, fluid and always changing. It is difficult to know how healthcare professionals develop their knowledge of how to implement these values in their work.

It is easier to give examples of healthcare scenarios in which these values were absent. As a healthcare professional, patient or carer, it is easy to think of examples where a patient was not treated with dignity and respect.

Small gestures, nuances of body language lasting just a short moment, can convey the presence or absence of these values. As a healthcare professional, it can be difficult be clear about the patient experience; but patients know intuitively that they have been treated with dignity, respect, empathy or compassion. Being rushed tired, or unintentionally careless, can leave the patient feeling ignored, humiliated or even hurt; but the patient might not talk about their feelings. Values can be held consciously or unconsciously, and are embodied in actions, behaviours, the voice, gestures and language. As a patient, I learned that the psychological benefit of being with dignity and respect can make an enormous difference. It helped me, coping with the practicalities of illness, to stay motivated, to cooperate with treatment, and to maintain a sense of hope. Elicia's values were important for her practice, and the patients she cared for.

5.2.3 Zoe

5.2.3.1 The essence

Despite having enjoyed working with older patients, working with older patients as an Occupational therapist is not as a desirable option for her.

5.2.3.2 Background information to the interview.

Zoe had agreed to be interviewed during a university holiday. Zoe decided to be interviewed at my house. I never had met Zoe before: a member of my family who knew Zoe had given her information about the project including my contact details.

We had communicated via text and phone calls to make arrangements for the interview. I was aware that she knew that I was a qualified Occupational therapist. Zoe was the youngest person I interviewed for this study.

5.2.3.2.1 ZOE'S LIFE AND CAREER STORY

At the time of the interview Zoe was 21 years old.

Zoe is one of three children having an older sister who was studying and younger brother still at school. She has contact with her extended family, but she did not talk in any detail about family.

5.2.3.2.2 MAKING DELIBERATE CHOICES

Zoe completed three A -levels at school. She chose her A level subjects before she was certain what she wanted to study at University. One of her A-levels was in psychology.

While still at school, she also worked in various jobs. Since the age of 14 or 15, she had weekend jobs as well as participating in work experience schemes arranged by her school. One of her weekend jobs was working in a shop, but did not like it.

In year 10, she did a two-week work experience at a local school for disabled children. Many of the children at the school were being severely disabled. The work experience was significant in her decisions about the direction she wanted to take long-term.

Working at the special needs school not only made her realise that in the future she wanted to work with people; but it also allowed her to refine her ideas what she wanted to do. Being based at the school for two weeks, she learned about the work the staff at the school do, as well as the work of healthcare professionals who are not based there but who came to the school to work with the children. Seeing the work the healthcare professionals did with the children made her think that she herself might want to become a healthcare professional.

When she was about 16 or 17, she also started to work in an old people's home. She was looking for a weekend job at the time and applied for the job thinking that she might like it. She enjoyed the job, but it was only when I asked her if other people considered her choice of job as strange, she laughs and acknowledges that other people were slightly surprised by her choice. She herself saw nothing unusual in the choice she made.

After choosing and starting her A-level courses, she started to consider which course she wanted to apply for at University. She chose her A -levels before she had decided what she wanted to study at University. Her aim was to go to University. She does not mention any other options e.g. working or pursuing other educational options. In order to prepare her university application (*UCAS*) form, she needed to decide what course to apply for. Knowing that she wanted to work with people, she considered her career options. She considered studying physiotherapy, nursing, speech and language therapy, and occupational therapy, all courses which prepare students for a career working face to face with patients or clients in health and social care, giving care and treatment.

Zoe chose to apply for occupational therapy courses. She highlights how her choice was a considered decision, and not done on a whim. She took her time over it.

Zoe's decision to study occupational therapy was influenced by a variety of considerations. She wanted a qualification that enabled her to have variety in her job. Becoming an occupational therapist would enable her to work with a wide range of people, compared to other healthcare professionals. Additionally, it was also the type of work occupational therapists do which attracted her to that the

profession: the focus on occupation and the option of working in the community and in people's homes,

5.2.3.2.3 BECOMING AN OCCUPATIONAL THERAPIST

At the time of the interview, Zoe was a second-year occupational therapy student at a UK university living away from home. She also worked as a carer for older people in the community during her University holidays. She found that being a carer can on occasions be in conflict to the ethos of occupational therapy she had adopted since starting the course. The time pressures of being a carer meant that she needs to do things for people:

> *"rather than helping people to do things for themselves"* (page 16).

She attends University for tutorials and lectures, as well as being required to complete two clinical placements each academic year, each placement lasting between 6 to 8 weeks. Each of the placements is different. The clinical settings and the patient/client groups vary from placement to placement. Her first placement was in a general hospital; the next placements were in a small mental health unit, followed by time spent in a neurology unit. At the time of the interview, she is completing a placement in a community mental health service. Being a student meant that Zoe has an allocated educator (who is an occupational therapist) in each placement.

From Zoe's reflections about her placement, it becomes obvious that her experience of the way occupational therapy is practised and the way she perceives the occupational therapist's role differs considerably from placement to placement.

5.2.3.2.4 PUSH AND PULL LEARNING IN PRACTICE

Her first placement was at a big general hospital. At this stage of her training, Zoe was not expected to work with patients on her own, she shadowed he work of the Occupational therapist, who is also her practice educator.

Zoe recounts that they covered a lot of wards "*with a big variety of conditions".* The turnover of patients is quick. Her descriptions do not give a sense of the patients she had contact with, the reasons they were in hospital, their circumstances or the age of any of her patients. It is very likely that a lot of the

patient she saw were old. She refers to the medical conditions but not to the patients as individuals. She describes the work of the occupational therapist as involving giving out quite a lot of equipment, and making sure that the patient's home was accessible. She sees no variation in the role of occupational therapist: it is the same with each patient. Her description of her experience focuses exclusively on the tasks the occupational therapist carried out, and not on the patients and the individual differences between patients. She expresses spontaneously how she experienced her work. She reflects how she might feel about working in a similar setting on a long-term basis in the future. She thinks that she might find the work monotonous and boring in the long -term.

The account of her second placement in a mental health unit for older people contrasts with the account of her first placement. The patients in the unit were diagnosed either with dementia, or with another mental health problem. The unit is a small, secure unit, with locked doors. The core team comprised doctors, nurses, and occupational therapists and assistants, with the nurses and occupational therapy staff being in the unit daily. It sounded like a difficult place to work in. Zoe found it an interesting place to work in.

All the patients in the unit were 65 years or older, and many were in their late seventies. Her voice changes as she talks about her experience, her enjoyment and interest in the second placement is obvious, and she reflects in some detail about her relationships with the older patients in the unit. The reasons she gave for finding the placement interesting are because: *"rather than giving out equipment, there were lots of group therapy sessions"*, showing that, for Zoe, the focus on individuals rather than the tasks are what matters to her. The work with patients with dementia was not always straightforward, and was challenging for Zoe. Working with some of the patients with advanced dementia was emotionally hard and she was not always sure how to interact with them.

She describes the working environment in a matter of fact way. Zoe explains that patients stayed in unit for a while, often a few months; so, in contrast to her first placement, Zoe spent time with the patients. When patients were discharged, they often needed big substantial care packages.

Most of the patients were socially isolated. Most of them did not have family, and if they did, the family did not see them frequently. Rather than seeing it as upsetting or negative, this added purpose to her being there, and she talks with confidence about her role as a student *"when I was a student I was somebody new and somebody different, they like that…."*. Many of the patients were depressed, *"and I think a big part of that was maybe because they were really lonely."*

Some of the unit's staff were knowledgeable and passionate about her work with older patients. Zoe learned a lot from an occupational therapy assistant, who she described as being very experienced and she spent a lot of time with her. This added interest to her work.

Her third and fourth placements were in the second year of her course. The third placement was in a neurological unit. It was during this placement that she could see the application of what she had learned over the course of her training. The placement asked for a variety of skills from the occupational therapist; and Zoe, as a student, was given opportunities to apply the skills she had previously learned in her course. She emphasises the specialist nature of the work, and that the staff selected the patients suitable for treatment. She describes the work as intensive. Therapy sessions involved the family and carers of the patients, so they can continue the treatment with the patients at home. Some of the treatment addressed memory or perceptual problems of the patients. Compared to her other placements, in this placement, there was not the separation between mental and physical health:

> *"…the skills I learned on training I actually could also put into practice, oh got to run groups, I got to do standardized assessments,…".*

She has almost completed her fourth and last placement in a community mental health setting.

In all her placements, she spends a considerable amount of time with the placement educator. The placement educator plays a significant role in how she experiences her work. How they feel about their work plays a central role in how much Zoe enjoys the placement, and her motivation:

> *"some of them you can tell are passionate about what they are doing, and that they*

want me to do it."

The practice educator acts as role model for the clinical setting. Zoe reflects how the enthusiasm of educator for their job, how they relate to the patients, and how much they do for the patients and when they go that extra mile for their patients, has a positive impact on how she thinks and feels about the work.

5.2.3.2.5 ACADEMIC LEARNING

As an occupational therapy student Zoe also spends time in lectures and tutorials at the university. When I ask her about the taught aspect of the course, Zoe talks with enjoyment about her time at the university. She emphasises the interdisciplinary nature of the occupational therapy course – some of the lectures and other teaching sessions being shared between physiotherapy- and occupational therapy students, while others are profession specific. She gives an example of how the teaching and learning is structured. She describes a variation problem-based approach to learning. Learning about patients who have rheumatoid arthritis, the students are given a lecture, and then the students are given a case study, which they work on in smaller groups before giving feedback to the whole group and the lecturer.

She describes her experience of being at University as positive, but she also highlights that she did not find all the learning easy. Anatomy and physiology was a challenge, but she really enjoys *"the OT bits*".

In the interview, I asked her more specifically if she learned anything about old age and the ageing process in the taught component of her course (not clinical placements). Zoe tells me that old age or the ageing process was not identified as a specific topic in the curriculum but was embedded into other topics rather than being addressed in specific or separate sessions. She gave one example of a lecture on social exclusion included how that affects many older people.

At the time of the interview Zoe was at the end of the second year of her three-year course. Talking about where she might want work as an occupational therapist in the future, she talked partly about the type of work other students wanted to do in the future as well as about her own thoughts.

There is a consensus in her peer group, she said, in that most people wanted to work in an interesting job. She agreed with her peer group's perceptions. Work with older people was considered lacking in both variety, and the ability to work with patients in interesting ways. This was not because her cohort had ageist attitudes. Her cohort aspired to work in posts where they could get to know the patients, and had scope to work in interesting ways.

5.2.3.3 Reflections of the interview with Zoe

Zoe seemed to like being with older people: she made an active choice to work with older people when she was still at school. It is interesting that, once she had started to study occupational therapy, the opening up of experiences and other options made her move away from working with older patients. The negative attitudes about working with older people seemed not necessarily to be what she feels about older people themselves but, rather, a bad reflection on her experience of organisational culture.

In gerontology textbooks, older people are described as a diverse group of people. Yet services for older people do not seem to be take into account older people's individuality and diversity. Working with older patients is perceived as monotonous, because the way the work seems to be organised in a task-orientated way, stripping the healthcare professional of the power to make decisions about how to work with a patient, and not enabling the healthcare professional to work with patients in an individual and interesting way.

The contrast between working in services for older people and in other adult services seems stark and, in many ways, surprising. Person-centred care for older people, which is advocated by many healthcare professionals, policies and professional bodies, in the quest to improve the care of older people, seemed not to have been the experience of the Zoe's cohort in practice. Yet their experience in other services is that the work as an occupational therapist can be interesting because they are able to get to know the patients, and have a certain freedom to practice.

5.2.4 Anna

5.2.4.1 In essence

Anna's story is one of transition and exploration of opportunities.

Anna has experience working with disabled children and is passionate about that work. Training as an occupational therapist extended her experience of working in different specialities and with different patient groups. Since qualifying Anna has not worked with children. Anna is open to these new experiences. Learning through experience has been very important to her, and has opened her mind to the different opportunities and options she might want to pursue in the future.

Anna has, through her upbringing, a strong connection to older people. As an occupational therapist, she sees that she can make a difference to patients, regardless of their age. Her focus is not on the patient' age, but on their potential. At this stage of her career, she knows that she is suited working with children, but she is not sure if she is suited working with older patients.

5.2.4.2 Background information

I met Anna for the first time at the time of the interview. A mutual acquaintance had put us in touch with each other, and we had contact via texts and email to arrange the interview. Anna had agreed to meet in the house of our mutual acquaintance. The interview was carried out in a room where we were not overheard or disturbed. I knew little about Anna except that she was a recently qualified Occupational therapist whose first job had been a challenge. Because the contact was facilitated I was not sure what information professionally or personally she had about me before the interview.

5.2.4.3 The reconstruction of the case: Anna's life and career story

At the time of the interview, Anna was working as an occupational therapist in a health trust. She was 29 years old.

5.2.4.3.1 MY GRANDPARENTS' GENERATION AND GROWING UP / LEARNING FROM MY GRANDPARENT'S GENERATION

The contact between the generations in Anna's family was significant for her. While talking about her upbringing she spontaneously highlights having spent a lot of time with, and having been close to, her grandparents. Anna's contact with her grandparents' generations whilst growing up has been an important influence on her. This contact has shaped how she views her older patients, now; has given her useful personal skills; and has moulded her personality. Listening to her grandparents' generation has given her an appreciation of their stories; she also become aware of their care needs. She did not provide care for them herself. She knows her experience differs from many people of her age. Not everyone of her age had as close relationship with the older generation as she did. For her being having been close to the older generation, has given her an advantage in her work as an Occupational therapist.

5.2.4.3.2 LEARNING FROM PRACTICE

Anna opens the interview, saying, *"I always wanted to work with children with special needs"*. This was a long-standing ambition of hers. When she was still at school, she knew that wanted to work with children. She did consider becoming a teacher but during her sixth form, she had the opportunity to work regularly with children with complex needs at special needs schools. She loved working there, and it made her consider her future career. She realised that in the future she wanted to work as healthcare professional rather than being a teacher.

After A-levels, she worked and travelled. Returning from travelling she looked for a more permanent job and applied for a post as a therapy assistant post, a post she worked in for almost 8 years. She was based at a child development centre and special schools. Her experience of working with children was very positive, confirming that long term that is what she wanted to do.

Working as a therapy assistant is a learning curve for her. She describes her learning from the bottom up, building her confidence and developing her ability to approach people. The experience had long lasting positive impact on her ability to cope with the demands of her current post as an occupational therapist, making the transition to working as a qualified member of staff in a health trust. Working as an assistant prepared her to work in the NHS, being able to face the difficulties as well as appreciating the services provided.

It was during the time working as a therapy assistant that she started to consider studying occupational therapy, because she liked the profession's focus of on cognition, and the treatment of sensory motor skills.

5.2.4.3.3 BECOMING AN OCCUPATIONAL THERAPIST –EXPANDING HER EXPERIENCE

Anna went to train as an occupational therapist on a part-time University course, while she continued working as a therapy assistant.

The course required her to attend University, as well as do a student clinical placement every year. Each placement lasted six to eight weeks. To meet the requirement of her course, she had to arrange placements to meet specified criteria including working in an acute and mental health setting, and working with older people.

She had an open mind towards her placements. She felt lucky to have a variety of clinical placements. She does not go into much detail about her work or mentions the age of the patients. As a student, she felt well supported in practice and she appreciated the opportunities to expand her experience working in different clinical settings. She worked in clinical settings she would not have necessarily chosen herself, and she considers her placements to have been very good learning opportunities. Anna sees learning through experience as being much more important than being taught in classrooms or books.

Asking her specifically about her work with older patients, she indicated that she worked with older patients in two of the placements, but she does not go into any detail about her work. She does not convey that she did not like her work with

older patients, but explains that she found working with older people then and now very draining.

5.2.4.3.4 TRANSITION FROM STUDENT TO THERAPIST /FIRST TIME I THOUGHT ABOUT THE AGEING PROCESS/ LEARNING TO WORK WITH OLDER DEMENTIA PATIENTS

After completing her university course, she started to work for a healthcare trust in a rotational post. Rotational posts allow occupational therapists to broaden their experience by working in different specialities for a few months at a time.

The transition from being an occupational therapy student to being a qualified occupational therapist was not easy. Once she was qualified she felt that what was expected from her changed overnight. She says that nothing can prepare you for becoming a therapist and it takes time, and working with more senior staff to feel confident as a professional:

> A: *"but for me it is only through experience and working on different rotations that has actually given me the confidence and the knowledge to be able to say actually ok yes we need to get this patient out but we need to also look at this this and this, and again that only comes from working with different seniors, different therapists approaches different teams, different specialities and yet in that you are not gain that from five placements you do at uni, and study, you know you are only going to get that after months and months and months actually being on the ground*
>
> DB: *"yes"*
>
> A: *"and doing it. I don't think really reading books doesn't necessarily prepare you."*

Her first post was on a dementia ward. The set up for a newly qualified therapist sounds difficult. She explains that most of the patients were at least 75 years old and older, and had very complex needs. She describes her feelings of shock, and being overwhelmed by the demands of the job. She was expected to manage a big caseload after a few days of induction with little support from more experienced staff. The pressure of work was confounded by the fact that Anna worked on the dementia ward during a very busy time, the whole team was working under pressure, and had to respond to external pressures. The expectation was to discharge patients as quickly as possible. At times, she felt the patients were not receiving the standard of care that she was used to and felt was appropriate.

The work with the patients and their families was very demanding. Anna highlights that working with dementia patients requires specialised skills and

expertise, but she was lacking confidence in knowledge. The families' expectations were high; the healthcare professionals were expected to solve all the problems the patients had.

The demands and lack of support proved difficult. Additionally, she felt a role conflict what she was expected to do within the organisation she was working with: the main aim was to discharge patient, and the role she was trained to do, as an occupational therapist, was working towards the patient's independence. Her professional role was not recognised within the team; her voice as a therapist was not necessarily heard by other members of the team. For a newly qualified therapist, and being a novice practitioner, who has not had the chance to develop the know-how of practice, the pressures seemed overwhelming.

Having previous experience working in the NHS helped her to deal with the feelings of frustration she felt at the time, and being able to draw on her empathy and personal skills – skills she developed early in life – helped her to deal with the demands of the job.

After about four to five months, she moved from the dementia ward to a different speciality within the rotational scheme. At the time of the interview she worked in her fifth rotation. Working in different specialities, with different therapists and teams, allowed her to increase her confidence and fulfil what she understood to be her professional role, and to become more confident in her professional identity within the multi-professional team.

> *A: "and essentially I'm an OT, I'm not a member of their profession and for me it is reaffirming what my skill base is and also learning where to draw the line when seeing something and thinking actually the best level of care for that person is being met by someone else"*
>
> *DB: "yes"*
>
> *A: "and you only learn that from joint working and understanding the team so yeah it is a massive learning curve, essentially."*

She describes how she felt that the multi-professional team appreciated her contribution to the assessment and treatment of the patients, and that her professional role was respected. Anna portrays a less pressurised environment where she felt nurtured. The positive atmosphere contributed to a learning environment where Anna could learn from other team members, and team

members learning from her. These factors all contributed to her finding a renewed motivation for her job.

5.2.4.3.5 BEING AGE AWARE AND AGE BLIND

Anna reflects on how her learning has taken place in different situations – the learning within the team, different team members interacting and learning from each other; and learning through more formal training opportunities. After working on the dementia ward where the patients were old – or could even be described as very old – Anna feels she has learned about the ageing process through attending training courses by run by the healthcare trust, her employer.

Attending these courses was the first time she had thought about the ageing process; and the dementia course allowed her to become aware of a repertoire of strategies that feel useful for practice.

In the different rotational posts, she worked with patients of different ages, many of them older patients. She gives specific examples of older patients she has worked with.

Anna talks about whether the age of a patient matters to her as an occupational therapist. The age of the patient is irrelevant to Anna, she feels the age of a patient is not an important factor or criteria for therapy. Ageing is not something she has been considering consciously or which is articulated in her work environment.

> *"But it is interesting maybe how people talk about it, it is actually for me I think you find that a lot of the time, people talk specifically about diagnosis, so you know you almost put people in groups, whereas you do not necessarily speak more generically about the elderly population, you speak about dementia you speak about stroke. you speak about COPD but not necessary ageing as an overall, which is maybe something missing from our training I don't know?"*

Anna compares a medical view of old age, and a therapist's view of old age, and sees the therapist's point of view as the way forward. For herself as a therapist, what matters is the ability of the patient to get better: *"so for me, age meant nothing, what mattered was functional levels"*.

Anna's concern is that if healthcare professionals pay attention to the age of a patient, it can lead to misleading assumptions and judgements. With older patients, her experience has been that the assumption is made that the patient

needs to go into a home rather than looking at the ability of the individual patients. However, age is not completely irrelevant when assessing the patient and planning therapy. Anna reflects how, in practice, the age of the patient can matter: the goals an older patient has for themself are likely to differ from those of a patient of working age. However, Anna advocates ignoring the patient's age:

> *"Let people surprise you. And I think too quickly, you could almost plan their future for them, you know either write them off or expect too much of them."*

5.2.4.3.6 OPPORTUNITIES ARE IN OLDER PEOPLE'S WORK, BUT IS IT FOR ME?

Talking about what she might want to do professionally in the future, Anna has an open mind. She misses working with children and still aspires to do so in the future. She is not sure if working with older people is for her, but she is certain that she is not suited to work with dementia patients. She feels that from her personality, she is more suited working with children than with older people. But perhaps she is less definite about where she wants to work on in the longer term. The different work experiences she had as an occupational therapist made her realise *"what is out there"*.

One of her motivations is knowing that she has helped vulnerable people:

> *"I don't know, the more I work in different areas, the more I get to see what is out there, and I do miss it but there are days I do really enjoy my job now, there is a huge amount of vulnerable older people out there, and knowing that you are helping, that is the reason I got into my job, and actually knowing that you helped that is great."*

She likes to help people to be able to make choices about their lives, she is confident that through her professional work as an occupational therapist can she can make a difference.

5.2.4.4 Reflections on Anna's case

5.2.4.4.1 BEING AGE BLIND VERSUS BEING AGE AWARE.

Anna raises an interesting question which arises not uncommonly in healthcare, even when it is not always asked out loud. Does the age of the patient matter, does it matter to the healthcare professional, does it matter to the patient, is it a factor when decisions about care and treatment are made?

Knowledge, professional background, experience, philosophy and ethics come into play when considering if healthcare professionals should be aware of the age

of the patient when they carry out assessments and plan for therapy and treatment.

The professional background affects how healthcare professionals see a patient. As Anne explained, occupational therapy focuses on function what matters is the patient's potential. She acknowledges the patient's age, regardless if they are young or old; but also sees that ignoring the age avoids making negative assumptions about the patient based on their chronological age. This position acknowledges the patient as an individual, and the diversity of ageing and older people.

Ignoring the patients' age and working in an age-blind way might avoid making assumptions and avoid negative stereotyping based on their age. But not taking the patient's age into account can be ageist itself. There are likely to be wide individual variations in how much individuals are defined by their age, but a person's experiences accumulate, and roles change with the number of years lived.

The chronological age can to a degree be part of a person's sense of self. It might also influence how the person themselves sees their life in the present. If the age matters to the patient, should healthcare professionals not also take it into account, and understand what their age means to the patient rather than avoiding the topic of age?

Ageing is individual but also takes place in a social and cultural context. Individuals have their own unique life experiences, but there are also historical events and social changes that define a cohort. Each life stage, according to psychosocial life course theories such as by Erickson and others requires the individual deal with different developmental tasks. Each person does not follow the life stages rigidly, but the life tasks of a twenty-year-old are likely to be different from those of a ninety-year-old. According to Erikson, for example, the individual's main psychological task in old age is to manage despair versus integrity, it is the time when the person reviews their life, its accomplishment and failures (Erikson 1994). If people become frail, they need to come to terms with the impact that can have on their lives, and adjust to loss of physical ability.

Not acknowledging the patient's age might condone inadvertently ageist attitudes: it can be seen as a denial of old age, potentially denying the individual patients' life experience, and the stage of life the person is at. This potentially can have an impact on the patient's sense of self, reinforcing feelings of worthlessness and loss of confidence in the patient.

5.2.5 Michael

5.2.5.1 In essence

Michael is a consultant geriatrician, and dedicated to his work. From early in his career, it was important to him to be knowledgeable and to have extensive experience, so he could look after his patients well. His account of what it is like to become and be a geriatrician is multi-layered. Being a geriatrician means being a generalist with sound scientific knowledge of the body, as well as having an area of expertise.

Apart from having that knowledge, having the right attitude is also necessary. This means being able to work in a multi-disciplinary team, enjoying looking after older patients and valuing them, as well as asking the question why? Michael likes the challenge and has a sense of pride in treating patients that other doctors are not interested in. He became the doctor he is today through working in different medical specialities over many years to build up a wide range of experience, learning as a junior doctor from senior geriatricians, and having had opportunities to get to know and learn from patients.

5.2.5.2 Background information

Michael and I arranged the time and the location of the interview was arranged through email. For the interview, I visited Michael in his family home. I did not know anything about his career apart that he was a geriatrician.

I was conscious that he had time set aside for the meeting. He came across a confident, and energetic. Not realising his age before the interview, I was surprised when he told me his age, as he was older than I had anticipated.

5.2.5.3 The reconstruction of the case: Michael's life and career story

Michael has been working as a consultant geriatrician for 30 years. Not having asked about his age before the interview, I was surprised to hear that he was 66 years old as he looked younger to me.

5.2.5.3.1 BEFORE MEDICAL SCHOOL EARLY MOTIVATIONS

Michael knew from his early teens that he wanted to study medicine. He always had a fascination in how the body works. His mother was a nurse and when he was 17 or 18, he had the opportunity to sit in with a General Practitioner, who was delighted that he wanted to study medicine. He enjoyed:

"…the general side of things; seeing lots of different people, different ages".

After leaving school, he went to medical school thinking that, in the long term, he might want to go into General Practice; but he also went with an open mind about his long-term career. He did not talk about his experiences at medical school, apart from commenting that he did not have any teaching about geriatric medicine during his time there.

5.2.5.4 Considering options for specialisation

After completing medical school and working as a house officer, Michael was not sure what speciality he wanted to go into. He knew he did not want to be a surgeon. He decided he probably would become a GP: he liked the fact that GPs were generalists rather than specialised, but he had doubts about working towards the exams by the Royal College of General Practitioners and becoming a GP. At the time, the exams were not viewed very highly *"it was not considered a particular clever diploma".* Instead he aimed to take the exams of the Royal College of Physicians, which was highly regarded and more challenging. At the time, he could envisage himself having his own cottage hospital in the future: *"I would have been the physician there"*. To work towards his goal, he decided to do his training in general medicine. He did a medical rotation as a junior doctor which included a post in geriatric medicine, cardiology, endocrinology, infectious diseases and gastroenterology

He was inspired by one of the geriatricians he worked with, whom he described as lovely, kind and intelligent. He realised that another reason he enjoyed working in

this field was that he enjoyed the challenge of looking after patients other doctors had no interest in, and this a factor which has consistently motivated him throughout his career.

Despite his good experience of working with inspirational doctors in geriatric medicine, he was also aware, despite only being a junior doctor, that some of the clinical judgements made by some of the geriatricians he worked with were poor, because they lacked the necessary experience and training. Geriatric medicine was a low status speciality at the time.

5.2.5.5 Becoming and being a geriatrician

Michael cannot pinpoint when or why he decided to specialise in geriatric medicine.

When he was working as a Registrar, he was asked to apply for a consultant geriatrician post. He declined to apply for the post as felt that at the time he did not have enough experience, it felt to him that it would not be fair on the patients.

Instead, he moved to take on a research fellowship in bone disease. To maintain his clinical skills whilst doing research, he worked in an outpatient geriatric clinic once a week.

He considered writing an MD (Doctor of Medicine degree), *"but it never happened"*. Michael integrated his knowledge and experience from his time as a research fellow into his future medical practice. He built on his expertise in bone disease, and developed orthogeriatrics as one of his area of clinical expertise; and he developed those services for patients in the locality.

After completing the research fellowship, he started his speciality training as a senior registrar in geriatric medicine. Overall, he felt his training was slightly disappointing. He completed a gynaecology, neurology, rheumatology and dermatology rotation. Gaining experience in all these specialities took time, but for him that time was well spent, because most of the patients who are seen by the geriatrician have multisystem failure, so getting a wide range of medical experience is essential to being able to diagnose and treat patients.

He identified some positive training experiences on the geriatric training scheme. He worked on a stroke unit which was at the time the domain of the geriatrician. It was there that he learned about the different roles of the multidisciplinary team members, and developed skills in management and administrative tasks. In the interview, he highlighted several times that working with a multidisciplinary team is integral to his work as a geriatrician and essential for the care of the patient.

During his specialist training he also learned about "psychogeriatrics", a field he knew nothing about previously.

This wide range of experiences all contributed to making him the doctor he is today. Michael learned from working with different consultant geriatricians over the course of his specialist training. When Michael started to work in geriatrics medicine it was a small speciality where, when attending specialist meetings, the geriatricians all used to know each other. Over the years it has become a growing speciality with many more people attending training events and conferences.

He considers himself lucky working as a junior doctor when he did. Compared to younger doctors today, who have to work to a different shift system, he was able to provide continuity of care to his patients; which he sees as an advantage, because he had the opportunity to get to know the patients and to know what happened to them.

He gave an example of doing social ward rounds in the evening, when he talked to the patients and their relatives:

> *"…you miss that as a consultant, you don't have time just to sit down and chat… Sometimes you learned an awful lot from their experiences"*

He bemoans the fact it is not possible for younger doctors to get to know their patients in the same way because the working conditions have changed.

Michael worked in a variety of contexts during his training: in addition to his work in acute hospitals, he worked in the community, going on domiciliary visits; and in day hospitals and rehabilitation wards.

5.2.5.5.1 BEING A CONSULTANT GERIATRICIAN.

At the time of the interview Michael has been a consultant geriatrician for 30 years. He works part time now. Indicative of his commitment to his speciality is the fact that when he decided to leave his full-time post as a consultant geriatrician, he continued to work in the post for two more years until a new consultant had been appointed.

There are certain qualities of being a geriatrician which motivated him in his career. He likes the nature of the work. Then and now, being a generalist, rather than a specialist is important to him; and that influenced his career choice when he had to make decisions about specialisation. Michael describes geriatricians as the last generalists in hospital medicine, with many of the other medical specialities having a focus on technical skills and machines. Being a geriatrician connects him to his early aspiration before he started medical school to work in general practice.

He did not hold all the geriatricians he had come across in high esteem. For him, it was important to be ambitious and to gain extensive medical experience, rather than becoming a consultant too early. He wanted to show others that you can be a geriatrician and a good doctor.

Michael also elaborated on some of the personal qualities he thinks are essential for being a geriatrician. *"You need to have a personality which enjoys being part of a team"*. Describing some of his work, he expresses professional trust between him and the members of multidisciplinary team. When making decisions about patients, he listens to the various professional opinions and values their points of view. There will be occasions when not everyone is in agreement. Overall, he describes that it is a process of consensus to make clinical decisions, but being the consultant and in a leadership position means that he is aware that, ultimately, he has the responsibility for any decisions made.

At the heart of his work is Michael's enjoyment of his work, and his commitment to his patients. Considering his approach to the patients, he makes a clear differentiation between himself and doctors from other specialities. Many of the patients he sees would be described as frail, and a significant proportion of the patients present as what can be perceived as being dysfunctional. He makes

reference to ageist attitudes present in healthcare, but often the patient themselves are being the most ageist, because they are accepting dysfunctions such as immobility or incontinence as part of the ageing process. When patients come to him, other doctors will have given up on them:

> *"that is the problem with the other specialities, they think that all of the patients are confused and demented, that they are dirty and smelly. But if they are, they are still people who it is worthwhile to sort out"*.

If a patient is not able to give a clear medical history, this does not bother him, and he will persist with communicating with the patient; he values his patients as people. He enjoys the challenge of finding out why a patient is not well, and finding ways to improve their function. His experiences working in the community shaped some of the services he set up once he was a consultant, because he knows that patients can live with support at home.

Michael's motivations to be a geriatrician go beyond technical knowledge and understanding, even he always had a great interest in how the body systems work and was determined to build up his knowledge through working in different medical specialities. He is critical of other medical specialists who rely on technical medical knowledge, and machines to investigate patients.

To work in geriatric medicine, it is important developing the right attitudes and to be and stay curious:

> *"…take things on board which you do not realise you take on board like the holistic approach……but the most important thing is wanting to answer the question why; why is the patient not functioning."*

This motivated him to get more experience when he was a junior doctor, to learn more, in order that he could be a good geriatrician; to prove to others that he was a good doctor.

Finding out what is wrong with an older patient is not always straightforward. But he knows how to find out the information he needs to know from the patient. He likes older people and enjoying the work with older people is a pre-requisite to his job.

5.2.5.5.2 LOOKING INTO THE FUTURE

I ask Michael to look into the future to consider his own old age, if he wonders if he could ever be one of the lonely frail older men he has described. When I ask the question, I do not know how old he is at the time. His initial answer is spontaneous and very clear:

> *"They are the patients, I'm a doctor"*.

He feels protected because he knows he comes from a different social class from his patients; he had opportunities his patients were not afforded; and he knows how to prevent disease through making the right life style choices.

The statistical knowledge that majority of people who become frail are from a lower social class than he does protects him from the anxiety that he might, one day, be an older, frail patient. He knows the statistics on social class and frailty, and they are confirmed by his experience in practice. In his work, he does not see patients who are highly educated, although there are many highly educated people in the geographical area he works in.

He considers what he had said, and adds:

> *"Perhaps I should worry about it, but I don't."*

Chronic disease is not something that is going to happen to him; but dealing with chronic diseases is a speciality itself, is part of geriatric medicine.

Talking about his views on his own old age and coming to the end of the interview, he remembered that he had also worked for a few months in a hospice where he learned about palliative care:

> *"I spent a few weeks learning a little about palliative medicine, and certainly part of, again it is a certain way of thinking".*

Unlike some doctors who see death of a patient as a failure, he feels if everything which can be done has been done for the patient, and the patients dies a dignified death, "…then I think that is a job well done, I'm quite happy. "

5.2.5.6 Reflections

Understanding how the body works is essential to being a good geriatrician. But Michael is not only making reference to the body in purely scientific and medical terms, he refers to the bodies of older patients and how the patients are

perceived by other hospital specialists. Old age and the body feel like an important issue because it can be linked to the image of decline, disability, loss of attractiveness.

Michael differentiates his views from those of other doctors who are likely to give up on older patients. He does not give up, but expresses a sense of curiosity, of needing to find out if something can be done for the patient, changed for the better. This sense of wanting to find out, to act, comes across as being associated with having a sense of pride of being able to treat and help an older patient, being hopeful for them, and having a strong commitment a group of people who are not always well understood by others because the way the can present themselves. Michael translates this curiosity and hope into action, if something can be done, then the patients can function better. Michael shows compassion for his patients but does not identify himself with them. He has a high degree of certainty that he can protect himself from becoming like one of his patients. He knows that the opportunities he had in life and the knowledge he has about the different body systems can help him to prevent the onset of chronic diseases. He feels a high degree of control over his body.

5.3 Themes

5.3.1 Introduction

In the previous section, each case is presented individually, the five case studies show the life and career story of each participant over time. Once the reconstruction of each individual case was completed, themes were identified for each of the interviews, and categorised into thematic domains. The thematic domains were compared between the case studies. This section presents the thematic domains identified across the cases. The themes were identified with the overall research question in mind: how did the participants learn about old age and working with older people throughout their lives and careers. The analysis is guided by the theoretical understanding of adult and professional learning theories and professional practise.

5.3.2 Experiences of older people growing up

All the participants talked about their experiences and the relationships they had with older people either in the family or at work whilst growing up.

Ruth, Elicia and Anna talked about their close relationships with older family members when they were young. Zoe and Ruth looked after older people in a care home and in a hospital while still at school.

Ruth describes how she looked after her grandmother; Zoe worked in a care home; and Anna highlighted that she was aware of the care needs of her older relatives, although she did not provide the care herself. Elicia talks about the cultural values held within her family, which shaped her views of older people.

In her late childhood and early teenage years Ruth looked after two generations in her family: there was an expectation that people would look after each other. She took on the responsibility for some of the daily domestic chores, and made sure that her grandmother was alright.

> *Ruth:* *"I looked after her, sort of everybody, because we lived together… I would come home from school and cook dinner, I did the shopping and generally it was just expected of me, I don't remember, I was not a slave child or anything, it was just something we did. "*

She identifies that she took on a caring role within the family:

Ruth: *"I looked after my grandmother had a heart attack when I was about 10.*

DB: *ok*

Ruth: *so perhaps I was in a caring role because I had to look after my sister and brother."*

Early on looking after others was part of who she was:

"I was the looker-after, rather than being looked after."

The role of looking after others had some positive connotations for her. She describes herself as a *"bossy-boots*", indicating a sense of being in control, being able to tell others what to do.

Elicia does not describe whether she herself had caring responsibilities for the older generation within her family. She links her passion about older people to those early influences, growing up with the cultural values and beliefs which her parents and grandparents had brought with them from South America. Older people were cared for by the family:

"we had a lot of people in the family and we always cared for the older people and I think that is where my basic passion emanated from, because my grandmother, especially my grandmother on my mother's side was a remarkable lady."

The cultural attitudes towards the care of older people held within her family differed from those prevalent in British culture.

"She died quite young, she died holding my hand, she died in our house suddenly. One day she came to visit my mum and dad and she died suddenly, I was there when she actually died. In our culture, we are not afraid of death we encourage the family to lay out and the family come and pay their respect when they are still there, so we see it and we are involved in it, my values come from the belief in the family."

Her story not only reflects how death was viewed within her family, but also a physical and emotional closeness between Elicia and her grandmother.

Anna elaborates unprompted on her close relationship with her grandparents' generation, and the significant influences that had on her.

Anna: *"Yeah, I think not everyone has that you know, and have grandparents but I spend huge amount of time with that generation of my family.*

DB: *OK*

Anna: *And yeah I think, that probably has, I think that shapes your personality doesn't it and also perhaps I was exposed at such a young age to care needs."*

She did not care for the relatives herself, but she feels that the relationships she had with her grandparent generation shaped her personally; in particular how she deals with her work as an occupational therapist. Comparing herself to her peer group, she feels she has greater insight into the lives of older people than many of the recently qualified therapists.

DB: *"what it sounds like your training or your education has shaped the way you think about things*

Anna: *yes. And possibly personal experience, because I think you know I grew up with my grandparents' generation and their brothers and sisters, so I was obviously very lucky to have experience of the older generation and creating relationships with older people…"*

This insight helps Anna her in her job as an occupational therapist in a pragmatic way. She feels at ease in talking with people, and it allowed her to develop a fascination and appreciation for the stories of the older generation.

Anna: *"…and don't have and don't ever really feel uncomfortable going to speak to anybody, and that is probably growing up yes I have had the opportunity to speak to many different generations, and again I see that for, it does make me sound so judgemental, but if you see people much earlier than graduates, yes they put on a ward and they have to strike up a conversation with someone in their eighties or nineties, well if they never had to do that before it is very hard, whereas it sounds really silly because of my grandad's generation, all of his brothers, were in the war and I grew up with those stories, and so you know I find then it very easy to start a conversation with someone of that generation, and also generally, I always was so fascinated by stories which I was told, still now I'm fascinated to hear anything by anybody. "*

Zoe and Ruth had regular contact with older people outside the family, helping to look after older people in care settings. Zoe chose to work in a care home at weekends while still at school. Ruth also worked from the age of 14 years old as a volunteer in a local hospital.

Ruth: *"And I started off even when I was 14 is used to go up to X Hospital (name of local hospital) to B. Ward taking out old people's teeth and giving them drinks. I was the youngest member of the league of friends of X hospital (name of local hospital). I have no idea how or why I really can't remember.*

Zoe applied for the job, she preferred working in a care home over other jobs she might have chosen.

DB: *"How come you found this basically a Sunday job, I mean you could have worked in a shop or something?"*

Zoe: *"Yeah, yeah, I think, I just, I don't really know, people ask me quite a lot, I do not really know, I sort of was looking for something and then I saw that, and I thought I quite like the idea of doing that, I did really enjoy doing that."*

Both enjoyed their work overall. Ruth talked about how she experienced two of the older people she was looking after, enjoying being with some patients but not with others.

Ruth: *"…and she had me chasing looking after her cat Tiggy who had gone missing… it was just so sweet and she was so happy… And equally, I remember a lady on one of those private side wards who was ghastly, and the room stank of twee perfume, and so I was under no illusion that older people were dear old ladies making me chase after elusive cats."*

5.3.2.1 In summary

The participants spent time or worked with older people before their initial professional training, these experiences can play a role later in their professional lives.

The relationships the participants had with older people growing up were with family members, such as grandparents as well as working in care settings with older people.

Three of the participants described the close relationships with older an older person(s) within their family, and these intergenerational relationships made them aware of the care needs of the older persons, and learned about the cultural values which their families held about older people. Working in hospital or care homes gave both Ruth and Zoe experience getting to know and looking after older people.

5.3.3 Formal Learning

The participants talked about the learning about old age and ageing during and since their initial training for a professional qualification. All of the participants' training included both classroom learning, and clinical placements.

Elicia and Ruth did not take degree courses initially: they trained to become registered nurses, working towards a degree in nursing later in their career. Much of the training took place on the wards. Anna and Zoe were both studying for a Bachelor's degree in occupational therapy – all occupational therapy courses in

the UK are now integrated into the University system. Anna and Zoe worked with older people for some of their clinical placements as occupational therapy students. Anna and Zoe described topics around ageing which were embedded in other modules within the taught curriculum.

Ruth was the only participant for whom the care of the older person was an explicit and formalised component of her pre-qualification training. She continued to participate in formal education, attending courses about the care of older people, early and later in her career.

Choosing her pre-qualification course, it was her interest in midwifery which motivated her to enrol on a course which had a focus on midwifery and gerontology.

Ruth: *"So I chose I always wanted to do midwifery, so I chose midwifery and gerontology and really enjoyed them both."*

She does not give any details about the content of the course or what she learned about older people. The course was structures in blocks, the student nurses rotating between working on wards, and attending lectures and other teaching session.

Elicia does not recount working very much with older patients or having formal teaching session during her initial training, or later when she studied for a nursing degree. During the interview, she only very briefly gives an outline about the content of her initial training; she does not elaborate about the content of the courses she attended when she was a student or about her feelings being a nursing student. She attended courses for CPD, if she attended courses about the care of the older patients as part of her continuing professional development.

Anna and Zoe, studying more recently, attended degree courses to gain their professional qualification. Anna explains that during her pre-qualification course she did not learn about old age and older patients as a specific topic or dedicated module during the academic component of her course, but that the link between the patient's function, medical conditions and age was considered.

Anna: *"I think that it was never like a specific module you know it was never focusing on the elderly or older population, it was always integrated in your study because obviously we learned obviously a lot about the*

functional impacts on a variety of conditions and then obviously on a variety of age, but I would say it was never a specific focus to say yes for the next term older age is young to be our focus it was never that specific."

Anna's course required her to demonstrate that she had gained experience working with older patients for part of her student placements, but she does not recall thinking about the age of the patient at the time.

DB: *"…because when you went out on placement obviously your client group how you say quite a few of them were old, was that something you expected, or you just walked in or you never think about it?"*

Anna: *"I don't think I ever thought about it really. I think it is just kind of learn as you go which I think in a way it is positive because then there is no prejudgement about age necessarily, but I do feel that I still kind of have a scope to learn more about the ageing process and I think that in a very generic way would have been very useful"*

Anna talks about taking an age blind approach to patients and what this means for professional practice in more details in other parts of the interview.

Zoe also did one clinical placement specifically with older people in a mental health unit as part of her pre-qualification course. It is very likely that she worked with older patients during her first placement which was in a big district general hospital where the occupational therapist assessed patients for equipment before their discharge home. Hospital statistics show that two thirds of patients admitted to hospital are over 65 (Cornwell 2012). Talking about her first placement, she does not make reference to the age of the patients she worked with. Reflecting on how she learned about older patients, she talks about her second placement in a mental health unit for older patients, and the importance of having daily contact over a period with older people.

Zoe: *"Well I think well personally, it is from working with old people and spending time with old people, just because, it is like with any group of people, I think you sort of learn from having to spend time with them, I do think the placement where they were all elderly was the one I learned the most because I was with them all day, like Monday to Friday, I was always with older people so I think that is where most of my learning took place really. "*

Zoe enjoys attending university as part of her occupational therapy course. She explains that the teaching and learning about ageing and older patients is integrated into the curriculum through case studies or embedded into other lectures, and not taught in separate or identified sessions.

DB: *"Do you learn anything specific around older people?*

Zoe: *Yeah it is hard to describe because we do, but it is never done specifically. For example if we have done a case study, and it is not per se on older people, say a case study on rheumatology and then they say so and so is the elderly, when we feedback, or the lecturer gives us feedback, they will tie in the fact that they may be older or what should be done, or when we learned thing before, when we learned about social inclusion they are often to bring up things like that older, the older generations are more likely to experience this, and it is important when working with older people, so although there is no set bit on like older people, they try kind of tie it into other things, if that makes sense."*

From this quote, it is not clear how much the students are encouraged to engage with the topic of old age at a core subject, or when working on a case study, as guided towards finding information.

Ruth and Anna both attending courses about older patients or the ageing process after qualifying. For both, it sparked an interest in understanding the impact on ageing on patients. Ruth worked towards gaining more nursing qualifications, attending an ENB course; Anna attended in service courses run by her employer.

For Ruth, her curiosity to understand of the medical care of older people started early in her career, Ruth attends an ENB course1 about elderly care when she changed from being a midwife to working as a district nurse. The course made her appreciate the complex nature of working with older patients because medical conditions may present differently in older people. She reflects how this understanding impacted on her practice,

Ruth: *"…also you know, if I get an UTI, I have, I get particular, you know, the signs and symptoms one gets in adult life. If an older person gets an UTI, the multipathology of old age is just so much more interesting and also requires so much more skill from the nurses, therapists, doctors, whoever*

[1] http://discovery.nationalarchives.gov.uk/details/r/C144 were courses which complied with the standards of the English Nursing board. (ENB).

to diagnose that is what I'm interested in, and you can't just go in and give the antibiotics and walk away which often people do hmmm it is rarely as simple as that."

Ruth highlights that working with older patients requires a combination of experience and training, but that is not often recognised.

Ruth: *"it is so frustrating that the general view is that the people who are the, the least experienced and the least trained should go and working with older people because to me it is the other way around it is the people who are the most experienced and are the most trained should be working with older people."*

For Ruth, attending a Master's degree course later on in her career helped her to develop her knowledge further. She found the interdisciplinary nature of the Master's course, and the other students coming from different specialities, particularly helpful in allowing her to develop her understanding of psychological and psychiatric problems in older patients. Only she and one other student followed the *"care of older patients"* pathway.

Ruth: *"Oh yes. It was good to see different perspectives, because you can get very community orientated or very hospital orientated, and I particularly liked to work with the people from the psychiatric side, because it is one of those undervalued areas and there seemed to be so little research and so little interest it always seemed to be the poor relation, yet it affected well, as a district nurse it was one of the most important things because it was one of the main reasons people fell, or were not functioning at home, or what have you it was one of the most difficult to treat because there wasn't the help out there, so working with her was very useful."*

Anna is at the beginning of her career and only recently qualified. Since qualifying as an occupational therapist and after having worked on dementia wards, she attended in service courses, one about the ageing process and another one on dementia care. She identifies attending a dementia course as relevant for any healthcare workers, regardless of the speciality they are working in. She sees as benefit of being taught by expert professionals as allows her to feel more prepared for clinical practice, and allows to increase the skills she can draw on in practice:

Anna: *"…so I think that I think again it's a balance the fact I like very much having some taught knowledge, so being able to sit down especially with specialists professionals who have that knowledge have that experience talking you through things, because then if you go onto a ward you are able to on to put into practice the techniques or the suggestions, the approaches they discussed, but also when you see something rather than coming away and thinking what was that you think ah this is probably*

related to this this and this and related to this this and this and…"

DB: *"yes"*

Anna: *"So I think training is essential to be able to understand what you are doing."*

Anna thought about the ageing process for the first time one year after she had qualified.

Anna: *"…one of the team leaders did something specifically an education session on the ageing process, and you know it probably sounds sort of awful so that was about a year after I qualified, and I had never even had thought this about the subject. The idea of the ageing process had never crossed my mind, and I don't know whether that is a good thing. It means I'm not judgemental or whether that shows a little bit of a hole in my knowledge."*

During the pre-qualification course, learning about ageing, old age or working with older patients was not necessarily named as a topic to be studied, but was embedded into other topics in the academic curriculum or in clinical practice. During the student clinical attachments, the participants worked with older patients in mixed settings, and in settings exclusively for older patients. The participants did not necessarily refer to the patients' age, and were neither conscious of the age of their patients, nor thought of it desirable to consider the age of the patients whilst working with on clinical placements pre-qualification, unless the placement was exclusively with older patients.

Courses post-qualification were seen differently. Attendance on courses after working with older people in practice about sparked curiosity about the ageing process and older patients, and helped to develop an understanding of how to work with older patients, and possibly added to the motivation to extend theoretical understanding about old age.

5.3.4 Perceptions, values and feelings

Healthcare professionals' perceptions, attitudes and values are part of tacit knowledge: knowledge which is not always conscious, or easily articulated by the individual. Healthcare professionals learn in and through experience in practice, though how this learning takes place is not easily understood. When learning occurs, experience is transformed into something meaningful which will be taken into the next interaction (Jarvis 1983). The healthcare professionals talked about

their work with older patients, how they perceived their lives of their older patients, and how they felt about their work. Perceptions individuals have of others are linked to experience; and with the interpretation and the emotions associated with those experiences. The perceptions healthcare professionals bring to their work with older people can influence how the healthcare professionals make meaning of their work with older patients, how they see their professional role, and have an effect on how older patients are treated and cared for. It can influence the motivation to work with older patients.

The participants did not talk necessarily about a specific or a one-off experience, but made reference to their accumulated experiences, referring to older people in general, or to groups of older patients with specific medical conditions, and in some instances to an individual patient.

Some of those perceptions the participants held about older patients became clearer, or came to the forefront, when the participants talked about the differences between working with older and younger patients.

5.3.5 Dealing with complexity

The needs of older patients, especially frail older people are often complex. Preparing healthcare professionals to deal with complexity and uncertainty within professional practice is seen as a challenge in the 21st century healthcare, which provides healthcare for an increasing older population.

Ruth, Elicia and Anna talk about the complex needs of older patients. Ruth and Elicia, talk from their positions of having worked with older patients over a number of years, and both discuss from the difference working with younger and older patients drawing on their professional experience.

> *Elicia* *"I think there are seminal things that are different when you are working with an older person, and I think number one is, if they are having medical problems, they are much more complex unless of course you have a younger person with cancer or something like this, if you are talking about general medical conditions they are much more complex."*

The complexity of older patients' needs can be a challenge, and increases the responsibility on the healthcare professional to get the treatment and care right

first time around. While the responsibility is higher, it is still possible to make a difference to an older patient.

> *Ruth: " Because you got to be Sherlock Holmes sometimes what you do can make a difference between people coping meanwhile the younger person you can try something else and if it doesn't work it does not work you know they got their health, they recover eventually with older people if you try something and get it wrong, If you misdiagnose whether in a social or psychological diagnosis, I'm not talking sort of medical diagnosis, I'm talking generally if you miss to diagnose something, they might not have that second chance."*

Ruth describes the reasons why the medical needs of older patients are complex to deal with as a nurse:

> *Ruth: "whereas older people you can dress the leg and given them antibiotics and the antibiotics don't work and the leg never responds as quickly, and you can't put this type of bandages on an older person because they have arterial problems as well as bad veins and it is never or rarely straightforward, and there is always another element to it."*

Anna and Zoe are at their beginning of their careers. They describe how they experienced working with patients with complex needs. Anna describes in two different sequences of the interview her experience and feelings working with different patient groups with complex needs.

At the beginning of the interview, Anna talks about working as a therapy assistant with children with very complex needs.

> *Anna: "And I just really enjoyed it really enjoyed working with children especially working with children with more complex needs and just found it very, very interesting."*

Later in the interview, she talks about her first post as an occupational therapist working with dementia patients. In contrast to her work with children, she expresses her feelings of self-doubt while making the transition from being a student to being a qualified therapist. It is not uncommon to experience the transition from being a student to working as a qualified member of staff as difficult, but feeling unprepared for her work exacerbates the crises she experiences.

In this sequence, Anna recalls some of the anxiety about her own knowledge and skills she felt at the time:

Anna: *"and that is a specialist area you know in as das as I'm concerned very complex client group, very, no only with the sort of complex needs of the patient, but what I felt with an incredible responsibilities of to be able to manage the family's expectations."*

Anna: *"…and I think for a newly qualified therapist with the best experience in the world, when you are sitting down with the family you know crying at you, they are so upset, you know what do you do with that, your own empathy and personal skills obviously kick in, but actually I feel there is a level of competence that you need to have gained to actually be able to sit there and take the responsibility as a therapist and provide information to that family and make sound clinical judgements."*

Anna: *"when you don't have you know the basic knowledge about thinking, about working with people with dementia, the basic knowledge around cognition and cognitive changes, and behaviour and managing behaviour, then you find yourself almost firefighting, and literally almost just being a discharge planner."*

Zoe talks about her second placement as an occupational therapy student. Like Anna, she worked with patients with advanced dementia. She echoes the feelings of insecurity Anna had, she is unsure how to approach or respond to some of the patients.

Zoe: *"It was quite hard, especially with the people who were already quite advanced in their dementia, because it was quite hard what was hard what to do or what to say to them, you were never really quite sure how much they would take how much they would be able to comprehend"*

Caring for patients with complex needs can make a job more interesting and demanding. It adds to the responsibilities of the healthcare professional in terms of problem solving. How the participant experienced complexity of the patient needs depends and level of experience and the patient group they are working with. The participants with many years' experience saw it as a challenge they dealt with. On the other hand, feeling inexperienced and lacking the necessary knowledge made the participants feel less confident in their interactions with the patients and families. This made the experience working with older patients with complex needs more difficult, and burdensome.

5.3.6 The lives of older people and the impact on feelings and practice

Ruth, Zoe, Anna and Elicia see the lives of older patients as lonely and isolated; and describe the absence of families of the patients compared to younger patients. Additionally, older people can become emotionally vulnerable when they become patients. The participants talk about the impact these factors have on them.

In various places in the interview, Elicia talks empathetically about the feelings of vulnerability of older people when they are in hospital. Patients bring experience, their own assumptions and beliefs with them.

> *Elicia:* *"They come with their own particular experiences of life, their own prejudices, their own premonitions and preconceived notions of what it is coming into hospital. For instance, I know a lot of older people still even in today's world see the hospital as the end. A lot of people going into nursing home, they go in there with trepidation and fear."*

Elicia sees a difference between an older and a younger person when they become patients; this difference means that they are likely to behave differently. Every patient feels vulnerable; older people have a heightened sense of vulnerability, and at the same time have a decreased ability to articulate and to stand up for themselves.

> *Elicia:* *"You should treat all people with respect and dignity, but older people, I don't know if it has to do with getting older but they feel less able to articulate. Right, they feel much more vulnerable. You must treat everybody the same but older people seem to lose the ability to stand up for themselves."*

Zoe paints a picture of older patients being isolated. She talks about the isolation of older people with some empathy and understanding, and the social isolation of the older patients added purpose to her being with them when she was a student.

> *Zoe:* *"When I was in the mental, the secure one, everyone in that service was 65 or over and some of them were like sort of in the late seventies, so some of them were actually quite old, and I think as well, especially, when they were sort of in there for a quite a long time really do not have any people or people who ever came to visit I think they did like just having, especially when I was a student I was somebody new and somebody different, they like that, because some of them didn't have, some of them, quite a few of them never had any visitors or no one ever came to visit them. "*

Zoe's awareness of the isolation of many older people extends beyond the confines of the mental health unit, it is also her experience when working as a carer in the community.

Zoe: *"…but actually there are some people I go see, that is just a companionship call, although they are elderly they are still capable of doing everything for themselves. I think they are just lonely, and you literally just go and have a cup of tea with them for half an hour, and just because they don't have anybody else to see, basically."*

Anna worked with older patients on a dementia ward, as a student on clinical placement and in her recent rotational post. She describes her feelings of profound sadness when working with older patients, because she knows that they are isolated. How she feels about working with older people cannot be separated from who she is as a person. She describes herself as an emotional person, and her work impacts on her. She describes contrasting feelings hope when working with children versus sadness when working with older people.

Anna: *"I found and I think I still do find, working with some areas of elderly care very, very difficult because, I think, working with children even if you have children with profound difficulties, for me they are young and there is always that hope that actually things could change, things could develop, I think what I find so sad really because I think I'm quite an emotional person anyway that actually working with some elderly people I just find it so sad how lonely their lives are, and how little support they have, and that really sort of kind of just pulls at my heartstrings."*

But it is not only the knowledge that older people are socially isolated which can cause difficult feelings. Medical conditions can be distressing to patients, and witnessing this distress can have an impact on the healthcare professionals. Zoe talks about her feelings being with patients who are distressed.

Zoe: *"They weren't so aware because it was quite distressing for them, and you could tell that they were not very content, and that they were actually quite distressed so that was quite upsetting after seeing people who were like that."*

Working with older people means accompanying some patients at the end of their lives. Ruth accepts mortality. The death of a person at any age is difficult, but the suffering and death of an older person is somehow easier to bear than the suffering and death of a younger person:

Ruth: *"I think, I think, you know with any age group if you know that somebody is really suffering but equally it is very hard when you got young people die, I mean none of us is going to live forever."*

DB: *No.*

Ruth: *"It is a tragedy if you die young and it is a tragedy if you get old sometimes because when you watch all the people you know they died you know and you really on your own, and working in places like W… …..but I think you are right it is much easier when people are older it is still very sad and you still shed a tear, there were times when we spent half our time in crematorium in T" (laughs).*

DB: *Right.*

Ruth: *"…at funerals and things"*

Healthcare professionals have to learn to manage their emotional responses to patients and events. They can be affected by the death of their patients, but Ruth found the death of an older patient less distressing than the death of a younger patient.

The patient's behaviour and emotions can influence on how they are treated by staff. Elicia expresses her shame and criticism about how older patients (compared to younger patients) are treated by some staff:

Elicia: *"I think that what nurses can get away with I say nurses because they are the largest group of carers… That sounds dreadful because I'm talking of my own profession, but this is what I feel and what I witnessed. And I sometimes feel that nurses become, they can't do it to a younger person so much because a younger person is not afraid so much, to voice and to challenge and confront. Where I find a lot of older people are more afraid to do it. But because they are more afraid to do it, but when they do it, they are labelled troublemakers."*

DB: *"Right."*

Elicia: *"I might be wrong, but this is my experience. I'm being very honest with you".*

Zoe reflects on the thoughts of her university cohort, and what it is like working with older people. At this point in the interview, she is considering the type of work she might want to do in the future. The perceptions her cohort have, how they see older people and their work with older people, and the work structures they have to work in all have a significant effect on the motivation for her and other students to work with older patients:

Zoe: *"as a general consensus, I think people do not tend, not that they do not like older adults, but no one's real ambition is to work with older people, because when I'm amongst my cohort and you say "oh, what are you interested in doing once you qualify, like want to do something exciting" they always say "I want to work in something like alcohol and drugs rehab" or "I want to work in neurology", meanwhile no one ever says "I*

want to work in a falls clinic which probably will be old people". No, many people seem to express that thing."

DB: *"Why do you think that is?"*

Zoe: *"…say I imagine a lot of hip and knee replacement are in older people, it is kind of, well from an OT setting, well just giving a lot of equipment, making sure their house is alright; whereas and it is quite quick and so is a falls clinic really, going to assess their home, and it is quite quick, quick meanwhile the other stuff the thing people seem to be very interested in like alcohol and drug rehab that every patient is very different , there is a lot of different things you can do, you can spend a lot of time with them."*

Zoe draws on the views of her cohort that working with older people compared to other option available to occupational therapists, is not seen as a desirable career choice. Zoe describes her work with older people is as monotonous. The organisation of services and the time spent with the patients did not to allow her to establish meaningful relationships with the older person, see the older person as an individual, or respond to the older patient individually. The diversity and individuality of old age, the variation in preferences, values and needs of older patients seems to be subsumed and lost.

5.3.6.1 In summary

Ruth, Elicia, and Zoe found that working with older patients can be different from working with younger patients.

The participants knew that the medical, psychological, and social needs of the patients were more complex than those of younger patients, and required understanding, sensitivity and humanity on part of the healthcare professional. Older people feel vulnerable when they become patients.

Anna did not think that the age of the patients necessarily made a difference. The chronological age of the patient should not matter in terms of therapy offered; but when talking about her own emotions, she found it draining because of her experience of the social circumstances of older patients. All the participants saw the lives of their older patients and older people as lonely and isolated. Knowing that older patients were isolated impacted on how they experienced their work with older people, and can, in itself, be upsetting for the healthcare professional. It influenced how the participants defined their roles towards their older patients, older patients need more continuity, advocacy, and understanding and time.

5.3.7 Values underpinning the work with older patients

Values are part of tacit knowledge. Values underpin healthcare professionals' actions. Some of the values which healthcare professionals are expected to adhere to are specified in profession-specific standards and behaviour. But the values an individual healthcare professional hold are not necessarily conscious, and have not necessarily been learned explicitly; they are adopted through lifelong socialisation, including primary and professional socialisation. Healthcare professionals might also adopt values found in their specific work settings. Different workplaces have their own cultures, beliefs and values.

The participants were not asked explicitly about the values which underpin their work, but as they articulated their experiences, they expressed some of their values and beliefs.

Values were identified during the analysis, and then categorised into three topics: seeing the patient as a person: giving choice to patients: and those values that shape the relationship between the older patient and the healthcare professional.

5.3.8 Seeing the patient as a person

Seeing the patient as a person is related to the concept of personhood, and person-centred care. Initially written about in relation to dementia care, giving person-centred care has been identified as especially important in the care of older people.

Elicia made explicit some of her values which underpin her practice, early in the interview:

> *Elicia:* *"My speciality was older people, I'm very passionate about, I was, I'm still am very passionate about. And I was passionate about professional care that they are being treated with dignity and respect."*

Elicia sees the patient is an individual who has a history, who has various roles in life, and who can feel stressed and vulnerable when they are in hospital. She aimed to cultivate this understanding into the staff she was working with:

> *Elicia:* *"I always used to say to my staff, everybody has a history, everybody has a life, and everybody has, you must respect, and everybody deals with stress and vulnerability in a different way."*

Here Elicia highlights that working in a person-centred way takes time; it involves understanding the person, and not making assumptions about them:

Elicia: *"What I tried to do is to get people to look at patients as a total individual, and it is hard because it took up more time. When I started my nursing career, we used to talk about patient in bed 5 who was the appendix. Now today we never should be referring to patients like that. Mrs X or if they want to be called by their Christian name that is fine, but again we should not make assumptions."*

For Ruth, it was important to give the patient the care that they needed, and to do things or tasks she identified as being important to the patient, even if others did not always consider these tasks to be the job of a nurse:

Ruth: *"…so if somebody wants if somebody needed if they had been ill and if they always had been house-proud and the one thing and if they just sat there in the middle looking at the hoovering I would get the hoover out and hoover."*

DB: "OK".

Ruth: *"Because that was important to their wellbeing, whereas people would not see that, you would not hoover as a nurse or wash the cups up and I thought it was too task orientated too. I'm not doing this because it is not my job. So I went into the intermediate care team and I thought that was really nice because it was, you could do, it was ok to walk the dog, it was alright to quickly get the hoover out you knew there were limits, you were busy, but you were expected to do what people needed doing within boundaries."*

Anna sees treating the person as an individual has positive effects on the patients, it aids their recovery:

Anna: *"I think as well, I think generally, it probably I think this stands anybody who is unwell and is in hospital, I think when, and I had feedback about this, when you show an interest in a person as an individual, they open up to you, I think as well it really aids their recovery."*

To be able to give time, and to understand something of the patient's personal life, it is important to be able to connect to the person, to look beyond the disease:

Anna: *"…they are not a number, you know they are not in a particular bed, they are you know that person, and sometimes sitting down with someone and having a chat about their garden or their dog is what matters to them, and we do, we have that luxury, we have that time."*

For Anna and Elicia, it is important to ensure that they or other staff do not make assumptions about the older person. In older patients specifically, there is the danger that if healthcare workers think about the patient in terms of their age, it can lead to negative labelling and stereotyping, and ultimately lead to the wrong professional judgements. Anna prefers not to consider the age of the patient; she takes an open attitude to the patient regardless of their age, but acknowledges that the patient's age can matter in terms of goal-setting and expectations. She highlights some of the tensions between taking the age of the patient into account, or alternatively approaching a patient age-blind:

> *Anna:* *"…so for me, age meant nothing, what mattered was functional levels. And I think, well I like to think that is kind of the way to go, that is how things should be viewed, because otherwise it is a judgement and it is a label, not to be so naïve to think that age should not matter at all, but not instantly look at a date of birth and kind get a picture in your mind too quickly. Let people surprise you. And I think too quickly, you could almost plan their future for them, you know either write them off or expect too much of them."*

Anna's professional background is as an occupational therapist. The goal of occupational therapy *"is to enable people to participate in the activities of everyday life"* (World Federation of Occupational Therapists 2011). This influences the way she views a patient, regardless of their age. Her view of the patient has a temporal element:

> *Anna:* *"…it doesn't matter that I'm going to see a 70-year-old, what matters is that I'm seeing a man before having a stroke walking two miles a day, it is I think that is in my training, partly my professional background, partly my personality who I am, how I view people really."*

Anna makes reference to seeing a person with a medical condition, not only in the here and now, but understanding something about the person's life before they became ill. Understanding the patient as a person, and imagining the patient's life in the past, present and in the future, are connected. To be able to see the life of the patient at another place and a time, either in the past or in the future is linked to empathy and imagination and to envisaging the patient outside the present care setting.

Elicia's account of her work on a geriatric ward early in her career demonstrates that not only seeing the patient in the here and now, but imaging a future life for the patient away from the hospital, also changes practise in hospital. Elicia talks about the need for patients to become independent and mobile, to prepare them for going home. She aimed to create an environment on the ward in which patients can work towards these goals:

> *Elicia:* *"But again I was too in advance of my time, I was trying to get patients to be independent and mobile. The consultant did not agree with me, because he said they were living in a very deprived part of (name of city), which it was at the time, and we should only aim to get the patient to move from the chair, from the bed to commode, commode, bed, chair. I said that I did not agree with that, I said that we should be socialising them, get them to eat and mix and learn to make their tea again and that type of thing."*

Elicia sees that patients will eventually need to negotiate life at home and in the community, and held on to her convictions despite opposition from senior staff:

> *Elicia:* *"…and when the consultant said to me: 'I do not want you to set my patient unrealistic expectations for when they get home', I could not condone that."*

Seeing the patient as a person is linked to treating the patient with respect and dignity. Appreciating and being sensitive to the person's feelings of vulnerability when they become a patient is part of understanding the patient as an individual. Getting to know the patient as a person, getting to know what matters to the person in their life, helps to create a person-centred relationship which can help to create positive outcomes for the patient. Considering function rather than disease, and focussing on the person's personal life, rather than focusing exclusively on the medical condition, can help to put aside assumptions and negative stereotypes which often are associated with old age, and which can lead to negative prejudgement. By imagining the patient's life in the future and outside the boundaries of the hospital, and acting on those ideas, healthcare professionals can create more aspirational and nourishing environments for the patient.

5.3.9 Choice

The concept of giving patients choice is linked to seeing the patient as an autonomous being, who participates in decisions about their care, and who has needs and preferences (Coulter and Collins 2011). For example, giving choice is a professional value, specified in the code of ethics and professional standards of occupational therapists (College of Occupational Therapists 2015).

Both Anna and Elicia saw giving people as linked to treating the patient as an individual with preferences. Elicia also links giving the patient choices to treating them with dignity and respect, and showing the older person that they are valued.

> *Elicia:* *"…so I used to help them to choose the nursing home and things like that, with their families. And older people want to know that they are valued. They want to know that they are respected."*

Some of the choices patients make can be life changing, other choices can be small choices most people make on a daily basis, which can impact considerably on the patients' wellbeing and sense of self.

Elicia believes that for older patients it is very important to enable them to make choices whenever possible, because they are terrified losing their independence in their activities of daily living. She acknowledges that there might be patients who are not able to participate in that process, but it is still possible to treat them with dignity:

> *Elicia:* *"…to lose your thinking ability, that is the biggest one I think for older people they are terrified, you know you never had anybody doing your personal hygiene or deciding what you would wear even if somebody is demented give them the choice and at the end some of them cannot actually make it but continue to treat them with dignity."*

She links giving patient's choice about day to day decisions to seeing the patient as an individual person, older people can make their own decisions, but it takes more time:

> *Elicia:* *"and I think what I tried to do to get people to look at patients as total individuals, and it is hard because it took up more time."*

In practice, Anna experienced a mismatch between what she was taught in her professional training about empowerment and choice, and the expectations and abilities of some of the patients and their families:

Anna: *"I think from my training of being told the ethos now is to empower patients and empower families well actually I think that isn't very successful with a certain generation of the populations because it is not how they were brought up it is not what they understand you know essentially, they understand that you go to a doctor to fix everything they don't understand that you have the choice what treatments you are going to have."*

Patients and families not necessarily wanting or being able to make choices about their care has an impact on how she feels about her job:

DB: *"Yes."*

Anna: *"…so it was very draining; very, very draining to be so responsible for all of that, I can't think of a particular, how I say, I probably can give you fifteen examples…"*

But using her professional skills to enable a patient to do what they want to do and to make a choice, knowing that she can make a difference to patients by for example enable a patient to die at home for example, or making small differences in their daily life, gives her a sense of deep satisfaction.

Anna feels this especially working with older people, because older people often are not given the worth they deserve, and they can feel worthless themselves:

Anna: *"Yes, yes that is deeply satisfying you know from a professional point of view, that is when I feel you know o be able to work with and achieve even the slightest thing somebody wants to do, especially with the elderly where some people give up on them and even themselves, they kind of think, they turn around and however old I'm probably no good anymore but then to make the coffee they like it at home that is what I find most, most rewarding."*

Ruth talks about patient choice from the perspective of treatment and informed consent. She saw giving older patients choices and asking them to give informed consent as more problematic older especially if they are unwell or have sensory loss impacting on communication. Drawing on her own experience, she herself does not necessarily want to make choices when unwell:

Ruth: *"You know all these things with choices as you get older it is all very well giving people choice and getting them to sign consent forms you know when I'm not well I can't be bothered with forms and choice and things, just get me better, so by the time you are a 100 you can't see because*

> *you have cataracts and macular degeneration and your hearing has gone and you are supposed to make choices when you are feeling rotten, anyway a lot of people are on their own who do they ask and where do they go for help and if their family are, they knew you, you were very much their advocate to try and they would trust you as well."*

She sees her relationship with patients being based on trust, and as she knows that many older patients have nobody else to advice and support them, she saw her role as supporting and advocating on their behalf.

Patient's choices affect day to day care, from giving patients choices about what to wear, to making decisions about their treatment or future. Participants have different views about how important or feasible it is for them to enable older people to make choices in their daily lives or about and treatment. Giving older patients choices, acknowledges that individuals have preferences and wishes, and can be part of treating them with dignity. Because of time constraints it can be difficult to allow the patient to make choices. However, enabling a patient to make choices can increase job satisfaction. But the participants' experience is also that older patients might not always want to be given, or able make, a choice. For Anna, having recently trained as an Occupational therapist, empowering patients and enabling them to make choices to is, for her, part of her professional role.

5.3.10 The relationship between the patient and the healthcare professional – the personal and the professional

The relationship between the patient and the healthcare professional is often considered the cornerstone of care. Professional guidance about the relationship between healthcare professional and patient or clients is informed by medical ethics, the law, and ethos underpinning professional practice. But a relationship between the patients and the healthcare professional cannot be regulated or mandated. The relationship between a patient and a healthcare professional is intricate. Nolan (2001) argues it is an inter-relationship. Healthcare students and professionals learn how to develop rapport and a therapeutic relationship with patients. So even though the relationship is governed by professional boundaries, the participants talked about their how they perceived the relationship between the older patients and themselves.

In this section, the feelings and the inner stance of the participants when interacting with their older patients will be described.

Ruth described her roles towards the older patients as that of being a friend indicating a relationship of mutual liking:

Ruth: *"when I first started, you were very much a sort of professional friend, particularly to older people."*

It is knowing the patient and the patient knowing her, as well as having confidence in her practice, which gave Ruth positive feelings when she worked with older patients:

Ruth: *"…because most, obviously not all, we had a core group of people with chronic illnesses they were predominantly the elderly people, not always"*

DB: *"Right"*

Ruth: *"But generally speaking, not always and it was just nice, it was this idea of being a professional friend again you know, you knew each other, and we it was almost comfortable knowing what you were going to do, knowing how you were going to do it, it is like any routine isn't it you know not obviously everybody, some people could be quite, there were some people who were not as easy you know, it was nice to see people."*

She also emphasises the need for older patients to have continuity of care, and making sure that she or a colleague can be contacted is an essential component of the care of older patients. Part of her ethos was that the older patient needs to know that a healthcare professional will be available should they have a problem; this gives the patient confidence to cope. She draws on her experiences working with families with young babies, and with older patients:

Ruth: *"If you have a baby and if you think you have a problem and if you think that there is nobody there to help you, you have a problem, haven't you? Whereas, if you have a nice health visitor you can trust, you cope with it. And I think it is the same with older people. If they know that they can phone you at any time, then they are likely to be more confident about things themselves."*

Ruth sees the relationship between the older patient and her as a mutual relationship. She illuminates the relationship between her and the older patient in more detail. She gives a lot to the patient, but there is also appreciates the patient's concern for her. Talking about the time when she was youngers, she identifies herself as being a younger member of the patients' extended family.

Ruth: *"I think it was always that stopping and having a cup of tea, that sort of mutual concern for each other to a certain extent of older*

> *people. Especially as I was younger just. It's part of an extended family. You did get much more involved very much more than which it is perhaps one of the reasons I ended up giving up at the end."*

Ruth contrasts her feelings when visiting an adult patient who was terminally ill, and when visiting one of her older patients when she was working as a District Nurse:

> *Ruth: "…I remember as a district nurse one weekend and I was in charge of two big, basically the whole of W (name of place) that weekend, and we had several terminally ill patients, and so you go from one to the other and some of them were quite young and because I was in charge I go from one to the other, one of them was a young lad with a brain tumour, …it was all ghastly, and then I went to Elsie …she was such an old dear, by this time she thought she kept pulling the plug out of her fridge, she thought the neighbours were listening through it. She was such a, just having that one bit of Elsie, to give her an eye drop or whatever it was so it just was the time it was just so, it brought you back well not exactly normality."* [Laughter] *"…So the other stresses of all the other work we are doing somehow just was Elsie with her eye drops, and having to put the fridge plug back or what have you in or somehow you have and I think it was always that stopping and having a cup of tea."*

Visiting an older patient after visiting seriously ill younger patients created positive feelings for gave her a feeling of normality.

For Elicia, looking after older patients is a privilege. Talking about her last post, where she had a wide remit of managerial responsibilities, as well as caring for patients, she says:

> *Elicia: "But I went back to working with patients and looking after them, because I believe especially older people are a Cinderella service but still caring for older people is a privilege because you are caring for people who have a lot to offer and a lot to share and a lot to learn from them. I think we were privileged to look after them at a vulnerable period of their lives."*

Like Ruth, her understanding of the patient-nurse relationship is that it is not one-sided; she describes a relationship of giving and receiving. Ruth, in her description, explains her personal emotional experience when being with older patient. Elicia describes the status she feels looking after an older patient: *"it is a privilege"*. Elicia expresses her awareness of the vulnerability of being a patient. Both the patient and the nurse bring something to the interaction; her description conveys a sense of balance and respect. She puts herself in the position of wanting to learn and receive, at the same time she is confident that she brings something valuable for the patient.

For Anna, the way in which she positions herself in relation to older patients has two arms to it. Like Ruth, Anna looks at an older person as if they were a family member; however she does not elaborate on her own feelings. Her close contact with older family members while growing up is significant for the job she is doing now:

> *Anna: "…and I think that, well I always look at people as if they were my granddad or they were my great-uncle."*

She interprets her relationship with older patients not on a purely personal basis, but sees her role in a wider societal context. She also expresses a sense of duty and intergenerational justice that she feels towards older patients:

> *Anna: "I don't know, it can be as simple as if we keep somebody in their own home rather than having them go into a care home, that to me is fantastic because if we, at the end of the day I feel if we got somebody who has giving to society for 90 years it is kind of our job to do the best for them."*

And that also means respects the fact that some patients do not want to establish a therapeutic relationship with her:

> *Anna: "…also it depends on that individual, sometimes you go to someone and you want to strike up that therapeutic relationship and they don't want it, or they want you give them an answer, so they go home. And that is fine, you respect that."*

Zoe talked about having conversation with patients while on placement and she sees this as part of her role as a student. Like Elicia, she identifies that having time with the patient is essential for building up a good relationship to get to know more about the person's life, a process which happens over time:

> *DB: "Do you think conversation is important?"*
>
> *Zoe: "Yeah I do, yeah I do, especially I think it is because it helps to establish a good relationship when you have to work with someone. Especially when you have to work with someone over a long period of time, also when you work with somebody over a long period of time, conversation you just learn things which you would not ask somebody in a standardized assessment questions which if you are dealing with somebody is probably quite important."*

She sees having conversations as especially important when working with older patients because they are more likely to be isolated.

> *Zoe: "When working with older, the actual older people I think as well sometimes with them even though even if you feel like you are not doing anything particularly productive you are just talking with them, I think for that age group it can be more important because some of them I find because they are elderly maybe they don't have*

> *a partner anymore or their family live far way actually just having someone to talk to is, really for them I actually a big thing."*

The relationship the participants described were influenced by their perceptions of the patients' needs, their experience, their own biography, their knowledge about older people, and their professional role. Each of the participants attached their individual meaning to the relationship.

Anna and Ruth compared the relationship between themselves and their patients to that of family relationships, mimicking the relationships between the different generations. Anna also cited societal factors.

The relationship between the professional and the older patient is not necessarily perceived as one sided, but rather as one of mutuality. The participants saw that with their professional know-how and personal skills, they can make a difference to their older patients' lives. Each participant interpreted their relationship with the patient from a unique viewpoint.

5.3.11 Conclusion for all the themes

The participants talked about their early lives, becoming nurses and occupational therapists, their formal education, participating in pre- and post-qualification courses, the perceptions they had of older patients, the impact these had on their practice, and their values underpinning their work with older patients.

Ruth, Elicia and Anna talked about relationships they had with their grandparents explained the influence this has on their professional life.

The accounts of what they were taught about ageing and old age at pre-qualification level were sparse. Zoe, Anna and Ruth had student clinical placements with older people as part of the pre-qualification course. Attending courses addressing the care of older people after having worked in practice, sparked an interest in the theoretical understanding of ageing and medicine of old age, and extended knowledge and confidence for Ruth and Anna post-qualification.

Participants developed perceptions about older people through experience. The participants acknowledged that working with older people required the ability to deal with complexity. The participants considered social and psychological factors

impacting on their patients' lives. Ruth, Anna and Zoe emphasised the loneliness, and Elicia the fearfulness of older patients. A mix of these perceptions, as well as knowledge and being able to imagine the patients' lives in the past, present and future, shaped how the participants understood and felt about their work.

The values underpinning the participants practice are interconnected rather than separate entities. Seeing the patient as a person requires understanding of the patients' feelings being a patient, as well as empathy and imagination.

Giving patients choices recognises the patient's autonomy, rights and preferences, but is not always feasible; and ethical considerations need to take into account the patient's circumstances.

The way the participants interpreted their relationship with older patients differed between individuals, depending on experiences in their personal and professional life, and their professional roles.

5.4 Conclusion to the whole chapter

One of the advantages of biographical narrative research is that the data do not separate formal and institutional learning, informal learning, the learning in and through practice, and personal learning. Keeping the professional and the personal together, allows one to explore the space and interconnectedness between them. The participants' subjective experiences, and the deeper meaning they attach to their experiences are interpreted within wider contexts such as the work environment, and societal and historic factors. Each case study is individual and can be understood on its own, and each case study gives insight into the learning of the individual. The biographical show some of the temporality of the participant's learning, and when, how, and what they learned about ageing, old age and working with older patients, the continuity and the turning points in their learning.

Comparing and contrasting cases highlights the commonalities and differences between the cases, and the context in which learning took place. Common themes which were significant to learning to work with older patients were identified such as dealing with complexity, values and perceptions underpinning

practice, seeing the patient as a person and building relationships with patients. Each of the themes sheds light on the nuances of the individual cases.

6 Chapter 6: Discussion

6.1 Introduction to the discussion

The discussion will address the strengths and limitations of the study. It will include reflections of the experiences as a researcher and some of the difficulties carrying out a research project like this will be explored.

The findings of the data analysis show the layers of understanding, the knowing and knowledge and understanding of the participants about ageing, old age and working with older patients.

The discussion of the findings has been developed in the light of the research question and the findings of how healthcare professionals develop knowledge about working with older patients throughout their life course.

Formal and informal learning, explicit and tacit knowledge, values and the participants' perceptions and beliefs about older patients were embedded in their narratives, making some of the factors which shape their learning visible. Working with older patients is understood to have specific qualities which are different from working with younger patients. The participants were conscious of the complex needs of the older patients.

Having analysed the narratives in depth, the findings show the connections between meaning-making and learning, and that that the development of knowledge and knowing is individual and nuanced. Learning throughout the life course does not take place in a vacuum but in a wider organisational and societal context. How the individual learns and what they learn impacts on their interpretation of their professional role and their relationship with their older patients.

6.2 Strength and limitations of the method

BNIM and the reconstruction of case studies allows one to understand how healthcare professionals learn throughout their career and over time. The narrative reflected biographical, the personal and professional, the cognitive, interactive, social and emotional, and interactive domains of learning which have

been identified in adult learning theories, and give insight, how the participants learn. It does not separate the two basic processes of learning which Illeris summarised as, firstly, the learning which takes place through the interaction between the individual and the environment and, secondly, the internal process when the learner interprets the external information (Illeris 2009). It does not break the learning into components such as formal and informal learning because health care professionals learn in and through practice as well as formal opportunities. The complexities of how professionals learn are difficult to disentangle. It is difficult to study because learning involves the whole person, but there are many components to learning which can be impossible to identify (Eraut 2009b, Jarvis 2009).

This study did not attempt to identify development of knowledge through studying phenomena which can be measured with some objectivity, but relies on understanding learning through the understanding of the subjective experience. The interviews reveal some of the outer and inner context in which learning takes place, the structural and sociological contexts and some of the inner processes of the individual. While healthcare professionals learn through practice which is based on action and doing, they also have to participate in courses and prescribed learning frameworks to gain a professional qualification and maintain their registration in the UK. The data need to be understood in the light of that.

The method relies on verbal accounts of the subjective experience of the participant and transcribed text, rather than observing the participant in a learning situation or through measuring what has been learned for example recall of explicit knowledge(Rosenthal 1995, Rosenthal 2006). The aim is for the researcher to try to understand the subjective experience of learning by understanding the meaning the participant attaches to their experiences and the social historical and organisational context the participant and the learner is embedded in. It is the story as told by the participant which is at the core of this research method. The limitations of the interview are that the researcher might not gain access to events and experiences which are verifiable through facts, the narrative however gives insight into how the participant constructs the memories of past events. How the participant tells their story can be influenced by the

circumstances of the interview and the perceived expectations by the participant and the researcher (Hermanns 2004).

One advantage of this method is that the focus is not only in understanding the participants' subjective experience, but also aims to understand the social context the participant lives and works in. Learning to work with older patients does not take place in a vacuum but in a wider social, organisational and attitudinal context (McLafferty 2005, Brown, Nolan et al. 2008). The findings give some insight why the wider context matters and how this impacts on learning of the individual. In a climate where active and successful and healthy ageing is promoted on a societal level, old age and older people especially vulnerable older people are often stigmatised. Addressing the vulnerabilities illness and old age, and a proportion of older patients can be frail and vulnerable, can be a topic which can be difficult to address (Nicholson 2009a, British Geriatrics Society and Royal College of General Practitioners 2015). Widespread societal attitudes towards older people, and especially older people who are ill and disabled, impact on how health services are organised and care is given, the patient experience and impacts also on the individuals who care for older patients (Biggs, Phillipson et al. 2006, Cornwell 2012).

The advantage of the research method used in this study is that the learning of healthcare professionals to work with older patients can be explored holistically and biographically. The method allows one to gain insight into the development of knowing and knowledge in depth and over the course of time rather than at a specific point in time. Because the participants set the agenda through their initial narrative, the method does not generate data about how healthcare professionals develop and maintain specific clinical skills, technical knowledge or prespecified values and attitudes, although these are all important components of healthcare professionals' practice. But exploring learning through BNIM does not prejudice the exploration of one form of learning such as formal, informal, institutional deliberate, unintentional or learning in practice over another, or different forms of knowledge, any form or component of learning can be explored in more details. The aim is to understand the deeper meaning the participants attach to their experiences(Chamberlayne, Bornat et al. 2000).

Each of the case studies is individual and unique covering different stages of the participants' lives and each case study can stand on its own. The case studies are not necessarily easily comparable. It is the in depth and nuanced understanding of each case which gives insight into the learning of the individual which the researcher can learn from. However, it can be difficult to know how transferable what is learned from a case study is to another context, although giving information of the context of each case study will assist with that decision.

In this study, common themes did arise during the analysis, which added to the detailed understanding of how the participants learned to work with older patients: the comparison and contrasting of the case studies at the end of the analysis helped deepen a nuanced understanding of the individual cases.

Because of the open nature of the narration at the beginning of the interview, not all of the data generated will be relevant to the research questions. Some of the data were interesting but not relevant for the project. The study aimed to recruit participants with varied and contrasting experience. The length of experience working with older patients varied between the participants, three participants who had extensive experience and two participants who had limited experience working with older patients.

The number of participants recruited is small because of the detailed analysis of each of the interviews. Participants were recruited from different professional backgrounds. Doctors, nurses, occupational therapists and physiotherapists are considered being part of the core team in the care of older patients(Department of Health 2001). I tried unsuccessfully to recruit a physiotherapist for this study, which would have increased the number of participants and opened another viewpoint.

Each profession has its own role in the care of older patients. The roles an occupational therapist, a nurse or a doctor will have in relation to the care of an older person is defined by the professional background, but also by the specific work environment. In some settings, the boundaries between the professional groups will have a degree of overlap, as well as complement each other. Each participant has attended a different course to qualify. The training at pre-qualification stage will differ for each profession and will depend on the year and

the location of training. The role of a geriatrician is the most clearly defined in terms of diagnosis and treatment of older patients.

Initially I felt unsure how the professional differences between the participants would affect the data, and was wondering if it would be better to recruit participants from one professional group only. The differences in qualifications, and roles in practice helped to crystallise and enhance the understanding of the experience of working with older patients. The professional background of each participant was part of the context for each of the narratives. The participants' professional backgrounds did inform but not detract from gaining understanding how health professionals learn, and the differences in professional background helped to illuminate what was specific to learning to work with older patients.

A study like this relies on volunteers to agree to be interviewed. The fact that the participants were willing to talk about their work and experiences showed a degree of openness to the topic of ageing and old age. By purpose participants were recruited who differed in their length of time they had worked with older patients, or if they saw it as a special interest of their work which allowed for contrasting cases. The three experienced participants saw themselves as experts in older people care or highlighted their special interest in ageing – two of them were retired which gave them a certain freedom to talk about their work, one of them was still working. In contrast, the other two participants who were considerably younger, but had taken different routes into their profession were at an early stage of their career and were still deciding the direction they wanted to go. Before the interview I was unaware of the exact length of experience each participant had working with older patients, each of the participants had a varied working life, although I knew that all had some exposure to working with older patients as this was one of the criteria specified for recruitment. The participants who agreed to be interviewed were likely, by definition of their participation, more interested in the topic of ageing and old age. They therefore might differ considerably from potential participants who were approached but declined to be interviewed.

Overall, the participants were open about their experiences, although they were careful to maintain the confidentiality of their patients, colleagues and workplace.

Health professionals will be conscious of how they will present themselves, and be aware of their specific professional code of conduct. They will have learned as part of their professional education, how to regulate the information they reveal about themselves or patients. One of the disadvantages of an interview which relies on the articulation of experiences retrospectively, they might be reluctant to reveal their deeper feelings, or negative preconceptions, such as disgust, dislike, shame or feelings they are embarrassed about. There were individual differences in how each participant talked about their experiences, and how freely or openly they felt they could talk. Overall there was a willingness to share their thoughts and feelings. As a researcher, I tried to create an open non-judgemental atmosphere and, in the second part of the interview, to engage actively through asking questions with the participants. But asking the participant questions also has limitation. During the interview, I was mindful to respecting the boundaries set by the participants, boundaries set by body language or the participant moving on to a different topic. I realised that the art of a researcher in BNIM research is to listen in a relaxed and respectful manner, but at the same time to show curiosity and in the second and third part of the interview not to be afraid to ask questions while remaining respectful about the participants' feelings. To balance all the demands of the interview is not always easy, and each participant will manage the interaction with the researcher in their own manner.

Participating in an interview can be an opportunity to reflect on past events. The participants reflected on events – some from many years ago –and their narratives and the stories embedded in the narratives made visible on how they made sense of those events and the meanings they attached to them (Bruner 1990). An interview like this relies on retrospective accounts of events and the interpretation of the person who tells the story. It therefore relies the participant's memory and the events and stories the participant consciously or unconsciously selects as well as generalised descriptions and views, accounts of their work (Rosenthal 1995). The selection will also be influenced by the expectations by the researcher and the interviewee, their interaction and the atmosphere. The person telling their story will try to create coherence of their past. It takes skill to actively listen to the participant and to decide when to ask questions. It can be difficult to formulate questions which elicit stories of specific

event as they give most insight into the interpretation and the meaning of the participant attached to their experiences (Wengraf 2001, Wengraf 2004). Developing the skill to ask to follow up questions and to elicit stories was part of the BNIM training. But research interviews themselves are demanding in terms of engagement with the participant, and the formulation of probing questions is not always easy during the interview.

Reflections and recalling past events might spark new feelings, evoke forgotten emotions and bring to the forefront a scenario in the participant and researcher. The participants can recall of events they have not thought about for a long time. One of the ethical considerations to manage during the interview and the analysis of the data are that the participants are likely to reflect on events which they did not reflect on previously. Because health professionals in practice can be time-pressured and the work very demanding, it might not, at the time, be possible to engage in reflection and consider what they learned from their experience or an interaction with a patient. From a research interview, it is impossible to know what meaning they attached to an event and what they experienced at the time when it happened. When individuals tell their story, they tend to create coherence. The meaning the participants attached might change over time, and as they are telling their stories and trying to create coherence of past events and interpreting life events (Bruner 1990). For example, had they been interviewed directly after an event e.g. attending a training course, or working with a patient, the way they recall the event might be very different from the account given about it months or years later. But in BNIM it is how the participant interprets his life and represents themselves in the interview which is of interest to the researcher(Rosenthal 1995).

Some parts of the interviews were difficult to make sense of, but those sections were significant as they reflect the complexities – and at times the lack of coherence – of clinical practice and life lived.

One of the limitations of the research that the data were analysed by one person only. Wengraf recommends carrying out some of the analysis of the data in a group to open the data, to generate hypothesis about the meaning of the text, and to compensate for the blind spots of the researcher.

BNIM presents some ethical challenges. According to Oevermann (verbal communication), it is not normal practice to allow participants to look at the data – and certainly not to allow them to make changes – once the data have been transcribed. I could see that the method has its own intricacies which need to be respected. In this sense, the method differs from some other approaches such as more participatory and feminist research where the participant is invited to discuss the data, add modifications or participate in writing up the data. Because the hermeneutic analysis looks for latent meaning, meaning which the participant might not be fully conscious of at the time of the interview but is expressed in the narrative, if the participants might want to change the data, "clean up" their accounts to present a more acceptable version; and this might interfere with the process of analysing their underlying and at time unreflected thinking. Nevertheless, all participants were invited to request a copy of the transcripts: none took up this invitation. I struggled with carrying out the analysis without the involvement of the participant. It is likely that doing this as part of a team would have helped. Consequently, I tried to arrange a meeting with two of the participants to share my analysis sending several messages. Of the two, however, one did not respond, and the other one did not want to see the data. The presentation of the data cannot be considered the pure voice of the participant but are rather a co-construction between the researcher and the participant.

As a researcher, I aimed to stay close to the data, including quotes into the presentation of the data as well as selecting the quotes with the whole text in mind, to capture relays some of what the participant has had said. Every transcription is the start of the interpretation of the data. As I had to make decision how to transcribe spoken language into text, which meant I had to make decisions about commas, pauses and full stops. It involves a certain amount of cleaning of the data. It is impossible to reflect the unconscious and non-verbal communication between the researcher and the participant. The recognition that the participant and the researcher play a role in the presentation of the data, relies on clarifying the position of the researcher as far as possible and making some of the reflections explicit. This description of the intersubjectivities will always be an incomplete process.

Each case study gives insight into the lived experience of the participating healthcare professionals and from each case study it is possible to draw some conclusion how the participant learned to work with older patients in the real world. It is not the purpose of a case study approach to generalise to a bigger population as the sample is not representative of a bigger population (Flyvbjerg 2006). But each case study gives insight into the learning of the participant and some of the insights can be transferable to other learning scenarios. Each case study gives a deeper understanding of learning, the processes, context and factors which supported or hindered learning how to work with older patients. The insight gained can help to generate hypothesis for further studies. Criteria to assess the quality of qualitative research criteria, such as those developed by Guba and Lincoln, and Cohen and Hammersley, are used to assess its credibility, dependability, relevance and plausibility (Lincoln and Guba 1985, Hammersley 2007, Cohen and Crabtree 2008). Quotes were used in writing up the findings to support the transparency of the project.

6.2.1.1 Reflections on being a researcher

In a qualitative study like this, the interaction of the researcher with the participants and the generated data influence the research process. In this section, I reflect on the more personal aspects of being a researcher, the intersubjectivities between the researcher and participants.

During the interview, the researcher identifies topics to follow up in more depth. This relies on an analytical process such as having the research aims in mind as well as theoretical understanding of the topic but also following hunches and intuition. When analysing the interview, I realised that in each of their interviews, there were missed opportunities to ask more questions and explore issues in more depth. In open-ended interviews, the researcher tries to follow the map set out by the participant, a map which at the time of the interview is unfamiliar to the researcher. Each interview shapes the subsequent interview. It seems unavoidable that some opportunities to explore questions in more detail are overlooked. At the time of the interview the meaning and significance what is being said by the participant is not necessarily clear to the researcher, many insights emerge from analysis of the text later.

Hermeneutics is the art of understanding and interpretation of data. A study based on phenomenology and hermeneutic theory asks the researcher to immerse themselves in the data, to understand the subjective experience of the participants (Crotty 1996, Finlay 2009b). The framework for analysis given by BNIM requires patience, and a degree of discipline when analysing the data, avoiding rushing to quick conclusions about the content and the meaning of the text. Having attended workshops with Oevermann has been particularly in helping me become more confident in my approach to analysis.

Listening and transcribing helps with the immersion into the interviews is part of the analysis (Flick 2014b). I developed an intense connection with each interview. The interweaving of the structured analyses of the interviews following the steps of BNIM, and being intuitive and reflexive, helped the understanding of each case study. The listening guide which focuses on the voice of the participant complimented the reading of the text, and before transcription as well as to understand the voice of the participant better (Gilligan, Spencer et al. 2006).It was surprising how intense the immersion into the data felt at the time of the analysis. The intensity of the connection gives a depth of understanding of the data which differs from content analysis. The understanding of nuances of the text connects the researcher to the different layers of the content, and subjective meaning and the emotions of the participant. Immersion *"thus entails a kind of empathetic identification with the actor"* (Schwandt 2003 p296) and is an essential part of interpretative phenomenological research, it helps understand more closely to the meaning of the participant.

It does not mean that the process is not problematic at times. Each interview takes weeks to analyse. Living with the interview can mean that the boundaries between the researcher and the researched can become blurred. Verstehen can lead to the empathic identification between the researcher and the participant. It was not always easy to distance myself from the data, to not overidentify with the narrative of the participant. The narratives evoked memories and feelings. Having worked as an occupational therapist with many older patients listening to the participants accounts I had on several occasions a sense of déja vu. At times, I found it difficult to distance myself from the data at times, to distance myself

enough from my own experiences, so I could understand the subjectivities of the participant more clearly. At times, the boundaries became blurred – especially when the participants described interactions with their patients reminded me of my own practice, where I had a spontaneous sense of recognition of a scenario. Because of the biographical nature of the interviews, the data activated memories of events I had forgotten, or I had not necessarily reflected upon. Being a researcher gave me the opportunity to reflect, review, question my own clinical and educational practice away from the day to day pressures of being absorbed in practice. It made me consider the relationships I had with older people in my own close and extended family and some of the interactions I had with older patients. It made me review and question my approach teaching students about ageing and working with older patients, and the values, beliefs and perceptions I conveyed to the students about ageing and being old.

The attempt to understand the biography of another person provoked reflecting on my own biography. I became aware of my own intellectual and emotional responses to the narratives, I felt curiosity, joy and pain. It certainly felt it exhausting at times, as I considered my past clinical practice, my own biography and the career choices. Oscillating between being close and distancing myself from the data, helps to understand the data cognitively and emotionally. Becoming aware of my own responses helped to step outside my own frame of reference to look at the data from a distance (Schwandt 2003). Understanding someone else's biography is a cognitive and abstract task, but at the same time is subjective and personal. As a researcher, I gained a deep understanding of the participants' accounts, some aspect of their lives and work to a degree I had not anticipated at the beginning of the study. Ethically this can be difficult as neither the researcher nor the participant can know what the interview will reveal. The detailed and layered understanding of the interview only emerges during the analysis of the interview, and when writing up each of the case studies.

Doing research felt like a very personal process, much more than I expected before starting the project. Recognising my own emotions and being aware that at times I had the tendency to overidentify with the participant, felt at times difficult. The shifting of perspective of being a researcher, a practitioner and a

patient enhanced my sensitivities and the understanding of the data, but I also became aware that the emotional responses to the data can potentially block the exploration of topics with the participant during the interview and over the course of the analysis.

The interviews brought to the forefront the here and now of my life, and the more recent experiences of having been treated for cancer. I found the accounts of the participants caring for cancer patients and their reflections felt very pertinent, very knowing and powerful. Having a diagnosis of a cancer means there is no clear past tense, the term *"in remission"* means that even post-treatment, the knowledge of having (had) this disease is always close to the surface, always feels present. During the analysis, there were times where I was barely being able to reread or listen to specific sections of the interviews, the fact that the participants had found it difficult to be witness the illness in their patients, these parts of the interview, however brief, laid bare my own vulnerabilities, my own fears and anxiety about suffering or dying, and brought to forefront of my consciousness that my chances of becoming old were diminished. Listening to the participants experiences of caring for cancer patients felt like they were telling me something about my new reality. There was – and is – a rawness to those emotions which make it hard to distance myself and not to feel disturbed by the accounts, to feel waves of anxiety about my own future.

Qualitative research is influenced by the participant and the researcher (Hollway and Jefferson 2013). Listening to the participant means interacting with one's own life story. As the participant tells their story in one point in time, and the researcher listens to the participant story at a certain point of their own life story. Research interviews differ from daily conversations or the interaction between a counsellor and client, but some of concepts developed by Rogers and Kitwood about client-centred therapy and personhood are helpful in understanding the inter-subjectivities of the research process, and empathetic understanding Writing about client-centred therapy, Carl Rogers defines being empathetic as *"where the counsellor is perceiving the hates and hopes and fears of the client…, but without himself, as a counsellor, experiencing those hates and hopes and fears."* (Rogers, 1951, p29). Kitwood uses the term *free attention*. Free attention is

possible when a person can acknowledge their own fears and conflicts, and the psychological defences they have built (Kitwood 1990). I found this one of the demanding aspects of carrying out this study.

As a researcher, and aiming to be self-reflexive, writing without censoring what I was writing, keeping a diary, doodling helped me to understand my own responses to the interviews and to " to clarify the conditions in which understanding takes place. "(Schwandt 2003). Considering the psychological adjustments, I had to made in my life and the lack of control I experienced at times, it is hard to tell if the data collection came at a good or a bad time. Having the experience of being a patient, and having to make enormous psychological and physical adjustments (which made me perhaps seem outwardly less resilient) changed my perception and sensitivities, and my way of seeing the data. Collecting and analysing the data at a different time is likely that I would have dealt with the process in a different way. Certainly, my own changing life circumstances demanded reviewing of my own life in more depth than I had anticipated, and those reflections became a part of the project as they shaped how I was seeing the world. Trying to find sense – to find meaning in illness and chaos – at the time when I was collecting and analysing the data, presented its own difficulties, but also opened up feeling and intellectual understanding of the data at a time when I was intensively interacting with the data.

6.3 Discussion of findings

6.3.1 Biography and learning

The study shows that the biography of the individual influences their practice. The experiences, the learning from experience, the adoption of values and beliefs, and the perceptions the participants developed about older people throughout their life time influenced how they interpreted their professional role, and the needs of their older patients.

In BNIM, the initial interview question is kept as open as possible to initiate an narrative of the participant and for the Gestalt from each interview to emerge, followed by an interactive style of interviewing (Rosenthal 1995, Rosenthal 2006). Biographical narratives do not focus exclusively on the here and now but aim to

capture life events, choices and transitions made over the life course of the participant and how the person who tells their story interprets their past. The participants gave accounts of themselves, their professional and personal lives with the past, the present, and the future being interwoven rather than chronologically ordered. The reconstruction of the life story as told by the participant as well as their life history is a powerful tool to help to understand the individual biography. Each case study gave insight into how and what the participant learned about ageing, old age and working with older patients over time. The narratives contained descriptions, reflections and stories of their younger selves, their life as students and practitioners, of themselves in the here and now as well as their thoughts about their future. The nature of the data reveals the connection between the life of the individual, learning and their biography. The reconstruction of each case study reveals how personal and professional learning about old age and older people is connected and interwoven with each other, and the personal and professional knowledge are not always distinct from each other. The case studies show some of the unique features of each individual, and bring to the forefront how diverse learning about old age and working with older patients can be and how the learning history and learning experiences varied between each of the participants. The comparison between the case studies also identified some of commonalities between the participants' experiences, and at the same time allowed to gain a nuanced understanding of each of the case studies as a whole.

Learning takes place in a wider social, historical and institutional context (Alheit 2009). At pre-qualification training, the curriculum the participants followed was situated in a broader profession specific framework, but also depended on the location and timings of their study. Anna, Zoe and Michael all had or were completing degree courses taught at different universities. Ruth and Elicia's initial pre-qualification courses were not were not degree courses, both completed degree courses later in their career to be able to develop their career opportunities.

None of the participants had to decide to specialise exclusively in the care of older patients at pre-qualification level. Ruth was the only participant who had chosen a

pre-qualification nursing course which contained an explicit gerontology and midwifery component at pre-qualification level. Michael made a decision to become a geriatrician after the completion of his medical degree and working in different specialities as a junior doctor. As a doctor, he was the only participant who had had to make a deliberate choice to commit to training in the care of older patients, and to specialise in geriatric medicine he eventually had to exclude other option he had considered for example to become a general practitioner or a physician. Early specialisation to work with older patients at pre-qualification level has been an option in other countries such Germany or USA for example (McCormack 2005a).

Three of the participants (Elicia, Michael and Ruth) had many years of clinical experience caring for older patients and at the time of the interview described themselves as experts in the care of older patients. In contrast, Zoe and Anna were at the beginning of their careers. They had not made any decisions as to where they wanted to work longer term, but both had some experience of working with older patients whilst being on student placement and Anna in her first post as a qualified occupational therapist.

Elicia and Michael had no recollection of learning anything about ageing and old age during their pre-qualification course. Studying at a time when geriatric medicine was just emerging as a speciality, issues relating to ageing populations and the care of older patients were not widely acknowledged(Grimley Evans 1997). For this reason, it is not surprising that they did not recollect ageing or old age being addressed as a specific topic in their pre-qualification training. However concern about the preparedness of healthcare workers to work with an increasingly older population has been on the agenda at the time when Anna and Zoe were occupational therapy students (McLafferty 2005, Westmoreland, Counsell et al. 2009, Baumbusch, Dahlke et al. 2012, Liu, While et al. 2012).

For Anna gaining experience working with older patients on student placements was part of the course requirements. But Anna did not expand on her experience working with older patients apart from describing how it affected her emotionally. Zoe's narrative included some descriptions and reflections of her experiences in practice when being a student in an older person's mental health unit. As part of

her course she still attended lectures and tutorial at university, but the topic of old age was not necessarily explicitly identified within the timetable of the undergraduate curriculum. Topics relating to older people were embedded in broader topics. For example, a lecture about social exclusion or a medical condition such as Rheumatoid Arthritis, might include some information how the topic relates to an occupational therapist working with older patients. Both Zoe and Anna were at the beginning of their careers as occupational therapists. Policy documents have identified the role of occupational therapy in the care of older patients. In the National Service Framework (2001), occupational therapists have been identified as being core team members in the health and social care of older people. In the light of increasing pressures in the NHS, a recent publicised report by the College of Occupational Therapy identifies the role occupational therapy in preventing hospital admissions and contributing to a safer and quicker discharge of older patients from hospital (College of Occupational Therapists 2016).

From the case studies, it is not possible to identify the number of taught hours or how topics related to old age and working with older patients were integrated into the curriculum. But the recollection of the participants indicates that the topic of working with older patients was not made explicit or of relatively little significance for them during their pre-qualification education. The amount of explicit teaching about ageing, old age, and older patients in medical schools in the UK has been identified, but also criticised for being inadequate considering that doctors of the future are likely to treat an increasingly older patient population with complex needs (Gordon, Blundell et al. 2010, Gordon, Blundell et al. 2014).

Post-qualification, the participants' biographies became more diverse as they made choices about their professional lives. Some of the choices they made were also influenced by personal lives and balancing the needs of their work and families. Early in in their career, Ruth and Elicia made the transition to being wives and mothers, and made career choices with the changing needs of their families and especially fitting being able to care for their young children as well as the need to provide financially for the family. Working in the care of older people was a positive experience for Ruth and gave her the flexibility she needed to look after

her young children as well. Her experience contrasted with Anna and Elicia who described the challenges working with older patients at the beginning of their working lives. Anna's account drew a picture of the tensions she experienced such as dealing with complex clinical problems of the patient, considering the wishes and preferences of the patients and their families, and meeting the organisational demands meant making complicated ethical and moral decisions. Anna, being a newly qualified occupational therapist, found that responding to the needs of the health trust to discharge patients if possible and at the same time addressing the complex needs of patients with dementia so they could be discharged safely, was an intense experience, especially as she felt that at the time she lacked the necessary specialist knowledge. Her reflections mirrored some of the tensions identified in other research studying the transitions from being a student to a qualified health professional. Newly qualified staff struggled to find their way around organisational demands and complex decision making and to be able to transfer what has been learned at university into new work environments (Fortune, Ryan et al. 2013). Learning in practice is situated (Lave and Wenger 1991).

Making the transition from being a student to a qualified member of staff means learning to work in a new context and adapting to change, and the expectations of others. Anna described how she had to adjust to working in a demanding environment very quickly taking on considerable responsibilities within a few days of starting to work. What has been learned in one context is not easily transferred into a new context (Lave and Wenger 1991). Similar challenges have been described by newly qualified nurses who found the demands working on an acute ward challenging and identified the need for mentors (Maben, Adams et al. 2012). The biographies of the participants in this study show the intensity of learning during transitions either from being a student to being qualified or changing jobs and working in new clinical and organisational context, the connection between the subjective experience of the participants dealing with the challenges of working in a new context and the tensions they experienced adapting to and learning in the new environment.

The narratives in this study show that transitions were not always successful for the individual concerned, the participants did not always become full members of a community of practice, the values of the individual and the community of practice are not always compatible or that a newcomer was not sufficiently supported, making it impossible to become part of the community. The case study of Anna shows that she felt relatively isolated in her first post, in Elicia's case the mismatch between her values and aspirations and those of her colleagues led to conflict which could not be resolved.

Transitions imply a period of change over time. However, points of crisis or through a one-off event can also be the starting point to learning and finding new meaning. The narratives included stories showing ostensible the unpredictability of clinical practice, and how a clinician can find themselves having to respond to a crisis unexpectedly. In healthcare, having to respond to unfamiliar situations are part of practice. Such scenarios can be an intense challenge for a practitioner, and at times even can feel traumatic for the individual concerned as the narratives show. Elicia described the sudden and unexpected death of a patient she was looking after at the time. Anna described finding herself in a challenging interaction with family members of a patient making her feel being out of depth in terms of her expertise. These events were the beginning of a learning process leading the participants trying to make sense of the events, and searching for meaning. The participants elaborated on the sense of disjuncture they experiences, which is often the start of the learning process (Jarvis 2007). They had a significant impact on the participants concerned, both Anna and Elicia identified a gap of scientific and technical knowledge and it made them consider how they will address similar scenarios in the future. For example, Elicia realised that she had not recognised the symptoms of the patients as being life threatening at the time. The learning described was not purely a cognitive or intellectual process, but changed how Elicia evaluated her behaviour in practice. She identified how she might acted differently and change her behaviour in the future. She realised the importance of communication, the need to ask questions. She described her sense of failure at the time, but decided how to improve her practice in the future. Anna realised her strength of practice knowledge she already had but also became aware of the gaps of knowledge. It influenced the

decisions they made about their future career. The scenarios the participants described in the narrative give specific examples how the participants of aspects of practice knowledge.

The case studies show that learning about older people, and the development of attitudes and perceptions about older people through early and professional socialisation. Ruth, Anna, Elicia developed some of their core of values and beliefs about older people within their families whilst growing up. It was through the contact they had with older people at that time, that they developed their values regarding for example the position an older person in society, the belief that older people deserve respect and support. These values stayed with them. The importance of the values during early socialisation and are brought into professional life, can lead to experiencing tension and conflict with the values found in a work place, and can have an impact on job satisfaction and attrition. These components of practice, are often invisible, not well explored or unacknowledged, but are found beneath the surface of day to day clinical practice (Fish and Coles 1998, Helmich, Bolhuis et al. 2012). Socialisation, which is part of the process of becoming a healthcare professional, can be passive as students and professionals absorb the knowledge and culture of a profession and workplace (Lindquist, Engardt et al. 2006). The beliefs and values are often not articulated (Higgs and Titchen 2001a). But the case studies give examples of professional socialisation being a dialectical process where the individual consciously engages with the culture of a workplace(Clouder 2003). Elicia's narrative contains stories of how she engaged with the values and beliefs in her work environment. Recognising her own values, which she had adopted during her childhood, she decided to reject a culture of low aspiration for her patients.

Although some values beliefs and perceptions, especially the values and beliefs about older people developed early in life showed consistency throughout the career (Ruth, Elicia, Anna), the participants also consciously made some adjustments to their values and beliefs they adopted during early or secondary socialisation to meet patients' needs. In this study, the participants gave the example of giving patients choice within the context of making treatment decisions and the patients' day to day life. Their reflections on giving older

patients choice about their care and treatment show some of the ethical dilemmas the participants responded to when making clinical decisions with and for the patient and the internal tensions they experienced. The principle of giving patients choice, something which is also specified in the code of ethics for some professions, was not always easy to implement in practice (Anna, Ruth and Elicia). For Anna, giving patients choice was a core value for her practice and her narrative shows how the fact that how to give choice to older patients with dementia, or if it was even possible, was not always clear cut, caused her internal struggles about her identity as an occupational therapist. The tensions she experienced potentially are related to belonging to a profession where enabling patients to make choices is highly valued, and the fact that at the time she was newly qualified. The stories of Ruth and Elicia illustrated how they wanted to give patients choice at times, they fine-tuned and adapted their actions in practice to arrive at pragmatic solutions to meet patients' needs.

However, the idea of giving patients choice was not a prevalent concept at the time of their pre-qualification training, ideas of shared decision making for example are relatively recent concepts in healthcare (Coulter and Collins 2011). Ruth and Elicia were very experienced nurse. The narratives show that they were taking into consideration the patients abilities and medical condition to evaluate how to involve the patient in decisions making process, as well as taking into the consideration the organisational and professional requirements. This meant getting to know the patients, evaluating their function, and trying to understand the patients' stories and the patients' preferences. Giving patients choice was a concept which became prominent later in their careers. Their stories highlight the art and wisdom of practice, the moral and ethical dimensions of caring, and the tensions which can arise when involving older patient who might have reduced function and no one to support them, into a decision-making process. The narratives of Ruth and Elicia show that they learned how to abide the tensions which arose in practice, especially how they learned to navigate the different and at times contradictory demands of patients, carers and colleagues and organisational cultures.

Building relationships with older patients was at the core of the participants practice. The importance of the relationship between the patient and health professional has been highlighted especially in relation to person- or relationship-centred care (Kitwood 1997, McCormack and McCance 2006, Nolan, Brown et al. 2006). The participants not only described the relationship they had with their older patients, but their stories about their day to day practice and the interactions they had with older patients included how they experienced their relationship with older patients and the meaning they attached to those experiences. The narratives of Ruth, Elicia and Anna, who all had close contact with older relatives within their family whilst growing up, revealed that values, beliefs and perceptions about older people developed before pre-qualification training and within their families, and were reiterated in the participants' practice. The values adopted through early socialisation and their experience with older people within the family shaped how they interpreted their professional role later in their career, and how they unconsciously or consciously positioned themselves in relation to their older patients.

The inner position the participants described varied between the participants. Ruth, who cared for her grandmother whilst still at school, felt a sense of comfort being with some of her older patients, wanting to be there for them, and doing for the patients what was important to them. She translated that into concrete actions in her practice. It included carrying out tasks for the patients, some of them such as hoovering or making sure that the patient had food available, can be described as domestic tasks. She identified herself as being a doer, and carrying out these tasks for the patient was important to Ruth because she knew it mattered to the patient, it was part of her role, of being there for the patient. She saw her role as being what she described as "professional friend" to the older patient, knowing that being there for the patient improved the quality of life for the patients and provided a point of stability and reassurance for them. It was later in her career when her role became restricted to clearly identifiable nursing tasks, that she experienced tensions and a sense of discontent.

Within Elicia's family older people were given a high status, she also grew up with strong cultural and religious beliefs about dying and death, and the importance of

maintaining the dignity of a person throughout their lives as well as after their death when dealing with the body of a deceased person. She carried those beliefs into her practice, they were an essential part of her practice. Anna, having extensive contact with older relatives whilst growing up, had a strong commitment to social justice and felt that older people deserved to be treated well because of the sacrifices they have made and what they have given to society when they were younger.

When I was analysing the data, the very personal elements found in descriptions and interpretation of the participants professional roles in practice surprised me. The descriptions of their relationship with older patients showed how strongly the personal and the biographical is embedded in professional practice of an individual health professional. The data show that the relationship between patient and health professional is not completely emotional neutral or learned exclusively through learned during professional education, or shaped by expectations, guidance and rules specified in a professional code of conduct and which all professionals have to abide by. But the latent meaning the participants attached to aspects of their work with older people was strongly influenced by biographical experiences of the participants, and as a result differed between the participants. The importance of the relationship between health professionals and patients has been highlighted specifically in relation to giving person-centred care. In person-centred care, it is acknowledged that the health professional's values and beliefs matter because they shape the care given to the patients (McCormack 2003, Titchen, McGinley et al. 2004). This study explores and gives examples of what individual professionals can bring to the relationship with an older patient.

The data also support the findings of other studies that building relationships is important not only to patients but also for the health professionals. Relationships between patients and healthcare professional are seen as being at the core of practice and gives meaning (Williams and Patterson 2009). Patients, especially those with long term and chronic diseases, and older patients are more likely to have multiple comorbidities, essentially want to build relationships with the healthcare professionals (Iles 2011). Relationship building with patients was seen as meaningful to occupational therapists (Williams and Patterson 2009). In the

research of Nolan et al, the term “relational care” rather than “person-centred-care” is used, because the term relational acknowledges that the health professional brings themself as a person and a professional into the interaction with the patient (Nolan, Brown et al. 2006).The case studies in this study give insight into how the participants brought themselves as a person to the relationship with their patients. The comparisons between the case studies showed how individual and unique that personal aspect in a relationship between a health professional and a patient can be. The type relationships they build with their older patients was partly related to their individual biography and in turn influenced how they interpreted their professional role in relation to their older patients and how their experienced their work.

In the narratives, the participants reflect that the relationship between them and the older patient is not necessarily only based on the professional giving to the patient. When the participants elaborated on some of the qualities of their relationship with older patients, they described relationships based on mutuality, giving and taking, learning from the patients, having a personal connection to the patient (Elicia and Michael) or feeling a sense of comfort and acceptance when being with a patient (Ruth), and gaining job satisfaction (Zoe). The experience of their relationship with older patients could be enriching, interesting, affirmative. The case studies identify some of the building blocks of relational care from the perspective of a healthcare professional.

Through their practice, the participants lived and implemented the values and beliefs they had about older people, and embodied those values through role modelling especially later when they were in senior positions managing and mentoring less experienced staff (Elicia, Michael Ruth). They aimed to help healthcare workers and students to integrate those values into their own practice (Ruth, Michael, Elicia). Michael was as a consultant geriatrician in a leadership role and being a mentor and role model to a younger generation of geriatricians. Viewing the data from the perspective of lifespan development and the theory by Erikson that each life phase is associated with specific life tasks, passing on positive values to a younger generation of healthcare professionals can be understood as generativity, a psychosocial development stage of middle age

where in midlife individuals passes on their values to the younger generation (Erikson 1994).

The participants reflected on the ageist attitudes they encountered in society and in healthcare settings. They drew a picture of the wider context in which practice took place and how the context shaped the learning about old age and working with older patients. Ruth, Elicia and Michael were all aware that working with older patients was considered low status work in the sixties and seventies, when they were in the early stages of their professional lives. The participants used the term *"Cinderella Service"*; Evans used the term when writing about the history of geriatric medicine (Grimley Evans 1997). Because of the way in which working with older patients was perceived by others, they had to transcend prevalent negative attitudes, go through a process of individuation. It is not clear from the narratives if the disapproval were colleagues or a general societal disapproval or both. They had to overcome the perception that working with older patients was considered low status and a poor career choice. In a more recent article, Oakley et al (2014) identified that working with older patients is still seen as a poor career choice by medical students in the UK, indicating that attitudes working with older patients have not changed significantly which is a concern considering that an ageing population means that an increasing number of doctors are and will be working with older patients in their day to day practice(Oakley, Pattinson et al. 2014).

Michael's interview demonstrates most clearly how he needed to overcome ageist attitudes. To specialise, he had considered several choices for specialisation, he eventually had to make a choice and made the commitment to train as a geriatrician, despite being aware that geriatric medicine had a relatively low status at the time.

Additionally, the participants gave accounts of being witness to poor care of older patients in the past. Witnessing poor quality care of older people made Elicia and Michael determined to improve the care of older patients and acted as a strong motivator to becoming expert in the care of older people. Each of the participants narratives reflected some tensions they had experienced in their work with older patients. The participants reflected on task-focused cultures, a culture which they

perceived as giving them little professional freedom to make decisions on how to care for an older patient. Ruth reflected on the limitations imposed on her role as a nurse. Zoe, the youngest participant, was considering her future career options. Zoe perceived the organisational culture of older people's care as too prescriptive and too task-focused which contributed to her decision not to want to work with older patients in the future. This was despite that fact, that Zoe had chosen to work in care homes at weekends whilst still at school. Her narrative of her work with older people reflected enjoying working with older people and positive attitudes towards them. However, thinking about her future as a qualified occupational therapist, she perceived the work with older patients as not being sufficiently person –centred and lacking professional autonomy and creativity to make treatment decisions. Her case study supports the findings of Robertson and Finlay(2007), that if the role of the occupational therapist is too specifically defined, the therapists feel that they cannot be responsive to the patient, and this can be experienced as point of tension (Robertson and Finlay 2007).

As an occupational therapy student Zoe is developing her professional identity including her preferences how she wants to work once qualified. Ruth found that over the course of her career and increasingly task-focused culture meant she could not give the care to the patients she wanted to especially it meant that she could not integrate the preferences of her older patients into her care. She found this particularly difficult: being a "professional friend" was part of her professional being. Both Zoe and Ruth case studies reveal that they themselves did not have negative attitudes towards older patients, but how they perceived the role of an occupational therapist or nurse in a technocratic culture as demotivating and stressful. it is important that health professionals have scientific and technical knowledge to be able to give care to older patients, but the importance of the relationship between health professional and patient, allowing two humans to meet, can be easily overlooked or not valued enough. Considering that there is a concern that healthcare students have negative attitudes towards working with older patients, the fact that it is not necessarily individual attitudes but the organisational culture which can be the main demotivating factor to work with older patients is concerning. Experience in practice, as well as the perceptions of work environments students have, are part of their motivation and learning.

Tadd's research on dignity highlights the influence of workplace culture on practice. Workplace culture impacts on staff and patients. Task-focused workplace cultures do not enable staff to work in a person-centred way (Tadd, Hillman et al. 2011). As Zoe's narrative demonstrates she examined their suitability for certain types of work by having developed an understanding of herself, and by assessing the match between her aspirations, values, developing professional identity especially how she wanted to work with patients once qualified. Both Ruth and (Manley and Cormack 2003). Zoe's case studies demonstrate the point that Yanow makes: that individuals choose a mode of practising which fits with their predisposition and values (Yanow 2014).

The interviews revealed the interconnection between the wider, external context of work; and the internal and inner life of the healthcare professional, the personal dimension in individual participants' professional work and the tensions the participants experienced. A complex interaction of factors such previous experience of older people, the values, beliefs, and perceptions about old age and older patients, a scientific interest in the medicine of old age, the feelings experienced when working with older patients acted as motivators as well as demotivators to work with older patients. The diversity of biographies in this study show that the participants' careers took different turns and that the participants made different choices about their careers and how to develop their career. Because of the individual nature of each biography, the personal understanding of healthcare professional to understand themselves can be helpful to their understanding of their practice and the organisational context they are working in and want to work in in the future. The experienced participants had at some point in their careers chosen to work with older people, despite the low recognition given to the work (Grimley Evans 1997). The close links between the personal and professional values and beliefs about older patients are tightly interwoven and linked to professional and personal identity, and instrumental in shaping the participants' professional practice.

The experienced participants who were at the time of the interview looking back over more than twenty years of their career, showed the transitions and changes they have gone through over the course of their career. They saw the lack of a

defined career plan at the beginning of their career as an advantage: it meant that they build up experience and knowledge in different clinical settings and medical specialities and that they could evaluate how well suited they were to certain types of work.

The temporal element of the biographical narratives show that the participants engaged with learning opportunities at different times of their career. Ruth was wanted an opportunity to widen her repertoire in practice, for Anna it was useful because she had an identified a gap in her knowledge. Formal learning was beneficial for some of the participants at times when they were receptive to learning.

6.3.2 Disjuncture, and turning points

Learning in healthcare is described as a continuous, cumulative and often unconscious process. Healthcare professionals learn from each interaction with the patient and the actions they take (Richardson 1999, Coles 2013). Over the course of their pre-qualification education, when initial professional socialisation takes place, all the participants described how they learned to become a health professional, a nurse, or a doctor or an occupational therapist. Professional socialisation continues post-qualification and is a continuous and cumulative process (Giddens and Sutton 2013). The narratives contained two intertwined strands of learning – learning to become and developing as a healthcare professional and developing knowledge to work with older patients.

The narratives show the participants had defined transitions and significant turning points in learning at different points in their career. It was at the point of transitions, turning points, or points of crisis where the narratives laid bare the experience of becoming and being a health professional. It is at those phases or points that a sense of becoming, of who they wanted to be in their future career became clearer. During transitions or turning points, a sense of movement, a development of professional identity, can be detected in the narratives, and because the participants had to interact with new and unfamiliar and at times challenging clinical situations or environments which challenged them, they recounted experiencing a sense of disjuncture.

Transitions involve a change of context and demand that the individual deals with the change psychologically, cognitively and socially (Ecclestone 2007). Experiencing a sense of disjuncture individual can be the beginning of learning. Jarvis describe disjuncture as an interruption in the taken-for-granted flow of time that creates a gap between what the individual expects, based on previous experience and biography and what is actually happening. Learning often begins when individuals experience a sense of the unfamiliar, discomfort, an emotional response or have a new cognitive insight. It is often at these points where reflection occurs or a gap of knowledge is identified and new learning can begin (Jarvis 2007). The participants told stories of when they had to deal with a clinical situation where they had no pattern available to them to guide their actions, and they had to deal with clinical scenarios which were challenging, where there was no obvious solution.

The participants identified these points as being significant to their learning about older people. The transition from being a student to be a newly qualified healthcare professional has been identified as being stressful and demanding (Fortune, Ryan et al. 2013). When there is a change of environment, transitioning from university to a clinical environment, or from one clinical environment to another that the skills learned in a different context might not be easily transferable. (Richardson 1999, Maben, Adams et al. 2012). The demands on newly qualified staff working in highly complex environments, and the care of older patients is recognized as highly complex, has been identified as difficult for novices. Having to work in an increasingly complex environment where they are expected to work without much support has been predicted to become more common for newly qualified Occupational therapist (Fortune, Ryan et al. 2013).

Anna describes the challenges of her first post as a qualified occupational therapist, and how she started to fill the gap in her knowledge when she attends the course about ageing and dementia after she had she had completed a rotation working on a specialist dementia ward. She identified how that knowledge might have been useful for her when she was working with patients with dementia but also might be useful in the development of her future practice. Learning in practice takes place in any clinical setting regardless of the age of the patients.

However, the case study of Anna describes with some clarity that it was the complexities of working with patients with dementia, which challenged her at the time. The participants also described feelings associated with their learning, and those feelings were part of the learning, and were part of a meaning making process. They described their sense of frustration, sadness, or humility when they failed to care for a patient as they had wished or hoped for, or a sense of achievement when they felt they had coped well and improved the life of a patient. The emotions health professionals or students experience in their work are often unacknowledged, but are linked to the development of professional identity (Helmich, Bolhuis et al. 2012). Anna recounted the sadness she experienced when working with older patients. Being aware of her feelings was an important part of her learning about herself, and the type of work she might want to do in the future. It was in the articulation of their experiences, and their reflections about the experience that their learning become tangible in the narratives.

Elicia's case study highlights also the tensions between structural, the work environment and the lack of aspiration for older patients which were reflected in the care they were given, and her inner world, the status she gave to older people in general and the ambitions she had for her patients. Her powerful reflections focus on the differences between her personal values about older people and the most senior colleague and the way of practice on the ward. Organisations have a cultural way of practice, reflecting collective values and beliefs (Yanow 2014). Being aware of the differences, it made her determined to act, to initiate changes and to challenge existing conditions, but the lack of support by others meant she could not transform existing practice sufficiently. Nevertheless, this experience had a long-term impact on her career and acted as a strong motivator to improve care of older patients throughout her career, and to find positions of leadership where she could make changes to the way older patients were cared for.

Observing how older patients were cared for made the participants question their own practice, and assisted to clarify how they themselves wanted to care for older patients. The case studies show that the conscious witnessing of poor care a clinician can lead to conflict and disruption (Elicia) and as well an increased

commitment to learning and transformation, but only if the culture of poor care is rejected, at least internally, and the participant decides not to become part of an organizational culture where poor care is the norm. It motivated Elicia and Michael to work towards being a mentor or role models for others in the future. It increased the awareness of the values they held, and their self-knowledge through critically questioning themselves as professionals and assisted them to define their future career choices.

The experience of disjuncture or a crisis in practice where the participants interacted with their clinical environment, led to self-reflection and self-knowledge, or an identification of a gap in knowledge. The case studies show that this can act as a motivator for development and learning and improving practice, or of taking actions which narrowed the gap between their internal and external world. It also could lead to a shift motivating the participants moving away from the care of older patients. Anna and Zoe's who were deciding on with the type of patients they wanted to work with in the future reveal how their experiences and perceptions of the care of older people, and the tension between the organisational cultures and themselves as occupational therapists were incongruent. Professionally this meant that they were less motivated to search for jobs which mainly involved working with older patients. Ruth's case study who found working with older patients rewarding but found that the culture she was working in was increasingly changing to a more task-focused way of working eventually suffered burn out. She tried but could not resolve the conflict and having to compromise increasingly on her preferred style of work eventually.

The experience of disjuncture, tension and internal and external conflict in practice can become points of learning. The narratives laid bare some of the challenges, the struggles, and emotions of the participants experienced. These experiences which can be points of crisis can lead to reflection and increasing self-knowledge, and the development of professional identity.

6.3.3 Types of learning: informal and formal learning

Because learning is multifaceted, the term learning can have many connotations and is open to interpretation. The participants for this study knew that the focus

of this study was on learning. However, the term learning in itself was specified or defined in the information sheet but not used in the initial question of the interview. After reading the thoughts by Rosenthal how to phrase the initial question for a BNIM interview, the initial question was kept open and vague so that the participants could be free to choose a starting point for their narratives (Rosenthal 1995) .

In the interviews, much of the learning they described was experiential, learning through practice and working with patients and with other members of a team. However, participating in courses were part of their learning.

The narratives reflected that the participants attached a varying degree of significance towards studying towards an accredited qualification or attending courses. The fact that formal learning was barely mentioned in some of the interviews does not only relate to the closeness of the experience or memory recall, but is also related to the meaning they attached to this. It might also be related to their feelings about the course or that they had negative associations they did not want to express. In a study like this it is impossible to be certain that if a participant did not recall formal learning opportunities meant that they were absent, or they might not have recalled them during the interview.

For Michael to understand the body scientifically was fundamental to his practice as a geriatrician although he learned a lot through working in practice and doing research, rather than being formally taught. In contrast Ruth recalled extensively and vividly the experiences she had on her pre-qualification course, she talked about becoming a nurse through immersion into practice, through sharing her experiences with other students and as well as having some classroom teaching. At the time of the interview Ruth's initial education was over thirty years ago, yet her recall was lively. It could be argued that much of her learning was informal, but the structures of the course facilitated learning through immersion into practice and interaction. Eraut sees the separation of the formal informal learning as too simplistic(Eraut 2004). Ruth's case study reveals the entanglement and of formal and informal learning and learning through practice. This is common in healthcare courses where student clinical or fieldwork placements are core elements of the curriculum, and learning is a combination of tutorials, lectures,

skills training and group learning. Anna's case study shows the acquisition of scientific knowledge, in her case through formal learning opportunities such attending short courses expanded her understanding of old age and theoretical understanding of medical conditions post-qualification.

Overall the narratives were weighted towards learning in and through practice and over time. Much of the learning described in the interviews was unplanned and unintentional, learning in practice, treating and interacting with patients, observation of practice, and interacting with colleagues. The narratives revealed the complex, multi layered environment of healthcare and the link between practice, learning and the individual experiences.

There was variation between the participants how they learned. The care of older people is described by being defined by complexity and uncertainty (McCormack 2005a). The participants reflected on how they learned and their preferred ways of learning. Michael was explicit that he developed the attributes which he considered being at the core of his practice as a geriatrician was through practice, through caring for patients and not courses. Ruth described how she became a nurse partly through doing in practice, reflection on practice, discussion and sharing of her experiences with her peer group. The learning with other practitioners from different clinical backgrounds widened her thinking how to care for older patients. Zoe learned about old age by spending time with her patients. Post-qualification the participants were challenged through practice to learn to deal with the complexities and uncertainties of practice. They learned to draw on a range of knowledge and knowing, blending scientific, tacit and personal knowledge, including knowledge which was biographical and unique to each participant, as well as integrating ethical and moral considerations into their practice. De Crossart for example identified fourteen forms of knowledge a surgeon draws on (De Cossart and Fish 2005). Mattingly identified different forms of reasoning experienced Occupational therapists use (Mattingly and Fleming 1994). The challenges newly qualified healthcare professionals for example Anna and Elicia faced demonstrate that it takes time to develop expert practice and professional artistry.

Anna's and Elicia's narrative highlights the intensity of learning which can take place at the beginning of working life, and highlighted some of the factors which might hinder learning. Anna recognised that she was part of a bigger organisation, but lacked interaction with colleagues and experienced staff in her immediate work environment. Interacting frequently with colleagues might have helped to learn the context specific knowledge relating to her work with patients with dementia, and feel that she was becoming a member of a community. Coles identifies discussion and dialogue with colleagues as a condition for learning in and through practice(Coles 2013). Anna identified a lack of discussion and dialogues with her colleagues in her first post. More interaction with colleagues, and having a mentor might have increased her confidence and knowledge in practice. She made meaning of the practice situation working with the values she developed during her professional training, but which were not necessarily easily applied in her specific context. Support can be essential when making the stressful transition from being a student to a qualified healthcare professional. (Coles 2013). Structured and unstructured support form mentors can ease the transition of being a student to qualified health professional (Maben, Latter et al. 2006).

The narratives reflect the diversity of the mode and timing of learning as well the meaning participants attached their experiences in practice and how they connected these experiences to their biography. Participants learned at different times in their career, and learning was linked to the context of their day to day practice, but also to specific, unplanned and unpredictable events in practice. How the participants attached meaning to these events at the time varied. Some of these experiences led to critical reflection, identification of a gap in knowledge, questioning who they wanted to be, and increased the receptiveness to new learning. It is at these points that the creation of learning opportunities might be particularly beneficial for the development of knowledge.

6.3.4 Does learning to work with older patients require specialist knowing

The body of knowledge about ageing, old age, and caring for the older patients is broad and multidisciplinary (Johnson 2005). The remit specified for the care of older patients is very broad (Oliver, Foot et al. 2014). The standard of education to

prepare healthcare students to work with older patients has been identified as problematic. (McCormack 2005a). Some of the knowledge and skills health professionals draw on in practice can be difficult to identify and articulate (McCormack and Ford 1999).

Michael highlighted the older patient and their problems might be not very well understood by other medical specialists who might be experts in one aspect of medicine but lacked knowledge necessary to be a geriatrician. Even in terms of learning technical and propositional knowledge about old age and working with older patients, it can be difficult for learning institutions such as universities to identify what future health professionals need to know about ageing and old age (Gordon, Blundell et al. 2014). For the individual health professionals, it might be difficult to identify what they need to know. Some of the practice knowledge they will observe in practice will be context specific to the clinical and organisational setting and tacit, will be implicit rather than explicit knowledge (Fish and Coles 1998).

Even within a formally taught course, a named topic might not be identified as being relevant to the care of older people. Even if topics related to older patients are included in the curriculum, Gordon et al found that the topics have narrow focus and do not reflect the wide field of ageing studies (Gordon, Blundell et al. 2010, Gordon, Blundell et al. 2014). Zoe recalled that the topics relevant to old age was embedded in other topics and not explicitly identified within her University schedule, and it was only during the teaching session that the lecturer related some of the content to ageing or older people. Both Anna and Zoe had student placements which included the care of older patients. Anna who was very articulate during the interview, did not expand on her experience working with older patients as a student. It is possible that the professional language relating to old age and working with older patients might not have been attained with the same confidence at the time.

The lack of learning and teaching about ageing and old age at pre-qualification stage raises the question how students acquire awareness and curiosity about old age, the scientific knowledge they need to draw on in clinical practice, and learn to articulate their professional work, exchange information and participate in

team meetings and discussion. Learning has many components and layers which can be interlinked and related. Educational theories highlight that the whole being is involved in learning including the senses, as well as language (Jarvis, Holford et al. 2003). Health professionals learn to work with older patients through experience, they learn through doing, and they develop skills and knowledge through observations and for example using vision and touch. In healthcare. *"we make sense of the world, form categories and concepts, weigh and evaluate evidence, make decisions and solve problems, all without language, or even being consciously aware of the process. "* (McGilchrist 2009 page 107). Even language is only one of the drivers of learning and developing knowledge, learning to understand and speak professional language is part of becoming a health professional (Sinclair and Toulis 1997).

Potentially not learning the professional language which relates to ageing and old age might make it more difficult for practitioners, especially novice practitioners in this field, to interact with confidence with their colleagues and members of a multiprofessional team. The narratives highlight that observation of colleagues was one way of learning. Interprofessional team work is integral to the care of older patients (Department of Health 2001), especially patients who have "*who have complex co-morbidities associated with older age are best treated by a dedicated specialised team"* (Department of Health 2001, p57). Language makes dialogue and discussion with colleagues possible. Coles links learning to talk with the thinking and action of the health professional *"…but crucially they also learn to talk. They acquire an understanding what is appropriate professional thought (and hence action) in particular situations"* (Coles 2004, p553). The development of a professional language is part of becoming a professional, it is part of the hidden curriculum, being able to talk like a nurse, a doctor or occupational therapist. Being able to communicate within an interdisciplinary team is part of learning and knowledge formation within a team(Finch 2000, Hall 2005). The absence of a professional and shared language could potentially hinder further learning in practice and the development of practice.

In the narratives, the participants made reference to the acquisition of scientific and theoretical knowledge as well as the formation of tacit knowledge such as

attitudes, values, beliefs and perceptions about older people and the knowing in practice. They reflected on the need to oscillate between seeing the patient as a person, and at the same being able to draw and on for example detailed scientific knowledge and understand the individual emotional and social needs of a patient, and to be able to integrate a range of knowledge in their practice. Anna, Michael, Elicia and Ruth agreed that specialist scientific knowledge about the impact of old age on the function of the body, and illness and disease commonly diagnosed in older people, informs the work with older patients. To understand the body and body function from a biomedical point of view, and how illness expresses itself in an older person was specifically emphasised by Michael and Ruth.

The experienced participants identified that one of the building blocks of becoming an expert in the work with older patients was being able to draw on the skills and knowledge on a broad range of medical and clinical specialities having worked with patients of all age groups. Having the wide medical and clinical knowledge of a generalist contributed to their development of specialist practice knowledge and self-knowledge, enabling them to eventually become experts in the care of older patients. Michael expressed most clearly that in geriatric medicine being a generalist as well as being a specialist in old age go together. For Michael being able to draw on detailed scientific knowledge how different body systems work, gave him the ability to address the medical needs of the older patients. Anna identified that she would have been more confident if she has had more specialist knowledge when she worked on a dementia ward.

Ruth, Elicia and Michael took the view their work with older patients benefitted greatly from the general knowledge they had built up over the years. This is interesting in terms of answering the question how healthcare professionals learn to work with older patients and the timing of specialisation. If working with older patients means being a specialist and a generalist at the same time, then wide range of experience can be seen as an advantage, or might even considered be essential.

All the participants highlighted that the personal knowledge including having communication skills, being able to work in a team, having positive attitudes towards older patients, empathy and compassion underpin the day to day

practice. Learning how to work with older patients relied on learning how to engage and interact with the patients. Anna recognised her ability to communicate with older people as a valuable asset, and was grateful that she had developed that knowledge before she started her education as an occupational therapist. It helped to sustain her when she was struggling with the complexities and uncertainties in practice. Building relationships with older patients, especially with patients who were considered vulnerable, frail, very ill or disabled, and who found it difficult to express their needs, was learned through personal and professional experience. The relationships were described as one of mutuality wanted by the patient but also wanted by the participants. The findings of this study reflect the findings of studies by Williams and Patterson (2009) and Iles where relationship building was seen meaningful and was valued by health professionals and was part of developing professional artistry. (Williams and Patterson 2009, Iles 2011).

In the narratives, the participants compared the challenges of working with older and younger adults. Elicia's narrative highlighted the specific difference between younger and older patients. Relationship building with younger patients was easier because younger patients could be articulate their concerns and were more assertive, with older patients, the onus to understand how to relate to the patient was on the health professional. But working with younger adults had aspects which were also difficult. Elicia and Ruth highlighted that the death of an older patient was easier to accept than the death of a younger patient.

Embodying values like dignity and respect, and being able to see patient as a person in the context of the patients' whole lives, rather than seeing the patient in a hospital, underpinned the therapeutic relationship between the participants and their older patients. Some of the values the participants had adopted were crucial to their practice, but were not always easy to implement. As Nicolini states " tacit knowledge is not only prereflexive, it is also and above all social, and hence open- ended, provisional, and subject to local negotiations. " (Nicolini, Gherardi et al. 2003) and working in different environments meant that the participants compared their own values with the values they identified in the organisational environment. The experienced participants also talked about passing on their

values to younger or less experienced staff. The concept of generativity described in the life course theory by Erikson can be useful to understand the motivation for passing on their values. Generativity is usually understood as something people in adulthood develop – passing on values to a younger generation. However, the case studies also show that the participants ensuring that the values they held about older people were translated into their practice and in effect passed on to an older generation.

Learning to live with emotions experienced as a health professional can be part of learning. The emotions the participants experienced in their work with older patients and were interwoven throughout their narratives. Their accounts contained descriptions and reflections of range of emotions they experienced when working with older patients, such sadness, fear, frustration, comfort, purposefulness, job satisfaction. The narratives show a range of emotions, positive and negative emotions. If emotions are considered part of learning, working with older patients can evoke difficult feelings around illness and the stigma of illness, physical decline, and death. These are not neutral and objective topics but can evoke subjective responses (Terry 1997, Tallis 1999).

The emotions the participants experienced were partly linked to the perceptions the participants had about their older patients lives. The emotions of health professionals evoked through contact with patients often stay unacknowledged, even they are part of the experience of healthcare students and practitioners (Shapiro 2011). The participants perceived the lives of their older patients as lonely and socially excluded. Anna was the most explicit in expressing her feelings and that the loneliness she has observed in many of her older patients evoked a lot of sadness in her. Being aware of her feelings when working with older patients, made her question if she was suited to work with older patients. On the other hand, the social isolation of their older patients could act as a motivating factor to be there for the patients.

For Zoe and Ruth knowing that their presence was important to the older patients, added a sense of purpose to their work as they knew that they could make a difference to the patients, to lessen feelings of loneliness or the absence of family and friends. Shapiro discusses that in medical students, patients,

especially vulnerable patients, might evoke emotions of helplessness. Medical students learn how to manage their emotions, to follow social norms of acceptable ways of dealing with difficult emotions they experience, when dealing with patients rather than learn to critically examine emotions they experience (Shapiro 2011). In a professional role dealing with emotions can be understood as an individual as well social and educational domain(Holman, Meyer et al. 2006). In this study Ruth's and Zoe's case studies showed that the experience of caring for patients who were vulnerable also add purpose of the professional role, if the organisational structure enabled them to work in a person-centred way. Ruth was a nurse, and Zoe an occupational therapy student, and therefore the role expectations are different from those of a doctor, and that might have made it easier to deal with the vulnerabilities of their patients.

For all the participants, the practice of caring for older patients was also driven moral, ethical and social considerations. These considerations were drivers of the participants' professional practice. The participants had a strong sense of the need to mitigate for factors such as ageist attitudes found in healthcare and wider society, and the loneliness and losses many older patients experienced in their lives. These factors shaped the sense of responsibility the participants felt towards older patients, and influenced how the participants build relationships with patients, and interpreted their professional role in relation to older patients. The participants realised that professionally there were times when they needed or wanted to compensate for absent families and friends, or the experience of ageist attitudes older people especially frail, vulnerable, and ill older patients faced. Iles described in her research: that healthcare professionals often replace absent family for the patients(Iles 2011).

For Ruth replacing absent family to the older patient was part of her role. They also attempted to mitigate ageist attitudes prevalent in healthcare, or the ageist attitudes patients had internalised about themselves, some older patients believe themselves that nothing could be done for them. The participants found that caring for older patients demanded accepting a high degree of responsibilities towards the older patients. The combination of ageism, and the increased physical, social and psychological vulnerability of many older patients increased

the sense of duty they felt towards older patients. The responsibility, empathy and compassion the participants felt towards the patients can be seen as a laudable, but there was another side to the coin, that it could have a negative impact on the individual concerned. The work with older patients was associated with considerable emotional labour, managing their emotions within the work setting, but Anna realised that she experienced a degree of sadness which made her question her suitability for this work (Anna) and the demands of the work and the emotional labour involved in her day to day work eventually lead to burnout in one of the participants (Ruth).

6.3.5 Learning to work with older patients – empathy, compassion, imagination, aspiration, hope.

The participants described aspirations for their patients, they draw on a kind of "optimistic" imagination, which propelled them to work towards improving the lives of the older patients through care, treatment and support they gave to their patients. Three participants, Elicia, Michael, and Ruth, reflected on being old themselves one day. It can take imagination to visualise oneself old. Imagining what it is like to be old, especially very old, can be difficult or impossible. Many adults defend themselves against old age and do not like to imagine themselves as being old (De Beauvoir 1996, Tallis 1999, Andrews 2014). All the participants talked about their older patients with empathy and respect. The participants distanced themselves from poor and neglectful care they had witnessed at times where lack of expertise, poor decision making, ageist attitudes and negative stereotyping of older people contributed to poor care. The problem of neglect or poor treatment of older patients has been of older patients as been widely reported (Patients Association 2011, Francis 2013).The fear of old age and death can mean that individuals defend themselves against the idea of old age and their own mortality, and this can be part of the reason that older patients often are negatively stereotyped. In the narratives, the participants expressed that they did not want to be part of a culture where patients were treated at a lower standard than was personally acceptable to them. Terry observed that healthcare staff can create a distance between themselves and their older patients to avoid engaging

in thoughts of their own death, which can potentially leading to neglect of older patients (Terry 1997, Terry 2008).

But learning to work with older patients does not take place in vacuum but in a wider social context. In three of the narratives the role of the family came to the forefront, and how the contact with older people within the family can play a role in developing empathy and positive values towards older patients. Whilst the participants talked with empathy about the older patients they cared for, the data of this study suggest that having close and affirmative contact with older family member within families can be helpful in developing positive values towards older people. It is not clear from the data how Zoe and Michael, who did not give an account of the contact they with older family members, how they developed the empathy they clearly had for older patients. Health professionals who care for older patients are by the nature of the job, younger than the older patients they care for, some who could be categorised as very old. The health professional does not have the lived experience of being old and very old themselves, but they gain insight what it might be like to be in this phase of life through their professional and possibly personal lives. The participants could put themselves into the shoes of the older patient, but did not necessarily see themselves or identify themselves as being like their patients in the future. The narratives show that the participants could imagine what it is like to be sick, old, and vulnerable or lonely. Elicia and Ruth made reference to perhaps becoming an older and vulnerable person themselves one day. Anna and Zoe did not refer to their own ageing but talked about the loneliness and segregation of their patients' lives. Being empathetic does not necessarily mean that the individual has to identify themselves with the patient. Michael who was in his mid-sixties at the time of the interview, drew the strongest boundary of all the participants between him and his patients, he did not see himself ever becoming like his patients. He anticipated his own old age to be very different to the old age of his patients, because he had the knowledge and had a life style which he knew would help to prevent the illness and disability commonly diagnosed in his patients, yet one of his motivations for his work were to improve the lives of older patients. He had a strong professional identity as a doctor.

Empathy for older patients the participants had was one of the factors which motivated them to want to give good care to their older patients. Having empathy with a patient can lead to better outcomes for the patient but it has been identified that it declines in healthcare students within the first or two years of starting their training (Nunes, Williams et al. 2011). But other elements also underpinned the work. Michael case study revealed a mix of elements which included wanting to work with older patients, seeing the person in the patient, staying curious, having the confidence in one's expert practice knowledge and that of the multidisciplinary team to be able to improve the life of a patient. Developing these personal qualities, attitudes and skills were essential in learning to be a geriatrician. Being able to imagine a future for his patients, when others could not, stayed a strong motivator for his work throughout his career. Many of his patients were sent to him because other medical specialists could not help the patient, but having in depth biomedical knowledge of how the body, he knew that he could improve their medical condition and quality of life. Even Michael talked about the body suggesting a biomedical approach to care, he also talked about building connections with the patient. The elements of practice which were apparent in Michael's case study also emerged in the narratives of the other participants. They all knew that their professional knowing and expertise, having the professional technical "know how", having positive attitudes and being able to connect and communicate with older patients made a difference to the patient.

Having hope for the patient and being able to imagine the patient to be in a better place were significant elements in in the underpinning of care of the older patients. The participants described how when working with a patient they looked beyond the here and now, but looked into the future of the patient's life. Elicia compared the life of the patients on the ward, which she perceived as very limited, with the life she thought the patients should have once discharged home, and her goal was that the patients can participate in life and lead the life they want to live. The participants recognised that many patients were constrained by illness, disability and social circumstances; that the losses experienced by an older person can be significant (Nicholson, Meyer et al. 2012). Unlike younger patients the recovery of an older patient from a medical condition can be slower, more difficult or absent (Cornwell 2012). The patient might be on a declining trajectory

and be close to death. The narrative of old age can be full of contradictory realities and stereotypes. When learning about working with older patients, focusing mainly on the physical and cognitive decline of older patients has been identified as off putting to nursing students(McLafferty 2005). Yet only focusing exclusively on what can be described as the narrative of successful ageing, creates the danger that older people who do not fit that picture and perhaps are in what can be described as the fourth age where loss and physical and cognitive decline become more apparent, are in danger of being stigmatised overlooking the nuances and diversity of the lives of older patients (Biggs, Phillipson et al. 2006, Oliver 2015). Old age can be an important time of development and life work (Twigg 2006, Tornstam 2011). The work of Nicholson (2012) which focuses on the subjective experiences of older patients, seeing the diversity of old age and older patients rather than relying on the categorisation of old age into third and fourth age or specific age groups, raises questions about the segmentation of older people's lives (Laslett 1996, Baltes and Mayer 2001, Nicholson, Meyer et al. 2012).

Being able to hold in mind that the patient has and has had different roles in life, by understanding their past and current life, and imagining what might be possible in the future, they were able to look beyond the first impressions they had of a patient, and they were able to imagine a better future for their patients (Elicia and Michael). For example, Elicia had the psychological insight that older patients might be distressed especially when they are hospital, and that older patients might not able to articulate themselves easily. Her narrative on the one hand showed that she tried to understand the experience of being a patient, and revealed how she positioned herself towards a patient, revealing the relationship between the patient and herself. One of the strong motivating factors for Elicia, Ruth, Michael, Zoe and Anna in their work with older patients, was their aspiration to improve their patients' lives and knowing that their professional roles gave them agency to act, to establish a relationship with the patient, to assess the patient. The anticipation that a patient might not get better did not change that position. If the patient was dying, and the length of time a patient might have left was short, they still adopted a hopeful stance, knowing that they could make a difference to the patient and their families. Examples are found in Anna and Michael's stories of helping a dying patient to have a good death - such

as being pain free, able to die with dignity or enabling a patient to die at home. Michael described how he had worked in a hospice, and having had mentors and role models in end of life care, he accepted that the role of being a doctor is also looking after a dying patient. The combination of wanting to do the best for the patient, having practice knowledge and the ability to transfer and adapt some of what they have learned to the context of the individual patient they were caring for, as well as having imagination, aspiration and hope for their older patients, shaped their practice. From the data, it emerged that having the aspiration to be a good health professional, and of giving good care and having hope for the patient, can be described as a form of knowledge, especially if it is combined with knowing that one can through having practice knowledge make a difference.

7 Chapter 7: Conclusion and recommendations

The study provides insight how health professionals learn about ageing, old age, and working with older patients. The biographies show: how the participants learned to become a nurse a doctor or an occupational therapist over time; and how and what they learned about ageing old age and working with older patients; and the link between biography, practice, meaning making and learning. Participants oscillated between continuity and change over the course of their careers.

The participants' stories reveal the joys, successes, challenges, frustrations and failures experienced throughout their careers, and the negotiation of transitions, changes and points of crisis. Biography and learning are connected. It was in the stories they told and their reflections that the meanings the participants attached to their experiences became visible. Learning is intricate, complex and multi-layered. Although the process of learning cannot always be fully understood, the analysis of the data provided some insight.

7.1 Learning and biography

The biographical nature of the data revealed the often-unexplored space between the professional and personal, exploring the connection between the individual biographies, the participants' experiences of older people, and their professional becoming and being. Learning is an individual process, and because it is related to the biography of an individual and the subjective experiences of an individual. Learning about ageing, old age and working with older patients can have a very personal component to it. At the same time, learning to work with older patients is embedded in a societal, historical and cultural context; it takes place within the context of the attitudes and beliefs found in wider society and in healthcare. The understanding of old age and how the work with older patients is perceived is laden with meaning, values and beliefs, it is also connected to the individual biography and how old age and older people are understood in the wider society. Working with older people requires so much more than textbook knowledge. The data show that the participants' values and beliefs, and the perceptions they had about older people played a role in their professional becoming, and how they

build their relationships with older patients. Each of the participants stories contained elements which were individual, unique, and deeply personal. Health professional will benefit from understanding how their subjective experiences throughout their lives impacts on their learning about and practice with older people, as well as understanding the cultural context in which the learning occurs. Understanding one's own biography increases self-knowledge.

> **Recommendation**: The participants' biographies showed some of the experiences they accumulated throughout their lives. The values, beliefs, and perceptions they had about older people Exploring their own biography can help health professionals and students understand the connection between the professional and the personal, the personal elements they bring into their professional life, including their values, beliefs and perceptions about older people as well individual experiences. Develop ways to facilitate health professionals' understanding of their own biography and how they shape their practice.
>
> Further exploration and evaluation of how to integrate the concept of biographical learning into the education and development of health professionals can inform if biographical learning supports the development of health professionals.

7.2 The science and art of practice

For the participants in this study, the experience of working with older patients differed from working with younger patients. A combination of components how the participants learned to work with older patients were identified in the study. The complexities of caring for older patients is demanding. Health professionals need to have a broad range of scientific and theoretical knowledge: knowledge which is specific to understanding health and disease in old age. But this is only part of the knowledge they need to acquire. Working with older patients requires them to be able to develop qualities which allow them to deal with the complexities and uncertainties which are associated with the lives of the older patients they are caring for. A health professional needs to be able to understand

their patients holistically, considering the medical, physical, psychological and social factors which shape the lives of their patients. The participants built up practice knowledge which was holistic, expansive, complex and personal. This requires health professionals to, simultaneously, be both a generalist and an expert, and being able to combine the science and the art of practice.

> **Recommendation**: Facilitate the learning of knowledge which is broad and at the same time has a focus on ageing, old age and working with older patients. Enable the health professionals to build gerontological expert knowledge at different times of their careers and support them to deepen and broaden their knowledge through creating a range of learning opportunities.

7.3 Learning to be with the patient

It is important to learn how to connect with the older patient, no matter how ill, distressed, frail and vulnerable the patient seems to be; to learn how to adopt an inner position towards older patients which allows them to see beyond the first impression. Health professionals need to be able to see the person in the patient, in the here and now, and recognise their past and imagine their future. This requires them to develop maintain a sense of curiosity throughout their career, to have imagination, compassion and empathy, as well having aspirations and hope for the patient, and learn the professional "know how" which enables them to make a difference for the patients. Learning to work with older patients requires health professionals to develop these qualities, and to develop a form of practice knowledge which is not always easy to make explicit, but which is expressed and lived in practice.

> **Recommendation**: Create ways of developing the knowledge which is essential for working with older patients, but which cannot be developed through textbook learning. Nurture qualities like imagination, hope, empathy, curiosity, aspirations and seeing the person in the patients; and consider the holistic nature of learning and practice.

7.4 Learning within a societal context

The organisational context the participants were working in, and the societal expectations placed upon them as health professionals played a significant role in their learning. The wider societal and organisations context and the continuing negative perceptions of what is it like to work with older patients may not support learning. All participants felt a sense of duty and responsibility towards their older patients, and a desire to mitigate the impact of the ageist attitudes, social exclusion, and loneliness that many of their patients experienced. Each responded in their own ways. Each participant adopted an inner psychological stance to the work with older patients. It took courage, determination, self-belief and self-knowledge. Because of the low status associated with working with older patients, this meant differentiating themselves from prevalent attitudes and perceptions at times, and defend themselves against the negative attitudes extended towards health professionals who work with older people. The participants struggled to make sense of their experiences of what it meant to work within the constraints of the organisational structures they found in the care of older patients; and at times challenged these constraints, sometimes at personal cost.

> **Recommendation**: Health professionals mitigate for some of the losses associated with illness and old age and the low status older people are given in society. There is a need to recognise the wide responsibilities which health professionals learn to accept when working with older patients. Health professionals who work with older patients need to be supported and the exploration how this can be recognised at organisational and professional levels.

7.5 Opportunities for learning

The case studies did not reveal a standard way of the learning. Much of the learning was informal, unintentional, and unpredictable and individualised, although formal learning opportunities did also play their part.

The preferred mode of learning, and motivation to learn varies both between individuals, and for each individual, over time. There are times in a health

professional's life when they are more receptive to learning, and creating learning opportunities for the individual at the right moments can be particularly beneficial. The case studies indicate individuals have preferences for different modes of learning at different points of their career. Interaction with colleagues and peer groups, mentors and role models can support learning. Learning can be particularly intense during transitions and points of crisis: phases when individuals are likely to searching for meaning and be receptive to new learning and change.

Recommendation: If possible anticipate the transitions which are intense periods of learning where individuals benefit from additional support. Creating open, flexible and responsive, and informal learning opportunities which involve interaction with colleagues encourage health professionals to engage with professional development.

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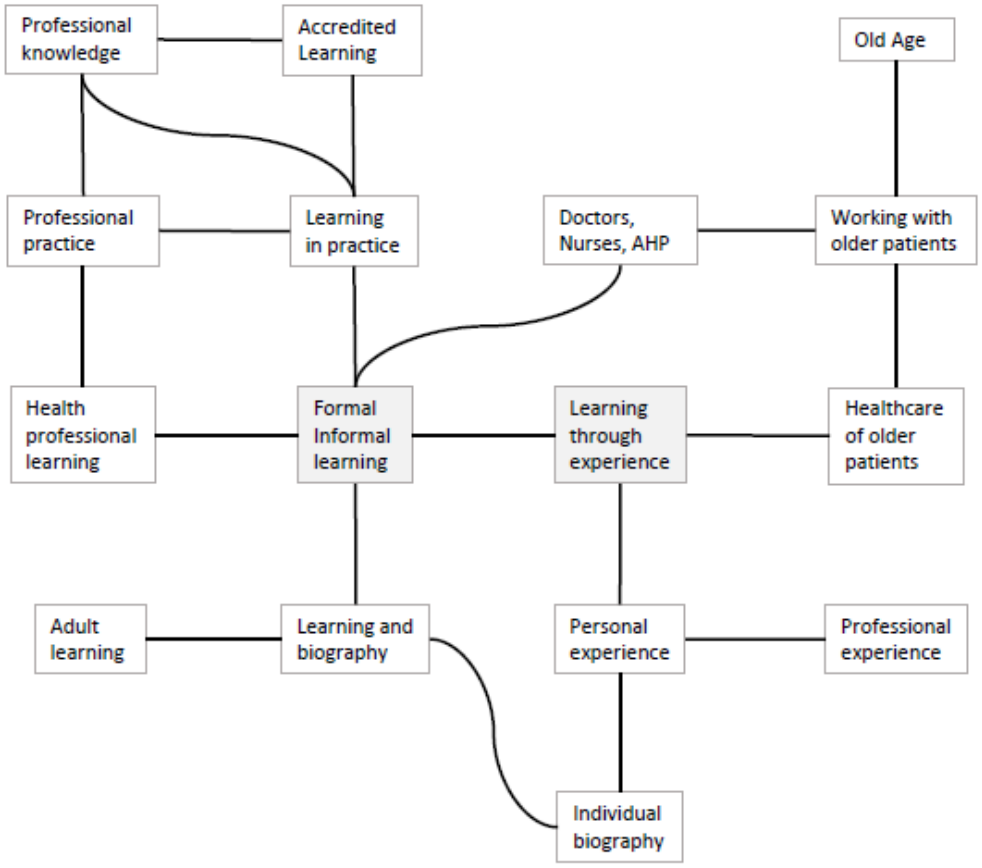
9 Appendices

9.1 Mind map of topics relating to this PhD thesis

FIGURE 2: MIND MAP OF TOPICS RELATING TO THIS PHD THESIS



9.2 Examples of data analysis

9.2.1 Sequencing of interview - example (full example)

This is the full sequencing, a part of which was used to illustrate the process in Text box 2 on page 95.

TEXT BOX 4: SEQUENCING OF INTERVIEW - EXAMPLE (FULL EXAMPLE)

- Opening of interview initiated by researcher
- Start of participant's narrative
- Retired now
- Nurse for 40 years
- Description of her role: Specialist in older people and stroke care
- Description of work role senior matron
- Management of nursing homes
- Detailed explanation of the different components of the job, including training of other staff, responsibility for delivery of care, ensure that care given to patients is individualised and personal.
- Change of job to working for a housing association. who was buying nursing homes.
- After couple of years, left to work in teaching hospital responsibilities for five wards including a stroke ward and continuing care wards. (This *was her last job before retirement*)
- Job in teaching hospital included the responsibility managing big budget and 300 staff
- Expression how she feels about her work: Passionate about older people and how they are treated.
- Highlights her values: Treat patients with dignity and respect
- Further explanation about her responsibilities: Did both, management and hands on practice.
- Enjoyed work with stroke patients. It is a challenge
- Identifies her preference of working on medical wards over giving care in surgical wards.

- Further explanation of her own role, and what she brought to older people care
- Experience: lists her different experiences.
- Reflects on the juxtaposition of older people services. Older people services are Cinderella services but looking after older people is a privilege
- Explains the reasons why for her it is a privilege to care for older people
- In hospital we see patients at vulnerable time
- Explanation how she sees the older patient in the context of the life history of the patient. “History, everybody has a life, and everybody has, you must respect, and everybody deals with stress and vulnerability in a different way”
- Description of her experience of patients who come into hospital
- Identification how patient might be feeling when admitted: Frightened
- Identifies the fear of many older patients: Loss of independence
- Description of practice she has observed: Staff forget about that patient has history; gives example how that might impact on their practice e.g. making decision for the patient instead of patient making decision.
- Highlights her own opinion: Disappointment in staff some who treat patients abdominally
- Description and examples of poor practice
- Reasons why it is difficult to improve practice
- Individual members of staff
- Attempts of changing practice
- Context such as group behaviour and laws can make it difficult to deal with members of staff who give poor quality care.
- Description of herself as a change agent
- Identified the qualities required being change agent.
- Description of herself as a change agent: Success at being a change agent

- Example of how she changed care for the better
- Contribution of other staff
- Explains the financial and political context in which care takes place.
- Change of topic: Question about career history (interviewer)
- Dates of training
- Life history?
- Transition to work
- Geriatrics
- Self
- Values
- Trained in cancer nursing
- Describes her experience of cancer nursing
- Did not get a job in cancer nursing and start of job in another hospital on renal ward and then in geriatric medicine
- Explains her goals for patients on geriatric ward: to increase Independence and mobility of patients.
- Description of the conflict of her goals and senior staff, and the disagreement she had with consultant of the ward.
- Gives examples she worked towards achieving goals with the patients in day to day practice.
- Got another job because of frustration with previous one
- Career change: Becoming a health visitor
- Description of work and role as a health visitor included all generations of a family: babies/older people
- Change in personal circumstances: got married and had child
- Decision to change job to maintain skills she felt she wanted to maintain
- Taking on role in training and development
- Description of emotions
- Description of role
- Career change
- Reason for career change

- Values and beliefs underpinning practice led to being made redundant.
- Explains consequences on career
- Values and beliefs
- Time of transitions
- Change of job: became infection control nurse
- Change of job: dental nurse
- Change of job
- Argumentations: Changes of job and working in different specialities lead to broad experience
- Studying for a nursing degree (formal education)
- Keeping a portfolio to show professional development
- Involvement with older people forum at the Department of Health
- Highlights differences in medical issues in different age groups: in older people medical issues are complex.
- Older person as patient: exploration of the patient's point of view what it means coming into hospitals
- Description of patient's emotions: Trepidation and fear
- What matters to the patient: Being valued, being respected
- Patient fears of loss of independence and dignity when coming to hospital
- Highlights the difference working with older and younger patients
- Explains and example of link between communication skills and seeing the patient as a person
- Description of behaviour of older patients: being vulnerable less able to articulate, not able to stand up for themselves
- Older patients and their families and interactions with families when she was nurse (example from practice: Story)
- Nurses and older patients
- Practice
- Labelling and stigmatisation of older patients
- Differences in behaviour of older and younger patients.

- Difference how healthcare staff see younger and older patients.
- Experience of practice
- Argumentation: Views and experience of younger nurses training
- Importance of bedside nursing
- Having the right people in older people care
- Having the right people leading in older people care
- Recent report on leadership in older person's care (this would have been a report coming out in 2011 or early 2012)
- Organisational environment staff numbers, and values of the individual staff member.
- Societal attitudes towards older people
- Explanations of her own personal values about giving care
- Need to give high standard of care to people of all ages
- Comparison between caring for cancer patients (care tends to be to younger patients/ can be traumatic) and caring for older patients
- Need staff who understand the process of ageing, and the impact of ageing process on a person's life.
- Ageing process
- Strategies how to increase that knowledge
- Know how
- Importance of understanding life history of patients.
- Description how this understanding can positively impact on care giving and day to day practice
- Importance of not making assumptions about individual patients
- Argumentation: the need for staff to understand diversity and the patient as an individual.
- Description how values underpin practice
- Criticism of referring to patients as conditions (description of her experience early in her career)

- Her own experience: Participant gives example how hospital. communication lead to loss of dignity and lack of respect of an older person she knows (experience by proxy)
- Description of nursing procedure: Describes procedure and how this might be experienced from a patient's perspective
- Link between communication skills and seeing the patient as a person
- Change of topic: Interviewer asking about if P2 made decision to work with older people early on in her career
- Talks about her own personal experience of being a patient as a child for a prolonged period of time.
- Experience of seeing poor practice with older people early on in her career. Origins of her passion for working with older people or improving care for older people
- Gives an example of her own experience of poor practice when she was a patient and the impact it had on her "It never left me"
- Description of the pathway she took from being at school as a teenager to nursing training
- Gives a self-description: expects high standard of herself and describes herself as a leader
- Description of her working life: Long hours, responsibility and dealing with complaints.
- Role modelling and asking questions
- Gives an example how she implements good practice on the wards
- Encouraging independence
- Experience of older patients: Older people what they fear and treating them with dignity
- Personal experience: Witnessing Experience of seeing her mother being cared for without dignity
- Poor care her mother received
- Her experience is that people hear even when they are not conscious
- Importance of treating patients with dignity and respect

- Story of the Death of her grandmother and explanation of the cultural values which surround death
- Argumentation: Treat staff with respect, be clear about expectations
- Role modelling
- Story from practice: how a nurse treated a son whose mother just had died
- Dealing with death
- Compassion, empathy and human love
- Whoever is in charge sets the tone
- Good apples, rotten apple – cannot change easily a rotten apple (education does not work)
- I failed sometimes
- Story of patient who died
- The need to underpin practice with theory combined with compassion
- Personal story about not being heard as a patient
- Knowledge means you are safe in my hands
- But some staff change when they see older person
- Importance of putting the patient at the centre of interaction

9.3 Consent form

Faculty of Education, Health and Social Care, University of Winchester

Consent form to be interviewed:

I, (please print name in box)

have read the information sheet and hereby give my consent to participate in the interview for the study

I confirm that I understand the nature of the project, any possible risks involved, and that my privacy will be safeguarded.

I understand that participation in the project is voluntary and that I can withdraw from the research at any time.

I agree that the data can be used for educational or research purposes, including publication.

Date:

Signature of participant: .....

9.4 Information sheets for potential participants

9.4.1 Information sheet for potential participants who had retired

Date: February 2012

Title of the project.

A study to investigate how healthcare professionals learn and develop knowledge about ageing and the rehabilitation of older patients throughout their careers.

Background information

I am a part-time PhD student at the Faculty of Education, Health and Social Care, University of Winchester. The aim of my study is to investigate how healthcare professionals develop professional knowledge about old age and older people throughout their careers. The study will contribute knowledge to how to develop educational and professional development initiatives for healthcare professionals working with older patients. I'm inviting you to take part in the study. Before you decide to participate, it is important you understand what the project involves and what you will have to do. So please take time to read and consider the following information.

Participation in the study

Participation in the study is entirely voluntary.

To be eligible to participate in the study you need to:

- have a recognised professional healthcare qualification such as medicine, nursing or allied health (current registration is not required).

and

- have been involved in providing health services to patients who were 65 years or older at some point in your career.

The Interview

If you are willing to participate in the project, I will arrange a mutually convenient time and place for an interview. The interview is qualitative in nature and will last between ca. 60 to 90 minutes. The interview will start with an open-ended question asking you to talk about your work. Some of

the topics which you will talk about in the interview will be, through interactive conversation, explored in more depth. At the end of the interview, I might use a topic guide to ask questions relating to the aims of the study if those topics have not been covered during the interview. Each interview will be audio-recorded and afterwards be transcribed by myself.

One of the risks of the interview might be that during the interview you might start to recall unpleasant or difficult memories which might be distressing to you. At any point of the interview, you can decide that you want to change topic, take a break, or if you wish to do so to break off the interview.

Informed and written consent

Before the start of the interview you will be asked to give informed and written consent to be interviewed and the data to be published. (Please see attached form). Your participation in the interview is entire voluntary, and you are able to withdraw from participating in the study at any time during the research.

Ensuring confidentiality and anonymity

The data collection, processing and dissemination of the data will be governed by the guidance given about the Data Protection Act (1998) by the University of Winchester, and by the British Educational Research Association Guidelines (2004). All data will be treated confidentially. Information which might lead to the identification of persons, or locations will be anonymised during the transcription of the data. If you want to see the transcript of the interview, please let me know and I will forward you a copy of the transcript. If there is any doubt of being able to maintain anonymity of the interviewee, the data either will not be used for publication or I will discuss this matter with you and seek further consent for publication from you.

Approval of the study

The project has been approved by the ethics committee at the University of Winchester.

Contacts for the project

If you want to discuss any aspects of the study please do not hesitate to contact me.

My e-mail address is: dorotheeb9@googlemail.com

The director of the study is Dr. Colin Goble, Senior Lecturer, Faculty of Education, Health and Social Care, University of Winchester email: colin.goble@winchester.ac.uk

Thank you for taking time to read the information sheet.

Doro Bechinger-English
PhD student
Faculty of Education, Health and Social Care
University of Winchester
Winchester SO22 4NR
e-mail: (deleted)

9.4.2 Information sheet for potential participants who had not retired

Date: March 2014

Title of the project.

A study to investigate how healthcare professionals learn and develop knowledge about ageing and the rehabilitation of older patients throughout their careers.

Background information

I am a part-time PhD student at the Faculty of Education, Health and Social Care, University of Winchester. The aim of my study is to investigate how healthcare professionals develop professional knowledge about old age and older people throughout their careers. The study will contribute knowledge to how to develop educational and professional development initiatives for healthcare professionals working with older patients. I'm inviting you to take part in the study. Before you decide to participate, it is important you understand what the project involves and what you will have to do. So please take time to read and consider the following information.

Participation in the study

Participation in the study is entirely voluntary.

To be eligible to participate in the study you need to:

- have a recognised professional healthcare qualification such as medicine, nursing or allied health (current registration is not required).

and

- have been involved in providing health services to patients who were 65 years or older at some point in your career.

The Interview

If you are willing to participate in the project, I will arrange a mutually convenient time and place for an interview. The interview is qualitative in nature and will last between ca. 60 to 90 minutes. The interview will start with an open-ended question asking you to talk about your work. Some of the topics which you will talk about in the interview will be, through interactive conversation, explored in more depth. At the end of the interview, I might use a topic guide to ask questions relating to the aims of the study if those topics have not been covered during the interview. Each interview will be audio-recorded and afterwards be transcribed by myself.

One of the risks of the interview might be that during the interview you might start to recall unpleasant or difficult memories which might be distressing to you. At any point of the interview, you can decide that you want to change topic, take a break, or if you wish to do so to break off the interview.

Informed and written consent

Before the start of the interview you will be asked to give informed and written consent to be interviewed and the data to be published. (Please see attached form). Your participation in the interview is entire voluntary, and you are able to withdraw from participating in the study at any time during the research.

Ensuring confidentiality and anonymity

The data collection, processing and dissemination of the data will be governed by the guidance given about the Data Protection Act (1998) by

the University of Winchester, and by the British Educational Research Association Guidelines (2004). All data will be treated confidentially. Information which might lead to the identification of persons, or locations will be anonymised during the transcription of the data. If you want to see the transcript of the interview, please let me know and I will forward you a copy of the transcript. If there is any doubt of being able to maintain anonymity of the interviewee, the data either will not be used for publication or I will discuss this matter with you and seek further consent for publication from you.

Approval of the study

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Contacts for the project

If you want to discuss any aspects of the study please do not hesitate to contact me.

My e-mail address is: dorotheeb9@googlemail.com

The director of the study is Dr. Colin Goble, Senior Lecturer, Faculty of Education, Health and Social Care, University of Winchester email: colin.goble@winchester.ac.uk

Thank you for taking time to read the information sheet.

Doro Bechinger-English
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