# What Undergraduate Nurse Education

# **Actually**

# Teaches Student Nurses About People Named as Older:

# A Foucauldian Discourse Analysis

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## *Abstract*

People are living longer and gerontology knowledge, or knowledge of the person named as older, is part of the learning required in undergraduate nurse education. Older age is considered, in Aotearoa New Zealand, to begin at 65 years and extends until death, hence represents a heterogeneous population, ranging from the employed marathon runner, to the frail and dependent person with complex healthcare needs. The purpose of this research has been to first trace the beginnings of gerontology knowledge in undergraduate nurse education, and from there to explore the contemporary discursive production of gerontology knowledge, establishing how people named as older are constructed for the student nurse, and what are the material effects. Understanding knowledge is socially constructed, this research draws on the philosophical and theoretical works of Michel Foucault and his notions of discourse and power/knowledge to inform a discourse analysis.

Data for this research were sourced from a variety of mediums including, historical documents, textbooks, journal articles and interviews with senior academic staff working in undergraduate programmes leading to registration as a nurse. Analysis of historical data revealed how people named as older became visible to the student nurse through material practices such as clinical experience in aged residential care facilities, and geriatric wards that divided older people off from the mainstream hospital population. The discursive effects were to produce, for the student nurse, the person named as older in a functional decline discourse intertwined with a biomedicalised discourse. A shift to current educational practices and nurse scholarship of gerontology knowledge revealed a continued deployment of a functional decline discourse supported by stereotypical assumptions of older people, and clinical placements in ARC. Analysis hence revealed, a very limited understanding of people named as older and a failure to capture the heterogeneity of the population defined as representing gerontology knowledge.

In the final analysis gerontology knowledge, as a construct, proved unstable and partial as a person named as older is not ubiquitously constructed by gerontology knowledge. The contribution this thesis makes therefore, is to highlight the contested domain of gerontology knowledge and from there generate dialogue about how older age is actually represented in student nurse education, as the current iteration perpetuates stereotypical assumptions about older age.

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## *Attestation of Authorship*

I hereby declare that this submission is my own work and that, to the best of my knowledge and belief, contains no material previously published or written by another person (except where explicitly defined in the acknowledgements), nor material which to a substantial extent has been submitted for the awards of any other degree or diploma of a university or other institution of higher learning.

Signed

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Name: Pam Foster

## *List of Abbreviations*

| | |
|---|---|
| ADL | Activities of Daily Living |
| ARC | Aged Residential Care |
| DHB | District Health Board |
| MOH | Ministry of Health |
| MOSD | Ministry of Social Development |
| NETP | New Entry to Practice |
| NZNO | New Zealand Nurses Organisation |
| NCNZ | Nursing Council of New Zealand |
| NMB | Nurses and Midwives Board |

## *Acknowledgements*

Symbolic of the final phase of this research project that has consumed my reality for the last few years, I write my acknowledgements with a sense of achievement both personally and professionally. It is done, and I would like to recognise and thank those who have guided and supported me through this journey. Firstly, however, thanks to the research participants who gave freely of their time and knowledge, ensuring this research represented undergraduate nurse education in Aotearoa New Zealand.

To my supervisors, Professor Stephen Neville and Associate Professor Deb Payne I offer a heart-felt thank you. You have patiently guided me through the complexities of Foucauldian discourse analysis as I grappled to apply his analytical tools. Your purposeful critique and feedback were ever welcome and useful. I particularly enjoyed our supervision sessions with the opportunity to discuss, debate, challenge and talk Foucault.

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# Chapter 1: Introduction

Globally, changes in scientific knowledge and technological applications are increasing life expectancy. Added to this is, declining fertility rates mean there is a shift in the age distribution of populations with an increasing number of people named as older in western democracies. The World Health Organisation (WHO) acknowledges success in health policy as for the first time in history, most people can expect to live to 60 years of age and beyond (World Health Organisation [WHO], 2017). Nevertheless, a paradox exists, as on one hand governments valorise increasing life expectancy yet on the other express concerns towards accommodating an ageing population. The WHO has a vision of a world in which everyone can live long and healthy lives. Health professionals, including nursing and the health systems they work within are integral to fulfilling this vision. The WHO has a mandate to ensure the health workforce has the capability and capacity to support the needs of an ageing population. One of the objectives of this global plan is to "combat ageism and transform understandings of health and ageing" (WHO, 2017 p. 9). Central to achieving these goals, is a nursing workforce prepared and resourced to promote the health and wellbeing of the older person. Adopting a methodology derived from the works of Michel Foucault, an influential social theorist and philosopher whose work focuses on power, knowledge, and discourse, this thesis sets out to critique how gerontology knowledge, articulated as knowledge of the person named as older, is constructed for the student nurse in undergraduate nursing education. Within this thesis a range of dominant discourses are exposed with the aim of generating critical discussion on the future direction of gerontology knowledge and nurse education**.**

## Overview of chapter

This thesis engages Foucauldian discourse analysis, a qualitative methodology, to examine how knowledge about people who are named as 'older' is constituted in undergraduate nurse education curricula. The first chapter begins with a background of myself as a researcher and moves on to scope out how I arrived at the final research question. Here I attend to a brief literature review on student nurse engagement with older people, and the role of nurse education in disseminating knowledge about care of the person named as older. Recognising various terms utilised throughout this work may be open to interpretation, I then provide a definition of terms central to the main argument of the thesis. This is followed with a brief synopsis of the theoretical framework used for analysis,

and then the final research question and aims are outlined. The chapter concludes with a brief summary of each of the seven chapters that form this work.

## Situating myself as a reflexive researcher

Research is inherently personal and reflective of the researcher's own world-view, hence, I will introduce myself and provide insight into why I elected to pursue this line of inquiry. A registered nurse for forty years, and a product of the apprenticeship system of nurse training, I have had a long and fulfilling career. My interest in research and theory was minimal until in the 1990's and early 2000's when I completed a Bachelor of Nursing degree followed by a Master of Nursing. My Master's project was centred on women 85 years of age and older, independence and positive ageing. I had had an epiphany: older people do not see themselves as frail and losing independence, and yet it appeared that was how they were being constructed by the dominant discourses in our western society. In the conclusion of my research I commented that independent community dwelling older people appeared almost invisible to the nursing profession as the primary focus was on the more frail, dependent older person in institutional care. An interest in promoting the healthcare needs of all older people continued as my career changed direction and I became a lecturer on a Bachelor of Nursing programme, where I continue to work.

### *Reflexivity*

To be a legitimate qualitative researcher I needed to be mindful of my own beliefs and taken-for-granted assumptions about how gerontology knowledge was positioned in education and the wider socio-cultural and political field. As suggested by Prasad (2017), I had to undo and acknowledge my own long-held assumptions stemming from who I am and where I have come from. It is difficult for me to remove myself from the discursive practices, that is my functioning in society, that have defined me to this point. Reflexivity enabled me to be open to a change in my own truths about what a student nurse should learn about older people. At the very beginning of this project, as will be discussed, I conflated gerontology knowledge with aged residential care, and ensured the student nurse was alert to the physiological changes associated with the older body, as outlined in the textbooks.

The worldview I bring to this project includes being a registered nurse and an educationalist. I am also a Pākeha/European female, a mother, and a grandmother. I have not known poverty nor hardship yet have seen many aspects of life that makes me

question the values of the society in which I live. I have a strong sense of fairness and see older people treated differently from younger people in a way that is disempowering. I was born to much older parents and while my father died when I was 15 years old, my mother lived independently into her nineties. I am in my sixties, and my siblings (three sisters) are all in their seventies. Having older sisters who engage actively and productively in the world has shaped my understanding of what it means to be named as older. I do not associate my sisters nor mother with what I see taught about older people in undergraduate nurse education. This appears to me a paradox, so I must be mindful not to let my perceptions about what is taught effect my analysis. Therefore, my proximity to the age group named as older brings saliency to my research and in a sense, a personal commitment to interrogate the contemporary social construction of older age.

A reflexive researcher "should be reflective about the implications of their methods, values, biases, and decisions for knowledge of the social world they generate" (Bryman, 2012, p. 393). Thus, as a reflexive researcher, my concern was not only the prior assumptions I brought to the topic, but also their influence on how I conducted the research and data analysis (Cheek, 2000). Through reflexivity I acknowledge my personal, as well as professional interest in creating the research question, and how that influences the decisions I made on how to proceed with the research (Pillow, 2003). To track my progress, thoughts, feelings, and decision making as I moved through data analysis, I maintained a reflexive journal as recommended by Koch and Harrington (1998) and Spence (2017). In particular, I utilised the reflexive process to keep myself true to my research aims and not be distracted by the broader social, cultural, and political positioning of people named as older in New Zealand society.

## Scoping out the final research question

### *A professional doctorate*

The decision to enrol in a professional doctorate served to guide and formalise my interest in how nursing and nurse education view the person named as older. A professional doctorate evolved as an alternative to a more traditional PhD as a mode of increasing the utilisation of knowledge generated by research into professional practice (Rolfe & Davies, 2009). The emphasis is on application of research to practice and to thereby contribute to improving the health of the wider community (Auckland University of Technology, 2018). Completion of a professional doctorate provides a vehicle that has allowed me to extend my understanding of undergraduate nurse curricula and how the older person is situated

within the pedagogy. Utilising Foucauldian discourse analysis permits me to shed some light the different ways people named as older people are positioned in undergraduate nurse education, and to interrogate and problematise these descriptions. This work offers a potential catalyst to challenge the way knowledge of all people named as older is taught, and to facilitate change. It is imperative that nurse education adapts to the contemporary needs of older people in the wider socio-cultural and political sphere. Knowledge generated through this work may be instrumental in alerting the disciplinary powers such as the Nursing Council of New Zealand (NCNZ) (Nursing Council of New Zealand [NCNZ] 2015a), schools of nursing and nursing related publications to the limiting ways in which knowledge about people named as older is currently positioned in undergraduate nurse education.

### *Nursing Council of New Zealand and undergraduate education*

Contemporary nurse education that leads to registration as a nurse is governed by the NCNZ. They are responsible for educational programme standards, accreditation, and monitoring of all undergraduate degree programmes that lead to registration as a registered nurse (NCNZ, 2015a). The onus is on education providers to deliver a programme underpinned by contemporary research and scholarship, and based on "national health priorities and contemporary health care and practice trends" and "across the lifespan" (NCNZ, 2015a, p. 7). Student nurses are required to complete an NCNZ approved programme that leads to registration as a nurse, with a minimum of 1100 hours in clinical practice. New Zealand does not have a standardised national curriculum, rather 17 unique undergraduate programmes across 23 sites that lead to registration as a nurse. In most instances it is a Bachelor of Nursing degree. Regardless of the education provider, all graduates must successfully complete the same State Final Examination to become a registered nurse (NCNZ, 2016). Acknowledging the title registered nurse is enshrined in legislation, hence forth I shall refer to a registered nurse as 'nurse'.

### *How I came to this topic and methodology*

With my transition into student nurse education and an interest in people named as older, I began to question how older people are represented in undergraduate nurse curricula. I was aware that few nursing graduates elected to work in areas designated for care of older people (Chu, Wodchis, & McGilton, 2014; Huntington, Wilkinson, & Neville, 2014; McCann, Clark, & Lu, 2010). I wondered if more student nurses recognised the heterogeneity of the older person along the life course, this insight would translate to more theoretical

engagement, and attitudes could change with more student nurses considering working with this demographic, in particular, in aged residential care (ARC). However, as I engaged with the literature, I completely changed my research goal. The following discussion provides background context to development of the final research question as I came to question my own limited understanding of how we teach about people named as older, despite drawing on a health and wellness discourse in my Master's research.

As I scoped out a focus for my research question, I followed a judicious path reviewing the literature applicable to my course of enquiry by first establishing the available knowledge on student nurses, curricula, gerontology knowledge, older people and ARC. Studies were accessed for this review through searching Scopus and CINAHL and ProQuest via EBSCO host platform. Search limits were inclusive of full text, English, date limiters 2006 -2016, and peer reviewed journals. The keyword search included: Undergraduate or student nurs* or baccalaureate; curriculum or nursing education programmes; "gerontology or geriatric knowledge" "attitudes, perceptions or perspective" "older adults/people" "long-term care" "aged residential care" "faculty or academic" also included was "integrated curriculum". Grey literature was accessed and included; keyword searches and manual searches of the Ministry of Health (MOH) website, New Zealand, and international nursing accreditation bodies, and websites of education providers and schools of nursing. This preparatory work presents the only literature review in this thesis as within a Foucauldian methodology literature becomes data.

In New Zealand, despite recent initiatives to attract nurses to areas specialising in care of older people, fewer than two percent of new graduates identified ARC as a priority for employment (Ministry of Health [MOH], 2013). It has also been identified that retention of those few graduate nurses has been a challenge (Howard- Brown & McKinlay, 2014). A further exploration of the experiences of graduate nurses revealed exposure to high levels of accountability, and considerable workloads with often being a sole nurse in charge of up to 45 residents (Grant Thornton, 2010; Huntington et al., 2014). Concluding the issue of encouraging graduate nurses to work in ARC was broader than increasing student nurse knowledge in care of dependent older people, I reassessed my research focus.

A second line of enquiry considered exploring how educational content and experiential learning contribute to knowledge of older people. Research established that student nurses often exhibited negative attitudes toward working with older people (Celik, Kapucu, Tuna, & Akkus, 2010; Duggan, Mitchell, & Moore, 2013; Neville, 2015; Rodgers & Gilmour, 2011).

Student nurses are regularly placed in an ARC facility in their first year of study to gain foundational nursing knowledge (Abbey et al., 2006; Haron, Levy, Albagli, Rotstein, & Riba, 2013; Page, 2011). This action has the capacity to support negative attitudes as literature suggests working in ARC tends to reinforce any stereotypical perceptions student nurses may have concerning older people. Reports indicate student nurses find working in ARC to be boring, repetitive and requiring low technical skills (Evers, Ploeg, & Kaasalainen, 2011; Henderson, Xiao, Siegloff, Kelton, & Paterson, 2008). This perception is further embedded when student nurses are poorly prepared to care effectively and knowledgeably for older people who are frail and dependent (Algoso, Peters, Ramjam, & East, 2016; Koh, 2012; Liu, Norman, & While, 2013).

A more inclusive attitude toward working with older people was reported when care practices and psychosocial understandings were more overt in the teaching (Bleinjenberg, Jansen, & Schuurmans, 2012; Kydd, 2014; Rodgers & Gilmour, 2011). When taught as a stand alone topic, rather than integrated across a curriculum, knowledge improved (Bednash, Mezey, & Tagliareni, 2011; King, Roberts, & Bowers, 2013). Likewise, activities centred on working with community-dwelling older people where student nurses could acknowledge the heterogeniety, made a difference (Reitmaier et al., 2014; Walton & Blossom, 2013). Nevertheless, ensuring student nurses engage with diverse groups of older people appears contingent on educators having operational knowledge and educational preparation in nursing this demographic. The contemporary reality is that few educators have the specialised knowledge to educate student nurses in the healthcare needs of older people (Baumbusch, Dahlke, & Phinney, 2014; Krichbaum, Kaas, Wyman, & van Son, 2015).

Commonly, care of the older person as a unique body of knowledge, is integrated or threaded through a curriculum (Deschodt, Dierckx, & Milisen, 2010; Ironside, Tagliareni, McLaughlin, King, & Mengel, 2010; Page, 2011). However, it was difficult to extract from the literature the exact extent of teaching about the older person within a programme of study. Similarly, in New Zealand there was limited information on how the 17 tertiary educational institutions providing a degree leading to nurse registration, integrated care of the older person throughout their curriculum (Page, 2011). Nurse education commentary implies educational processes do not include enough specific knowledge about older people (Clendon, 2011; Coleman, 2015; Duggan et al., 2013). A pedagogy challenging an integrated curriculum raises concerns that specific knowledge related to care of the older person will be “lost” or minimised, resulting in student nurses ill-prepared to work with

older people**.** Regardless of where gerontology knowledge is situated, I began to question what constitutes 'gerontology knowledge' or knowledge about the person named as older**.** This notion of what is taught or understood about older people will be revisited later in the analysis chapters.

### *Associated teaching*

The aforementioned literature review raised issues around delivery of content relating to the older person in undergraduate programmes, but did not establish what was taught. An original goal of this research was to improve how care of the frail and dependent older person was taught in undergraduate programmes. When I enrolled in this doctoral programme I was teaching a year one clinical paper which included a two week placement in ARC. Drawing on information providing ideas on how to improve student nurse attitudes toward working in ARC, I was mindful to include teaching and learning related to the independent older person. Furthermore, inspired by my Masters research to instill a broader more holistic understanding of older people, I organised for the student nurses to meet with members of the University of the Third Age who lived in the community.

The paper also required the student nurses to write an essay "Ageing in Aotearoa New Zealand" with the expectation they would comment on socio-political and legislative factors in New Zealand that supported health and well-being in older people. Interestingly, few of the student nurses constructed the older person in New Zealand as being healthy and independent. Rather they brought up ageist perceptions positioning people named as older as physically disabled, forgetful, resistant to change, lonely and depressed, having poor nutrition, and needing some form of care, all qualities listed in stereotypical assumptions about older people (Eliopoulos, 2014). It appeared that despite directing student nurses to consider healthy ageing strategies (MOH, 2016b; Ministry of Social Development [MOSD], 2001) and research focused on independent community-dwelling older people, essay content repeatedly constructed the person named as older in a deficit framework focused on loss of functional capacity. This revelation brought to the fore my final research question in the raw form. "How on earth did this group of student nurses come to that conclusion about people named as older? What are we teaching them?" From this juncture I sought an appropriate research methodology to question how it came to be student nurses constructed people named as older in such a limited way, and to critique what did nurse education actually teach student nurses about older people.

Atul Gawande in his book "*Being Mortal*" concludes western society treats older people differently from younger people (Gawande, 2014). Does nurse education perpetuate this difference by teaching care of people named as older as a separate topic? The dominant way of thinking about the ageing body educates the student nurse about physiological changes that become problematic to the older person bringing them into the gaze and sphere of the health professional. This way of thinking requires nurses to be alert to these potential changes and modify their care practices accordingly. I therefore questioned whether or not teaching about difference perpetuated negative stereotypical attitudes towards people named as older. My dilemma grew as I advanced through analysis beginning to question what was considered critical knowledge about the older person. I realised that I myself was complicit in propagating a limited attitude to ageing by alerting student nurses to physiological changes associated with the older body. As illustrated above, my initial research idea concentrated on ARC. I recognised that I was interpellated, or hailed, (Althusser, 1971) into a dominant discourse in nurse education that infers older people become dependent on others, as my initial research question focused on working in ARC. This revelation directed me to interrogate how I arrived at that position that is apparently shared by the wider nursing profession.

## Terminology used throughout the thesis.

Some terms used throughout my thesis require definition to ensure the reader understands them in the same way as I, the writer, intend. True to a social constructionist view I acknowledge the following terms are socially, culturally and historically constructed, and imbued with meaning representing only a western or modernist version of truth. By presenting these terms I am myself deploying knowledge production embodied in strategies of power; however, the terms are central to the argument presented in this work. Throughout this thesis, the single quotation mark will be used to indicate an understanding the word in use is a discursive construct and loaded with discursive effects. I begin with a definition of who is deemed as a person named as older in New Zealand.

### *The person named as older*

The concept of age is historically and culturally constructed; it is contested and has multiple meanings within societies. Age is depicted as relative with multiple ways of understanding. Human beings are seen as having a chronological age, measured in years lived since birth, a biological age relating to the complex process of physiological change at a cellular level, and a functional age related to what a human being is able to accomplish in activities of

daily living (Anderson-Wurf, 2017; Patton, 2019). Prior to the twentieth century, older age was loosely defined, based more on loss of functional ability than number of years since birth. The aged, were those who were infirm, frail, suffering some form of incapacity requiring assistance and who appeared old. Differentiation between the mature person and older person founded on chronological age became apparent as twentieth century legislative changes introduced policies around mandatory retirement age and provision of an old age pension (Bernoth, Neville & Foster, 2017; Roebuck, 1979). The state of old age became, and continues to be defined by a chronological measure rather than other factors such as functional ability or biological changes. Definitions of when the period of older age begins differ between countries. The United Nations (2015) defines the older person as anyone over the age of 60. In contrast, the WHO (2015) definition avoids a chronological term, stating the older person as "a person whose age has passed the median life expectancy at birth" (p. 229). Both definitions reflect diversity of life expectancy across the globe, accounting for the differences between for example, sub Saharan Africa and continental Europe.

In New Zealand, demographic data are collected according to age groups that differentiate between younger and people named as older, with 65 years of age and over being the category adopted by Statistics New Zealand (2013) and used by New Zealand government policies and legislation. While New Zealand does not have a mandated retirement age, an individual is eligible for the state pension, known as superannuation, at 65 years of age (MOSD, 2015a). The Healthy Ageing Strategy (MOH, 2016b), a government policy promoting sustainable options in healthcare spending for person named as older, likewise uses 65 years and older as a chronological indicator. Further categories differentiate between the young-old (65-74 years of age), the middle-old (75-84 years of age) and the old-old (85 years plus), (Tabloski, 2014). Statistically, for those over 75 years and particularly over 85 years there is an increase in frailty and dependence associated with chronic illness (Boyd et al., 2016; Powell, Biggs, & Wahidin, 2006). As my research concerns the New Zealand situation, I have adopted the New Zealand MOH's (MOH, 2016b) definition of the person named as older as someone who is aged 65 years and older. In this work, I will use the term 'older person' and 'a person named as older' with the understanding the person is aged 65 years and older.

### *Geriatrics as a school of knowledge*

The term 'geriatrics' was first used by Nascher, 1909 to differentiate "the long-term elderly sick" from those younger patients with chronic conditions (Warren, 1948, p. 45). In Mosby's a medical dictionary, geriatrics is defined as "the branch of medicine dealing with the physiological characteristics of ageing and the diagnosis and treatment of diseases affecting the aged" (Harris, Nagy, & Vardaxis, 2006, p. 742). However, an informal vernacular also ascribes meanings of 'decrepit, very old or outdated' to the term (English Oxford Dictionaries, 2017). In historical medical literature the older person was often referred to in derogatory terms. For example, Burstein, (1957) and Ginzberg, (1952) when writing in a medical journal both referred to the older patient as a burden, frail, a waste of time, senile, and infirm. This naming and labelling were reflective of a wider societal prejudice, or as it came to be known, 'ageism' (Butler, 2005; Fulmer, 2016). A contemporary nursing text defines geriatric nursing as a study more closely aligned with medicine that involves "study of health and disease in later life: comprehensive healthcare of older persons and the well-being of their caregivers" (Tabloski, 2014, p. 4). The geriatric nurse is mainly concerned with management of disease and assumes the older person has caregivers. The term 'geriatrics' continues to be used, however, more commonly the term 'gerontology' is employed, and has a different meaning.

### *Gerontology as a school of knowledge:*

'Gerontology' relates to the specialised care of the older person and offers a broader perspective of the healthcare needs. An early definition from Gunter (1980) views gerontology as concerned with care of the elderly:

> The study of nursing care of 'the elderly' for two purposes: one to provide knowledge of the ageing process, and two to design and evaluate nursing care and services that best promote health, wellbeing, and the highest level of functioning and independence in the aged. (p. 26)

A more contemporary definition from Mosby's dictionary shows how language associated with those who are considered older people has changed. Now gerontology has become "the study of all aspects of the ageing process, including the clinical, psychological, economic and sociological issues encountered by older persons and their consequences for both the individual and society" (Harris et al., 2006, p. 760). This definition is supported by Eliopoulos (2014) who states "gerontology nursing strives to help older adults achieve wholeness by reaching optimum levels of physical, psychological, social and spiritual health" (p. 77). Interestingly, a holistic approach to care is espoused as all aspects of

personhood are to be considered. Note the change in the use of 'elderly', a term no longer apparent in Eliopoulos's definition.

A New Zealand definition of gerontology nursing was located in the New Zealand Nurses Organisation's (NZNO) *Gerontology Nursing and Knowledge Skills Framework* (New Zealand Nurses Organisation [NZNO], 2014). These particular guidelines are designed to assist the nurse working predominantly in a long-term care facility but follow a similar holistic discourse: "Gerontology nursing is an evidence-based nursing specialty practice that focuses on the age related physiological, psychological, developmental, economic, cultural and spiritual changes of older adults and the health needs these changes generate" (NZNO, 2014, p. 4). The above definition provides a foundation to what is considered gerontology knowledge and offers a broad spectrum of related, and inter-related factors.

To summarise, geriatric and gerontology nursing are similar but different as they both include care of the person regarded as older. Eliopoulos (2014) makes a useful distinction, "gerontology nursing involves the care of aging people and emphasises the promotion of the highest possible quality of life and wellness throughout the life span. Geriatric nursing focuses on the care of sick older persons" (p. 73). Gerontology nursing, therefore, appears to valorise strategies that promote wellness and health, rather than management of disease as focused on by the geriatric nurse. Throughout this thesis I challenge the broad interpretations of gerontology knowledge and by association older people, arguing the primacy of a pathologised version of ageing that affords a very limited version of gerontology knowledge and is more akin to a geriatric definition. Having introduced the term gerontology, it will be used throughout the thesis as a specific body of nursing knowledge related to the person named as older**.**

### *Ageism*

An understanding of ageism and associated practices is central to this study. The advent of geriatric medicine highlighted an indifference among health professionals towards older people (Warren, 1948). This indifference and even negative attitude towards older people, particularly within medical schools, concerned Robert Butler, an American doctor. Robert Butler, introduced the term ageism to describe this behaviour in a sentinel work titled "*Why Survive. Being Old in America*" (Fulmer, 2016). Palmore (1999) believes that ageism, along with sexism and racism are the most significant 'isms' in society. Ageism constructs a negative perception of older people, for example, old people are senile. Ageism provides a stereotypical view that supports prejudice, discrimination and stigmatises people based on

their advancing age (Abrams, 2010; Love, 2011). Achenbaum (2015) notes that ageism is not a new concept that arrived with the twentieth century. In some ancient societies, older people once their usefulness declined, were cast aside and left to die.

My review of medical literature that predated Butler's coining of the phrase ageism revealed considerable bias toward the ageing patient. Ginzberg (1952) acknowledged that there was a negative attitude towards the 'elderly', noting:

> We understand an approach based on both a feeling and a conviction that the elderly are lost causes, that those advanced in age are doomed to regression and degeneration leading to such loss of vitality that they are placed outside of any working active social group, whether family, clan, tribe or society. (p. 297)

Other publications reviewed were rife with problems created by an increasing number of ageing and infirm people. The articles also acknowledged a lack of interest in care of older people from the medical and nursing fraternity (Leake, 1959; Rechtschaffen, Atkinson, & Freeman, 1954; Warren, 1948).

Although language may have changed, a dominant biomedical discourse on ageing still perceives old age as a time when biological and physiological functional decline leads inevitably to frailty and dependence (Powell et al., 2006). A prejudicial attitude towards care of the older person has been attributed to the resistance encountered in introducing and maintaining education programmes focused on gerontology (Gunter, 1980; Levenson, 1981). In the twenty-first century little appears to have altered as nursing literature reports that ageist attitudes persist among healthcare professionals and have been shown to negatively impact the quality of healthcare delivery (Coleman, 2015; Liu et al., 2013; Maben, Adams, Peccei, Murrells, & Robert, 2012; Phelan, 2010). The concept of ageism, along with discursive practices that construct the older person in a particular way within a nursing education framework, will be critiqued within this research.

## Theoretical position

As outlined earlier, the intent of my research became to critically analyse and explore how nurse education contributes to and perpetuates a view of the older person constructed around loss of functional capacity and dependency. The contributing causes of this issue are found not only in contemporary practices in nurse education that circulate stereotypical perceptions around older people and gerontology knowledge, but also in historical events. This rudimentary concern then shaped my epistemological beliefs, and guided an informed selection of a methodology congruent with my research question.

I was drawn to works of Michel Foucault, who wrote about discourse in a way that differed to those of his contemporaries (McNay, 1994). The appeal of Foucauldian discourse analysis rests in its capacity to challenge the taken-for-granted aspects of a social field, for example the practices and knowledge accepted as a true and only possible version of reality. Michel Foucault was specifically interested in the conditions that existed which resulted in one way of practice or thinking becoming normalised or common sense while other practices became less visible. He suggested a researcher look for the invisible rules that meant we could talk about an object or practice, in a certain way but not in others (McHoul & Grace, 1997). This position resonated with my question as to how it was student nurses wrote about older people in a very limited way.

Foucault's view was that, what is considered acceptable knowledge is dependent on complex networks of power, meaning not all forms of knowledge have equal status. The larger question became, how was it that this version of knowledge about older people came to the fore as opposed to another form. To answer this question, Foucault promoted an examination of historical text and other mediums such as material practices, social, historical and political conditions to ascertain how they directed the contemporary version of knowledge while marginalising others (Garland, 2014). A Foucauldian genealogical approach affords an historical dimension, therefore data reviewed for this work will span from the inception of nurse education in New Zealand, the early days of pre-nurse registration education, through to present-day nurse education. Using Foucault's terminology, the research will trouble not only gerontological knowledge, but also promote critical thinking as to how older people are rendered visible in undergraduate nurse education.

Having established a methodology that allowed a critical exploration of my topic I turned my attention to epistemological and theoretical perspectives to further inform the field of inquiry. A reading of Crotty (1998) provided a brief overview of a variety of epistemologies. Of those included, constructionism resonated with the aim of my study and was congruent with Foucault's thinking (Miller, 2008). A social constructionist approach attends to the assumption that accepted knowledge or truth is not a natural interpretation of reality, but rather is created through a complex relationship between discourses that circulate in the social milieu (Burr, 1995). Hence, the nursing perspective of gerontology and the older person cannot be separated from the wider encompassing society and its normative constructions. As an epistemology, social constructionism provides a vehicle to critically

review how through commonly enacted practices within nurse education, a particular mode of gerontology knowledge is presented.

The final requirement was to find a theoretical perspective compatible with my epistemological and methodological approach. Foucault's work provides a methodological framework to problematise present forms of knowledge and truth. Although Foucault refused to be identified with any one movement, I have positioned his work as postmodern (Best & Kellner, 1991). Adopting a postmodern stance, I centre my interest not in establishing 'the facts' about curricula content, which is contrary to postmodern thought (Rolfe, 2000). Instead, I troubled how this particular representation of gerontology knowledge and the older person gained prominence.

### *Study question and aims*

Literature accessed during the preliminary phases of my research and marking student nurse essays on ageing in Aotearoa New Zealand, helped to focus my final research question. This preliminary research appeared to indicate nurse education is failing to educate student nurses on the health and wellbeing needs of all older people. By engaging a Foucauldian discourse analysis, I propose to map out discourses and their practices that are influential in constructing how health and wellbeing are constituted in people identified as older in undergraduate nurse education. I argue, that while nurse education may educate student nurses about the older person, there is a collective need to uncover what is actually conveyed and the effects such knowledge produces. Consequently, the purpose of this thesis is not to bring about change per se, but to problematise what we do and generate a discussion for future consideration. The research question therefore considers how is it we do what we do and what that doing does. How does the particular ways nurse education teach about older people affect student nurses' understandings of people named as older? As posited by Foucault, "people know what they do, they frequently know why they do what they do but what they don't know is what the doing does" (Foucault, cited in Dreyfus & Rabinow, 1983, p. 187). The question to be asked in this project is:

"How is gerontological knowledge discursively constructed in New Zealand undergraduate nursing curricula?" The study's objectives are:

1. To reveal the discursive practices that have predetermined, sustained or hindered gerontological knowledge and the older person in contemporary undergraduate nursing curricula.

2. To illuminate the power/knowledge relationships and discursive practices in contemporary undergraduate nurse education which construct gerontological knowledge and the older person in a particular way.

3. To problematize the capacity for nursing education to prepare graduate nurses to meet the health and wellbeing needs of older people.

## Overview of the thesis

This thesis is presented in seven chapters. Chapter One introduces the field of study along with the research question and aims, including a short discussion pertinent to the embryonic stages of research and a range of definitions. There is no literature review as following the conventions of a Foucauldian discourse analysis literature is used as data. Throughout this work the central focus is on how gerontology knowledge and the older person are represented in New Zealand published nursing literature and within nurse education. In Chapter Two, the methodological approach founded on the works of Michel Foucault is outlined with discussion on how postmodernism and social constructionism contributed to the structure of the thesis. This is followed in Chapter Three by a description of methods used in analysis and evidence of meeting ethical requirements. Chapter Four marks the beginning of the three analysis chapters. Starting from an archaeological and genealogical perspective, Chapter Four presents the historical conditions that led to the modern-day construction of gerontology knowledge and the older person in undergraduate nurse education. Having identified three sites founded on practicum requirements where student nurses may engage with older people (ARC, hospital and community), Chapter Five uncovers and analyses the discourses operating in ARC. Extending this process, Chapter Six analyses the discourses circulating in hospital and community areas that shape student nurses understanding of older people. In the final chapter, Chapter Seven, discussion draws the findings together and presents a range of issues that may trouble gerontology knowledge construction in the future.

## Conclusion

This chapter has introduced the key concepts inherent in this thesis. I have positioned myself as a researcher and offered insight into how I arrived at my final research question. A brief outline of my methodological approach, research question including aims, and relevant definitions have also been included. In the following chapter, I expand on my use of Foucault and justify locating my research within postmodernism and social constructionism.

# Chapter 2: Theoretical Positioning

## Introduction.

Chapter One introduced the broader concepts and aims of this study while contextualising events and phenomena contributing to the contemporary approach to the teaching of gerontology knowledge in undergraduate nursing curricula. The current chapter presents an overview of the theoretical positions that inform this study. In structuring this chapter, I have employed the theoretical framework suggested by Crotty (1998), which includes an epistemology, theoretical perspective and methodology. Firstly, I present my epistemology, situated as a social constructionist interpretation of reality and experience. I background this with a brief summary of the Enlightenment project and the emergence of thinking and reason. This section has been included to cement my own understandings of the development of contemporary thought but also as a foil or backdrop to the changes represented by postmodernism, the theoretical perspective which guides this thesis. In the final section, drawing on Foucault's (1972, 1981) concept of discourse analysis, I outline the key aspects of my methodology. The chapter begins as per Crotty's framework and an overview of my epistemological position.

## Epistemology: Social constructionism

An epistemology outlines what is regarded as an appropriate way to acquire knowledge as there are many ways of apprehending the social world (Bryman, 2012). One way of understanding the social world is social constructionism. 'Constructionism' is proposed by Crotty (1998) as "all knowledge, and therefore all meaningful reality as such, is contingent upon human practices, being constructed in and out of the interaction between human beings and their world and developed and transmitted within an essentially social context" (p. 42). As a means of constructing knowledge, this translates to the premise that ideas do not just exist within us, rather they are created as we are influenced by our interactions with the world around us. From that, we construct our understandings of what is real and normal. This term is also referred to in the literature as social constructionism.

Constructionism as a term began to appear in the social sciences in the 1960s, as for example in Berger and Luckman's (1966) book titled, *The Social Construction of Reality*. As they argue and as authors continue to interpret the descriptor today, social constructionism is antithetical to the idea that how we understand, interpret events, and phenomena in the world is natural and innate. Instead it proposes that meaning is not

inherent in an event or phenomena, but is constructed through social processes. A social constructionist framework thus challenges what is considered a fact or the truth and how we come to know it as such (Gubrium & Holstein, 2008).

A further explication of social constructionism based on Burr's (1995) work, positions it as an appropriate epistemology for my inquiry. Social constructionism requires researchers to look at things that are taken-for-granted and considered a normal part of our social reality. To provide an example, I suggest it is considered acceptable in New Zealand for dependent and frail older people of European descent to be cared for in an institution. In other societies it would be considered unconscionable to have family members cared for by strangers. Social constructionism is premised on the understanding that how we make sense of the world is relative to historical and social factors or contingencies, and may change or has changed over time (Andrews, 2012). Through these social processes and use of language we collectively come to socially construct the world around us. Once this reality is constructed it informs our understanding and becomes normal, and hence difficult to think in other ways (Burr, 1995). To further illustrate this point, Conrad and Barker (2010) contend that illness is socially constructed, as some illnesses such as HIV AIDs are stigmatised while others are accepted. Employing a social constructionist view suggests gerontological knowledge, as situated within undergraduate nursing curricula, is a product of the social construction of the older person within the broader socio-cultural and-political field and the culture of nursing education. For some social groups the truth about older people may be quite different, however neither is right or wrong.

Ian Hacking, (2000) in his articulation of social constructionism, proposes we should argue not so much about what social constructionism is, but rather what is the point. He offers that it is against inevitability a social constructionist produces work that is critical of the status quo. He holds that if we take X as the subject or object under scrutiny " X need not have existed, or need not to be at all as it is, or X as it is at present, is not determined by the nature of things, it is not evitable" (Hacking, 2000, p. 6). Therefore, Hacking contends X as it is constituted by a society is contingent on events or forces that could have been different. This line of thinking is congruent with Foucault who argues, knowledge is not a passive reflection of an object but rather produces an object that is constructed, culturally, socially and historically to form a representation of reality (Rabinow, 1984). Foucault also requires researchers to consider the contingent events that lead to the construction of the object under scrutiny (Miller, 2008).

## Theoretical perspective: Postmodernism

The postmodern perspective is derived from a series of shifts in modern thought. In western societies, previous to the sixteenth century, what was considered truth was relatively clear as truth was based on Christianity and the teachings of the Bible (Rolfe, 2000). Religious dogma determined what was appropriate knowledge and those who challenged that knowledge were often persecuted for alternative beliefs. A new form of knowledge, scientific knowledge, began to emerge in the sixteenth century as men of science like Galileo Galilei and Francis Bacon challenged the dominant narrative of religion and the Christian Church (Kvale, 2002). Such was the power of the Church, Descartes (1596-1650), considered the founder of modern philosophy, modified his writings to ensure they did not contest the teachings of the Church. It was also understood he restrained his commentary as he feared persecution from the Church (Sorrell, 2000).

Modern ways of scientific thinking slowly gained traction to the point where they could no longer be supressed. By the seventeenth century a scientific narrative began to supplant previously privileged religious knowledge (Kvale, 2002). This became known as the period of Enlightenment. The thinkers of the Enlightenment embraced the notion of social progress through reason and scientific endeavour. The Enlightenment project believed in justice and had an imperative to establish the ultimate truth, a way of understanding the social world through all-encompassing theories that offered a stable explanation of behaviour and a grand narrative or meta discourse (Sarup, 1996). Knowledge became empirical, in that it could be measured and observed. For example, an experiment in the seventeenth century had to be witnessed by 'men', men of means, before it could be considered legitimate knowledge. Lesser men were not deemed appropriate because they had more worldly concerns and could not be trusted to observe without prejudice (Jorgensen, 2003).

The term 'modernism' began to appear in the eighteenth century as the relentless pace of scientific discoveries continued. The nineteenth century heralded the arrival of technologies like the locomotive and the telegraph. Sarup (1993), defines modernism as referring to the "cluster of social, economic, and political systems" (p. 130) that arose in western society from the eighteenth century onward. There was a sense of progress towards a universal good, with the future always seen as better than the past and science as the dominant way of establishing the truth (Rolfe, 2000). Lyotard (1984), defines modernism as "any science that legitimises itself with reference to a meta-discourse

making an explicit appeal to some grand narrative" (p. xxiii). By definition therefore, modernism still operates if defined as progress and innovation. The dominance of the scientific narrative continues in the provision of healthcare and assumes authority as to the continued health of the populace. However, following events of World War Two, contemporary thinkers began to associate modernism with production of forms of oppression and domination under the guise of liberation. Challenges to modernist ideals were voiced by modern philosophers such as Lyotard, Derrida and Foucault who questioned whether there was only one truth, and the term 'postmodernism' began to circulate (Best & Kellner, 1991).

The Enlightenment project and modernism therefore contributed to the development of postmodernism as an intellectual movement. Postmodernism rejects modernism which espouses a linear progress of history, and an unquestioning acceptance that the future is always going to be better than the past. Postmodernists also reject that a coherent explanation of reality is founded on a scientific understanding. In contrast, postmodernism suggests that reality is socially constructed through multiple representations, and challenges our taken-for-granted understanding of reality as being explained through science. As a consequence, postmodern thought problematises what is understood as truth or reality (Cheek, 2000). Prasad (2017) observes "postmodernism is interested primarily in challenging centuries of received wisdom about knowledge and reality and therefore calls for a radically different orientation towards phenomena such as data method and analysis" (p 257). A postmodernist approach, therefore provides a vehicle to undertake research not beholden to scientific understandings of phenomena.

An imperative to challenge coherent scientific explanations of reality is not limited to research techniques. Disagreement and resistance to conforming appears to be endemic in postmodern thought. Even the term itself is open to debate. A literal definition would assume it is after modernism with the inference that modernism is past, however that is inherently false as modernism continues (Crotty, 1998). Sarup (1996) implies that it means the next step in development of ideas, while Best and Kellner (1991) interpret it to mean "an active rupture with what preceded it" (p. 29).

Lyotard (1984) offers an explanation of postmodern: "I define postmodern as incredulity towards meta-narratives" (p. xxiv). By meta-narratives Lyotard is referring to the dominance of scientific knowledge which he saw as being in conflict and dismissive of small stories and personal knowledge. Rolfe (2000) counters by arguing that, postmodern

thought does not reject meta-narratives completely, but rather "entails neither an acceptance or rejection of all narratives, but instead an attitude of incredulity, radical questioning of taken-for-granted beliefs and assumptions" (p 77). To this end, postmodernism purports there is no ultimate truth, and no point to seeking order or pursuing the notion of grand theory or meta-narrative when really knowledge should be interpreted at a more local level (Sarup, 1993). This notion of questioning the taken-for-granted is paramount in a postmodern worldview and challenges the modernist ideology of legitimacy through scientific enquiry. In summary Lyotard (1984) asks, "Who decides what knowledge is, and who knows what needs to be decided" (p. 9). Postmodernism, therefore, resists a comprehensive definition as do those thinkers who are associated with its ideals. Michel Foucault is considered by many authors to be a prominent postmodernist, but he is also as likely to be named a poststructuralist, although he himself resisted any such definitions (Agger, 1991; McHoul & Grace, 1997). Postmodernism and poststructuralism are very similar as theoretical perspectives and both offer an alternative to a modernist position. Agger (1991) proposes that postmodernism is a theory of society, culture and history, while poststructuralism is a theory of knowledge and language. Both theoretical perspectives are compatible with contemporary health research (Fox, 2015).

### *Nursing and postmodernism*

The contemporary understanding of nursing knowledge arose from the work and writings of Florence Nightingale (1820-1910), who famously served as a nurse in the Crimean War. Florence Nightingale, drew on a modernist narrative that privileges positivism and empiricism and was credited with introducing healthcare concepts based on observed evidence of what made a difference. Utilising statistics she was able to demonstrate that her changes in nursing practice improved the morbidity and mortality rates of her patients (McDonald, 2010)**.** Modernism privileges a scientific response to the treatment of disease and maintenance of health. There is an emphasis on evidence-based practice founded on empirical knowledge. Evidence-based practice implies the only acceptable nursing knowledge is scientifically based, measurable, quantifiable and generalisable (Porter & O'Halloran, 2009). Rolfe (2009) suggests that in the early days of nursing scholarship, empirical knowledge was promoted as a means of making nursing knowledge credible as a foil to the dominance of medicine. Modernist ideals remain relevant to nurse education as evidence-based practice discourses are widely relied upon as validation of nursing knowledge (Huntington & Gilmour, 2001; Winch, Creedy, & Chaboyer, 2002). However, overtime some nursing scholars have contested this particular version of nursing

knowledge and proposed different forms of representation (Cheek & Rudge, 1994; Williams, 1996).

During 1980s and 1990s nurse researchers seeking to challenge the primacy of evidence-based practice began to adopt a postmodern approach arguing that other forms of knowledge have legitimacy (Lister, 1997; Parsons, 1995). A postmodernist stance applied to nursing practice and education opens up avenues to challenge the dominance of evidenced-based scientific knowledge. The decision to adopt a postmodern philosophical lens to my study reflects a statement from Agger (1991): "postmodernism is profoundly mistrustful of social sciences that conceal their investment in a particular worldview" (p. 117). As Crotty (1998) notes, what is considered valid knowledge is inherently political and maintained by the dominant groups within society. A postmodern perspective allows me as nurse researcher to question who decides what is considered legitimate nursing knowledge about older people and challenge how that version of truth has gained acceptance. I seek to problematise the specific worldview nurse education valorises when including knowledge of the older person. When scoping out my research topic, I noted that despite numerous studies expressing concerns with the paucity of gerontological knowledge in student nurse education, no studies problematised what contingencies contributed to that phenomenon.

By adopting a postmodernist approach, I have positioned myself as somewhat of a rebel against the hegemony of evidence-based practices. A theoretical modernist perspective framed around absolutes and statistical data that advances itself to be the truth provides a very limited view of what is considered legitimate knowledge, whereas a postmodern perspective acknowledges heterogeneity and difference (Sarup, 1996). Such a stance resonates with my study as it challenges the dominance of positivism and empirical epistemologies in relation to gerontology knowledge. Empirically derived literature holds a position of privilege, and attracts the majority of the funding in the research world (Lincoln, Lynham, & Guba, 2013). Employing a postmodern perspective permits me to trouble contemporary understandings of gerontology knowledge and older people in undergraduate nurse education, without unquestioningly accepting empirically derived epistemologies, while still acknowledging their use.

## Methodology: Foucauldian discourse analysis

The choice of methodology, 'Foucauldian discourse analysis', draws on the ideas of Michel Foucault (1926- 1984), whose work came to the fore during the 1960s. A prolific writer, he authored multiple publications including books, lectures, interviews and essays, which continue to be translated and published. His interest centred on historical events, although his approach to the past was counter to contemporary understandings of historical literature (McNay, 1994). His propensity for difference was also reflected in his reticence to be identified with a particular intellectual movement (Cheek & Porter, 1997; Hook, 2001). This resistance to being labelled continued throughout his career as he sought new ways of thinking counter to the accepted ideas of the time, an action in alignment with a postmodern perspective (Foucault, 2000b; McHoul & Grace, 1997).

Foucault's work has also had its critics; for example, his work on sexuality has attracted the interest of feminist writers with some rejecting his writings citing a failure to understand or support feminist perspectives (Phelan, 1990). Others feminist writers such as McNay (1993), argue a major flaw in his work is the reduction of an individual to a docile body, which serves to negate the many experiences of women in society, and does not explain how individuals may act autonomously. Foucault has also been accused as having gender blindness, as he does not attend to the gendered nature of disciplinary techniques (McLaren, 1997).

Notwithstanding specific critique, Foucault's work has been rigorously analysed, critiqued and interpreted, influencing a variety of disciplines including human sciences, physiotherapy, medical sociology and nursing. Foucault (1995) has called his work "a history of the present" (p. 31), adopting a historical lens to trouble a contemporary problem (Kendall & Wickham, 1999). His work has subsequently been drawn on by a range of different health disciplines to address contemporary health associated issues, for example-Fadyl (2013); Nicholls (2009); Sochan (2011); Springer and Clinton (2015). Foucault's work moved through various phases as he altered and developed his thinking. His early work, for example *Order of Things* and *Archaeology of Knowledge,* introduced the question of knowledge formation concentrating on discourses and how they come to construct or be constructed by knowledge. Later his work, particularly *Discipline and Punish* and *History of Sexuality Volume One*, added the dimension of power and knowledge to discourse formations (Gordon, 2000; McHoul & Grace, 1997). These different modes of analysis became known in his earlier works as 'archaeology', and in the later works as

'genealogy'. Scholars may identify these as two separate methods of analysis (Mills, 2004), however Kendall and Wickham (1999) suggest Foucault himself considered the two methods as complementary. Foucault (1980b) offers an explanation of the difference between the two, suggesting archaeology is the tool to be used to analyse local discursive practices, and genealogy examines the tactics uncovered by archaeology and how they are then operationalised. Kendall and Wickham view genealogy not so much a method but more as "the strategic development of archaeological research" (p. 31). Similar to Kendall and Wickham, I found as I moved through the data, the tools described in both archaeology and genealogy were useful in contributing analysis insights.

Another crucial aspect of Foucault's methods is the necessity to remain impartial. True to a postmodern perspective Foucault offered no critique of a right or wrong, or true and false; things were what they were (Burr, 1995). This calls for the researcher to be non-interpretive, but to look for the hidden ideological message. Foucault was reluctant to offer judgement, the intent was merely to expose the discursive beginnings of the phenomenon under question (Kendall & Wickham, 1999). However, while he did not judge, his work did seek to challenge the assumption that knowledge is value free and an objective interpretation of the social realm (Cheek, 2000). Foucault (2000e) later clarifies this issue of the purpose of his analysis of discourse in an interview saying "it consists in seeing historically how effects of truth are produced within discourses that, in themselves are neither true nor false" (p. 119). Here he clearly states he will not offer an opinion as to the validity of truth claims revealed through analysis. As I in turn adopted a Foucauldian and postmodern lens, I was mindful to not make judgement calls on phenomena, events and practices that emerged from my study. This could be considered a limitation of my research as I do not intend to provide a solution, but rather problematise the issue, opening up avenues for later and further debate.

In completing this project, I have drawn on a variety of Foucault's analytical tools and concepts derived from both his archaeology and genealogy writings. As this chapter progresses, I systematically introduce and provide a brief overview of the methods of analysis I utilised. I begin with an explanation of discourse, as Foucault's interpretation of discourse differed from many of his contemporaries and is the foundation of a Foucauldian discourse analysis. As stated earlier, Foucault was a prolific writer and the scope of ideas to support analysis was concomitantly broad hence I present below the ideas I found most useful but not a complete overview of all Foucault's ideas.

### *Discourse*

Discourse is a difficult term to define, with a variety of interpretations offered by writers depending on the discipline. For example, Potter and Wetherell (1987) see discourse as associated with use of language, as language is central to constructing a social world and its meaning. Burr (1995) says it "refers to set of meanings, metaphors, representations, images, stories, statements and so on that in some way together produce a particular version of events" (p. 48). Therefore, through language discourse constructs and brings meaning to the social world around us. A discourse is constructed from what knowledge is culturally, socially and historically available at that particular period of time and may be subject to change as social conditions alter over time. The concept of discourse is pivotal to Foucault's work. However, Foucault had a more unique critical approach to discourse, and while including text he was also concerned with the material conditions or practices that exist(ed) thereby contributing to a particular and preferred version of reality (Kendall & Wickham, 1999). Thus, discourse analysis from a Foucauldian perspective is not limited to language, but rather requires a surveille of heterogeneous elements. For my research, this includes the material practices that are informed by and brought into play through legislation, disciplinary bodies such as NCNZ, and the institution of nursing.

Throughout his work, Foucault advanced his understanding of discourse. His conceptualisation of discourse began in what is known as his archaeological period and progressed through to his genealogical period. Foucault did not provide a definitive definition of discourse in his works, however he did describe discourse as "practices that systematically form the objects of which they speak" (Foucault, 1972, p. 49). Here Foucault has attached discourse or discursive practices to the formation of objects, hence events and phenomena are derived meaning in a particular way (Kendall & Wickham, 1999). Foucault suggests that production of a discourse is influenced and controlled by a number of processes which are not suddenly invented for a purpose but emerge over time often without any conscious awareness (Foucault, 1981). For any one object or event to be constructed though a discourse there may be multiple discourses circulating, but not all discourses are accorded the same status as representation of valid knowledge. Hence for indeterminate reasons, some discourses gain prominence while others are marginalised (Cheek, 2000).

Discourses may also change at different periods of time. Here Foucault (1972) suggests the researcher look for discontinuities where events brought about this change. A discourse

analysis therefore determines not only perceived validity of knowledge at any given time period, but the social practices and conditions that make it possible for certain things to be said and done and known as the truth (Kendall & Wickham, 1999). This perspective requires the researcher to explore how certain objects of discourse, concepts and strategies intersect to make particular events, practices and phenomena possible, and then how they relate to the construction of knowledge (Carabine, 2001; Foucault, 1972).

Dominant discourses in particular influence ways of thinking and behaving to the extent that they make possible our current social reality. Such is the power of discourses to craft our understanding of reality, it becomes difficult or impossible to think and behave in a way that opposes a certain discourse (Foucault, 1981; Hook, 2001). For this project, how older people are produced as an object of discourse is interrogated. A nurse/education discourse appears to privilege a biomedical discourse that constructs the older person as a pathologised body synonymous with decline and frailty, while discourses associated with health and wellbeing remain on the periphery of most commentary. The power of this biomedical discourse is such that it would be difficult to change pedagogy to a model that sought to valorise the health and wellbeing aspects of ageing. Of course, multiple discourses are available and these compete and contradict each other; some are dominant and not all have equal authority (Cheek & Rudge, 1994).

An essential unit to the analysis of discourse is the 'statement', which Foucault referred to as 'enounces', as it renders the object of discourse visible. Foucault (1972) defined statements as the "atom of discourse" (p. 80). A statement can be a "sentence or a series of signs" (p. 98) and "possess a particular relation with the subject" (p. 92). A statement is not restricted to an utterance or written word but may encompass things such as maps, or spatial arrangements. A statement therefore, is so much more than just what it says or does. Dreyfus and Rabinow (1983) coined the phrase "serious speech act" (p. 48) to identify a statement that makes a claim to knowledge. Therefore, what differentiates Foucault's idea of statement from a linguistic function is how it is used, or "its field of use" (Foucault, 1972, p. 104). A serious speech act with a claim to knowledge displays similarities that align it to other serious speech acts which then coalesce to create a discursive formation or discourse (Dreyfus & Rabinow, 1983). Statements that are considered true are those authorised within our society and generally it is only those that are circulated (Mills, 2003). As an example, the medical fraternity has the authority to make statements about physiological changes of ageing and risk of disease yet older people have scant authority to

counter those statements with narratives of ageing that do not align with physiological changes.

Analysis of discourses, therefore began by identifying statements from a variety of sources that constituted knowledge about the older person. Inherent in these statements, operationalised through language, behaviour and spatial arrangements, is the production of an acceptable and socially recognisable reference to the object of discourse; in the case of this research, the older person. Recognising discourses are socially and historically located, my priority became to trace 'conditions of possibility' that lead to the contemporary construction of older people in undergraduate nurse education (Foucault, 1972).

### *Archaeology*

Foucault was specifically interested in the pre-existing conditions resulting in one way of practice or thinking becoming normalised or common sense while other practices and ways of thinking became less visible or less valued. Foucault questioned how the invisible rules emerge that meant we could talk about an object or practice in a certain way but not in others (McHoul & Grace, 1997). In *Archaeology of Knowledge*, Foucault offers a set of tools, 'the rules of formation' enabling the researcher to recognise events, practices and phenomena that intersect to form the object of discourse (Foucault, 1972). These rules outline the conditions of possibility as there are potentially multiple ways events or phenomenon could be produced. Application of these rules brings into focus how the object became nameable and describable within the social field. For this study, through an historical lens and application of these rules of formation, the emergence of the older person as a nameable and describable object of discourse in nurse education was traced.

The first rule is to map out 'surfaces of emergence', that is, places where the discursive object became visible and individual differences accorded status (Foucault, 1972, p. 41). The rule requires an examination of contingencies, for example societal mores that lead to an object emerging to be constructed within discourse. In my study the older person first became an object of a nursing discourse within institutions for care of the infirm and aged.

The second rule identifying the 'authorities of delimitation' considers who has the authority to speak about the object and construct it in a certain way. In this instance medicine already had appropriated the authority to speak of older people, confining knowledge to the (dys)function of the body (Katz, 1996; Rose, 1994). As will be discussed in Chapter Four,

nurses were under the control of the medical fraternity who decided what nurses needed to know.

The final rule requires an analysis of the 'grids of specification' that involves establishing how discursive objects can be categorised, identified and contrasted within a discourse (Foucault, 1972, p. 42). For example, I suggest a biomedical discourse differentiates a person according to chronological age that may result in different models of care being enacted. Grids of specification also indicate the way in which the object of discourse may be rendered accessible (Kendall & Wickham, 1999). Following this rule, I searched for ways the older person became classified by age characteristics. These three rules, enabled me to map out the historical events, practices and phenomena that came together to identify and construct the older person in a particular way in undergraduate nurse education.

In addition to rules of formation and the understanding that a discourse is not created in a vacuum but is socially and historically contingent, events and practices external to the discursive formations are also to be considered (Kendall & Wickham, 1999). Foucault (1972) identifies these as non-discursive domains and includes "(institutions, political events, economic practices and processes)" (p. 162). However, I understand the aforementioned non-discursive domains are also affected by demographic changes, thus socially and historically contingent. For my study, I considered non-discursive domains to include legislation introducing the *Old Age Pensions Act 1898* that began the identification of older people and the *Nurses Registration Act 1901*. The *Nurses Registration Act 1901* created the registered nurse role, and was instrumental in formation of student nurse education and the methods employed to ensure a safe and competent nurse.

Archaeology provides a useful vehicle to trace the beginnings and conditions of possibility of discourse. However, it fails to adequately address issues of power and knowledge in the construction of truth statements (Kendall & Wickham, 1999). My discussion now moves on to the next phase in Foucault's repertoire: genealogy, or a history of the present (Garland, 2014).

### *Genealogy: A history of the present*

Genealogy extends Foucault's thinking on the conditions of possibility as he grappled with the need to account for power and its relationship to knowledge and truth. A genealogy, or a history of the present (Garland, 2014), begins with a contemporary situation that is taken-for-granted but conversely may be problematic, and then reaches back, as Foucault

says “to numberless beginnings, whose faint traces and hints of colour are readily seen by a historical eye” (Foucault, 1984, p. 81). A genealogy presents a description, through matrices of power, of what can be said and seen in the social field seeking to reveal the material conditions existing that resulted in the present assumptions of what constitutes truth. A genealogy utilises concepts derived in archaeology but is more concerned with “describing the procedures, practices, apparatuses and institutions involved in the production of discourses and knowledges and their power effects” (Carabine, 2001, p. 276). In this way, Foucault’s treatment of historical events differs from a usual modernist view of history that follows events back to an identifiable origin. Rather he sought examination of seemingly disparate conditions or contingencies that then led to the emergence of the contemporary situation (Rabinow, 1984).

Foucault’s principles of genealogical analysis were introduced in a variety of works including *Discipline and Punish*, *History of Sexuality Volume One*, as well as lectures and essays on power/ knowledge and truth, but not presented as one cohesive framework. Through operationalising these analytical tools, I did not seek to explain historical events based on the notion of cause and effect that produced a ‘truth’, instead the intent was to disrupt what has become accepted as truth or valid knowledge. This required me to map out, through the lens of power relations, the pre-existing material conditions that allowed certain knowledges and material practices related to gerontology knowledge and older people, rather than others, to appear and become accepted as the truth (Mills, 2004). Kendall and Wickham (1999) in their explication of genealogy suggest that as an approach it allows identification of assumptions that may have passed unnoticed.

An imperative to identify historically derived assumptions is congruent with the aims of this study as through revealing the power relations at play, genealogy creates the possibility of doing things a different way (Dreyfus & Rabinow, 1983). In his earlier works Foucault was criticised as being deterministic, suggesting there was no possibility of human agency with the individual powerless and oppressed, unable to contest the dominant discourses (Frederiksen, Lomborg, & Beedholm, 2015; Miller, 2008). The sense of a determinist future is based in part on his reticence in offering modes of resistance to dominant discourses (Rabinow, 1984). However, Foucault did not offer a purely deterministic position as he contended that where there was power there existed the capacity for resistance (Kendall & Wickham, 1999). Hook (2001) credits Foucault’s approach to analysis as being political and having the capacity to form critique and enable resistance. Thus, his approach affords the

opportunity to facilitate change as it reveals the conditions that led to the contemporary construction of the object under scrutiny (Garland, 2014).

As stated above, implicit in Foucault's writing is the notion of foreshadowing change, as under different circumstances other outcomes would be possible (McHoul & Grace, 1997). Foucault, (1972) believed that use of his ideas had the potential to transform, and should be used. To reveal and trouble discursive practice, is to expose how it operates and examine its material effects. Once revealed it becomes possible to form new discursive constructions (Foucault, 2000b). The current research, through troubling the dominant discourses perpetuated in the teaching and associated practices of gerontology knowledge, may generate discussion and lead nurse education to consider the effects such practices have on student nurses' perceptions of working with older people.

To trouble present day reality requires exposing how contemporary understandings of gerontology knowledge and the older person have gained and maintained prominence. Such exposure provides a vehicle to apprehend how certain understandings of the older person have been enabled while others are constrained in educational practices. When this is understood, it becomes possible to contest how certain forms of knowledge gained supremacy within institutional practices (Prasad, 2017). Genealogy, therefore permits me to question how it has occurred that in nurse education there appears to be dominant discourses that privilege a particular type of knowledge that divides people who are named as older from younger people. I can critique the circumstances, through times of change in nurse education within New Zealand that led to emergence of gerontology as a recognised body of knowledge. I can then ask how has nurse education sought to construct people named as older? What were the conditions that resulted in people constituted as older becoming visible to the student nurse? How did some discourse become privileged while other discourse marginalised? By expanding the knowledge of the dominant discourses operating in nurse education, I trouble the status quo and potentially begin discussion to raise critical awareness of the material effects of these discourses. Inherent in analysing these discourses is the power/knowledge phenomenon.

### *Power and knowledge*

Foucault's model of power relations examines the complex interaction between power and the production of knowledge. Foucault is clear that "it is in discourse that power and knowledge are joined together" (Foucault, 1978, p. 100). He showed how the workings of power negated or limited alternative versions of truth while ensuring that a certain version

of knowledge was taken-for-granted and natural (Rabinow, 1984). The relationship of discourse to power and knowledge were foreshadowed in Foucault's earlier works but introduced as a central construct with his work on genealogy. Foucault's view on power differed from his contemporaries and earlier philosophers such as Marx. Foucault saw power infused through society (McNay, 1994), but not the overt use of power to constrain the populace in the sense of Marxism which views power as used oppressively by institutions and certain groups and classes of society. For Foucault, the observation of power in action is about how it operates on a more quotidian level between people and institutions or society, and how power is circulated (Gordon, 2000). Foucault argues the effects of power should not be described in negative terms that suggest power excludes or represses. Rather, Foucault explains "power produces; it produces reality; it produces domains of objects and rituals of truth. The individual and the knowledge that may be gained of him belong to this production" (Foucault, 1995, p. 194). The effects of power Foucault refers to may be so subtle that it is taken up without conscious thought (McHoul & Grace, 1997).

As described by Foucault, power does not exist until it is brought into operation by people through action, however the mode of its existence rests in the social field of possibilities: "Power exists only as exercised by some on others, only when it is put into action, even though it is inscribed in a field of sparse available possibilities underpinned by permanent structures" (Foucault, 2000d, p. 340). This power is not owned or tangible as a thing to be seized by a group or individual but, when combined with knowledge, it is reproduced as discourse (Dreyfus & Rabinow, 1983). Foucault later comments, that power can make certain actions easier or more difficult. This led me to consider how difficult it might be to change the accepted knowledges in nurse education. My analysis will reveal, how existing power/knowledge networks are deployed and intersect in nurse education producing a narrative of ageing that draws on powerful biomedical and functional decline discourses. I will show how these ways of constituting older people are assumed as common-sense, taken-for-granted knowledge in undergraduate nurse curricula. Through the use of Foucauldian analytic tools and the concept of power/knowledge it is possible to challenge the contemporary understanding that constructs knowledge of the older person in a particular way (Gastaldo & Holmes, 1999).

Application of Foucault's notion of 'systems of exclusion' proved useful in deciphering how it came to be that certain knowledges about older people circulated, while others were

excluded. Foucault (1981) introduces systems of exclusion which operate on discourse to limit and marginalise certain ways of thinking and speaking. He argues that potentially there are multiple ways of speaking within discourse, yet societal mores and processes constrain us to a limited repertoire (Nicholls, 2009). Foucault includes three external systems of exclusion but focuses most on the third. "Of the three great systems of exclusion which forge discourse - the forbidden speech, the division of madness and the will to truth, I have spoken of the third at great length" (Foucault, 1981, p. 55). Similarly, the third exclusion resonated with my project, as the will to truth lies in the "way in which knowledge is put to work, valorised, distributed" (Hook, 2001, p. 524). Foucault contends the will to truth resides in institutional support. Through a whole raft of practices including pedagogy, books, libraries, and the internet, the will to truth is reaffirmed and strengthened. By being aware that discursive power is contingent and operates to create and maintain these practices, I was able to question what counts as truth. Applying these processes sought to reveal truth, or what is accepted as a contemporary version of truth, as a product of discourse and power/knowledge (Hook, 2001). In Chapters Five and Six I examined a range of data looking for what ways of constructing an older person, noting those that are present and what are absent. Applying the concept of exclusion allowed me to highlight the absences**.**

Internal systems of exclusion also operate but are concerned more with the role of the commentary, author and discipline in the production of discourse (Foucault, 1981). Foucault suggests, while we may believe we are creating new knowledge, in actuality an iterative process exists that only repackages the dominant narratives of our society: "it allows us to say something other than the text itself, but on the condition, it is the text itself that is said" (Foucault, 1981, p. 58). These procedures are all concerned with determining discourse, to differentiate between who has the authority to speak, and which discourses are privileged by commentary and disciplines and which are not (Mills, 2003). As posited by Foucault (1972) a discipline(s) may be interpreted in two ways, as either scholarly disciplines such as medicine and science, or disciplinary institutions that exert some form of social control such as schools, hospitals, and prisons (McHoul & Grace, 1997). Applying the principles of exclusion has allowed me to consider the kinds of knowledge made available to student nurses through the disciplinary practices of nursing and education and question why some are privileged and some marginalised. How is it that despite a mandate to resist the narratives of a decrepit old age, nursing manages to recirculate the dominant discourse that disease and functional decline are inevitable?

### *Biopower and the politics of gerontology knowledge*

In a chapter titled *Right of Death and Power over Life* Foucault (1978) traces how in earlier times, the sovereign had the power of life or death over his/her people and yet had little concern regarding their health and wellbeing. This began to change in the eighteenth and nineteenth centuries as the growth of capitalism and the need to have a productive workforce required maximising the health and wellbeing of individuals and the overall health of the population (McNay, 1994). Foucault suggested that as interest grew in the care of the population, a new form of power developed. This form of power was different, it was more subtle and when exercised less visible to the population. Foucault used the term 'biopower' to describe this new focus, and identified two forms or poles. The first form, 'anatomo-politics' approaches the human body not as a physical entity but as an object that through the action of disciplinary technologies can be made docile, compliant and useful. He attributes this form of biopower to disciplines such as medicine, and education. In *Discipline and Punish* Foucault (1995) sets out how disciplinary technologies, which include things like training, timetables, examinations and assessments, arose in various forms in places like schools, hospitals and workshops as a means of producing a docile body. These disciplinary technologies successfully create a docile body as they regulate activity and maintain constant surveillance measures to monitor performance and ensure conformity (Best & Kellner, 1991). Recognising disciplinary technologies as a ploy to control the body had salience for this inquiry, I considered how student nurses are educated to produce a regulated product, the nurse.

The second, form of biopower, 'regulatory controls': or a 'biopolitics of the population', is focused on the body and how it is "imbued with the mechanics of life" (Foucault, 1978, p. 139). Interest is in population demographics, morbidity and mortality, birth rates, overall health of the population and conditions that may cause variations. I found the application of biopolitical principles allowed me to examine how the older person was constructed through demographic information, including information that was readily available and information that what was less apparent.

A consequence of biopower, a disciplinary technology of power centred on life, is the development of a system of normalisation (Foucault, 1978, 1995), Best and Kellner (1991) define normalistaion as "the elimination of all social and psychological irregularities and the production of useful and docile subjects through a refashioning of minds and body" (p 47). Or as Rabinow (1984) explains, "a system of finely graduated and measurable intervals in

which individuals can be distributed around a norm" (p. 20). Normalisation operates with biopower as a means of regulatory control. Mechanisms such as statistics and gathering of documentary evidence make possible descriptions of groups and distribution within a population. Normalisation also enables recognition of those groups or individuals who fall outside the established norm (Foucault, 1995). Healthcare in particular, through a biomedical discourse, circulates around this notion of the norm. Biomedicine strives to maintain for example, a 'normal blood pressure' or expect 'normal' behaviour. Through assessment, diagnosis and intervention, the health professional seeks out deviation from the norm and enacts ways to achieve the norm. The person/patient to maintain a normal blood pressure is expected to take medication and perhaps make life style changes prescribed by the doctor. By adhering to the expected normal blood pressure measurements, the patient is positioned as a docile subject. Refusal to take said recommended medication, or adopt life style changes the person is positioned as a bad or non-compliant patient.

Also operationalised within my study was Foucault's idea of 'dividing practices'. First introduced in his early works as a mode of objectification of the subject, these are practices that relate to where the person is divided within themselves or divided from others (Foucault, 1983, 1994). Foucault provides the example of a binary of sick from the healthy or the mad from the sane, and relevant for my study, also includes division of the young from the old and independent from dependent. Within a binary the first term has primacy with the second in a subordinate position hence young is valued over old and healthy from the sick (Cheek & Rudge, 1994). As I read through my data, I looked for dividing practices. Dividing practices apply to those who are on the margins of society. It is through these dividing practices, which may be spatial in the instance of special wards or social arrangements, the object of discourse is given identity (Rabinow, 1984).

Another term associated with Foucauldian discourse analysis is 'governmentality'. Foucault introduced governmentality as he developed a shift from biopower; the term does not replace biopower but broadens the concept (Foucault, 2000a). Governmentality is not government per se, rather it is about the "general mechanisms of society's governance" (Holmes & Gastaldo, 2002, p. 559). McNay (1994) identifies governmentality as a way "modern societies are characterised by a triangular power complex: sovereignty-discipline-government" (p. 117). Governmentality operationalises a complex form of power that targets the population through surveillance and disciplining of both individuals and the

population with the end goal a stable and docile social body (Cheek, 2000; Foucault, 2000a). Applying Foucault's definition of governmentality, Holmes and Gastaldo contend nurses constitute an important group, as through their actions the state is able to govern from a distance. They introduced the phrase 'agents of the state' to explain this phenomenon. Hence nurses through registration and various forms of legislation have become the legitimate carers of older dependent people ensuring the older dependent person becomes less of a problem to the state, as the next section will elaborate on.

### *Subject positions*

While governmentality is concerned with the broader interpretation of a body within a population, Foucault also operated at the level of the individual. In an essay titled *"The Subject and Power"* Foucault (2000d) argues that through a process of objectification and deployment of power, people are made into subjects:

> this form of power that applies itself to immediate everyday life categorises the individual, marks him by his own individuality, attaches to him his own identity, imposes a law of truth in him that he must recognise and others have to recognise in him. It is a form of power that makes individuals into subject. (p. 331)

Within a discourse then, people may take up a particular 'subject position' which ties them to their own identity and self-knowledge. A person recognises her/himself as constituted within that discourse and is also recognised by others as constituted by the discourse (Davies & Harre, 1990). For Foucault, a subject is "not the speaking consciousness, not the author of the formulation, but a position that may be filled in certain conditions by various individuals" (Foucault, 1972, p. 115). Therefore, an older person who is admitted to an ARC facility will identify her/himself as a resident and be recognised by a student nurse as such. By being identified as a resident, hence an object of care, she/he has the subject position of being dependent on others for care. Once a position has been taken up then people have available to them a limited range of concepts, with certain ways of behaving and speaking about themselves (Burr, 1995). This limited range offers a position from which the person can speak the truth (Arribas-Ayllon & Walkerdine, 2017). As my analysis progressed, I drew on the notion of subject positions and sought out the discursive subject positions made available not only to the older person, but also the student nurse.

The subject positions available to an older person within a nurse/education discourse are, I propose, contradictory and more complex as they may not be ones through which a person may recognise themselves. In a study of women over the age of 85 years who lived

independently in the community, the women constructed themselves within a health and wellness discourse, focusing on health and not on health concerns (Foster & Neville, 2010). This observation led me to consider what subject positions older people were offered in nursing textbooks and journal articles featuring gerontology knowledge and whether these differed to how participants mentioned in the above article positioned themselves. To explain how people may be positioned in a discourse by another Davies and Harre (1990) introduced the term 'interactive positioning'. It is through interactive positioning, as well as deployment of various discursive practices and effects which are central to later chapters that I seek to reveal how older people are positioned by within the data.

## Conclusion

This chapter has presented the key theoretical concepts drawn upon throughout this work to inform the analytical process used to critique the present-day construction of gerontology knowledge in undergraduate nurse curricula. I have demonstrated how a social constructionist epistemology is congruent with other elements of the project, premising the notion that how we operate in the world is not innate and natural but rather constructed through human actions. By introducing a brief history of the evolution of modern thought I have situated postmodernism as a contemporary theoretical perspective that allowed me to challenge long held truths within nurse education. In the methodology section I have described a range of analytical tools from the work of Michel Foucault and provided some indication as to why they are applicable to the aims of this work. In the upcoming chapter, I summarise how I generated text for analysis, including the interview process and how I applied the analytical tools outlined in this chapter.

# Chapter 3: Research Methods

## Introduction

Chapter Two explained the theoretical foundations of this study which have been informed by the writings of philosopher Michel Foucault and his approach to analysing discourse and strategies of power. I demonstrated how the theoretical positions that underpin this study, enable, challenge and critique of commonly held assumptions of truth (Burr, 1995; Crotty, 1998; Rolfe, 2000). Chapter Two also recounted how this particular approach was the most legitimate to trouble the contemporary understandings of gerontology knowledge in undergraduate nurse curricula.

Chapter Three now provides a brief overview of the methodological principles guiding my work before elucidating the data sources that informed this study. As this work employed interviews, all the procedures undertaken to ethically complete data collection are clarified. The active process of analysis is then tracked evidencing how I engaged Foucault's various analytical tools and sought guidance from a variety of other authors. In the final summation I present crystallisation as a process to establish the legitimacy of my work.

## Establishing data sources

Discourse analysis may be approached in a number of ways but is essentially the study of language and meaning in the social context. It provides a means of analysis as to how dialogue or texts are used to construct the social world (Wetherell, Taylor, & Yates, 2001). Therefore, anything can be used including textbooks, magazine journals, diaries, advertisements and policy documents. Drawing on Michel Foucault's principles of discourse analysis (Foucault, 1981) allowed me to explore the social, political and historical circumstances that existed for the older person and student nurse education, and how they contributed to certain statements becoming true or false (McHoul & Grace, 1997). As a consequence, data collection had to encompass both historical and modern perspectives (Hook, 2001).

Carabine (2001), cautions researchers to consider the length of time required to collect and analyse all valid data for an historical enquiry and if necessary, to impose limitations. I was cognisant that time limitations imposed by completing a professional doctorate within two and a half years did not allow such an in-depth critique as afforded to a longer timeframe. Hence my data searches, historical and contemporary, remained narrow and tightly focused on my research topic. The broad scope of my potential data sources led me to

make clear decisions on what I would consider and what I would omit, as discussed later in the chapter.

Following Foucault's principles, texts reviewed were not considered an impartial reflection of the social reality but included as knowledge that actually becomes part of producing social reality (Ahl, 2007). As Cheek (2004) has outlined, I understood I would require both, data to be analysed but also other separate bodies of data to provide a context and background information to situate and make sense of my discussion. As I debated my approach to the study, I concluded there were three distinct characteristics to data sources that separately but also together informed each of the three analysis chapters. I had historically situated data for my history of the present, as well as contemporary textual data, and interviews. Drawing on Foucault's (1972) interpretation of data, this collection formed an archive. The archive reveals "the conditions (the set of rules) by which it is possible to know something at a specific historical point" (McHoul & Grace, 1997, p. 31).

### *Historical and contemporary textual data*

Before embarking on my project, I first took time to consider if there would be a distinct beginning point of my genealogy or history of the present. Initially, I intended to begin with events leading to a formalised nurse training scheme and nurse registration. However, Foucault recommends exploration of conditions that exist to allow a discourse to emerge at that particular socio-historical period (Foucault, 1972). Therefore, I extended my historical study to events and conditions in nineteenth century New Zealand that contributed to the emergence of formalised nurse education and the object nameable as the older person. The term 'gerontology' had yet to be conceived or defined at that period of time, hence I sought primary and secondary sources referring to the older person, both in the societal sense and also in reference to hospitals, charitable institutions, community and nurse education.

Sources for historical data included both online resources, in particular the papers including Appendices to the Journal of the House of Representatives (AJHP), government documents, and hard copy evidence such as books on New Zealand history, textbooks, nursing school archives and New Zealand nursing journals. AJHP was a wealth of information including old hospital reports and parliamentary documents dating back to the mid nineteenth century and reflecting the social mores of the period. The library at NZNO also proved to be a fruitful source of historical data, having all editions of the New Zealand nursing journal *Kai Tiaki Nursing New Zealand* which began publication in 1908, and some early nursing

textbooks. The early editions of *Kai Tiaki Nursing New Zealand* proved to be a valuable resource in ascertaining what was considered valid knowledge for the student nurse to meet the standards of registration at the time. I also accessed the National Archives for information that could contribute to backgrounding the early years of nurse education. This documentary evidence contributed to Chapter Four which aligns to my first aim, to establish why gerontology knowledge emerged as a specific body of knowledge in nurse education.

The contemporary data collection proved to be more straight-forward, as I limited my data sources for analysis to three New Zealand nursing journal publications, two commonly used undergraduate nursing textbooks, two student nurse textbooks specifically on care of the older person and government health strategy documents concerning the older person. I imposed this limitation to ensure I sourced material representing text used in New Zealand undergraduate nurse education and journal publications with knowledge generated from a New Zealand perspective.

Of the three New Zealand nursing journals available *Kai Tiaki Nursing New Zealand (Kai Tiaki),* was the most prolific. The journal is produced by the NZNO, a nursing union that includes both nurses and student nurses as members. The journal itself contains news, views, education resources, industrial updates and research. Another publication, *Gerontology Nursing Knowledge and Skills Framework,* published by NZNO on the role of the gerontology nurse was also used as data (NZNO, 2014). Many of the articles in *Kai Tiaki* were written by co-editors, often from interviews with various practitioners, so not necessarily reflective of the authors' personal perspectives. The other two New Zealand nursing journals, *Nursing Praxis in New Zealand* and *Kai Tiaki Nursing Research*, were focused purely on publishing New Zealand nursing research. I extended my search back to 2006, as student nurses are advised to use sources less the 10 years old when writing an essay. All the New Zealand journals were accessible through nursing journal databases such as CINAHL and hardcopy from my organisation's library. The two textbooks were compulsory text in my own organisation and confirmed by a New Zealand representative for the publisher Elsevier as commonly used throughout undergraduate nurse education (D. Usher, personal communication, 18 May 2018).

### *Interview as data*

In addition to published documents another set of data were collected through one-on-one interviews with senior nurse academics employed in management roles in undergraduate

nurse education. My decision to include interviews as a data set arose when it became apparent there was little publicly accessible data on how gerontology knowledge was constructed/included in undergraduate nurse education. Interviews allowed me to complement the available academic commentary with first hand, practice-based accounts and ascertain how nurse education positioned gerontology knowledge within programmes of study.

Allen and Hardin (2001) advocate the interview as a suitable vehicle for postmodern inquiry as it explicates the relationships that exist between the individual, and social and historical structures that may normalise discursive practices. In a Foucauldian discourse analysis, use of interviews can be limited and problematic. Foucault did not himself use interviews as a form of textual data, however he did critique the confessional in *History of Sexuality Volume One* (Foucault, 1978). Both interview and confessional are contrived to elicit information from the interviewee, and for some commentators, the interview could be considered a progeny of the confession (O'Rourke & Pitt, 2007). However, others like Fadyl and Nicholls (2013), caution the use of interview for several reasons, citing a Foucauldian lens implies historical rather than contemporary data. Still other authors suggest interviews are a legitimate form of data for a discourse analysis and can be employed (Bryman, 2012; Frederiksen et al., 2015). Noting that although the veracity of the interview can be debated, it is nevertheless an effective tool to discover what is considered the truth (McHoul & Grace, 1997). A number of nurse academics employing Foucauldian methods have utilised interview as a rich data source (Carryer, 1997; Moreau, 2017; Payne, 2002; Wilkinson, 2007). The aim of the interview in this study was to illuminate contemporary discourses of gerontological knowledge within undergraduate nursing curricula that were not available through any other medium.

**Data Sources for each Chapter**

| **Chapter 4**<br>**Historical Data** | **Chapter 5**<br>**ARC Data** | **Chapter 6**<br>**Hospital & Community** |
|---|---|---|
| Kai Tiaki Nursing Journal<br>AJHR<br>National Archives<br>Textbooks<br>NCNZ documents<br>MOH documents | NZ Nursing Journals<br>Textbooks<br>Interviews<br>Participant curriculum<br>NCNZ documents<br>NZNO documents | NZ Nursing Journals<br>Textbooks<br>Interviews<br>Participant curriculum<br>NCNZ documents<br>MOH documents |

### *Managing data*

As the amount of data expanded, I decided on a manual means to organise and track all information. I had investigated using a computer software programme such as NVIVO but opted to work with hard copies of documents, including transcribed interviews, as opposed to electronic. Consequently, I developed a process of printing off relevant material, scanning it and if appropriate assigning it to a category, for example, curricula information, which was then filed in a labelled document box. In the case of journal articles, I numbered them then wrote a short summary recording which box they were stored in. As I worked through analysing the collection of documents, I recorded those I would incorporate in my analysis on Endnote database to keep track of reference information.

## Interview process

### *Participant selection*

The decision to interview participants was followed by the question of who would be most appropriate. The interview sought an understanding of the wider discursive field of gerontology knowledge and how it was operationalised across the whole of nursing curricula. I therefore required participants with a broad overview. Data would likely be limited if I interviewed someone who taught within a particular area, for example medical and surgical nursing. Being aware of the structure of degree programmes I settled on approaching the programme co-ordinators or those in a similar senior role. NCNZ requires that every programme has an identified programme co-ordinator who is not necessarily the head of school but "ensures cohesion across the total programme" (NCNZ, 2017b, p. 50). This role then met my requirement of a participant with an overview of their curriculum. Foucault (2000b) asks us to question who decides what is considered knowledge, a notion central to this research. Therefore, my potential participants also included members from NCNZ as they are the regulatory body who provide the standards for degree programmes and also through examination, determine who is appropriate to be a state registered nurse.

There are 17 tertiary institutions in New Zealand providing a qualification that leads to nursing registration by the NCNZ. The tertiary providers include universities, institutes of technology and polytechnics. To ascertain who would be a likely participant I searched the online staff lists with associated job titles. A similar process was carried out for NCNZ representatives. Once I had compiled a list of potential participants, I approached them directly through email with an invitation to participate in my research and a Participant Information Sheet (Appendix B) outlining the purpose of the research. I sent a different

information sheet to NCNZ (Appendix C). In total I had eleven positive replies representing ten different tertiary providers and one response from NCNZ.

The decision to target programme co-ordinators and members of NCNZ meant sampling was purposive. That is, I did not seek participants on an opportunistic basis, but rather strategically planned who I would approach as a prospective participant (Bryman, 2012). Based on the considerations discussed above, criteria included the following:

- Must be a New Zealand state registered nurse with a current practising certificate
- Employed in a programme-lead capacity for a New Zealand undergraduate degree programme leading to nursing registration, or
- Employed by the NCNZ in an area that is relevant to undergraduate nurse education.

### *Ethical considerations*

In preparation to commence the interview phase of this research, official ethical approval was sought. Ethical approval was gained through Auckland University of Technology Ethics Committee. Ethical approval was granted on the April 2017 (Appendix A). I was approved to recruit programme co-ordinators or senior academic members of staff from the New Zealand tertiary institutes that provided an undergraduate qualification that met the requirement for application to become a registered nurse, and to approach the NCNZ. Ascertaining who would be an appropriate participant proved more difficult than I had originally anticipated. In my initial ethics proposal, I had intimated I would approach the heads of each teaching faculty with a request to forward my invitation to the programme area lead, who potentially could have been themselves. I was dissuaded by this approach by an ethics advisor as there was the potential for perceived coercion. Plan B required more online and telephone detective work but eventually I was able to locate the name of the programme leads or similar roles for each institution.

### *Confidentiality*

I was unable to totally guarantee participant anonymity due to the limited number of people employed in senior roles and the small number of institutions that were eligible to be included in the study. This anomaly was noted in the Participant Information Sheet and I ensured participants understood the implications prior to commencement of the interview. To mitigate this risk, a generic term ‘Senior academic member of staff’ was used when referring to participants. Participants’ place of employment was indicated through a

similarly generic term 'Tertiary Institution'. When incorporating excerpts from interviews I have identified each participant by a gender-neutral name to ensure participants could not be recognised by gender. If referring to a document from the participant's organisation I used a generic term 'Tertiary Institute curriculum document'. Participants were reminded, they could share involvement in the study with whomever they wished. Any other form of identification, for example the name of an institution or a local town/city that emerged from the interview was removed from transcriptions. Voice recorded interviews were typed by a professional transcriber who had signed a confidentiality agreement (Appendix D). The recordings were erased from the recorder once transcribing was completed and stored on a password protected computer.

The transcribed interview records once stored electronically on a password protected computer were identified by a code only, containing no identifying information such as the name of the participant or their employer. Access to these notes was limited to myself and my primary supervisor. Signed consent forms were stored in a locked cabinet in my office at my place of employment. After a period of six years all electronic data kept on my personal computer and One Drive cloud storage account will be deleted and hardcopy information held locally will be likewise shredded.

### *Conflict of interest.*

I identified that as I also work in the tertiary sector there may be concerns raised that information garnered from interviews could be used for other purposes. I assured participants that no specific information about curricula content would be disseminated to a third party. Participants were assured that information would only be used for its intended purpose and not for any other research.

### *The interviews*

Through negotiation and fitting around busy schedules I was able to complete my interviews over a period of four months. I had envisaged conducting all interviews in person but time constraints and the broad geographical location range of participants meant I also conducted some interviews via Skype. Using Skype as an interview platform has become established in the qualitative research community particularly with geographically dispersed participants (Deakin & Wakefield, 2014). I add here a note of caution. I had never thought interviewing could put one's life and limb at risk, however, I now conclude it is safer to avoid interviewing in the winter. In the course of meeting

interviewees, I experienced heavy snow, treacherous icy roads and floods. Personal dangers aside, the face-to-face interviews flowed more easily than those conducted via Skype and were worth the extreme travel conditions.

Whether via Skype or face-to-face, interviews were semi-structured and ran between 45 minutes and an hour and a quarter. All participants signed a consent form before interviews began (Appendix E). Interviews were conducted in a private room at the participant's place of work or through Skype from my place of work and the participant's. All interviews were audiotaped using a digital recorder and later transcribed. All interviews were one-to-one except for my interview at NCNZ. Here I had two participants as my original participant invited a colleague to join the interview. This added participant signed a consent form.

I had prepared two sets of questions to guide my interviews, one set for senior academic staff members and one for the NCNZ participant. Two sets were necessary as with the education providers I was focused on an individual programme of study, but for NCNZ the questions were broader relating to decisions about appropriate gerontology content to ensure a work-ready nurse. For both, questions ranged from seeking specific information about material practices concerning gerontology knowledge to broader questions about educative process. I was alert to not pre-empting any dialogue with my own understanding of gerontological knowledge, however that proved to be challenging as I was approaching as an insider (Kanuha, 2000). Taylor (2001) suggests that when an interviewer is an insider, they remain neutral and not add any information that indicates they have knowledge on the topic. This was particularly difficult as the participants were aware of my interest in gerontology knowledge and made assumptions about what I wanted to know. I tried to compensate for this possibility by initially asking very generic questions as per examples below.

The following are questions posed to participants illustrating examples of both general and specific questions. First are the general questions:

- NCNZ requires that the curriculum teaching reflects 'the health care needs across the life span'. How is this interpreted in your curriculum?
- What practicum experiences do students have in your programme?

Then to more specific questions such as:

- Tell me how gerontological knowledge or care of the older person is taught across your programme?
- Do you think your graduates are fit for purpose in the care of older people?

Questions posed to NCNZ were similar but offered a broader view of gerontology knowledge across the providers. I also included questions on the State Final Examination as I was interested in determining what questions were included about care of the older person. I asked, in relation to the categories to be covered in the examination:

- Within those categories would there be a percentage that covered the older adult/gerontological nursing? Is there a requirement to include this demographic?

The interviews sought to provide information on gerontology knowledge in undergraduate nurse curricula, however, from a postmodern perspective, in a discursive interview there is a shift from an objective presentation of what is considered knowledge to a social construction of knowledge (Tanggaard, 2007). Foucauldian discourse analysis understands that a subject's (interviewee) beliefs and actions are shaped by discourse (Graham, 2011), and in this instance are reflective of the normative educational processes and technologies employed by education providers. The ultimate goal was to elicit the discourses that inform and shape undergraduate nurse curricula and produce truth statements about how gerontology knowledge is constructed. I was initially concerned my interviews had not been discursive enough, however, as I proceeded to apply my notions of discourse, power/knowledge and subject position to data, I appreciated I had a rich source of data. I will now work through my processes of analysis.

## Data analysis

As outlined in the previous chapter, my analysis was guided by Foucault's principles and concepts drawing on both his archaeological and genealogical applications. In keeping with a postmodern perspective Foucault did not set out any prescriptive method for data analysis, but rather provided within his works a suggestion of methods or tools a researcher might employ. Foucault suggested that:

> All my books are little tool boxes if people want to open them, to use this sentence or that idea as a screwdriver or spanner to short-circuit, discredit or smash systems of power, including eventually those from which my books have emerged… so much the better. (Foucault, as cited in Patton 1979, p. 115)

Following Foucault's directive, I moved between his suggested methods, drawing on in particular for the historical chapter, rules of formation (Foucault, 1972). This allowed me to

discover the discursive conditions that exist for the present-day representation of the older person, student nurse and gerontology knowledge. In the contemporary data chapters I built on the power/knowledge effects, discourses, objects, and subject positions available to both student nurses and older people that had emerged from my history of the present. I employed similar techniques of analysis for my historical chapter and the two contemporary chapters, requiring an extensive data search followed by reading to make sense of the material. In the planning stage I concluded there were three distinct data sets: the historical; the modern textual data; and interviews that represented different surfaces of emergence. The historical data provided the conditions of possibility for the contemporary construction of the older person. The modern texts, from 2006 till 2017, including journal articles and textbooks, became surfaces of emergence, illuminating how the older person was constructed for the student nurse. The interviews meanwhile related to what gerontology knowledge was included in curricula and also material practice that informed knowledge construction.

Reading between Foucault's work, methodologically relevant theses and authors offering guidelines about how to conduct Foucauldian analysis, I began to make sense of how I would approach this task. In particular I drew on examples of application such as Carabine (2001) in a genealogical work on unmarried motherhood, and also more theoretical endeavours proposed by Arribas-Ayllon and Walkerdine (2017); Mills (2003), and Kendall and Wickham (1999). My initial step was to decide on the corpus of statements utilising a suggestion from Arribas-Ayllon and Walkerdine. A corpus of statements refers to examples of texts that are representative of the rules which construct the object under scrutiny. The statements together form the archive (Foucault, 1972). The statement is central to commonalities evidenced in a discursive formation and from there signify the discourse. Statements adhere to a set of rules that dictate how statements are formed, circulated and maintained but also limit what can be said (Foucault, 1972).

### *Historical data analysis*

As my collection of historical texts continued, I proceeded to read through them, formulating ideas on how to approach the analysis. Foucault's conditions of possibilities resonated with me as I applied his rules of formation to the data set. I began with the surfaces of emergence. These were the places where the older person became an object of discourse. I looked for the institutions and authorities that had the power to define how the older person may be treated. Finally, I examined the grids of specification that

considered how the older person was categorised, organised and divided (Foucault, 1972). I applied these tools moving across my data set toward the twenty-first century while also seeking out discontinuities and continuities, when events or statements changed or as it became apparent, did not (Foucault, 1981, 2000e). I viewed this data set as looking for contingencies that led to contemporary situatedness (Kendall & Wickham, 1999) of the older person, student nurse and gerontology knowledge in undergraduate nursing curricula. I also applied a set of questions to my data which I will elaborate on in the next section

### *Contemporary data analysis*

Foucault provides a comprehensive summary of how to approach analysis, emphasising the significance of the statement:

> The analysis of the discursive field is orientated in quite a different way; we must grasp the statement in the exact specificity of its occurrence; determine its conditions of existence, fix at least its limits, establish its correlations with other statements that may be connected with it and show what other forms of statements it excludes. (Foucault, 1972, p. 28)

Requiring a little more detail, I sought out secondary sources to further guide my analysis. The following directions were applied to all contemporary data, both textual and interview, however, although I read through all data to gain a sense of the content, I completed analysis of the textual data before moving to the interviews. Kendall and Wickham (1999) proposed five steps to navigate the analysis of discourse. I found these steps particularly helpful as I approached this task and formatted the steps which would guide my analysis:

1. Recognition of a discourse as a set of statements whose organisation is regular and systematic
2. The identification of rules of the production of statements
3. The identification of rules that limit the sayable (which of course are never rules of closure)
4. The identification of rules that create the spaces in which new statements can be made
5. The identification of rules that ensure practice is material and discursive at the same time. (Kendall & Wickham, 1999, p. 42)

The process of analysis for the textual data included sourcing and collating texts that were deemed relevant to the study. Moving from there I scanned through all the New Zealand journals including *Kai Tiaki, Nursing Praxis in New Zealand and Kai Tiaki Nursing Research* from 2006 and editions of textbooks within the timeframe. This allowed me to gain an impression of how the texts talked about people named as older or gerontology knowledge

and how this was then available to the student nurse. This first reading established a connection with the text and confirmed their relevance or lack thereof. As I read through the material, I made notes of the various ways in which older people and gerontology knowledge were talked about and the language used. For example, the older person was often referred to as frail and infirm. Reading through the material I also highlighted all the sections that would contribute to my corpus of statements. As I worked through the documents I numbered and recorded each document that contributed to my corpus for later tracking. Before proceeding with a second round of analysis I decided to facilitate analysis and bring congruence to the array of data by dividing my texts for analysis into three separate sites where the older person became visible to the student nurse during clinical practice. The sites I identified were ARC, the acute care hospital and community settings. These three sites served as the reference point for my analysis chapters.

From this first reading, I then arranged texts into three metaphorical piles representing the three sites I had identified. As analysis progressed, I traced the relationship between the words spoken and the objects of which they spoke: the person named as older, and gerontology knowledge (Foucault, 1972). Utilising examples from Foucault's writing I looked for statements in the data which could be a "sentence or a series of signs" (Foucault, 1972, p. 98) but something that is so much more than just what it says. A statement is not limited to a linguistic unit like a sentence, therefore I also considered pictures that might represent people named as older and terms employed in text relating to said people (Graham, 2011). For example, when reading through journal articles, the title of the article as well as the statements within the article became a source of analysis.

Concomitantly, I interrogated data with a set of questions for guidance informed by the guidelines discussed above and also drawing on the work of Foucault outlined in the previous chapter (Foucault, 1972, 1995, 2000d). I had written my questions on a bright yellow card so the list would not become lost among the other documents on my desk. My significant questions directed me to ask: "What are the dominant discourses?", "How is the person named as older and gerontology talked about?", and "What are the subject positions made available to the person named as older?". Use of metaphor was also examined, particularly the terms employed when discussing older people. In relation to the notion of power, I questioned how power is exercised and by whom, and who had the authority to speak about older people or decide what gerontology knowledge should be. As recommended by Kendall and Wickham (1999), I continued to think about what was *not*

*said* and the rules that governed what could be said and by whom. I questioned whether the discourses changed across the three sites of ARC, hospital and community, or were the dominant discourses maintained?

As I read, a number of discourses began to emerge, some privileged, while others were marginalised. In particular I identified a dominant discourse I determined as a functional decline discourse. I decided to label this as such as almost every reference to an older person mentioned loss of, or potential loss of, physical capability and capacity through physical or cognitive changes associated with an ageing body. The marginalised discourses were ones that discursively positioned an older person as 'healthy', 'being well' or 'living independently'. Having identified a number of discourses operating, I developed a visual code highlighting in different colours the samples of text I felt constructed the discursive object in relation to the discourse. For example, in a functional decline discourse the older person became an objectified as a body with reduced mobility.

Once I had identified the discourses in play, I proceeded to consider the subject positions these discourses produced for the older person and the student nurse. In the final phase I considered the power/knowledge effects these discursive practices had on constructing and keeping in play gerontological knowledge in undergraduate nurse curricula. The completion of this process highlighted the limited ways in which the person named as older and gerontology knowledge were written about and represented in information accessible to the student nurse.

Analysis of the interview data followed a similar format discussed above, working with printed hard copies, and reading through all transcripts to establish a sense of what was being said. Prior to beginning analysis, I had completed a first draft for my historical chapter. Consequently, I had already identified a number of discourses at play that positioned gerontology knowledge, nurse education and people named as older in particular ways. Applying the same questions, I interrogated the data, identifying similar discourses. Extending the analysis, I noted various subject positions available to the older person and the student nurse within the discourses. For example, in a nurse/education discourse the student nurse was afforded the subject position of a 'beginning learner' while it became apparent the older person was often identified as 'frail and dependent'. I drew on Foucault's systems of exclusion considering how institutional practices determined what could or could not be counted as gerontology knowledge (Foucault, 1981). By applying Foucault's tools, I opened up the discursive constructions and material practices that

sustained a taken-for-granted truth about gerontology knowledge in undergraduate nurse curricula.

Finally, a point of clarification. When I came to write up my findings, I realised I needed a system to differentiate supporting information from interview data. As a consequence, all direct quotes from interviews are presented in italics and indented. I have identified the interviewee by pseudonym, and included the page number from the transcript.

## Establishing rigour

Having outlined the methodological process, attention now turns to the fluidity and partial nature of truth statements produced within the research and how rigour might be established. As discussed earlier, nursing research has a propensity to value an evidenced-based biomedical approach to knowledge acquisition drawing on quantitative research methodologies which adopt a positivist stance. A quantitative researcher must prove the validity, reliability and accuracy of their research, that it is a true representation of findings and can be counted as truth (Polit & Beck, 2018). Qualitative research associated with social sciences also requires rigour to ensure findings are trustworthy and valid (Bryman, 2012). Validity criteria, however, are dismissed as not necessary nor a suitable process when conducting a project from a postmodern theoretical perspective which eschews a positivist claim to a single discoverable truth, yet findings must stand up to scrutiny (Denzin & Lincoln, 1994; Ellingson, 2014).

In Chapter One I identified the various social positions I occupy and introduced myself as a reflexive researcher. A reflexive process was particularly important to maintain through the interviews and subsequent analysis as I approached the research with my own beliefs and assumptions. Reflexivity is a tool commonly used by qualitative researchers, including those informed by postmodernism, to legitimise their data (Ellingson, 2014; Koch & Harrington, 1998; Pillow, 2003). Notwithstanding the efficacy of reflexivity, more is required to established rigour, also trustworthiness and credibility.

A postmodern stance contends that there is no objective reality waiting to be discovered and described; rather, various realities exist where truth is partial, fluid, subjective and contingent. Foucault, in his numerous works, questions what is counted as truth, stating the goal is to problematize what is considered to be true instead of trying to reproduce or confirm it. It therefore follows, establishing rigour is more indeterminate in Foucauldian discourse analysis (Cheek, 2000). Notwithstanding this position, it is argued (Lincoln et al.,

2013) there is an obligation for postmodern research to establish rigour and trustworthiness. One such tool to enable the postmodern researcher to establish their research as credible is crystallisation.

Crystallisation has been proposed as a useful postmodern method to draw together findings from multiple sources to provide trustworthiness (Ellingson, 2014). Using the metaphor of a crystal which is multifaceted, crystallisation provides "a depended, complex, thoroughly partial understanding of the topic" (Denzin & Lincoln, 1994, p. 522). Crystallisation can be employed when there are different forms of analysis and varied writing genres to bring all methods into a coherent text (Denzin, 2012). Ellingson (2014) provides a five-point framework to guide the researcher, requiring the researcher produce an in depth understanding and interpretation of the topic.

In this study, I have facilitated a unique understanding of the topic by tracing and critiquing the emergence of nurse education and gerontology knowledge from inception to present day. This understanding was accomplished through applying a range of analytical tools to data from different sources, which are other dimensions to utilising crystallisation. Finally, crystallisation requires evidence, whether subtle or overt, of reflexivity on the part of the author. Reflexivity facilitates tracking the influences and actions of the researcher (Koch & Harrington, 1998), meaning that as a researcher I must acknowledge and reflect on how my own unique ways of thinking were embedded in the process (Grant & Giddings, 2002). Established at the beginning of the thesis, I adopted a reflexive approach through journaling, tracking my progress and process of analysis. I acknowledged who I was, attending to my uniqueness, my professional identity and my worldview. What is written then is my analysis which emerged as I interacted with the data (Willig, 2017).

Through applying the principles outlined by Ellingson (2014), I have been able to expose the multiple layers of meaning that surround gerontology knowledge and the person named as older in nurse education. I have problematised what are perceived as truth statements about older people and gerontology knowledge. Through systematic analysis, and keeping true to a postmodern stance, readers of the research will be able to "audit the events, influences and actions of the researcher" (Koch, 1994, p. 976). I have established rigour, trustworthiness and credibility in a number of ways: through being clear in my methodology and its appropriateness to the topic so the reader may be assured of my findings; by showing fairness as I engaged with both education providers and NCNZ; and by consulting and reviewing my findings with my peers and supervisors throughout the

process (Morse, 2018). Credibility has been established through analysis of texts currently used by and readily accessible to New Zealand nursing students. The final test to credibility is, as outlined by Willig (2017), that this research will be useful to society and nursing scholarship.

## Conclusion

This chapter has offered an overview of the methods employed in conducting this project. I laid out the processes used in data collection, including interviews, and explained how I met ethical requirements. Throughout, I have demonstrated how Foucauldian discourse analysis has shaped every step in my research process. A sample of the questions used to interrogate the data were also included. By adopting a reflexive stance, being forthcoming as regards my processes, and drawing on the concepts of crystallisation, I have established the trustworthiness of my results. Having established the background to this study, I will move to my analysis chapters. The next chapter offers a historical perspective and traces the emergence of gerontology knowledge and the person named as older in undergraduate nurse curricula in New Zealand.

# Chapter 4: History of the Present

## Introduction

This chapter describes how the discursive conditions that have predetermined, sustained or hindered gerontological knowledge in undergraduate curricula, are inextricably linked to the way people named as older became represented in the social field and within healthcare in New Zealand. Discourses do not just appear from nothing: they have a foundation or emerge from certain material conditions that existed politically, socially and historically. Foucault argued from his archaeological works that discourses cannot be isolated from the social context and treated as an independent construct (Foucault, 1972). Discourses are contingent on the events or circumstances of the period, and may change over time (Kendall & Wickham, 1999). A discourse that framed a human being of a certain age as an older person to the nursing profession, therefore required a visible population of people named as older. What constituted nursing as a profession at a particular space and time, and produced nurse education that trained student nurses in a specific way was also contingent on various events and phenomenon.

From a social constructionist perspective, it is valid to include cultural events and phenomena identified as influential in the development of social policy and legislation that came to objectify the older person in particular ways (Powell & Hendricks, 2009). A brief overview of the first wave of European migration provides context for later developments and begins analysis. Applying Foucault's (1972) 'rules of formation', I then proceed to identify the political and social phenomena that led to the emergence of the older person as a nameable object of discourse. From here I cover the inception of student nurse training, the development of public hospitals and the forerunner of ARC facilities. Drawing on historical documents and secondary sources, changes in student nurse education from inception to the commencement of an undergraduate degree-based qualification in the 1990s will be discussed. Concomitantly, how the older person came to be constructed within healthcare and nurse education will be described. Throughout, I draw on some of the methodological devices, including 'rules of formation', Foucault conceptualised from his archaeological period, recognising that a variety of different tools can be used in a genealogical study or history of the present.

## Ageing in colonial New Zealand

In the late 1700s and early 1800s, New Zealand was considered a young country, and British Crown representatives administering this new territory encouraged active migration from people seeking a new life. Signing of the Treaty of Waitangi, or Te Titiriti ō Waitangi (1840), heralded a prolonged period of active migration (Orange, 2003). A young populace was required, consequently the bulk of migration was restricted to those aged 35 years and under. Predominantly, although not exclusively, from Britain, immigrants were an eclectic mix of families, single women, some of whom were nurses, and a considerable number of young single men (Department of Internal Affairs, 1939). As the century progressed this youthful population began to age. Statistics from the end of the nineteenth century reveal a disproportionate number of people 65 years and older. Reflecting the earlier migration patterns, there were 100 men for every 70 women (Statistics New Zealand, 2006). Many of these men had never married and did not have the support of an extended family. Eventually after years of hard labour, many older men were no longer able to work and had limited means of support. This resulted in increasing numbers of destitute older men with limited options, who often lived rough (Moon, 2011; Tennant, 2007).

### *Construction of the older person: An archaeology*

When applying archaeological tools of analysis Foucault (1972) suggests beginning with the "rules of formation" (p. 40) to ascertain "what has ruled their existence as objects of discourse" (p. 41). The first rule is to map the "surfaces of emergence" (Foucault, 1972, p. 41), the places and events where the older person became visible and nameable as an object of discourse. Early New Zealand societal and political response to the older demographic foreshadowed how the older person became constructed in nurse education. It is therefore appropriate to review the legislative and discursive practices impacting on the older person in the late nineteenth and early twentieth century.

New Zealand, in the nineteenth and beginning of the twentieth century did not have a social welfare system. This limited options for the poor, both young and old, if they were unable to earn a living. Benevolent and friendly societies provided some charitable services for the very poor, but New Zealand, unlike more established countries, lacked people of means who might provide adequate funds (Gauld, 2009; Hospitals and Charitable Aid Report, 1913). Without welfare, the destitute older male, because of increasing numbers and the lack of workforce options, had become problematic to the state. Katz (1992) observes that historically 'elderly' are not constructed within the state apparatus as a

dependent demographic based on their age, but rather on ability to work. The original Poor Laws in England had three categories for those who might require aid: children, those with disability and the infirm. The older indigent person represented a new category of people requiring aid.

As the nineteenth century drew to a close the numbers of indigent aged continued to increase, compelling the government to intervene (Hutchison, 1894; Tennant, 2007). Two pieces of legislation were subsequently introduced that made provision for the aged (mainly male) poor. The first, in response to a growing need for healthcare services and the continued lack of funding for charitable institutions, was the *Hospitals and Charitable Institutions Act 1885.* The introduction of this Act acknowledged the state's role in maintaining the health and welfare of the nation through ensuring partial funding of charitable institutions (Condliffe, 1959; Gauld, 2009). Institutional care provided one solution to the problematic older, poor, predominantly male population, who through lack of any financial means often lived on the streets. Institutionalisation of a troublesome population draws on Foucault's notion of biopolitics where the government employs techniques to "achieve the subjugation of bodies and the control of populations" (Foucault, 1978, p. 140). The provision of the Act that sought to solve the problem of the needy older poor, began the connection between ageing, illness and older people with institutional care becoming a factor in the social construction of ageing in New Zealand (Saville-Smith, 1993). This connection, which sought to pathologise the ageing person and identify them as a separate category, can be traced to evolving medical/scientific discourses emerging at the end of the nineteenth century (Katz, 1996).

The second piece of legislation offered the older poor person an alternative to institutional care. In 1894, following considerable parliamentary debate, an old age pension was proposed. The age of 65 years and over was selected by the government because although 60 years was perhaps desirable, the state funds could not afford to pay the pension from this younger age (Hutchison, 1894). Numbers eligible for the pension were considerable as although life expectancy for men was only 58 years and women 63 years, if a person had survived to that age, they could reasonably expect to live another 10-15 years (Statistics New Zealand, 2006). Hence, the decision to categorise older age as beginning at 65 years was based on economic constraints, not on humanitarian need. Prior to this legislation, old age was arbitrary and hidden; by setting a chronological indicator, older age became a discursive construct, and hence a nameable object (Foucault, 1972; Katz, 1992). Finally

enacted in 1898, eligibility for the *Old Age Pensions Act 1898* was restricted to those 65 years and over with limited financial means and exhibiting a good moral character with evidence of "leading a sober and reputable life" (Old Age Pensions Act 1898, p. 4). Those convicted of crimes or drunkenness, regardless of how poor were precluded from state funds. This moral directive meant many of the indigent older men remained without financial support and were forced to reside in charitable institutions (Tennent, 2007).

Names for these institutions reflected their main demographic, for example "The home of the aged needy" and the "Napier old men's home" (MacGregor, 1901, p. 2). These institutions catered not only for the destitute older person, but also "the infirm, and incurable" (Hospitals and Charitable Institutions Act 1885, p. 158). Conditions for the 'inmates' varied but reports indicated they often experienced unsanitary conditions with few creature comforts (Willis, 1904). The homes were run by a Master and Matron (usually the Master's wife) with some auxiliary staff but in the main, more able inmates cared for the bed-ridden (Tennent, 2007; Willis, 1904). These homes were similar to the custodial care institutions of Britain where inmates had few rights and life was regimented (St John & Hogan, 2013). Despite a number of inmates being fully dependent on others for all their personal care, trained nurses were not employed in these institutions. This raises a paradox as while the use of institutional care funded through Hospital Boards effectively pathologised ageing, the invisibility of a trained nurse suggests a way of thinking that saw little value in this group of people.

Regarding in-hospital care at the time, it is difficult to ascertain the percentage of older people admitted to public hospitals as age was not recorded in the hospital reports (Gauld, 2009; Neill, 1902; Valentine, 1908). A report on the distribution of the Old Age Pensions suggests that few in this demographic sought treatment in hospital with only 22 old age pensioners recorded as being a patient in a hospital (Register of Old Age Pensions, 1907). Although hospital care was partially funded (Condliffe, 1959), it is difficult to draw any firm conclusions as to who could afford hospital care. During this time the medical fraternity began to assert dominance in the provision of healthcare, both in the private sector and within public hospitals (Gauld, 2009). Again paradoxically, as with the nurses, doctors had little association with the charitable institutions and their inmates. Katz (1996) in his seminal work on ageing also noted that at this time the older person, whether poor or wealthy, was not commonly attended by a physician. A binary of curable/incurable produced by a discourse regarding the provision of healthcare services to the older person

was beginning to emerge. The existence of charitable institutions and low numbers of older people in public hospitals, infers a lack of will to provide either medical or nursing care for older people and those who had chronic and incurable conditions. The notions of older age, poverty and reduced access to acute care became intertwined, perpetuated by the practice of institutionalising the destitute aged. The effect was to render the poor older person invisible to the student nurse, who, as will be discussed later, worked solely in public hospitals.

Foucault's second analytical principle, 'authorities of delimitation', establishes how the voices of authority in society, including health professions, judicial proceedings and political action adds legitimacy to what can be said and what cannot be said about older people. It also takes account of who may say it and what position they may occupy (Foucault, 1972, p. 42). Official documents I sourced between the late 1890s to early 1900s, contain scant evidence of the self-managing older person, suggesting this group did not cause problems for the state as opposed to the poor and needy older person (Foucault, 2000c). References to the indigent older person are evident in annual government reports about the provision of the Old Age Pensions, and in Hospitals and Charitable Institutions reports (MacGregor, 1901; Neill, 1902; Register of Old Age Pensions, 1907; Valentine, 1908). In these documents, the older poor were constituted as destitute, problematic and dependent on the state for their existence. For the state, as a voice of authority, any references to the older person were constructed through economic and functional decline discourses (described in Chapter Three) based on poverty and dependence. This is reflected in the name of one charitable institution, 'The home of the aged needy' (MacGregor, 1901), as previously mentioned in this chapter.

During this period, the medical and nursing profession as voices of authority had little commentary on the older person. Grace Neill, a nurse, in her role as Assistant Inspector General of Hospitals, raised concerns as to the conditions in some charitable institutions and began to advocate for a qualified nurse to become part of the institution's staff. She believed that the lot of the infirm, the old and the frail, could be improved under the ministrations of a qualified nurse (Neill, 1902). But there was an apparent silence from the medical fraternity as to the plight of the indigent infirm aged. Authority in charitable organisations resided with the members of the hospital boards, predominantly men of standing in the community, with doctors infrequently calling to attend to inmates who presented with medical problems (Willis, 1904). Again, this out of sight out of mind

approach suggests as a group, the infirm older person had less value than the acute patient in hospital.

The third principle of the rules of formation articulated by Foucault concerns what he calls 'the grids of specification'. These are the ways through which an object can be categorised, organised and divided (Foucault, 1972, p. 42). Through provision of the *Old Age Pensions Act 1898* and the *Hospitals and Charitable Institutions Act 1885*, the older person became a named object, a special population enabling statistical data to be collated and analysed by the government (Foucault, 1978, 1995). The government's chronological indicator of old age as commencing at 65 years determined eligibility for the old age pension. In healthcare, categorisation was less defined. The boundaries between those considered to be older versus incurable or chronically ill were blurred, and statistical data was not collated by public hospitals or charitable institutions (Valentine, 1908; Willis, 1904). As observed earlier, the aged, incurables and chronically ill were divided off from the mainstream hospital population. The following statement from Dr Valentine, an Inspector General of Hospitals, typifies the exclusionary stance adopted by the state towards the chronic and incurables, and older people:

> Though there is much to be said in favour of treating chronic and incurable cases in a special ward in the hospital grounds, I am personally against such a scheme and much prefer such wards being established in connection with Old Men's Homes, where many inmates, slightly paralysed, who need the ministrations of the female nurse, rather than the rough but well-meant assistance of their co-inmates. (Valentine, 1908, p. 4)

The rational for this segregation rested on the role of the hospital which was for acute cases, and those that had the potential to be cured. It was a practice that privileged and assigned more value to the younger demographic and those deemed curable.

This historical overview has been presented primarily to establish how the older person, in particular the indigent aged male, was viewed by the state as a social problem based on a lack of financial means and an inability to care for themselves. One solution to this problem, the provision of institutional care, became established as the only viable option for poor older people without family support and set the foundations for the medicalisation of ageing. There is little evidence that either the nursing or the medical profession had an interest in the older person's healthcare needs. The commentary on the older person was limited to the poor indigent aged, requiring institutional care, drawing on discourses of poverty and dependency. It is important to note that it was during this time

period formal nurse student education began in New Zealand. The next section traces the beginning of nurse training and the advent of nurse registration, before introducing how the person named as older was rendered visible or invisible to the student nurse.

## Student nurse education and knowledge of the older person

### *The beginnings of hospital-based student nurse training*

Continuing to draw on the 'rules of formation' (Foucault, 1972), I now attend to the early beginnings of hospital-based student nurse training. Established in Wellington in 1846 (MacLean, 1932) and in Auckland in 1850 (Brown, Masters, & Smith, 1994) the first hospitals were very small. Nursing care offered in these early hospitals was haphazard and appeared to be the responsibility of a mixture of male ward attendants and untrained females, known as nurses. Often attendants were people who had themselves been a patient (Sargison, 2001). By the 1880s standards in hospitals began to change as trained nurses were recruited from Britain and the notion of a New Zealand trained nurse began to emerge.

The first training school for nurses was opened at Wellington Hospital in 1883, shortly followed by Auckland Hospital in 1892 which introduced a three-year training programme based around an apprenticeship model (Rattray, 1961). However, in the words of Hester MacLean, a famous pioneer of nursing in New Zealand, "hospitals were small and not too well organised and the training of nurses was in its infancy" (MacLean, 1932, p. 20). One problem noted was that the term 'education' was loosely interpreted, with complaints by student nurses as receiving minimal or no lectures and learning their duties on the job (Rodgers, 1985). After completion of a suitable training period, certificates of competence were issued by the training hospitals, although it was not long until questions were raised over the quality of the training and inconsistencies in the completion of a final examination. It became evident that to ensure the training programmes produced a qualified, disciplined and competent nurse, change was required. This notion of training to produce a disciplined and essentially reliable nurse is supported by Foucault (1995), who writes about producing the disciplined body through training and examination.

Change occurred as the twentieth century dawned. Together, Donald MacGregor, a doctor and the Inspector General of Hospitals (MacGregor, 1901) and Grace Neill, an English trained nurse who was employed as Assistant Inspector of Hospitals, recognised the need to introduce and maintain a standardised service-based apprenticeship training programme

that led to registration as a nurse. This provision of a registration would afford some form of protection for the title 'nurse' (Department of Health, 1951; MacGregor, 1901). Through their efforts, New Zealand became the first country to mandate the state registration of nurses when the *Nurses Registration Act 1901* was passed into law in 1901 (Papps & Kilpatrick, 2002).

The passing of the *Nurses Registration Act 1901* created a disciplinary apparatus (Foucault, 1995) that was then able to control who or what constituted a registered nurse. Standardised training ensured that only nurses on the register were entitled to call themselves 'nurse'. The goal of registration was to achieve "efficient and trustworthy nurses" (MacGregor, 1901, p. 3). Despite a centralised examination, known as the State Examination, and national registration, nurse education standards varied between hospitals with each having its own version of a curriculum. In response to this variation in standards a national curriculum was introduced in 1908 (MacLean, 1909a; Sargison, 2001).

The societal norms that existed at the turn of the twentieth century facilitated the continuation of a service-based apprenticeship mode of training situated exclusively within a hospital system and under the control of the medical profession (Department of Health, 1951). In this space the student nurse was under the constant disciplinary control of nurses and the medical profession (Papps & Kilpatrick, 2002). This "discipline produces subjected and practised bodies, docile bodies" (Foucault, 1995, p. 138), that were appropriately trained in the disciplinary ways of becoming a nurse. As an object within a nurse/education discourse the student nurse was therefore constructed as a worker to be trained, and to follow orders. Nursing students became a cheap, reliable and compliant workforce, and in practice, a subservient handmaiden to the doctor (Chick & Rodgers, 1986). It was acknowledged that without the student nurse, hospitals would not have enough trained staff to provide care (MacLean, 1909b). Hence, maintenance of a student nurse workforce required that student nurse training advantaged the care of the hospitalised acutely sick. Student nurse theoretical education was dominated by the medical profession, who not only took most of the lectures, but also wrote the questions and marked the State Examination (Rodgers, 1985; State Examination of Nurses, 1908, 1909). This medical domination delimited other forms of knowledge that would have relevance outside the hospital space. As recognised by Foucault (1972) and later commented on by Rose (1994), the medical profession was a powerful authority, which set the rules of engagement and what was considered valid knowledge.

### *The older person and the student nurse at the turn of the twentieth century*

The previous section has laid the foundations for the emergence of the modern construction of student nurse training and how the older person was rendered visible to the state through discourses of poverty and dependency. My intention was to bring the two disparate threads of the older person and the student nurse together, to demonstrate how the older person was constituted in early student nurse education. This intention, however, has been constrained by a paucity of references to the older person in either the State Examination questions or in the nursing journal *Kai Tiaki* (State Examination of Nurses, 1908, 1910, 1914, 1922). Student nurses were essential to the provision of care for the acutely unwell patient in hospital and that factor determined what was valid knowledge. As has been discussed, the older person was infrequently admitted to hospital.

Reacting to contemporary requirements, educational content for hospital training was reflective of the health concerns of the time. The dominant narratives in nursing and medical literature revolved around maternal and child health, as the high mortality rates among infants and children remained a key concern to the colonial government, alongside communicable diseases such as tuberculosis (Department of Health, 1951; Hospitals and Charitable Aid Report, 1913; State Examination of Nurses, 1908). The State Examination offers a contemporary representation of the knowledge required by student nurses in an acute care environment drawing on a biomedical discourse and eliding other possibilities. An analysis of the State Examination questions from four representative years, revealed a range of topics from management of communicable diseases, to care of the post-operative patient, medical conditions such as pneumonia and heart failure through to how to prepare food suitable for a sick baby. These topics drew strongly on knowledge privileging the treatment of disease. The age of the patient was rarely mentioned (Rodgers, 1985; State Examination of Nurses, 1908, 1910, 1914, 1922).

A biomedical discourse, that is, knowledge used by medical professionals that focuses on how the body functions and the development of pathologies or diseases and treatment, was framing nursing knowledge of the time (Ryan, Carryer, & Patterson, 2003). Due to advances in medical treatment, student nurses learnt not only technical nursing skills, such as hygiene cares, drawing on a nursing discourse that was concerned with personal cares, but also how to implement a medical plan of treatment (Longway, 1972). A nurse/education discourse, on the other hand, dictated that nursing skills and knowledge were gained through working long hours in the wards under the direction of more senior

student nurses and/or the nurse in charge (MacLean, 1932). However, the more theoretical knowledge was controlled by the doctors, who conducted most of the lectures and also wrote and marked the State Examinations (MacLean, 1932; State Examination of Nurses, 1908, 1910). As medical treatment for diseases became more advanced and chances of a cure improved, so did the scope of the nurses' role broaden to incorporate more complex and technical biomedical skills to support the doctor (Longway, 1972).

At this point in the early twentieth century student nurses' education prioritised the care of the acutely ill child and adult, reinforced by legislation that ensured student nurses worked exclusively within a public hospital (Rodgers, 1985). Admission to a public hospital was not a universal right for the New Zealand population, but restricted to those who had the ability to pay for services, with the aged, infirm and incurables confined to charitable institutions (Gauld, 2009; Hospitals and Charitable Institutions Act 1909). The detail contained in the *Hospitals and Charitable Institutions Act 1909* was summarised in an edition of *Kai Tiaki* in 1910 showing the categorisation of aged persons alongside infirm and incurable persons:

> …hospital; or other institution for the reception or relief of persons requiring medical or surgical treatment, or suffering from any disease.
>
> …charitable institution for the reception or relief of children; or of aged, infirm, incurables, or destitute persons. (The Hospitals and Charitable Institutions Act 1909, 1910, p. 106)

These statements suggest a two-tiered system had developed, formulated around the hierarchy of the treatment of disease and the assumption of cure, juxtaposed against institutionalisation of those considered too old, poor or incurable. Public hospitals were the domain of the acutely ill or curable who were legitimised and produced in a biomedical discourse. In contrast, the indigent aged, infirm and incurables came under the auspices of charitable institutions and were provided with a place to stay, some food, but little else (Willis, 1904). The following statement clearly delineates between those who could be in hospital and those denied treatment:

> It [District Boards] may grant charitable aid to indigent sick or infirm persons; may provide medical, surgical, and nursing attention for persons **not** [emphasis added] inmates of an institution. (Hospitals and Charitable Institutions Act 1909 cited in Condliffe, 1959, p. 294)

The tacit effect of such discursive practice was to segregate the indigent older person from the public hospital population, should they become acutely unwell and require a 'cure'. The

social construction of the older poor population was based on residency in charitable organisations and dependency on the state. The older person became a homogeneous social group viewed as poor, dependent, infirm, incurable and a marginalised population (Lewis, 2001; Saville-Smith, 1993; Tennant, 2007). This had the effect of dividing off a named portion of the population and normalising that division through material practices such as rationing care, as sanctioned by the medico – administrative field of the time (Foucault, 1995).

To conclude this section and draw the discussion back to the original intent of the project, this review of the historical nursing journals, hospital reports and legislation, can be summarised as demonstrating that in the early years of the twentieth century the older person did not come under the gaze of the student nurse and was essentially invisible to the nursing profession. Hospitals, as surfaces of emergence, produced the student nurse, as a disciplined subject and an object of both a biomedical and nurse/education discourse. The older indigent person was problematised by the state under a discourse of poverty and age which became constituted as dependency through institutional care, but not visible in the hospital population. The following section now moves to a shift in the healthcare system and marks the emergence of the older person as a named entity in the nursing student's field of practice.

### *The emergence of the 'geriatric' patient*

A shift in healthcare provision occurred during the middle of the twentieth century due to demographic and socio- political factors. Life expectancy continued an upward trend in the twentieth century, attributed to improved living standards, a decrease or elimination of many diseases through public health initiatives, and advances in medical science and provision of health services (Beck, 1958). By the 1930's life expectancy in New Zealand had risen to 65 years for Pākeha/European men and 69 years for Pākeha/European women. Social mores were changing and a more liberal ideology began to emerge in the political narrative (Duncan, 2004). The *Social Security Act 1938* introduced a fully funded public healthcare system complemented by a universal old age pension. This meant that older people now had access to free healthcare. Hence the older person became a more visible presence in the gaze of the student nurse. Family dynamics were also altering, no longer was there an expectation or desire to care for the dependent older relative (Labrum, 2009). In response, privately owned ARC facilities became prevalent, catering for the more affluent older men and women (Boyd et al., 2008).

Access to free hospital care and new treatments that could cure previously untreatable conditions meant more people across all age groups sought hospital care (Duncan, 2004). This changed the previous situation when older people were only a small percentage of the hospital population. In the words of Leake (1959), an American physician, "for centuries of previous human experience with old folks they could conveniently be diluted out of the scene, usually by family care, sometimes by homes for the aged, often by poorhouses" (p. 337). Now with the introduction of free healthcare, the percentage of people aged 65 years and over in public hospitals moved from approximately 11 % (Department of Health, 1934), to approximately 50% of the total number of patients in hospital by the 1970s. While attributable in part to continuing changes in the treatment of many diseases it also reflected the new practice of providing long-term care for older people in public hospitals (Salmon, 1981).

The increasing number of older people in hospital resulted in pressure on the limited available bed space formerly occupied by younger acutely unwell patients who could technically be cured. This perceived shortage of beds for younger patients foreshadowed the creation of a new category the 'geriatric patient'. They were older patients who were perhaps over the acute event but had lingering co-morbidities that required ongoing nursing and medical intervention (St John & Hogan, 2013). Utilising Foucault's (1994) notion of the clinical gaze, the older person had become visible to the medical and nursing gaze and was found to be problematic. In medical literature the older person was often overtly referred to in terms such as a burden, frail, a waste of time, senile, infirm and incurable (Burstein, 1957; Ginzberg, 1952). In general, the dominant biomedical position operated on the premise that older hospital patients were not long for this mortal earth and therefore not worth too much attention. This notion of ageing as a prelude to death deployed a discourse of functional decline offering the older person the subject position of being not worth treating. This use of terms such as a 'burden' to denote the older patient also drew on an ageist discourse subsequently recognised as endemic in medical practices (Butler, 2005). An ageist discourse is one that deploys the stereotypical negative assumptions about older people (Phelan, 2018), such as those outlined in Chapter One.

The acutely unwell older person was not exempt from treatment in public hospitals but there was often a failure to fully assess and utilise modern treatments available to younger people (Warren, 1948). Older people were seen as a problem by their sheer numbers and also their propensity to occupy hospital beds for exceedingly long periods of time (Turbott,

1952). The older patient needed to be out of hospital to free the hospital beds for the younger demographic (Durand, 1952). Words of the superintendent of Wellington Hospital in the 1950s sum up the dilemma:

> A hospital as we now understand it, is a repair shop of the human body and mind. Once the article is repaired it must be removed out of the repair shop, or if it cannot be repaired it must still be removed to some store to clear space for more repairs. (Durand, 1952, p. 52)

As a metaphor for the biomedicalisation of ageing this statement subscribes to the notion of Cartesian dualism that constructs a mechanicalised view of the body, as a thing to be repaired (Koch & Webb, 1996). An underlying assumption is that the older person is not worth treating when compared with a younger person, as their body is viewed as worn out and no longer useful. In effect, treatment of the older worn out body would hinder the important work of doctors. This view operates on a binary that values only the curable or repairable subject who is seen to contribute to the production of the state, and not those who don't (Foucault, 2000c). The prevailing medical profession's position, therefore drew on an ageist discourse that devalues the older person within a biomedical discourse operating as functional decline.

A solution to the continuing problem of what to do with older people who occupied hospital beds was proposed by Doctor Margery Warren, often considered the founder of modern geriatric medicine (St John & Hogan, 2013). She championed improvement in care of the older person. Her remedy was to establish separate wards for the geriatric patient (Warren, 1948). A basic tenet of the geriatric ward was that it separated the 'elderly chronic' patient from the 'younger chronic' patient. According to Dr Warren, criteria for admission included those people 60 years of age and older "who are likely to need a very long stay in hospital or who are unlikely to improve very much" (Warren, 1948, p. 45). Although the intent was altruistic from Dr Warren's ideological position (St John & Hogan, 2013), the outcome was more challenging for the older person. By classifying a patient based on age, the older body was seen as deviant to the normal functioning of the younger body. Therefore, the older body was considered problematic and it became permissible to introduce different modes of care for older people (Lewis, 2001). Just as with dividing practices established in the previous century, a tacit agreement developed ensuring care appropriated to the older person was at a lower standard, although this had not been Dr Warren's original intent (St John & Hogan, 2013).

Through establishment of geriatric wards, the older person became categorised and divided off from the mainstream hospital population. This provides a clear example of what Foucault, (1995, 2000d) termed dividing practices, a system of exclusion that separates a particular group of people from the population. Admission to a geriatric ward constituted the older person as infirm, dependent, and incurable. The binary construct of younger/older body and the age of a person now became the determining contributor to the amount of resources that might be legitimately expended (Pickard, 2014). It also continued to biomedicalise the older person who may have remained in hospital for more social than medical reasons. Keeping people in hospital for social rather than medical issues conflated ageing with also being about disease, essentially pathologising the normal ageing process (Davis, 1981; Koch & Webb, 1996; Salmon, 1981). A practice that had its foundation in the institutionalisation of the indigent aged now assumed truth status, that age was synonymous with pathology and the need for medical intervention. The normal process of ageing had come under the biomedical gaze and constituted as a disease (Katz, 1996).

In Foucault's later work he theorises how the modern state associated the overall health of the population as the means to maintain the economic productivity and stability of the state (Foucault, 2000c). The older person, through their physical presence, were blocking beds better utilised for the younger curable population. This then affected the ability of the state to provide adequate care and cure to the productive portion of the population (Rose, 2001). The solution resided in separating the older person, who could be constituted as non-productive, from the younger, potentially productive hospital population (Saville-Smith, 1993). This trend continued under the guise of a separate geriatric ward for many years (Davis, 1981; Lewis, 2001).

The introduction of geriatric wards established the continuous presence of the older person in public hospitals. Thus, the educational needs of the student nurse required change to include knowledge in how to care for this new category of patient. Commentary now returns to the student nurse and changes in the national curriculum to ensure the student nurse was versed in the care of the older hospitalised person, known as the geriatric patient.

## Curriculum changes and the older person

### *Hospital-based training and the geriatric patient*

Until the advent of geriatric wards in the 1950s, care of the older person as a separate body of knowledge in nurse education did not appear in the New Zealand curriculum. The 1945 national nursing curriculum and a medical dictionary from the 1930s made no mention of a person named as older nor the term geriatric (Comrie, 1937; Nurse and Midwives Board [NMB], 1945). The curriculum outlined a reductionist model of care, focused on completing the task and medically aligned to the physiological care of the body. Requirements were ascribed to a biomedical discourse that negated the patient authority to speak and be included in their care decisions (Beck, 1958; NMB, 1945).

Subsequent to the *Social Security Act 1938* and the introduction of fully funded hospital care, hospitals began to admit more older people. Consequently, the 1958 iteration of the national nursing curriculum introduced a number of new topics including, care of the geriatric patient, a section on human growth and development inclusive of the process of ageing, and obstetric nursing. It became mandatory for the student nurse to complete six weeks of geriatric nursing and 10 hours of geriatric theory (NMB, 1958). In the intervening years between the 1945 and 1958 curricula, the geriatric patient had become a named entity in the hospital environment requiring specialised theoretical knowledge and nursing skills. The older body therefore was categorised as a special group differentiated by their age and pathologies that set them apart from the 'normal' patient. This in effect amounted to the addition of a whole new body of knowledge to the nursing skill set. Despite searching through historical or contemporary literature including *Kai Tiaki* during this period, and an unpublished thesis on development of teaching content in nursing curricula (Raynor, 1983), no public mention appears to have been made of the impending introduction of this whole new body of knowledge to the national nursing curriculum. The addition of obstetrics however, did generate debate in the literature (Cook, 1957; Hospital Boards' Association of New Zealand, 1957), suggesting a privileging of knowledge concerning a younger demographic and perpetuating a binary of younger/older patient with the younger demographic assuming more importance.

The 1958 curriculum (NMB, 1958) required the student nurse to provide evidence of caring for a person who was named and categorised as geriatric. The term geriatric with its foundation as a medical discipline (Ginzberg, 1952) has a subjectifying and objectifying effect that seeks to locate the older person within the biomedical discourse. There is an

implicit assumption that all older people exhibited evidence of functional and psychological decline and associated pathologies. Requiring valid knowledge of older people to be confined to the geriatric ward appeared to invalidate and marginalise knowledge of healthy independent older people. A discourse of ageing as inevitable functional decline became apparent, legitimised by valorising geriatric knowledge. These notions of inevitable decline were reified and repeated as the truth statements in the nursing text of the era. Toohey (1957), a medical textbook for nurses, provides scant mention of the older person stating, "old age, the last scene of all that ends this strange eventful history is heralded by a further decline in the physical and intellectual abilities of the individual" (p. 549).

The final iteration of the national nursing curriculum for hospital-based training published in 1973 remained relatively unchanged, based around body systems and treatment of disease. The programme document required that the student nurse must have 12 hours of geriatric theory, but the clinical experience in a geriatric speciality had become an optional elective rather than a mandatory requirement (NCNZ, 1973). The rationale for this change to an optional elective is not apparent. Considering nearly 50% of the hospital population was 65 years of age and older, although not all in the geriatric wards (Salmon, 1981,) the decision suggests a devaluing of the student nurse experience of caring for the geriatric patient in a geriatric ward. Experiential learning about care of the hospitalised geriatric patient was no longer considered necessary and priority was given to medical and surgical care. Theoretical knowledge continued as in the 1973 curriculum (NCNZ, 1973). The 12 hours of theory included the topics that reflected knowledge of degenerative changes to the body:

> …care of the elderly sick and bedfast patient; methods of rehabilitation including the activities of daily living. (p. 6)

Knowledge of conditions commonly associated with ageing including:

> …the prevention or alleviation of disabilities which particularly affect the aged, for example- malnutrition, rheumatism and arthritis; respiratory infection; incontinence; mental lethargy and loss of memory. (p. 6)

The community dwelling older person was also acknowledged as students were required to learn about:

> … elderly citizens flats and homes. Social amenities and facilities. (NCNZ, 1973, p.6)

Notwithstanding a brief mention of the community dwelling older person and the notion of rehabilitation, the main knowledge requirements in this curriculum are situated in a

biomedical discourse. Specifying conditions such as incontinence, mental lethargy and memory loss deploys an ageing discourse that constructs the older person as at risk of functional decline and dependency. This functional decline discourse delimits and constrains student nurses' understanding of the older person. The student nurse is produced in this discourse as provider of personal cares. There is little acknowledgement of the heterogeneity and diversity of the older person. The independent and healthy older person appears to receive scant acknowledgement in the national nursing curriculum. Rather the prevailing nurse/education discourse positions the older person as frail and dependent.

During this period, government policy favoured building ARC facilities as a means of managing the potentially dependent older person (Boyd et al., 2008; Davis, 1981). By the 1970s, New Zealand had one of the highest rates of institutional care for the older person in the western world (Green, 1993). Despite the propensity to institutionalise the older more dependent demographic, and a high admission rate compared with other countries, only about five percent of older people resided in some form of long-term care (Boyd et al., 2008). Although geriatric knowledge was no longer compulsory, personal experience as a student nurse in the 1970s would suggest it was common practice to use ARC facilities as a student nurse placement to acquire foundation nursing skills. This constrained any knowledge of a heterogeneous older population for the student nurse. Historically, working in a geriatric ward or ARC was unpopular among nurses and student nurses alike. Caring for older people was viewed as unimportant work because it was not challenging and required little skill (Geriatric Nursing, 1976; Snape, 1986; Treharne, 1990). Therefore, the student nurse's experiences with older people, sanctioned by the programme and counted as knowledge, were limited to those people requiring some level of support in institutionalised care, notably an area devalued and perceived as having low status among nurses.

Numerous material practices or discursive mechanisms that constituted the older person offered a subject position of dependency in a discourse of functional decline. Geriatric was a commonly used term in the lexicon of hospitals (geriatric wards) textbooks (geriatric patients) and journal articles (Geriatric Nursing, 1976). A nursing textbook from 1971 included comments on the older person as being an economic burden. The language used assumed commonly held assumptions about older people that were paternalistic. There was an "expectation of loneliness, challenge to learn new things, a nurse must speak

slowly" (Smith, Germain, & Gips, 1971, p. 31). Another comment stated "since older people tend to hoard things, it is sometimes necessary to help them sort out their treasures and discard some" (Smith et al., 1971, p. 43). Within the excerpts the older person is being produced as having attributes that required the nurse to adopt the subject position of a mother who supports and guides errant behaviour. *Kai Tiaki* during the 1970s contained few articles relating to the older person. One commentary included pictures of residents enjoying geriatric care facilities while another alluded to the difficulties older people had with taking medication (Low, 1974; Simpson, 1980).

The creation of the geriatric ward out of political and medical expediency, coupled with the use of ARC facilities for foundation nursing skills, offered very limited subject positions for the older person. Older people were, by the very nature of admission to a geriatric ward or ARC facility, considered dependent with functional decline. This dominant discourse of functional decline was reinforced by the nursing texts available to the student nurse. These discursive strategies constrained any attempts that may have disrupted a more heterogeneous and diverse subjectivity of ageing for the student nurse. The student nurse remained an integral part of the hospital workforce, and the system did not recognise engagement with well community dwelling older people as having value. Ironically many older people were also patients in numerous other areas of the hospital but they were not apparent within the nursing texts.

Foucault, in his analysis of discourse, is interested in the structure of discourse and how this effectively controls what can be said (Mills, 2003). One of the strategies deployed is that of exclusionary practices; those who are defined as experts or authorities decide what can be said as the truth and therefore what may count as legitimate knowledge (Foucault, 1981). For nursing students, the truth about older people was espoused in the textbooks they read, the content of their lectures, and reinforced by experiential learning within the clinical environment (MacMillan, 2016). The next section tracks the changes to nurse education moving from a hospital-based apprenticeship style training model to the tertiary sector. Concomitantly, I continue to critique how older people were constituted as objects of discourse and the subject positions offered as new curricula were developed.

## Changes to nurse education.

### *Background to change*

Nursing curricula are significant as what a student nurse recognises as valid knowledge of a particular topic, for example care of the older person, is shaped by curricula content. Curricula should be reflective of the needs of society, hence influenced by social, cultural and economic factors (Beck, 1958; Keating, 2015). The apprenticeship training system established in 1901 continued to legitimise nursing education for many years. Subsequent legislation established the Nurses and Midwives Board (NMB) in 1925 as the regulatory body for the nursing profession. The NMB was renamed Nursing Council of New Zealand (NCNZ) in 1971 and it remains the regulatory body for nursing today (NCNZ, 2017a; Papps & Kilpatrick, 2002). Among other responsibilities, the NMB and later the NCNZ developed and maintained the national curriculum, ensuring it changed over the decades as treatment regimens improved and medical technology became more complex**.**

Internationally, the fundamental tenets of nursing practice were being challenged. There was a recognition that the profession needed to care for the whole person and not just treat the disease (Beck, 1958). A shift began to occur in the nurse/education discourse that constructed the student nurse in a certain way. Discourses are not static and unresponsive but change over time as contingencies alter (Foucault, 1972; Kendall & Wickham, 1999). Changes in the social milieu meant that the image of the student nurse as docile, obedient, and self-sacrificing projected in the service-based apprenticeship model was contrary to the societal norms of the 1960s. Attrition rates were steadily increasing, due to both the archaic practices of a nursing hierarchy and higher levels of responsibility for complex patient care impeded by insufficient preparation (Board of Health, 1974). A nursing workforce based on an apprenticeship model was no longer meeting the needs of hospitals nor of the wider society, particularly with the technological advances in medical care (Department of Health, 1988). The resultant nursing shortage had become a national concern and in response the government commissioned Dr Helen Carpenter, a short-term contractor for the WHO, to review our education system and offer an alternative method of producing a competent registered nurse (Taylor, Small, White, Hall, & Fenwick, 1981).

The Carpenter Report, published in 1971, recommended abolishing hospital training and creating a new style of education within the tertiary sector (Carpenter, 1971). As a result, responsibility of nurse education was transferred from the Department of Health to the Department of Education (Taylor et al., 1981). By 1973 a pilot scheme was introduced at

Wellington Polytechnic and Christchurch Institute of Technology. The programme content prepared student nurses to practice in psychiatric, psychopaedic, community, medical/surgical, and maternal and child health areas. On completion of study, a student nurse could register as a 'comprehensive nurse' with a diploma (Christensen, 1973; Department of Health, 1988; Shetland, 1976). The premise of this change was to move nursing away from the dominant biomedical discourse which had the discursive effect of emphasising disease and situating the nurse as an adjunct to medicine, to a more humanistic or holistic approach that considered the patient at the centre of care (Papps, 1997). Registration as a comprehensive nurse was formalised with the passing of the *Nurses Act 1977*. The move to the tertiary sector was unpopular with hospital boards who were in effect losing their cheap workforce, and were required to employ more registered nurses (Department of Health, 1988; Shetland, 1976). The apprenticeship model of training was eventually phased out and by the mid-1980s all prequalification nurse education was in the tertiary education sector. Programmes were provided by universities, institutes of technology and polytechnics (Papps & Kilpatrick, 2002).

### *The older person and change of diploma to degree*

The change to a comprehensive nursing diploma enabled tertiary providers to determine curricula content, assuming objectives set out by regulations surrounding registration and mandated by NCNZ, were met. Regulations were provided to guide development of content but specific content was at the discretion of the provider (Taylor et al., 1981). The 1977 comprehensive training supplement issued by NCNZ states that programmes should have a philosophy that "expresses the beliefs of the staff concerning teaching and learning processes" (NCNZ, cited in Papps, 1997, p. 130). Reflecting what Foucault (1980a) calls a 'regime of truth', curricula content highlighted relationships between knowledge and power. Power inherent in the institution determined what was normal and acceptable knowledge for student nurses and therefore could limit or valorise other forms of knowledge. The teaching staff had the mandate to determine the knowledge appropriate to produce a work-ready student nurse and were not constrained by any particular theoretical foundation, nor NCNZ directives on specific content as previously. This set up the potential for different regimes of truth about what a student nurse should learn.

Accompanying this change, nurse/education discourse began to shift to acknowledgement of a more holistic humanist philosophy of a tertiary-based nurse education. Nursing discourse also reflected a holistic philosophy. Ryan et al., (2003) offered a definition of

nursing discourse stating, “nursing may attend to the bodily issues experienced by a person but understands those to be mediated by the psychosocial, cultural and political context of that person” (p. 53). A nursing discourse thus valorises person-centred care that embodies a caring ethic and views the person as not just an object of physical care (Edvardsson, Watt, & Pearce, 2016; Watson & Smith, 2002).

However, despite this new approach, the terminology used in positioning the older person was not dissimilar to that of the previous system, suggesting that little had changed for the older person. Within the new curricula documents terms such as ‘elderly’ continued to be used (Auckland Technical Institute [AIT], 1975). The term ‘elderly’ is socially constructed, laden with assumptions and connotes an individual separate from mainstream society who needs special care and attention, possessing undesirable traits and characteristics (Avers, Brown, Chui, Wong, & Lusardi, 2011; Ford, 1973). An excerpt from an early polytechnic programme illustrates the how the term ‘elderly’ continued in the new system and had the discursive effect of dividing older people off from the mainstream, younger population. A student nurse was required to be able to “…adapt[ing] the environment for the elderly” (AIT, 1975, p. 32).

Although a new regime of student nurse education had been introduced, hospital-based training continued. In both forms of education, the student nurse had the option of an elective placement in a geriatric ward. The notion of segregating and categorising the older person as different was illustrated in the statement in the NCNZ’s supplementary notes for general and obstetric nurse training:

> Students may be assigned to the specified area of patient care or, on a patient assignment basis, to the care of patients, who are for instance, acutely or critically ill or who have **geriatric** [emphasis added] or psychiatric health problems although they may be receiving care in the general medical surgical areas. (NCNZ, 1977, p. 4)

This separation of the older person, labelled as geriatric inferred dependence and functional decline and operated as a form of social control mandated by a biomedical discourse and targeted at the older body (Brown, 1995). Hence, regardless of where a student nurse might interact with an older person within the hospital, the above definition produced the older person with a focus on chronic disease, and all the assumptions and preconceived notions contained in the term geriatric health problems, inferring difference. A biomedical discourse rather than a nursing discourse continued to shape how older

people were constructed in student nurse education, contradicting a perceived shift to a more holistic approach to care practices.

While nurse education went through a process change, care of the older person remained predominantly in geriatric wards and ARC facilities. The attitudes, perception and knowledge of student nurses toward caring for the older person had not been substantively researched at this time (Tollett, 1982). Ageism however, was acknowledged as a major deterrent to incorporating more knowledge on ageing within curricula, reflecting societal perceptions of older people (Levenson, 1981; Palmore, 2005). By naming ageism as a problem offered some resistance to an ageist discourse, yet one author who resisted ageism also perpetuated the notion of older age as being a time of functional decline. Tollett (1982) notably, when advocating a more inclusive attitude to ageing, essentially re-enforced a deterministic and homogenised view of ageing when stating "old age, with its concomitant loss of health, income, and status, has been less valued" (p. 16).

Internationally, during the 1970s and 1980s a shift occurred as nurses advocated for a gerontological focus that favours a psychosocial understanding of older age promoting health and wellbeing (Gunter, 1980), rather than a geriatric account that implies senescence and pathological changes (Dahlke, 2011). Katz (1996) argues that regardless of this new terminology in disciplinary labelling, a gerontology discourse continues to coalesce with a biomedical discourse of ageing, and operate as a dividing practice. In education, although the terminology began to change from geriatric to gerontology, authors decried the lack of knowledge about older people in nurse education (Verderber & Kick, 1990). The only apparent difference in New Zealand curricula development regarding care of the older person that indicated an international influence in nurse education, was removal of the word geriatric from the standards for registration. This was not, however, replaced with gerontology knowledge as a requirement (NCNZ, 1990).

By the end of the 1980s standards for registration in New Zealand offered a more diverse range of options for clinical experience, no longer dominated by hospital placements (NCNZ, 1990). Services particular to the older person were not differentiated and a rather more generalist approach to nursing care prevailed. Though terms such as 'geriatric' and 'elderly' had been removed, inclusion of a continuing care placement, that is commonly considered ARC, became a requirement. This espoused a limiting practice as the dominant way in which a student nurse engaged with the older person. An ARC placement

highlighted specific care practices for the older person, imbued with the notion of decreased functional capacity and dependency.

The *Education Amendment Act 1990* introduced the final and current change to student nurse education. The Act enabled polytechnics and institutes of technology to award degrees which had previously been restricted to universities. Within nursing there was a drive to follow the international trend of requiring an appropriate undergraduate degree as a minimum standard for new registrations. With an undergraduate degree a nurse was considered more versed in critical thinking, analysis and problem solving, than a diploma prepared nurse. The degree prepared nurse was also considered, more able to develop a research capability to advance knowledge (Allen, 1992). Following a period of consultation and debate, NCNZ and the New Zealand Qualifications Authority (NZQA), decided that the minimum qualification leading to registration as a comprehensive nurse would be a three-year undergraduate degree (Christensen, 1993). Tertiary institutions developed their own degree programmes which then required approval by both the NCNZ, ensuring they met the standards of registration, and the NZQA. NCNZ hence retained the disciplinary power and controlled what was considered appropriate knowledge for a student nurse to ensure the production of a safe and competent nurse (NCNZ, 2012).

The move to a degree-prepared nurse provided the opportunity for nurse educators to do things differently. The change offered a freedom to explore different means of practice and ways of constituting knowledge of the older person within education. The student nurse within a nurse/education discourse was now afforded the subject position as a critical thinker but there is little evidence this notion of critical thinking extended to the older person. NCNZ standards of registration provided a framework for development of individual programmes of study supporting a broad scope of interpretation (NCNZ, 1999). Notwithstanding this more open rhetoric, clinical content remained relatively prescriptive, and had to include, “community health nursing, maternal and infant health nursing, medical nursing, surgical nursing, mental health nursing, disability, rehabilitation and continuing care” (NCNZ, 1999, p. 9).

By the 1990s the geriatric ward of the past had gone, replaced by assessment and rehabilitation wards which continued with the tradition of admitting mainly older people. Acutely unwell older people were admitted and cared for in mainstream wards such as medical, surgical and orthopaedic wards (Saville-Smith, 1993). This practice distributed the older person throughout the hospital system, affording the older person a subject position

as an acute care patient. Institutional care for the dependent older person continued to be provided in private ARC facilities supported by government subsidies (Boyd et al., 2008). Long-term care facilities met the requirements of continuing care as noted in the NCNZ standards for clinical experience, and were often utilised as student nurse placements in the first year of education (NCNZ, 1999; Waiariki Institute of Technology [WIT], 1996). Despite changes to a nurse/education discourse, the power/knowledge effects remained similar to previous iterations of nursing curricula.

A review of a representative Bachelor of a Nursing programme illustrates how the older person was constructed for the student nurse during the early part of their education in the 1990s. While only evidencing one education provider's perspective, it appears to perpetuate a biomedical discourse, highlighting the pathologised ageing body, coupled with functional decline as a discourse objectifying the older person as a body with decreasing functional capacity. In this particular programme the first placement was in a continuing care or ARC facility to learn foundation skills of nursing. These included "lifting and transferring, pressure area care/positioning/ administration of medications, basic observations**"** (WIT, 1996, p. 6)**,** all tasks that limit thinking of an older person as anything but dependent. Added to this, the assessment skills required are at lower level as inferred by use of the term 'basic observations'. In Chapter Five I will further investigate and trouble the conflation of foundation skills and care of a dependent older person through this practice of using ARC to embed foundation skills. So, although the method of education had fundamentally changed, knowledge of the older person continued as a homogeneous representation depicting the older person as dependent.

### *Discussion on changes in curriculum*

Continuing from the first mention of the geriatric patient in the 1958 curriculum document (NMB, 1958) to the contemporary iterations, the identified discourses of biomedicine, nurse/education and functional decline have constructed the older person as dependent and frail. The discursive practice of using first geriatric wards, and later ARC as placements for developing foundation skills keeps in circulation statements about ageing that are then considered true (Mills, 2003). The words may have changed and nursing curricula moved from a body systems approach to a more holistic approach, but for the student nurse the discursive practice of utilising ARC to learn foundation skills ensured a homogeneous view of older life was preserved.

The labels geriatric, gerontology or elderly are social constructions, although physiological changes to the body attributed to a progression of time are grounded in physical actuality. The problem is the determinist perception of ageing as a period of both inevitable physical and mental decline to the point of dependency. This truth statement appears to dominate nursing knowledge reinforced by material practices such as placement in ARC facilities. Reviewing the documentation within her/his field of knowledge, the student nurse would still see older people constituted as objects of both a biomedical and functional decline discourse based on an assumption of a frail and physically failing body. Despite the change in nomenclature from geriatric to gerontology in nursing literature, inviting consideration to all aspects of ageing, the focus still positioned the older person as dependent and needing the care of the student nurse for activities of daily living. The valorising of a functional decline discourse is exemplified by Ryden and Johnson (1992) who, when calling for more gerontological content in nurse curricula, suggested it should contain knowledge on "iatrogenic problems, behaviour problems, assisting family and caregivers of the aged" (p. 349). The list of problems a student nurse should learn about ended with the statement "normal ageing" (p. 349). This description again positions the older person as a problem, constructed within a functional decline discourse.

In the words of Foucault, normalisation is an instrument of power that "supervises every instant in the disciplinary institutions: compares, differentiates, hierarchizes, homogenizes, excludes. In short it normalizes" (Foucault, 1995, p. 183). Normalisation associated with disciplinary power differentiates individuals when contrasted with the desired or acceptable norm. This normalising function is defined and reaffirmed in social policy and the institutional practices that have remained relatively static over time. The normal was the younger demographic who did not need assistance with personal care and were considered able bodied. Foucault's conception of normalisations means that those who deviate from the desired norm, are "subject to systems of control that seek them out" (McHoul & Grace, 1997, p. 72). For the older person this had translated to separate wards and separate entries in nursing textbooks with a name that constituted them in a certain way, based on a nominal scale of chronological age.

## Policy changes for the twenty-first century

Toward the end of the twentieth century government policy on the future of healthcare in New Zealand's was being revised with the focus changing from production of services to improvement in population health. The long-term goal was to raise health status and

reduce inequities through a population-based funding model (Starke, 2010). Government was beginning to promote policies that encouraged and supported independence in the older person in response to increasing life expectancy, with a concomitant increase in health spending for the older person (MOH, 1993).

The introduction of the New Zealand Health Strategy outlined the future direction of healthcare in New Zealand (MOH, 2000). The Health of Older People Strategy (MOH, 2002) followed soon after and represented a discursive shift in the perception of the needs of the older person. The primary aim was to provide integrated healthcare services reactive to the changing needs of the older population. The underlying premise was to promote the notion of ageing-in-place, thereby supplying services to ensure older people who required some level of assistance to maintain activities of daily living, could remain independent in their own homes (MOH, 2002). The priority was two-fold: to raise the health status of the older population and reduce perceived economic inequities in healthcare delivery. Another goal was to reduce cost by providing more in-home support thus reducing institutional care requirements (Laugesen & Gauld, 2012).

This change in policy direction brings to the fore Foucault's perception of governmentality. The number of older people and costs associated with providing healthcare had become problematic to the state. Foucault contends governmentality is a form of power over the population that operates "through techniques that will make possible, without the full awareness of the people, the stimulation of the birth rates, the directing of the flow of the population into certain regions or activities and so on" (Foucault, 2000a, p. 217). Thus, through implementation of these strategies the government was directing the older population in a particular way that suited the long-term management of the population (Rose, 2001), and reduced costs by providing in-home rather than institutional care.

Utilising the term discontinuities, Foucault directs the analytic towards ruptures and changes that disrupt the current narrative (Foucault, 1972). The change in policy with the introduction of the Health of Older People Strategy (MOH, 2002), invited nursing programme developers to adopt a new construction of ageing, one that recognised the role of the older person in the wider community. This chapter then draws to close with the older person being offered some form of resistance to the dominant discourses of a biomedicalised older age associated with an inevitable functional decline discourse. This rupture and focus on an independent community dwelling older person invited a new construction of ageing, however did this different construction of older people bring about

change in undergraduate nurse education? The response of nurse education to this change in policy regarding the older person is the subject of the following chapters.

## Conclusion.

Drawing on components from Foucault's archaeological and genealogical methods, this chapter sought to bring together events and phenomena that led to the emergence of both the student nurse and the older person as constructed by gerontology knowledge in contemporary undergraduate nurse education in New Zealand. Beginning with population and political changes in the nineteenth century, and establishment of hospitals, an analysis of historical documents has revealed how contingencies meant older people and student nurses had limited interactions until the mid-twentieth century. Establishment of geriatric wards, and the introduction of theory relating to the older person into the standardised student nurse curriculum, have been argued as influential in positioning older people within a biomedical discourse and a functional decline discourse.

Furthermore, nursing texts, including accepted pedagogical practices, excluded a heterogenic representation of the older person, focusing rather on the physiological changes and functional decline considered inherent in this population. This practice perpetuated the myths that resonant through society about how an older person is constituted. The modern iteration of education continues to engender biomedical and functional decline discourses, delimiting the subject position offered to the older person and observed by the student nurse. This chapter ended with the introduction of a degree-based education programme and government policy promoting a more heterogeneous construction of the older person**.** The following chapter applies a Foucauldian lens to contemporary New Zealand undergraduate education that enables particular visibilities of the older person for the student nurse. The discussion seeks to illuminate what knowledge has changed and what knowledge has remained unchallenged. Chapter Five is founded on the surfaces of emergence and begins the analyse of three sites identified as where a student nurse interacts with older people. The chapter is primarily about ARC and the discursive practices evident in this environment that come to construct gerontology knowledge, the student nurse and the older person in a specific way.

# Chapter 5: Aged Residential Care: A Surface of Emergence

## Introduction

In the previous chapter I traced the history of nurse education, documenting how the older person became objectified and discursively constructed in the healthcare system and wider socio-cultural and political field. As a history of the present, the chapter analysed the contingencies that lead to how gerontology knowledge was represented in undergraduate nurse education. I demonstrated how within nurse education the older person became an object of discourse. Extending that analysis, attention now turns to the contemporary construction of gerontology knowledge in New Zealand undergraduate nurse education.

Founded on clinical placement requirements mandated by the NCNZ, I have identified three sites where student nurses may engage with older people: the acute care, community and continuing care settings. A continuing care placement, or ARC was consistently referred to by participants as central to gerontology knowledge. Most participants stated ARC was a first-year clinical placement in their programme, a finding repeated in other New Zealand nursing programmes and internationally (Abbey et al., 2006;. Brown, Nolan, Davies, Nolan, & Keady, 2008; Koh, 2012; Rodgers & Gilmour, 2011). Similarly, a preliminary data search uncovered a tendency among authors of New Zealand published journal articles to associate gerontology knowledge and the older person as operating in ARC settings. As the majority of data relates to ARC, this first contemporary chapter focuses solely on ARC.

A brief overview, arguing the relevance of government strategies to how knowledge about the older person is positioned in undergraduate curricula foregrounds the analysis. The overview serves to illustrate how nurse education delimits a heterogenic knowledge of the older person in contrast to government policy. Following on is a critique of the gerontology nurse's role and what subject positions are offered older people who are considered clients. Drawing on data from interviews, and textual sources, analysis then seeks to excavate the discourses operating in ARC and the subject positions offered to the student nurse and the older person who resides in ARC.

## Policy changes, the older person and nurse education

The Health of Older People Strategy (MOH, 2002), as mentioned in Chapter Four, introduced the older person, through increasing numbers and their statistically significant likelihood of requiring advanced healthcare and disability services, as problematic to the

viability of the healthcare system. As a means of managing cost and services, the policy and its subsequent replacement the Healthy Ageing Strategy (MOH, 2016b) emphasised prevention of illness, with support to maintain wellness and independence through later life. This indicated a shift in expectation around ageing, introducing the notion of responsibility of self in matters of health and management of the life course, in a sense devolving responsibility from the state to the individual (Rose, 1999).

Age and ageing are social constructions that are fluid and partial, varying across cultures and through history (Powell & Hendricks, 2009). Hence the aforementioned policies represented a state sanctioned attempt to reposition the social construction of ageing in New Zealand, as now including health and wellbeing. As an example of governmentality (Foucault, 2000a), management of the older population began in the nineteenth century with enactment of the *Old Age Pensions Act 1898* and *Hospitals and Charitable Institutions Act 1885*, and later extended into the deployment of geriatric wards and ARC. A change from a focus on institutional care was signalled with introduction of the Health of Older People Strategy (MOH, 2002), and consolidated in the Healthy Ageing Strategy, which required "developing health-smart and resilient older people, families and communities to help older people age positively" (MOH, 2016b, p. 13). These policies represented an opportunity to change the social construction of the older person in healthcare.

Foucault's work takes particular interest in the body and how, through discursive formations the body becomes the object of discourse. He is of the opinion that in relation to power/knowledge "one needs to study what kind of body the current society needs" (Foucault, 1980a, p. 58). This new strategy therefore drew attention to the older body as a way of maximising the quality of life, but also sought to mitigate the cost that may be incurred by the state through government funded advanced healthcare or institutionalisation (Laugesen & Gauld, 2012; Strake, 2010). The Health of Older People Strategy, (MOH, 2002, 2016b) was an attempt to reduce the burden of the older person to the state through privileging positive healthy ageing initiatives. The state required a healthy older body responsible for self-care, or as Foucault (1995) would write, a self-disciplined body.

Enactment of the Health of Older People Strategy (MOH, 2002) and Healthy Ageing Strategy (MOH, 2016b) is relevant to student nurse education as NCNZ (2015a) requires that undergraduate degree programmes leading to registration as a nurse be "based on national health priorities and contemporary healthcare and practice trends" (NCNZ, 2015b,

p. 7)**.** Through the enactment of the strategy the government has announced it wants healthcare services, and by association educational services, to advantage wellbeing and independence. Hoeck and Delmar (2018) observe "thus [the nursing] discipline must continually be re-evaluated by society and by the profession, which means that nursing ontology and epistemology is developed and changed parallel to the development of society" (p. 2). This quote directs nurse education providers to keep pace with the changing socio-political landscape to ensure knowledge is contemporaneous and reflective of societal needs. The question central to this work, therefore, is whether nurse education has mirrored this change in construction of the older person. Technologies of power/knowledge operate in the texts and educational requirements, constituting the older person in a particular way across a variety of settings. Employing a Foucauldian discursive analysis, I seek to demonstrate how gerontology knowledge, or knowledge of the older person, espoused by nursing recognises the older person, beginning with ARC constructed as a place where frail older people reside.

## ARC as a residence for (some) older people

Yeung and Rodgers (2017) define ARC in New Zealand as an "accommodation and support system available for frail or disabled people who are unable to live independently at home" (p. 29**).** Use of the term 'aged' restricts use of this institution to only those who are older, hence conflating dependent care solely as a need for the older person. This conflation of dependency and older age is reinforced in the funding model for ARC which favours people aged 65 years and older. Only under certain contractual conditions will ARC include people under 65 years of age requiring full time care (MOSD, 2015b). The practice of dividing the dependent older person into a separate setting that is physically removed from the general population, as discussed in the previous chapter, has developed as a well-regulated practice in New Zealand (MOH, 2012). Hence ARC has become a surface of emergence (Foucault, 1972), where older people are concentrated and by being in this separate site, are accorded the status of functional decline and dependency through an inability to self-manage. ARC was not only a surface of emergence, but a product of a societal discourse that accepts care of frail and dependent older people as being the responsibility of the state (MOH, 2016b; MOSD, 2015b). Another societal discourse embedded in ARC infers that because mainly women work in ARC, the work is seen to be unskilled, have low status and attracts lower wages (Palmer & Eveline, 2012). Further supporting the notion of less value, current wage agreements mean nurses who work in ARC receive a lesser wage than those employed in District Health Boards (DHB) (NZNO, 2019).

Representation of the older person as a resident in ARC appears as the dominant display of gerontology knowledge in New Zealand published literature. Published literature establishes ARC as a place where certain discourses can bring objects, in this case the frail and dependent older person and 'gerontology' nurse into being (Montayre, 2017; NZNO, 2014). Data from the interviews show that ARC becomes an object of a nurse/education discourse produced as a useful site to educate and train student nurses. Clinical placements serve a purpose, they provide real life experiences for student nurses to learn skills necessary for a nurse (Alderman, et al., 2018; NCNZ, 2015b). In these sites, therefore, the student nurse is socialised into the ways of being and practices of the nursing profession. In a sense the student nurse mediates her/his learning of what it means to be a nurse when out on clinical placement, and this is how student nurses become discursive subjects positioned by discourses (Frederiksen, 2010; Hiraki, 1992; MacMillan, 2016). Hence technologies of power/knowledge manifest in textual data and deployed by interviewees, construct the student nurse and the older person in certain ways (Foucault, 2000d). ARC is the main location where older dependent people are cared for in New Zealand, yet as will be argued later in the chapter, working with older people is not always valued. Through analysis of data I will illustrate the power/knowledge nexus operating in nurse education, and how the use of ARC as a clinical placement produces a limited subject position for older people and the student nurse with the effect of shutting down other ways of knowing and thinking about ageing and the older person.

### *Discursive positioning of older people and the nurse*

Recognising that gerontology as a term is a social construct used to refer to people named as older, it is useful to show how a range of discourses operate to construct the gerontology nurse and what is constituted as gerontology knowledge. Articles featuring institutionalised older people predominated in the New Zealand nursing journals (Manchester, 2016a, 2016b; Stoddart, 2016), with few articles concerning those living in the community, suggesting gerontology nursing privileges knowledge of the frail, dependent older person. This draws strongly on a discourse of functional decline. The gerontology literature that I reviewed is mainly silent on the other aspects of gerontology knowledge such as the psychosocial aspects, including wellness and independence (Neville, Montayre, & Jackson, 2019). This observation exemplifies Foucault's systems of exclusion (Foucault, 1981), as knowledge pertaining to other representation of older people becomes subjugated knowledge, and marginalised as not legitimate knowledge. For the student nurse who may source these publications, the result is a homogeneous view of ageing that

draws on numerous stereotypical constructs of older people. This then constrains how the older person may become visible and thought of by the student nurse, although in actuality it represents only one component of gerontology knowledge (Eliopoulos, 2014).

Drawing on work from Tabloski (2014), a text on care of older adults states a gerontology nurse's role is to "identify and utilise the functional strengths of the older person, to assist them to minimise impacts of disability and disease, and where possible achieve a peaceful death" (Bramble, 2014, p. 12). At this juncture it is useful to revisit a dictionary definition of gerontology, the "study of all aspects of the ageing process, including the clinical, psychological, economic and sociological issues encountered by older persons and their consequences for both the individual and society" (Harris et al., 2006, p. 743). This definition is broad, and encompasses more than just the older person who is dependent and requiring nursing care. No age is given when a person may meet the criterion, leaving this explicit categorisation open but still operating as a dividing practice that sets the older person up as different to a younger population. By concerning 'issues encountered' the definition sets up the older person to become 'problematic' when they are older. Similarly, the excerpt from Bramble (2014) constructs the older person as a pathologised body heading towards an inevitable death. Paradoxically, the goal of establishing a separate body of knowledge aligned to the needs of the older person was to improve societal aspects of ageing, to make the older person less problematic to the state (MOH, 2016b). As such, the term seeks to divide knowledge about a particular group of people founded on aged-based characteristics as different to the mainstream, younger population.

Foregrounding Foucault's (1995) interpretation of normalisation, older people deviate from what is considered normal in a non-aged body and thus require different modes of interventions. Russell (1989) argued 30 years ago that gerontology, rather than improving societal attitudes toward ageing, in fact has had a deleterious effect. Russell suggests gerontology has perpetuated the myth that ageing is associated with inevitable functional and physical decline, which is constituted as an increasing burden of a dependent older population. I concur, and argue that this functional decline discourse continues 30 years on. In addition, gerontology knowledge has remained relatively unchanged over proceeding years and perpetuates a functional decline discourse as explicated in the contemporary data drawn on for this research.

In 2016 *Kai Tiaki*, began dedicating an annual issue to 'aged care' with the editorial written by a nurse practitioner who specialises in gerontology nursing, Michel Boyd (Boyd, 2016).

Use of the title ‘aged care’ associates the older person on two fronts as symbolic of requiring care and also implicating older age as different to the mainstream population. As a gerontology nurse practitioner, Boyd is the expert, hence her article deploys the power/knowledge function of speaking the truth from a position of authority (Foucault, 1978). Her editorial has legitimacy as a regime of truth as to what constitutes gerontology nursing, which in this instance is care of the dependent older person. Her comments in the editorial could be considered as serious speech acts or “what experts say when they are speaking as experts” (Dreyfus & Rabinow, 1983, p. xxiv). Boyd’s (2016) editorial states, “people move into ARC facilities as a step along the natural continuum of life and healthcare provision. Needing 24-hour care at the end of life is not an anomaly rather a norm” (p. 2). This comment has the effect of legitimising and normalising the discursive practice of institutional care. By portraying admission to ARC as a natural, normal event, thus limits any other options for the person as she/he reaches the end of her/his life.

Further supporting the regime of truth that views gerontology nursing as limited to nurses who work in ARC, a number of other examples were noted. One example, from *Kai Tiaki* provides a view point on gerontology nursing that acknowledges the “complex nature of aged care nursing” (Montayre, 2017, p. 17). In another article titled, “A passion for gerontology”, a nurse is described as being “passionate about gerontology and committed to running a facility where residents feel safe and happy and staff gain some real job satisfaction” (Manchester, 2006, p. 28). A quote taken from an article by the same author titled “Maintaining quality care for older adults” states “elderly people need to be cared for by skilled staff” (Manchester, 2016a, p. 27). An education package set up to “Fast track a gerontological career” was in response to a nursing leadership in the aged care sector attempting to “mitigate a looming staffing crisis” (Stoddart, 2014, p. 12), further conflates gerontology nursing with frail and dependent people. All these examples present a truth statement that juxtaposes older age and use of the term ‘elderly’ with the imperative of being cared for by others, hence inferring a state of dependency on nurses for all ‘elderly’ people. These articles from *Kai Tiaki*, produce a very narrow but dominant representation of gerontology nursing as being confined to ARC. A power/knowledge relationship between gerontology nursing/knowledge and ARC is produced supporting a truth statement that older age is synonymous with needing supportive care. The articles also establish a nurse working in ARC as a special or different kind of nurse, one who works with frail dependent older people.

Perpetuating the perception that the nurse named as a gerontology nurse works solely in ARC, is an NZNO publication providing a guide for the gerontology nurse who works in ARC titled *Gerontology Nursing Knowledge Skills Framework* (NZNO, 2014). The stated goal of the guide is explicit, to "make gerontology nursing visible and valued" (NZNO, 2014, p. 4). In Foucauldian terms, this is a purposeful statement produced in an authorative voice by NZNO making a truth claim that this is the only type of gerontology nurse. Certainly, publication of the guide is a useful tool for those who care for the frail and dependent, however a counter effect is that it also seeks to legitimise dependency among older people as a normal state (Fine & Glendinning, 2005). As a consequence, the gerontology nurse's knowledge is confined to care of the frail and dependent older person and not the well and independent.

The guide outlines a number of care technologies espousing a focus on a "holistic person-centred approach" (NZNO, 2014, p. 5) thus deploying a nursing discourse for care of the frail dependent older person. Paradoxically, the initial holistic comprehensive assessment begins with medical history followed by medication, and a list of physical assessments- all actions that draw strongly on a biomedical discourse. By advancing biomedical parameters first, the psychosocial forms of knowledge are relegated to a position of less importance although not subjugated knowledge (Frederiksen, 2010). Promoting assessment of, for example; falls risk, functional ability, and pressure injury, further produces the older person as an object of risk requiring the constant gaze of the nurse. This draws on Foucault's notion of the clinical gaze that continually looks for markers of change (Foucault, 1994). These requirements mingle both a biomedical discourse, the diseased body, and a discourse of declining function, producing the older person as an object of risk, affording the older person the subject position of dependent, frail and at constant risk of further decline.

The guide also requires the gerontology nurse to work in partnership with the older person, by "respect[ing] preferences and treat[ing] older adults as partners" (NZNO, 2014, p. 5). Details of how this partnership is operationalised appear problematic. An inadequate response to partnership is epitomised when the nurse is required to "promote usual functioning (mobility, nutrition, hydration) during acute illness to reduce the risk of decline and deconditioning" (p. 8). The recommendation fails to demonstrate partnership, as a partnership is "open, caring, mutually responsive and non-directive" (Jonsdottir, Litchfield, & Dexheimer Pharris, 2004 p. 241). A later study on partnership suggests "patients as partners are active rather than passive agents" in their care decisions (Pomey, Ghadiri,

Karazivan, Fernandez, & Clavel, 2017, p. 15). Contrarily, the statement in the guide privileges countering the risk of deconditioning against the right of the individual to make the decision not to eat or mobilise because they feel too unwell. Within the context of gerontology knowledge, the older person loses the right to determine their own response to illness, and so is disempowered. In this way a tension is created between the nurse who knows the importance of an older person maintaining some level of activity when unwell, and the older person who wants to rest. The gerontology nurse, through power/knowledge relationships assumes authority over the individual. An older person's self-knowledge hence becomes a subjugated knowledge to the authorative/expert knowledge of the nurse, thus there is little evidence of an equal relationship founded on partnership.

Further, the guide also evidences a response to older people that draws on ageist assumptions. When communicating with an older person the gerontology nurse is reminded to "communicate in a respectful and patient manner using non-derogatory language" (NZNO, 2014, p. 10). The stipulation to use non-derogatory language implies this is a problem when communicating with a frail and dependent person, or any other older person. Derogatory language infers elderspeak which includes using terms of endearment and/or use of plural pronouns when addressing someone (Marsden & Holmes, 2014). The recommendation to be 'patient' is paternalistic, suggesting the nurse is required to tolerate behaviour as one would with a child (Kagan & Melendez- Torres, 2015). A paternalistic attitude and a perceived use of elderspeak has an effect of infantising the older person by treating them in a way that fails to recognise their maturity, and treats them as one would a child. This way of responding to older people then diminishes their personhood (DeVries, 2013). Overall, the guide espouses a holistic approach to care yet positions the older person as disempowered, a risky body and an object of physical care, valorising a biomedical construction of gerontology nursing. Promoting a holistic approach yet deploying a biomedical response to care demonstrates, as observed by Foucault (1972), "it obeys that which it hides" (p. 151).

A particular interest in the older person being constructed in a biomedical discourse imbricated with risk was articulated in two articles on assessment of quality measures. Again, these articles produce only one way of knowing an older person, drawing on biomedical descriptors focusing on the body at risk of functional decline. In one article, quality of care delivery was measured through "pain management, mobility, skin integrity, nutrition and weight, hydration and continence management" (Whitehead, Parsons, & Dixon, 2015, p. 31). Another article, promoted evaluation of care using "indicators of the

quality of care: falls, pressure sores, malnutrition and untreated pain" (Casey, 2017, p. 21). In both these accounts, care was constructed around tangible measurable and quantifiable biomedical descriptors. From a nursing perspective, such a construction troubles the notion that nursing is said to be from the humanist paradigm, and nurses are purported to be holistic practitioners (Catalano, 2015; Kleiman, 2005; NCNZ, 2012). There is little mention of other quality measures such as enjoyment of life, a sense of wellbeing or interest in the unitary being as an older person who lives in ARC. The quality of care is not evaluated with a humanistic face, but rather picks up the biomedical and functional decline discourses that construct the resident as a defective body. This focus on a specific understanding of quality produces the resident as an object of risk through the provision, or lack of provision of care technologies which effectively diminish the subjectivity of the resident (Moreau, 2017). The dual discourses of biomedicine and functional decline serve to construct the older person for the student nurse as little more than a body that is at risk, and render other ways of knowing the older person invisible to the student nurse.

In summary, these aforementioned sample statements produced by discourse promote the notion of a knowledgeable gerontology nurse who is skilled in the care of frail and dependent older people living in ARC. As introduced earlier, New Zealand published journals predominantly feature older people as residents in ARC. When referring to the gerontology nurse who works in ARC, a particular set of skills are required drawing heavily on biomedical and functional decline discourses. The gerontology nurse occupies the subject position of being knowledgeable in a biomedical understanding of care in the frail and dependent older person, thus operating a functional decline discourse. Employing Foucault's (1983, 1994) concept of dividing practices, demonstrates how this categorises and divides knowledge of some older people, and the gerontology nurse from the rest of the community dwelling older population.

### *So, who is the resident?*

In his writing, Foucault cautions that a Foucauldian analysis should also consider what is not written about a topic, although it might be expected. The researcher therefore needs to also look for the absences and the silences in the text (Carabine, 2001). Through my data search it became apparent that texts conveying the personal experiences of people who lived in ARC were not evident. Only one article was located that examined values supporting personal autonomy for older people living in ARC, however it was about autonomy as a concept, rather than the autonomy of the person (Rodgers & Neville, 2007). An ambivalence toward a resident's personal reality of living in ARC was illustrated in

another article that investigated “Staff beliefs about sexuality in aged residential care” (Gilmer, Meyer, Davidson, & Koziol-McLain, 2010, p. 17). Rather than the residents’ perception of their own sexuality, personal knowledge was not sought and subjugated in favour of nurses’ knowledge of residents’ sexuality. However, as research about older person’s sexuality is a subject that attracts little attention, this research does serve to acknowledge sexuality is an inherent human need in older people (Haesler, Bauer, & Fetherstonhaugh, 2016). While not exploring a residents’ reality, both articles offer resistance to the almost hegemonic representation of older people as having different needs to younger people, and those residing in ARC as being dependent and disempowered. The articles serve to remind a student nurse that being dependent on others for personal care does not determine a loss of autonomy, nor negate the need for a sexual relationship.

Surfacing as an example of the power/knowledge effect, the more typical, constrained ways of writing about gerontology nursing renders this group of older people silent and invisible outside of ARC settings (Biggs & Powell, 2001; Gilleard & Higgs, 2010). Absence of literature concerning a personal knowledge about life in ARC suggests the nursing profession is complicit in rendering the older person who lives in ARC silent**.** An article honouring a personal view on life in ARC would serve to legitimise self-knowledge and imbue older dependent people with authority and agency shedding light on other discourses that may be operating. Representation of the personal experience of living in ARC may have resisted, or conversely reinforced the hegemonic functional decline discourse evident in the data. However, the uncontested focus on the frail and dependent older person, while acknowledged as necessary knowledge for nurses who work in ARC, serves to illuminate the dependent frail group of older people as representative of older people, eliding other ways of constituting older age.

Foucault (1978) iterates that where there is power/knowledge there is resistance, but resistance to the dominant functional decline discourse remained elusive in this review of the literature and interview data. Legitimate representation of life for residents was located, but proved very controversial on publication. In May 2006 *Kai Tiaki* published a photographic essay depicting interactions between healthcare assistants and residents in ARC which included showering, assisting with meals, mobility and general interactions (Knowles, 2006). The purpose of the feature was to show caregivers in action, to elicit a wider appreciation of their work with dependent older people living in ARC. Publication of the pictures generated a furore of debate within the nursing community, particularly as in a

number of the photos the recipients of care were in various stages of undress. Numerous letters to the editor followed with most deploring the exploitation of the older person to make a political point. At the time of publication caregivers working in ARC were bargaining for a wage increase (Knowles, 2006). NZNO, publishers of *Kai Tiaki*, are a nurse's union that advocate and lobby for members' pay and conditions, hence *Kai Tiaki* provides a vehicle to make a point about the value of the caregivers' work.

The photographic essay effectively presented a hegemonic view of the reality of the older frail dependent person, supporting the social construction of ageing as a time of dependency and frailty (Pickard, 2014; Powell et al., 2006). However, it was acknowledged that all pictures were published with the full consent of either the individuals or their family. Interestingly, many of the letters expressing dismay at the representation of residents in various state of undress, assumed that the residents were incapable of making that decision for themselves, as in this representative comment: "Elderly residents have a right to live in a residential home without exploitation and to be protected from invasion of privacy such as this" (MacManus, 2006, p. 5). Implicit in this statement is the association between disempowerment and the loss of ability to self-determine actions. The comment infers that because residents were older and required extra support with the activities of daily living (ADL), they were incapable of personal agency. One respondent to the editor, who rallied against the construction of a resident as one who could not give consent, "noted that her mother was particularly annoyed when people assumed, she was unable to decide for herself what she **wanted** [emphasis added]" (O'Malley, 2006, p. 5). By presuming all residents in the photographs were incapable of providing informed consent, demonstrated how many in the nursing profession bought into an ageist discourse that offers residents a limited subjectivity founded on loss of personal agency and their right to self-determination. The tacit assumption that a resident in ARC was incapable of consent was predominantly uncontested by the nursing fraternity, producing an inevitable conflation between frailty, physical dependency and a loss of personal agency. The ethical imperatives of the photographic essay continue to generate debate (Sayers & Brunton, 2019).

Unpacking these examples from New Zealand nursing publications highlights a regime of truth about how the gerontology nurse and gerontology knowledge are constructed. I have argued that limited representations of older people were evidenced in the journals, producing a power/knowledge effect among readers, including student nurses, that gerontology knowledge/nursing is restricted to dependent and frail older people, who, as

Gilleard and Higgs (2010) contend, have less societal value. Having established a partial understanding of gerontology as a body of knowledge, I return now to the main focus of this thesis, nurse education, the student nurse and the older person.

## ARC and the student nurse

### *As a site of disciplinary practices*

Data analysis now moves to include excerpts from interviews. Interviewees, who all hold senior positions in nurse education or with NCNZ, are referred by gender neutral pseudonyms: Tracey, Adrian, Alex, Sydney, Kerry, Bailey, Pat, Robbie and Riley are nurse educators in management roles, while Jan and Ricky are from NCNZ. In the majority of cases, interviewees indicated her/his programme has a clinical placement in ARC in the first year of education. The central purpose of an ARC placement in year one appeared to be the acquisition of non-technical skills deemed essential to the development of a core set of nursing technologies such as hygiene care, mobilising, assistance with meals and basic vital signs (Tertiary Institutes Curriculum documents [participants]; Toi-Ohomai Institute of Technology, 2019). Learning such skills is an example of disciplinary practices that when enacted for the purpose of training begin with the basic tasks to be completed and mastered, before continuing on to learn more complex skills (Foucault, 1995). This represents a hierarchy of skills, beginning with skills requiring minimal technological involvement for the novice student nurse, then advancing to learn more technically advanced, complex, and arguably valued skills as the student nurse demonstrates competency (MacMillan, 2016; Stayt & Merriman, 2013; Thomas, Jack, & Jinks, 2012).

The following excerpts from interviews present examples of the skills a novice student nurse is expected to acquire while on a clinical placement in ARC. One participant, Pat, a nurse educator, laid out the care technologies to be practised and learnt in the placement:

> *…there's nothing in the first six months. Second six months is approximately three and a half weeks in older people's health in the rest homes and hospitals. They [first year student nurses] learn foundational nursing care. And establishing communication. And learning about being professional too.* (Pat, p. 5)

Pat went further, and while confirming the function of an ARC placement was to learn foundation care techniques, the response also provided an indication of what those should include:

> *Yes, yes. And you know that [student nurse educators] are passionate about, foundational nursing care. That they can relay that to students. For example, we've got one senior lecturer here that's gone into clinical and she always makes sure that*

> *she runs through with every student a bed bath or a wash and a shower so that the student feels really confident in providing hygiene cares. And I just think doing those sorts of thing, are really helping launch the student in the programme.* (Pat, p. 11)

Pat described how one senior lecturer prioritised the mastery of foundation skills such as hygiene care. The older body is rendered visible to the student nurse as a perfect vehicle to practise the task of washing. By offering the example of washing, Pat was drawing on a biomedical discourse that privileges the care of the body over other skills such as communication or providing comfort that could take place during the wash (Grant, Giddings, & Beale, 2005). Promoting more person-centred skills, such as communication, would serve to position hygiene cares within a nursing discourse and resist the biomedicalisation of the body. Pat in essence regarded this senior lecturer as exemplary in her passion for student nurses learning to wash people in a prescribed way. To the student nurse, the senior lecturer is the voice of authority and is key in socialising the student in the behaviour expected of a nurse (Frederiksen, 2010; Kamolo, Vernon, & Toffoli, 2017; New Zealand Nurse Educators Preceptorship Subgroup, 2010). Hence, Pat's testimony provides an example of disciplinary power as through oversight, the lecturer is ensuring skills are learnt and completed to a certain standard (Foucault, 1995; McHoul & Grace, 1997). The student nurse is being disciplined to become an appropriate type of nurse. Drawing on a biomedical discourse, this offers the resident the subject position of a useful and docile body. The student nurse is afforded the subject position of being a good student nurse as the task of washing a dependent body has been mastered.

By using the term 'to launch the student' Pat implied that being able to wash people, provided a foundation for student nurses to learn more complex skills. To continue the metaphor, to 'launch' conjures up imagery of a beginning journey. In journeys through life the beginning of a career is not necessarily the place one returns to. As ARC is a place of work few nurses return to after registration (Goa, Newcombe, Tilse, Wilson, & Tuckett, 2014; McCann et al., 2010), the notion launching serves to construct ARC as a useful place to start but not a place necessarily to learn more advanced technical skills that are considered necessary in acute care nursing.

Valorising the importance of completing hygiene cares illustrates a tension in nursing and warrants further unpacking. The expectation that a student nurse must be able to attend to personal hygiene care is central to nursing practice and embodies the caring aspect of nursing (Edvardsson et al., 2016) although, as argued earlier, it also draws on a biomedical discourse as care practices focus on the body (Grant et al., 2005). In earlier times mastery

of hygiene care was considered imperative, as it defined the competent student nurse (Bradshaw, 2000). When student nurse hospital-based training was finally phased out in the 1980's, hygiene care became part of the nurses' role as the student nurse who had historically completed personal cares, was no longer part of the workforce. However, more recently the use of unregulated care workers to perform personal hygiene cares has become commonplace in all areas of healthcare (Annear, Lea, & Robinson, 2014; Dahlke & Baumbusch, 2015; Palmer & Eveline, 2012). Papps (1997), commented this passing on of personal hygiene cares was a response to nurses being expected to be competent in more technically complex skills as medical technology advanced. Other writers disagree.

The term, 'too posh to wash' has been coined by those who disparage the kind of nurse who does not attend to personal hygiene cares (Olesen, 2004). Critics of this construction of nursing, suggest attending to personal hygiene care espouses the caring role purported to be central to being a nurse and lament the perceived loss of this skill (Feo & Kitson, 2016; Olesen, 2004; Rolfe, 2014). This example, exemplifies the tension between the hospital-based apprenticeship training of the past where the student nurse was responsible for all personal care, and the higher education requirements of the tertiary sector that promote critical thinking and assessment skills over personal hygiene cares (Morrall & Goodman, 2013; O'Connor, 2007).

Assessment skills are inherent in a biomedical discourse that value the notion of treatment, cure and improvement. Learning to complete these potentially less valued personal care skills aligns more to a nursing discourse that respects the notion of personal care and responding to people as individuals (Meehan, Timmins, & Burke, 2018; Watson & Smith, 2002). Hence, the institutionalised frail older person, provides a 'body' for the student nurse to practice skills once considered central to being a competent nurse, but in the current environment seen as a less valued skill. It is important to note, nurses are professionally responsible for all care delivered by unregulated care workers, therefore it could be argued personal hygiene care remains a necessary skill for the student nurse to become competent in, so they may supervise unregulated care workers (NCNZ, 2011).

Riley, a nurse educator, contributed another understanding of the skills a student nurse is expected to become competent in while on placement in ARC, when introducing the concept of ADLs:

> *The skill acquisition that we are hoping to get is that we hoping that students will be able to perform nursing care to maximise day to day the activities of daily living at a year one level.* (Riley, p. 5)

ADLs draw on a range of discourses. In the above example, ADLs refer to ensuring the student nurse becomes competent in hygiene cares, mobilising and assisting with meals hence drawing on a nursing discourse. ADL's are also a medically based system that grades physical functional status based on the ability to normal daily tasks such as mobility, and personal hygiene (Moreau, 2017). That discussion aside, the above excerpt from Riley acknowledged a resident would need considerable assistance in performing ADL's and hence supervision akin to foundation nursing skills. This skill set can then become transferrable, ensuring a student nurse is deemed safe when caring for a patient in an acute care setting who may need assistance with mobilising and hygiene care.

Similarly, Alex, a nurse educator, placed value on ARC placement as a site to learn foundation skills. Alex's programme did not have a first-year placement in ARC, raising concerns among faculty that student nurses lack some of the foundational skills, such as mobilising a person with functional disability:

> *And the final thing we are actually thinking about doing is introducing the rest home [placement] in year one. [This would be] In the concepts week in year one when we do concepts on mobility, because we think that in those rest-homes we can select clients where they really challenge the students helping with mobility and they might not get experience in hospital.* (Alex, p. 7)

For Alex and Riley, the appeal of using ARC for year one students, rests in the skills the student nurse might acquire that are not always accessible in the hospital. Both construct ARC as a place that provides a plentiful supply of disabled older bodies that would be able to offer opportunities for the student nurse to learn how to assist with ADLs, therefore produce a safer practitioner. Here the binary opposition of ability /disability reflecting a society that valorises able-bodied people (Fadyl, 2013) has in essence been reversed as it is the disabled body that is now of value to the student nurse and the educational organisation. The emphasis is not on the resident as a unitary being per se, but rather the value they bring in preparing the student nurse to be skilled in mobilising people with some form of physical disability. It is the disabled body that is valued, not the resident. Valuing the disabled body reinforces the perception that older people are dependent on others for simple activities such as mobilising and self-care.

Robbie, another nurse educator, indicated a broader perspective on what the learning may include by introducing communication, assessment and professional identity:

> *A lot of the focus for the first years is assessment skills and communication skills so they have to be professional, developing … that professional identity [of] being [ a] registered nurse. So, the lecturers go with the students to the placements they work*

> *alongside healthcare assistants and the registered nurse and the focus is, is not as much on, just doing hygiene cares.* (Robbie, p. 5)

Robbie acknowledged the predominance of personal cares but introduced other reasons for the ARC placement. Nurse/education, nursing and biomedical discourses operate in this statement. A nurse/education discourse constructs ARC as an appropriate place to develop a professional identity. Learning assessment skills readies the student nurse to interpret changes in the body, for example signs of changes in skin integrity (NZNO, 2014), that draws on a biomedical discourse by beginning to teach the student nurse about surveillance, to look for deviations from the expected normal functioning of the body (Foucault, 1972, 1994). Valorising communication skills produces the student nurse within a nursing discourse that embodies person-centred care and values human relationships in which communication is fundamental (Edvardsson et al., 2016; Jonsdottir et al., 2004; NCNZ, 2012).

In the above excerpts, participants produce ARC as a location of a nurse/education discourse that provides the right opportunities to develop multiple skills. As identified in an earlier excerpt, Robbie also included the importance of learning to be professional, of learning what it means to be a nurse. All these interwoven facets of learning serve to socialise the student nurse into the professional milieu of a nurse. A nurse/education discourse that mandates skill and knowledge acquisition is premised on certain behaviours that are controlled by the regulatory body and the supervising nurse (NCNZ, 2012). To produce a useful student nurse, nurse/education discourse deploys disciplinary practices operated by the supervising nurse and the regulatory body. Tactics deployed to create a work ready student nurse epitomise Foucault's notion of discipline:

> It exercised over them a constant pressure to conform to the same model, so that they may all be subject to subordination, docility, attention to studies and exercises, and to the correct practice of duties and all the parts of discipline. (Foucault, 1995, p. 182)

An ARC facility therefore, as an object of nurse/education discourse, is produced as a useful site for first-year student nurses to acquire certain foundational skills before they advance to areas providing more complex and technical care. Here the student nurse is offered the subject position of being a 'good' novice who follows directions and learns a certain skill set.

Nurse educator participants identified ARC as a suitable site for student nurses to learn foundational skills. In this place disciplinary tactics, such as assessing competency, are

brought into play by the supervising nurse with the dependent ageing body a necessary vehicle to learn foundational skills. A nurse/education discourse valorises these skills, yet contrarily, the skills being taught to the student nurse (personal hygiene cares and ADL's) are not those performed by the nurse in an ARC facility or in other healthcare environments, but more usually undertaken by an unskilled worker (Annear et al., 2014; Darbyshire & McKenna, 2013; Kitson, 2018). However, as alluded to earlier, the nurse through her/his professional overview is ultimately accountable and responsible for the performance of the unskilled healthcare worker (NCNZ, 2011). Davies and Harre (1990) contend discursive practices have material effects and seek to position subjects or objects within a discourse. The practice of assigning hygiene care to the unskilled worker then offers the object of personal care as having less value with the concomitant effect of ascribing less value to care of the older body. The important implications for this study are that without understanding the responsibly and accountability of the nurse for care delivery, the student nurse may apprehend these as unnecessary skills to learn and position knowledge acquired in ARC as having less value.

### *ARC and a nurse/education discourse*

Surfacing in the above analysis is the notion that ARC within a nurse/education discourse is produced as having value as a site of learning foundational skills. I contend, therefore that the nurse/education discourse has the power/knowledge effect of producing the resident as the ideal practice body for the nascent student nurse. The older body is produced by a nurse/education discourse as an object to be practised on hence, the resident becomes an object of convenience for the student nurse who is being incrementally socialised into being a nurse. In his writing Foucault (1995) talks about a docile body, a body to be improved and to be worked on; "A body is docile that may be subjected, used, transformed and improved" (p. 136). The body, in this case the student nurse, is subjected to certain disciplinary tactics, which attempt to improve it with the goal of increased production. "What was then being formed was a policy of coercions that act upon the body, a calculated manipulation of its elements, its gestures, its behaviours" (Foucault, 1995, p. 138). By practising necessary skills on the resident, a symbiotic relationship is produced that requires the compliant dependent resident to develop the trained disciplined product of a student nurse. The resident is not receiving the attention of the student nurse for the benefit necessarily of the person as a unitary being, rather to develop the skills deemed necessary in a student nurse.

This purpose of an ARC placement is clearly articulated in one course outline that states: "Students will be assigned to an individual or small group of older adults in a residential or home care setting to practise foundational nursing intervention" (Tertiary Institute Curriculum Document, 2017, p. 5). This means that when attending to more complex care technologies, nurse educators can be assured that the student nurse will know how to complete foundational skills as these are 'on tap in ARC'. The plurality of discourses constitutes the older body as useful, the ideal practice body on which the student nurse can hone their preparatory skills. To draw on the popular nursery rhyme, *Goldilocks and the three bears* (Cole & Calmenson, 1989); the resident is not 'too acutely sick', and they are not 'too independent or well', they are 'just right'. Not only is the resident the ideal practice body but as discussed next, the institutions themselves are also shown to be convenient and readily accessible as a place of experiential learning. Paradoxically, aged care institutions are produced as useful sites of learning and practice yet some of the skills taught are not as valued in the core work of a nurse, as evidenced by the use of less qualified healthcare workers.

## ARC as a convenient yet contested space for learning

In addition to being a site to learn foundation skills, a nurse/education discourse also positions ARC as a convenient placement based on accessibility. In a sentiment echoed by other participants, Adrian, a nurse educator stated, when discussing the availability of placements in ARC:

> *We've plenty of placements that we can get you know. Its more the other way around, you know that you sometimes have difficulty finding placement in hospital but aged care they're always happy to have our students.* (Adrian, p. 11)

Tracey, a nurse educator, too confirmed:

> *We don't have any problem getting placement in our aged care facilities.* (Tracey, p. 5)

Tracey and Adrian are drawing on a nurse/education discourse that positions ARC as a suitable site for experiential learning. However, ARC becomes an optimal choice based on the availability of placements and not necessarily on the type of practice knowledge available. The apparent plentiful supply of ARC for placements was also alluded to by Jan from NCNZ, however, Jan provided a different perspective:

> *So, I mean in some ways because there is an availability of aged care placements there is not the pressure on aged care placements that there is on medical surgical*

> *wards, mental health primary health care and in fact they are probably a default mechanism.* (Jan, p. 10)

Here Jan's use of the term 'a default mechanism' suggests a tacit agreement that ARC will always be considered a possibility when other clinical placements are in short supply. Implicit in this statement is an acknowledgement that some of the skills associated with acute care environments can be acquired in an ARC setting. This statement offers resistance to the nurse/education discourse that positions ARC as limited to learning foundation skills and draws on a complex care discourse that values technical skills such as administration of intravenous medication and care of the post-operative patient (Brown, Edwards, Seaton & Buckley, 2015).

Not all participants agreed with the use of ARC as an optimal first year placement. Adrian referred to a staff debate noting some staff expressed personal uncertainties, again resisting a nurse/education discourse that positions ARC as only appropriate to learn foundation skills:

> *In year one they learn the fundamental nursing skills. We've had lots of debates as to and, and opposition from some staff as well of using residential care settings and saying that we shouldn't because we're signalling in effect you don't need any experience, you don't need a lot of knowledge, anybody can work with the elderly person. Our argument is no, that's not, not true. It is a very specialised area.* (Adrian, p. 8)

This view was shared by Pat who also voiced concern over the use of ARC in the first year of placement:

> *And you know, older people's health is incredibly complex. It's been something that we've debated going back to Year one, about how we start off students in practice in the most probably the most complex area of health in, that is older people's health and the ethics of it.* (Pat, p. 13)

Adrian and Pat's concerns illustrate tension in a nurse/education discourse that positions ARC as a place to learn foundational skills by deploying a discourse that constructs the care required by the older person as complex, more associated with an acute care environment. Pat believed an ARC placement inappropriate for year one student nurses, positioning them as not skilled enough to care for older people who may have multiple chronic health concerns (Eliopoulos, 2014; Moyle, Parker & Bramble, 2014). Both participants also drew on a human rights discourse that challenges the ethics of implying ARC does not require a high level of skill because people are older and do not require acute care interventions. In this discourse the older person is objectified as having equal rights in society. The debate brings to light an unvoiced stereotypical complex care discourse held in nursing that a

nurse who works in ARC has fewer skills than one who works in acute care areas (Algoso et al., 2016; Kaine & Ravenswood, 2014).

Adrian then goes on to justify the continued use of ARC despite staff considering it inappropriate:

> *…however, if you want some consistency and ability to relate and connect, you need an area that has a low turnover. And in the hospital where length of stay is going back to you know two, three days, it becomes really tricky.* (Adrian, p. 8)

Here, Adrian conceded the usefulness and convenience of an ARC placement can in part be attributed to the fact the same residents will be available to the student nurse throughout their time there. In a nurse/education discourse the resident is objectified as a reliable and constant body. Deploying this strategy makes ARC an ideal site to learn how to relate to people and develop physical and social skills founded on the 'low turnover'. In justifying use of ARC in the first year, the resident is again positioned as the ideal practice body. Adrian, though, offered the resident a different subject position, resisting the nurse/education and biomedical discourses that focus care of the body as the object of discourse. Instead, the resident is valued because of their permanence, meaning that the student nurse can develop meaningful and continuing relationships with the resident. Relationship building is a central tenet of nursing discourse and an integral part of working in partnership with clients (Jonsdottir et al., 2004; NCNZ, 2012; Pomey et al., 2015). The student nurse is positioned as being interested in the older person as an individual; the resident is positioned as a person of interest for their psychosocial attributes to the student nurse.

Tracy contrarily, offered yet another position to the student nurse, that of the bored student. Tracey's comments exemplified findings from research that report student nurses often find ARC placements boring and uninteresting (Algoso et al., 2016; Haron et al., 2013).

> *Yes, that is always in aged care and **just to keep them stimulated** [emphasis added] we also do a med surgical exposure day and they get a one day, an eight-hour shift, in the second semester.* (Tracey, p. 3)

For Tracey, an ARC placement may draw on a nurse/education discourse and position ARC as a convenient site, yet it comes at a price that may not be agreeable to the student nurse. By use of the word 'stimulated' Tracey positioned ARC as less valued and not as exciting as the more acute care areas. There is an implicit assumption that the learning to be gained about caring for a frail dependent body is not privileged, and that the important, more interesting work occurs in the acute care environment. Tracey's comment embodies the

stereotypical and ageist view that older people have diminished value in contemporary society and constitute less important work for the nurse.

Deferring to a biomedical discourse mingled with a nurse/education discourse that recognises most residents as complex as they may have a number of chronic health conditions, some programmes introduce an ARC placement in the final year of education (Tertiary Education Curricula Documents). Here emphasis changes from foundational skills to learning to care for people with multiple pathologies, advancing the idea of scaffolding skill acquisition (Alderman et al., 2018). As the object of the nurse/education discourse the resident becomes the pathologised body, producing ARC nursing as more than foundation skills; the nurse is required to have advanced assessment and critical thinking skills, coupled with the ability to implement complex care regimes while assuming significant levels of responsibility (Clendon, 2011; Phelan & McCormack, 2016). Alex was enthusiastic about the use of an ARC placement in final year of the programme and outlined the learning possibilities for the student nurse:

> *So, we recognise that the aged care sector area is incredibly complex with co-morbidities, poly pharmacy, and you know you can't get very much more complexity these days and it's incredible what kind of care is required in rest homes particularly the hospital wings.* (Alex, p. 4)

Alex's comment demonstrates how in this site, the notion of nursing care draws more strongly on a biomedical model with care described as favouring disease states. The aged body is the object of a biomedical discourse, with "its focus on illness rather than health" (Rose, 1994, p. 53). Invoking the term co-morbidities, Alex inferred all older people have a number of chronic health conditions that require the attention of a skilled nurse. Adding polypharmacy suggests managing these diseases requires administration of a number of medications, signalling this is an advanced skill integral to being a nurse. A tacit assumption ensues that privileges the biomedicalisation of knowledge pertaining to the older person. The power/knowledge premise is that residents, and by association older people, are defined by the various pathological challenges they manifest. Residents are categorised by parts of their bodies that can be modified and maintained. As with learning foundation skills, this knowledge acquisition legitimatises and delimits a subjectivity of the resident that projects the inevitability of chronic disease while imbricating a functional decline discourse.

Like Alex, Ricky referenced a repertoire of skills required to be a competent student nurse. Other skills included time management, assessment, documentation and working with

others. The resident is again produced as an ideal practice body providing the opportunity for the student nurse, but the focus has shifted. For Ricky, drawing on nurse/education discourse included a biomedicalised knowledge of the older person:

> *But also, things like time management, communication with the older adult, the importance of documentation and communication with the residents, if there is a fall or something like that, direction and delegation, assessment particularly so many things.* (Ricky, p. 12)

This excerpt serves to demonstrate how the resident, unlike someone who lives in their own home, is submitted to a constant state of surveillance deployed through assessment and documentation of their daily lives. Residents are perpetually being assessed for signs of change, or any deviation from the norm that may require some biomedical response, operating Foucault's, (1994) notion of the gaze. As mentioned by Ricky, a central tenet of working with older people in ARC is the constant assessment for signs of deterioration (NZNO, 2014). A resident is objectified in biomedical, functional decline and nursing discourses as a risky body to be surveilled. The older person represented as a resident, is not free to make choices, as every aspect of life is watched over and regulated by nurses and caregivers. Residents are not autonomous and lack personal agency to make decisions over everyday aspects of their lives (Gawande, 2014). The student nurse is learning through a biomedical discursive lens to be a regulator of a previously autonomous older person. A counter or resistant nursing discourse is also present as Ricky includes the importance of communication with residents. Communication is a core tenant of holistic care (Burnell & Agan, 2013). However, a biomedical and functional decline discourse focusing on care of the body dominate, constituting the resident as an object of surveillance and affording the resident the subject position of frail, dependent, and at risk.

### *ARC as a place of employment*

Earlier analysis, in Chapter Five, positioned the gerontology nurse as working in ARC and a valuable resource in care of the dependent older person. Yet a dichotomy exists, as working in the aged care sector has been viewed as unpopular with nurses, raising concerns about poor wages and conditions coupled with a deterioration in the ability to provide quality care due low staffing levels (Chenoweth, Merlyn, Jeon, Tait, & Duffield, 2014; Grant Thornton, 2010; Kaine & Ravenswood, 2014). Commentary in *Kai Tiaki* reinforces the understanding that ARC is a challenging place for a nurse to work. Over the years, reports into the aged care sector have described "substandard care with overworked and underpaid staff" (O'Connor, 2010, p. 22) and noted "staffing levels are too low to provide quality care" (Wait, 2015, p. 40). All commentary serves to reinforce the perception

that working in ARC is not valued by the wider community nor the state who partially fund the sector (MOH, 2016a). Reflecting this perception of working in ARC, newly qualified nurses typically seek employment in acute care areas such as public hospitals, with ARC the least preferred option (Chenoweth et al., 2014; Huntington et al., 2014; NCNZ, 2017a).

Ricky from the NCNZ offered a partial explanation as to why student nurses may not elect to work in ARC that supports the above discussion:

> *They [year three student nurses] realise how much responsibility there is and how much learning they can have as they may be the only or one of the only RN's on who has to make big decisions because there is not a doctor standing there or close. So, there is a lot of learning to be done.* (Ricky, p. 5)

Ricky positioned working in ARC as requiring a complex range of nursing skills that the graduating nurse must learn, and that it is the level of knowledge and responsibility required which may deter some student nurses from working in the area. Ricky deployed a work-ready discourse that affords the student nurse working in ARC the subject position of needing to be highly skilled and operating at a level independence not expected in an acute care setting. This highlights the competing ways working in ARC has been positioned by nurse/education discourse, ranging from a suitable place for the unskilled learner, to one requiring complex skills with high levels of responsibility.

Other participants also discussed how educators and student nurses in the final year of education constructed working in ARC during transition and as a new graduate**.** Transition is the final stage of education when a student nurse must complete 360 hours in one clinical area. Successful completion means the student nurse is deemed competent to practice at the level of a beginning nurse (NCNZ, 2017b). Following registration, new graduates are able to apply to a supported new graduate programme known as a 'new entry to practice programme' (NETP). There are limited NETP placements available, with the majority of placements offered in acute care settings such as a public hospital. A political mandate appears to be operating through funding of the NETP programme, which supports acute care areas over other practice areas (MOH, 2013). Jan from NCNZ alluded to how this allocation model privileged acute care areas by restricting access to ARC.

> *For the NETP year there was some funding in older adult [aged residential care] but that funding has left so now there are not those NETP places there.* (Jan p. 6)

Selection processes mean some graduates are not offered a place on the NETP programme (MOH, 2018b). These graduates may then seek employment in ARC through expediency

rather than a desire to work with frail and dependent people. Reasons for working in ARC were expanded on by nurse educator participants Alex and Kerry.

Alex described how student nurses whose academic record may be insufficient to gain a place on the NETP programme, negotiate the best option to procure employment on graduation:

> *I think some do [seek a transition placement in ARC] because they genuinely enjoy it and I think others do because they are trying to be strategic. They know that their colleagues might have higher grades than them and so they are not going to get a NETP position, in their minds. And so, if they can line up something in the aged care sector then it sorts of guarantees them a job type thing so they see it as something they could do.* (Alex, p. 6)

This excerpt reiterates a truth statement that working in ARC is for those of lesser or different ability. Alex acknowledged some student nurses may enjoy working in ARC. For others however, working in the area was no more than a job they can be confident securing. A desire to work with frail dependent older people was not the motivator. Student nurses who propose to work in ARC are often those who position themselves as preferring to work in acute care but recognise they lack the educational achievement to gain a place on the NETP programme (Huntington et al., 2014).

Kerry offered a different perspective of working in ARC during transition, however the discursive effect is similar. For Kerry, the nurse/education discourse produces a shift in how working in ARC is positioned. Previously the education provider used ARC in transition when they could not secure enough placements in acute care areas. The placement was not used to showcase how it might be to work there, but rather as a final option when acute care placements were filled:

> *So, we do use it [ARC] as an attractive option. We used to in transition, to use it as the fall-back option when we couldn't get students into surgical/medical. We now put it up there [ARC] as a good place to go and do transition where you're well supported as a nursing student for 9 weeks, in the event that you get it as a new grad on the non-supported programme.* (Kerry, p. 8)

Excavating the comment further reveals a subtle reference to the lower academically achieving student nurse being directed to transition in ARC. The pitch has changed as ARC is now sold to the student nurse as a good placement but the intent is unchanged. A further reading adds to the comment directed toward the student nurse who would be unlikely to secure a place on the NETP programme because of lower academic results, and captures another type of student nurse, the non-New Zealand resident who is not eligible for the NETP programme (MOH, 2018b). Both groups of student nurses are positioned as not able

to secure a place on the more valued NETP programme. In a way these comments illustrate the hegemonic status nurse/education, nursing discourses, and DHBs who support the NETP programme, place on working in acute care areas (Howard-Brown & McKinlay, 2014; Huntington et al., 2014). It seems almost inevitable, then, that student nurses construct working with older frail dependent people only as an option if more desirable areas are not available, drawing on an ageist discourse that older people have less value. This is despite an acknowledgement that work in this area carries additional complexities and responsibilities than would be expected in an acute care area.

In summary, in this chapter I have argued that most articles assessed from New Zealand nursing publications in the last ten years, position older people as residents in ARC. The high proportion of articles on ARC in comparison with other representations of older people suggests this as almost the only site wherein nurses engage with this demographic. The gerontology nurse, the expert in the care of the older person, also features prominently in this site. The repeated commentary in New Zealand journals which assumes that older people are institutionalised, sets up a regime of truth about being an older person in New Zealand. This has the power/knowledge effect of establishing ARC as an inevitable part of ageing in New Zealand society. It supports a common-sense reality that older people are dependent and their only option is to reside in some form of long-term care (Angus & Reeve, 2006).

Foucault (2000e) comments on the "limits and forms of the sayable" (p. 59), suggesting there becomes only one way of speaking about the older person. By constraining gerontology knowledge to a particular domain, a single point of view of the older person is reinforced. Within a nursing discourse the gerontology nurse is afforded the subject position of caring for the frail and dependent older person. With visibility of the older person being valorised in ARC, older age becomes conflated with frailty and dependency. However, research has shown that older people are in the main, only admitted to an ARC facility in the last two years of their life; consequently, residents are representative of only a small proportion of older people (Boyd et al., 2008; MOH 2018a). Added to this, the majority of residents in ARC are over the age of 85 years and represent just over 25 % of the over 85 years demographic (MOH, 2018a).

This thesis would not dispute that frail, dependent older people have the right to be cared for by skilled practitioners. However, it is the emphasis on the care of the frail and dependent older body as a regime of truth about ageing for the student nurse that is

problematic. Most participants assumed the interview questions on gerontology knowledge related primarily to ARC. I have used excerpts from interviews to trouble how material practices such as prioritising attending to physical needs has the totalising effect of marginalising the person who is a resident. These individuals are seen as not in terms of their social and cultural needs but only as an object of care practices. This illustrates the power/knowledge effects within biomedical, functional decline, nursing and nurse/education discourses that constitute the resident as the ideal practice body to acquire both foundational and more complex skills. The power/knowledge outcome embedded in the use of ARC also deploys an established, self-evident and taken-for-granted truth that older age is accompanied by inevitable functional decline. Foucault posits "each society has its regimes of truth, its general politics of truth, that is, the types of discourse it accepts and makes function as true" (Foucault, 2000e, p. 131).

All discourses revealed serve to reinforce for the student nurse, the stereotypical view of ageing as senescence, and gerontology knowledge as only requiring skills associated with dependency and diminished functional capacity. The older person is rendered visible to the student nurse as dependent and in functional decline. This then produces a homogenous view of an older person and elides other subjectivities that may position the older person as independent, well and living in the community. It also serves to endorse an ageist discourse promoting an implicit assumption that older people will eventually reside in an ARC facility (Boyd, 2016; Eliopoulos, 2014).

A nurse/education discourse produces contradictory positions on the value of ARC as a placement. On one hand a nurse/education discourse constructs ARC as suitable for the less skilled and later the less academic student nurse, yet on the other hand some participants recognised it as a place of great responsibility requiring exemplary skills. Nurse education must assume some responsibility for this dichotomy. Privileging skills required to care for frail and dependent older people will remain unachievable while care of this demographic constitutes foundation nursing skills juxtaposed against an area that requires significant skill and accountability. As Foucault (1978) writes "discourses are tactical elements or blocks operating in the field of force relations; there can exist different and even contradictory discourses within the same strategy" (p. 101-102). Nurse education's strategy to use an ARC placement for foundational skills produces the older person predominantly in a discourse of functional decline, and offers the resident the subject position of the ideal practice body. The transition student nurse working in ARC is offered, in a nurse/education discourse, the subject position of not being quite competent enough

to work in the more favoured acute care setting. Similar discourses are played out in the hospital and community environments, the subject of the next chapter.

## Conclusion

At the outset of the chapter I introduced the Health of Older People Strategy (MOH, 2002) and Healthy Ageing Strategy (MOH, 2016b) as indicative of a political change in managing the healthcare needs of the older demographic. I postulated whether or not their introduction portended change in the construction of the older person within nurse education. Analysis then began with ARC as it had surfaced in the data as the area most associated with gerontology knowledge. Here I uncovered discourses operating and how they produced, the nurse, the student nurse and the older person in ARC. I revealed the competing ways nurse education positioned the student nurse working in ARC, and how discourse constitutes the older person as the ideal practice body. I exposed a continued propensity among New Zealand nursing authors to focus on positioning of older people and associated gerontology knowledge with healthcare needs of those who are frail and dependent. The gerontology nurse also featured predominately as working in long-term care, coalescing the role of the gerontology nurse with older people who are frail and dependent. From a pedagogical perspective, nurse educators and NCNZ participants preferentially positioned gerontology knowledge as centred in ARC.

By constructing ARC as suitable place for both learning foundation skills and for the transitioning student nurse, who did not meet entry requirements for NETP; I argued nurse/education discourse positions care of frail older people as having less value when compared with caring for people in acute care areas. This notion draws on a socially constructed perception of older people played out in the wider social field. The next chapter moves the analysis to hospital and community areas and continues to explore and analyse how nurse education and associated discourses are deployed.

# Chapter 6: Hospital and Community: Surfaces of Emergence

## Introduction

Student nurses come in contact with older people throughout the educative process. Through the power/knowledge effect of education, student nurses are socialised into the nursing profession. Therefore, how older people are constructed within a nurse/education discourse becomes a regime of truth. In the preceding chapter I illustrated how the older person who lived in ARC was produced by a functional decline discourse, and as such recognised as the primary focus of gerontology knowledge. In this chapter, I extend the analysis of literature and interview data to consider additional sites where student nurses may engage with the older person: public hospitals and community care.

The term gerontology is infrequently used in the sourced literature; however, the older person is often referred to as a separate category of patient. *Potter and Perry's Fundamentals of Nursing* (Crisp, Taylor, Douglas, & Rebeiro, 2014, 2017) categorise the older person as requiring special attention by providing supplementary information in vignettes titled, "Working with diversity focus on older adults*"*. Similarly, a chapter in *Community Health and Wellness. Primary Health Care in Practice* (McMurray & Clendon, 2015) relating to the older person is titled "Healthy Ageing" (p. 231). Utilising the aforementioned undergraduate nursing textbooks and other data sources including interviews, and two textbooks dedicated to the older person, this chapter begins by examining how the older person is constructed in the acute care setting, or public hospital, and then proceeds to consider the community setting. Through Foucauldian analysis, a range of discourses that objectify both the older person and the student nurse and afford them particular subject positions are revealed and as argued, reflective of the socio-political and cultural milieu.

## The hospital as a contested site of gerontology knowledge

Potentially, student nurses will engage with older people in most areas of a hospital except those specialised areas restricted to care of babies and/or younger people, such as paediatric wards or obstetric wards. People 65 years and older are a significant proportion of a public hospital population accounting for close to 50 % of all inpatients at any given time (MOH, 2016a). Contradictory views were apparent in the interviews as to who the older person is, and what could be defined as gerontology knowledge. Questions to interviewees on such knowledge drew few responses about the hospitalised older person.

This may in part be due in part to an accepted truth, as identified in Chapter Five, that gerontology knowledge is strongly associated with the ARC environment. Foregrounding the analysis, I contend an older person in hospital is discursively produced as an object of a range of discourses in competing and resisting subject positions in the acute care mainstream (non-specialised areas) environment. This argument is premised on the observation that in some data, a nurse/education discourse produces an older person as part of the mainstream population: that is chronological age is immaterial as the individual is produced in a biomedical discourse as an object of an acute medical/surgical pathological condition, that can be treated and potentially cured. Conversely, a functional decline discourse dominates other data delimiting construction of the older hospitalised person to rehabilitation areas and orthopaedic wards that offer a subject position of being at risk of dependency.

The older person is admitted to an acute care facility for a multitude of pathological conditions that can be treated through surgical or medical interventions. In this setting the biomedical response to treatment prevails as this is the core business of hospitals (Dreyfus & Rabinow, 1983). However, reducing the older person to physiological and pathological perspectives supports the notion that ageing is a time of physical decline (Phelan, 2010). It follows therefore, that biomedicine has played a pivotal role in producing truth statements about what constitutes older people within the hospital environment (Powell, 2009). Although a biomedical discourse legitimately operates in hospitals as a surface of emergence, nurse/education discourse produces the older person and student nurse who works with older people as objects and subjects of discourse, in a variety of subject positions that are neither uniform nor stable.

### *Gerontology knowledge: A contested term*

Divergent views were voiced by participants, who hold senior positions in nurse education, when considering what constitutes gerontology knowledge and to whom that knowledge is applicable. As I analysed the data, I sought to excavate how a nurse/education discourse offered the older person and student nurse different subject positions. It was interesting to consider when a person became categorised as older and from there, identified as belonging to the category known as gerontology nursing/knowledge. Pat, who works in nurse education, commented that older people are a significant part of the inpatient population:

> *Wherever they [student nurses] go! You know, for example, in the hospital setting it is often older adults that they're caring for so there is a focus on gerontology throughout.* (Pat, p. 9)

Here 'anyone' included people 65 years and over as being an older person, and hence under the category of gerontology. Robbie, also in education, held a similar opinion:

> *...we had a child and family paper we had an adolescent and young adult paper and we had an older adult paper. We would find particularly with the adolescent and younger adult paper the students were going to the hospital settings and we were trying to get them to have a case study about a younger adult and you know they couldn't find anyone. … That was one of the main reasons we shifted to this approach [teach about older people across the whole curriculum] that was meant to be across the life span but also, we were acknowledging more that [the] older adult population is the predominant population in the hospital public care.* (Robbie, p. 8)

Both Pat and Robbie position the older person within a public hospital as part of the mainstream population. The older person in a nurse/education discourse is constructed as an object of care without further categorisation. For Pat and Robbie gerontology knowledge is inclusive, aligning to aged-based characteristics with no other qualifying parameters. Pat and Robbie resist a functional decline discourse, as articulated in the previous two chapters as they do not align gerontology knowledge with older people recognised by their frailty.

A question was posed to Ricky and Jan from NCNZ on how gerontology knowledge might be assessed in the State Final Examination for NCNZ registration. Both participants cited a construct of gerontology knowledge and the hospitalised older person which exemplified the fluid, competing and contradictory ways in which gerontology knowledge is apprehended within a nurse/education discourse. Ricky commented:

> *…because older adults we don't think of older adults as say 73 is necessarily as old in the exam [State Final]. So, they might be in a surgical ward or a medical ward or they might have had an MI [heart attack] or a wound or something like that so they can be in those categories as well.* (Ricky, p. 1)

Contrary to the comments about older people being everywhere in hospital, Ricky did not equate an acute care question featuring a 73-year old person with gerontology knowledge. Rather, Ricky drew on a biomedical discourse focusing on medical/surgical conditions and views age as a feature of the patient, rather than a category. Age assumes little relevance as the person is objectified within a biomedical discourse, as it is the medical/surgical condition that is central to the question. Interestingly in the excerpt, the 73-year old is produced within a biomedical discourse that focuses on a pathological condition, rather

than a nursing discourse which might draw on a person-centred care question (Feo & Kitson, 2016; Grilo, Santos, Rita, & Gomes, 2014).

Further commentary from Jan illustrated the unstable interpretation of how gerontology knowledge is categorised within the State Final Examination:

> *But again, it is sort of do you want to have a cut off? These people are now older adults, do you want to be an older adult when you are physically able and capable you know and I mean our thinking is changing about that isn't it? I mean some 70-year olds used to be old and now we think 70-year olds are young so I mean do you plan to just lock them in a group*? (Jan, p. 9)

During interviews, Jan was disturbed by who is named as older; the dilemma appeared to be that a person is not constituted as an older person, and the focus of gerontology knowledge, until they exhibit signs of deteriorating functional capacity. To extrapolate further, Jan was intimating that in the State Final Examination, a question relating to gerontology knowledge was linked to diminishing functional capacity and dependency. Hence legitimate gerontology knowledge, to Jan, involves older people who are becoming or are dependent, drawing on a functional decline discourse and synonymous with a fourth age account in which a person is deemed frail and dependent (Gilleard & Higgs, 2002; Laslett, 1996). Gerontology knowledge by definition is a dividing practice that positions the older person as different from other population members, yet who may meet that criteria was contested by Jan and Ricky. Inherent in these comments, drawing on a nurse/education discourse, Jan and Ricky resisted an understanding or interpretation of gerontology knowledge meaning all individuals who may be 65 years and older. Rather, than resisting the dominant discourse of functional decline, Jan and Ricky are, however, perpetuating the notion that gerontology knowledge is related to older people who have diminishing capacity and are dependent on others, as contended in the previous chapters.

Similar to the view espoused by Jan, Kerry did not extend gerontology knowledge to all older people:

> *We have come through a lot and have an older care paper…The paper is run every year and we call it Care and Wellbeing of the Older Person. So, it's not a gerontology paper it's a, because old people are everywhere, medical wards, surgical, so it's a predominantly taught paper, it's not too much on line. So, getting people [student nurses] to think about aged care not just in a residential care area.* (Kerry, p. 9)

Here, Kerry recognised that just because someone is in hospital and chronologically classified as an older person, they do not necessarily fit with gerontology knowledge. By identifying the older person in hospital as not constituting gerontology knowledge, Kerry

was operating in a biomedical/nursing discourse that affords the older person the subject position of being part of the mainstream hospital population. By including 'wellbeing' in the title of the paper, reference is made to a nursing discourse that embraces a psychosocial understanding of an older person (Ryan et al., 2003), and objectifies the older person as a body to be kept healthy. This understanding serves to resist biomedical and functional decline discourses evident in earlier commentary. Contrarily, Kerry continued to clarify the aim of the paper was to consider that the care of 'old people' as they are everywhere in the health service, not just in ARC. Although student nurses are encouraged to think about older people living in areas other than ARC, implicit in the comment is the notion that older people who are not in ARC group may still have similar aged-based care needs. Kerry did not consider gerontology knowledge as operating in an acute care hospital, yet through the deployment of terms 'old people' supports an ageist understanding that separates older people from the mainstream younger population (Gendron, Welleford, Inker, & White, 2016). Such commentary seeks to offer a heterogeneous view of older people drawing on a nurse/education and nursing discourse yet imbued is a sense of different interventions initiated by age-based characteristics.

The above excerpts are indicative of the uncertain nature of defining what a person being named as older means, and who is recognised by gerontology knowledge. Drawing on a biomedical discourse, Jan concluded inclusion of a 73-year old requiring acute care as a State Final Examination question, did not suggest application of gerontological knowledge. In essence, a 73-year old did not meet the criteria for gerontology knowledge as they were independent. Although Kerry ascribed to a similar position on the definition of gerontology knowledge, the older person in hospital was differentiated from the mainstream population by being labelled aged. These excerpts exemplify the contradictory forces at play, illustrating how gerontology knowledge is not unitarily understood, in an acute care setting, as being inclusive of all older people. Interestingly, in mental health, services for older people begin at 65 years of age and are a separate service (MOH, 2011).

### *The student nurse and the older person*

When asked to consider how student nurses might engage with older people, participants provided examples of wards that predominantly included an older demographic:

> *So that's in year one. In year two then there is an opportunity within the hospital placement sometimes they [student nurse] end up on some of the rehabilitation wards which often is older. And actually, we know that the majority of people in hospital end up being aged care anyway.* (Bailey, p. 8)

Here Bailey, a nurse educator, as with Kerry in the excerpt before, has used the term 'aged care' to describe the type of care an older person may be privy to in hospital. By stating most older people end up being aged care anyway, Bailey is operating a functional decline discourse with a tacit assumption that an older person in hospital requires a level of care synonymous with long term care. Bailey also stated, older people were more likely to inhabit areas such as rehabilitation wards, again drawing on discourses that position the older person as being at risk of functional decline.

The following quote from another participant, Pat who is an educator, extends discussion on wards more likely to have patients who are older and offered some direction as to the services available:

> *Yes, and we also have placements with a number of students in what we call a dedicated education unit. It would be now at [name of hospital] I would imagine, the community rehabilitation assessment unit for older people.* (Pat, p. 7)

Admission to a rehabilitation ward requires a particular kind of body. Admission criteria are limited to mainly people 65 years and older, however any person over 16 years is eligible for admission if they have experienced a significant event such as a stroke (Auckland District Health Board [DHB], 2019; Bay of Plenty DHB, 2019; Waikato DHB, 2019). In these areas, care practices are directed towards rehabilitation rather than acute care that requires more technical skills (Tyrell, Levack, Ritchie, & Keeling, 2012). A rehabilitation ward provides co-ordinated services to give people, who do not meet the standard recovery time set out by the MOH in contractual agreements (MOH, 2019), the time and space to convalesce from an acute medical or surgical event. The goal is to mitigate effects of hospitalisation on functional ability or to restore as much functional ability as possible following an untoward health event (McKillop et al., 2015). For the student nurse, a rehabilitation ward tacitly constructs the older person as requiring foundational type skills such as assisting with ADLs, rather than necessitating more technical skills associated with acute care wards. In these wards an older person becomes the object of a functional decline discourse constructed as a disabled body needing assistance with ADLs. To be admitted to a rehabilitation ward positions the older person within an ability/disability binary opposition. As such the older person becomes known to the student nurse when there is a disability that affects a person's capacity to perform daily activities, thus reinforcing a functional decline discourse.

Pat provided an understanding of how care practices may differ between care afforded a patient in a mainstream ward and that provided to an older person in a specialised older

persons ward or rehabilitation ward. Pat recounted how student nurses who struggled to keep up the busy pace in an acute care ward were better suited to the slower paced, less technical areas associated with care of the older person:

> *… is considered less acute and more suited to a nurse who is not up to an acute care environment... So, you know it is quite a challenging area [older peoples' health ward] and we do have students who are in, that it is kind of considered less acute in [Older peoples' health ward] so that suits some students much better so that they do shine.* (Pat, p. 12)

Pat considered placement in an older persons' ward as appropriate for a student nurse who does not appear to demonstrate the necessary skills mandated in the more fast-paced and technical acute care environment that has a high patient turnover. In an acute care ward the student nurse is expected to be alert to rapidly changing pathological conditions, and ensure the patient is stabilised through such tasks as intravenous drug administration (supervised by a nurse) and monitoring physiological status (Brown et al., 2015). In an area such as a rehabilitation ward patient length of stay is longer, the patient has been stabilised and care practices focus more on restoring some level of independence in ADLs (McKillop et al., 2015). By placing the student nurse who is struggling in a fast-paced acute care environment in a less acute area, Pat acknowledged a different set of skills are required and that not all student nurses are created equally. However, by using the term 'not up to' there is an assumption skill required in an acute care area is privileged and requires a highly functioning student nurse (MacMillan, 2016; Stayt & Merriman, 2013). This assumption offers the student nurse considered suitable for a rehabilitation ward, the subject position of being less capable of functioning at the level required in an acute care area.

Pat drew on a functional decline discourse that constructs the older person as an object of care that is different to the mainstream hospital population. Pat was also operating a nurse/education discourse that views an ideal student nurse as one who is highly functioning in an acute care environment that requires technical skills. An ageist discourse was also apparent in constructing the older person as 'challenging', hence recognising they have complex healthcare needs but may not require the same technical skills as patients in acute care areas. Use of the word 'challenging' perpetuates the myth that older people are different to younger people, and can be more difficult to care for (Gendron et al., 2016). For the student nurse who struggles in an acute care environment, the less acute care older persons' ward offers an alternative. The older person/ patient in an older persons or rehabilitation ward becomes the ideal practice body for a student nurse who is not quite

capable of managing the more valued and complex technical skills, to learn rehabilitation and restorative care skills.

Similarly, Adrian, a nurse educator, raised the commonly held belief that wards with a predominance of older people are less acute and more suitable for the nascent student learner. As an object constructed through a nurse/education discourse, experimental learning is scaffolded, hence foundation or basic skills come first (Alderman et al., 2018). These foundation skills are commonly acquired in areas associated with older people (Algoso et al., 2016; Koh, 2012). While mentioning year one practicum placements and gerontology content, Adrian commented:

> *They have aged care facilities in semester one and we do that in semester two as well but only in [name of a campus]. The other two campuses they go into hospital… we try and put them [first year student nurses] in not so acute areas. And so quite often there are elderly people there as well. You know there are, the rehab and assessment wards, those types of settings. Orthopaedic wards yeah. So that's where they, come across it* [gerontology knowledge]. (Adrian, p. 9)

The term 'elderly' attracts a stereotypical view of the frail older person and it is the frail more dependent older person who is associated with gerontology knowledge. Use of ageist terms such as elderly has the discursive effect of diminishing the value of the older person (Avers et al., 2011). The value of caring for an older person is further diminished in commentary such as Adrian's, above, which considers areas with a high number of older, more dependent people as appropriate for the first-year student nurse who has the subject position of having less technical skill than a second or third-year student nurse. Repeating practices identified in ARC in a hospital setting, the older person is again positioned as the ideal practice body for the beginning student nurse. A first-year student nurse does not yet have technical and advanced biomedical skills such as administration of complex drug regimens that are valorised within a nurse/education and biomedical discourse (Thomas et al., 2012).

Bailey further supported this construct of older people requiring some form of support and inevitable functional decline when discussing what was taught about the older person:

> *It's understanding how the body ages. Understanding ageism and other social factors that influence how the aged live in our communities. It is mental health issues that can be a consequence of being aged and being less able to get out and develop social networks that you need. It includes policy around aged care. Gerontology and probably some of specific health concerns that older people might have as a result of everything from bodies wearing out to losing all their social networks because of friends dying and things.* (Bailey, p. 11)

Bailey began by alluding to ageism, and the importance that student nurses learnt about this construct that prejudices, but then there was slippage as Bailey moved to draw on ageist understanding of older age. By referring to older people in such a limited way, Bailey was producing older people as the discursive object of both a biomedical discourse, as the focus of health concerns, and a more holistic understanding in a nursing discourse, concerned with an older body losing social connections. Dominating these limiting accounts of older age is a discourse of functional decline, perpetuating all the ageist assumptions about the life experiences of an older person. Bailey's comments showed an understanding of health in older age as taught from a deficit model emphasising a failing physical and social body, thus constraining other understandings of older age that draw on wellness and health. A similar position afforded to the older person as an inpatient in hospital.

I close this section with comments from Riley and Pat that provide a powerful reminder of how nursing care of the older person has been, and continues to be, negatively perceived among some student nurses. It also is reflective of a casual acceptance of ageism amongst educators:

> *It is really interesting that [student]nurses will say they don't want to work with elderly but they want to work in a medical ward but to us that is nonsense because everybody in a medical ward is could be considered young old to middle old, old.* (Riley, p. 1)

With a similar comment from Pat:

> *I always kind of chuckle when students say to me, they don't really want to nurse older people because that's who they are nursing.* (Pat p. 9)

When I first heard these comments in interviews, I also smiled to myself and agreed, as I too have heard similar statements from student nurses. However, on deeper analysis these comments are symbolic of a socially accepted and inherent ageism that is played out every day within contemporary western society (Achenbaum, 2015; Angus & Reeve, 2006; WHO, 2017). Both Riley and Pat appeared tolerant of the idea that student nurses do not want to work with older people and left the statement unchallenged, except to consider it showed a lack of awareness as most people in hospital are of an older age demographic. The expectation from the student nurse is that older people are somewhere else, they are separate from the mainstream population in hospital and not valued or interesting enough to warrant the student nurse's attention. However, the question is not why a student nurse does not want to work with older people, rather why for educators the suggestion of not wanting to work with older people is not outed as being prejudicial? Kagan and Melendez-

Torres (2015) posit socially constructed ageist attitudes and behaviours toward older people embody discriminatory practices that remain socially and politically acceptable. Findings from this research appear to support this observation**.**

### *Intersection of functional decline and biomedical discourses*

Discourses of functional decline and a biomedicine's construct of older age appeared to be valorised in the textual data. New Zealand nursing journal publications had few articles concerning the hospitalised older person, yet those I located produced a homogeneous understanding of older age drawing on these same discourses that inferred all older people have multiple chronic health conditions and declining functional capacity (Oda, 2017; Weaver & Gavin, 2014). Gerontology focused textbooks *Healthy Ageing and Aged Care* (Bernoth & Winkler, 2017) and *Care of Older Adults* (Moyle et al., 2014) made mention of the older person in acute care. On the other hand, the textbook *Potter and Perry Fundamentals of Nursing* (Crisp et al., 2014, 2017) had two chapters dedicated to care of the older person. Further references to older people are situated in vignettes throughout the text providing information about age- related issues that may affect care decisions (Crisp et al., 2014, 2017). For example "older adults are very sensitive to slight changes in temperature" (Forbes, 2014, p. 70). The vignettes serve to construct age as a signifier of difference to the student nurse, objectifying the older person as a specific area of knowledge, thus perpetuating a discourse of difference (Hockey & James, 2003). The older person objectified as different to the mainstream hospital population was apparent in all the texts analysed, as will be discussed in the following paragraphs.

A journal article on oral care for older people while in hospital, made the statement "many of them [older people] experience decline in hospital due to the complexity of their co-morbidities and iatrogenesis (harm caused by hospitals)" (Oda, 2017, p. 14). This comment was supported by Boyd et al. (2016) who also stated older people in hospital have multiple comorbidities and require complex care. Here both Boyd et al. and Oda produce truth claims about all older people in hospital by presenting them as having multiple co-morbidities. Co-morbidities are defined as extra conditions affecting the body in addition to the main disease (Harris et al., 2006). Use of the term co-morbidities objectifies the older person in a biomedical discourse and infers all older people admitted to hospital have numerous health problems, and not just the condition prompting admission. Oda goes on to say "hospitalisation of older adults can cause cascades of functional decline (deconditioning) leading to a loss of independence diminished quality of life and increased falls and dependency" (p. 14). Deploying a functional decline discourse positions all older

people as being at risk because of they are older. Use of the term 'older adults/people' in both examples serves to conflate all older people with a group who are recognised by their frailty rather than representative of all older people in hospital (Pickard, 2014). This cohort of patients requiring oral care are named as older people but recognised by their frailty, hence are produced in a functional decline discourse as being unable to self-care.

A functional decline discourse that affords the older person the subject position of inability to self-care is deployed when Oda (2017) stresses how important it is that "elderly receive oral care while in hospital" (Oda, 2017, p. 14). Certainly, while poor oral care in a group of older frail people is of concern and does warrant attention, it is the discursive effects of including all older people that is problematic here. Dental health, a slightly different concern, gains attention in the *Potter and Perry Fundamentals of Nursing* textbook but draws on an ageist discourse in which most older people are offered the subject position of having poor dental health because of age and an inability to self-care. Burton (2014b) suggests "50% of clients over the age of 65 are edentulous (without teeth), and those present are often diseased and decayed" (p. 1011). This statement is presented as an almost absolute truth about all older people. In the later edition, the chapter on hygiene care has a different author yet the statement is repeated again stating. "50% of people over the age of 65 are edentulous" (Huynh, 2017, p. 953). The endurance of this observation in the most current edition is interesting, suggesting this statement has not been challenged as problematic and considered to still be the truth.

Historically, before the Second World War, removal of teeth and replacing with dentures was commonplace in New Zealand. However, this practice stopped as dental care improved (Schmidt & Moffat, 2011). Can such statements about edentulism still apply as the baby boomer generation become categorised as older people? Regardless of scientific merit, or the lack thereof, the commentary deploys an ageist understanding that implies poor dental health is a result of being older rather than for other reasons (Ng, 2007). There is a tacit suggestion that an older person has, through age-attributed biological changes and deficient self-care, lost their teeth. A different view would be to correlate poor dental health with poverty and not associate it with advancing age (Australian Institute of Health and Welfare, 2012), an alternative not offered in the nursing texts and journal referenced above.

Positioning the older person as being at constant risk of loss of functional capacity, has a power/knowledge effect that transforms the older body as an object of knowledge

different to the younger body (Phelan, 2010). Similar to the comments on oral and dental health, a person when they reach their 65th birthday is suddenly constructed as being at risk in a way that is different to a younger person. “Falls in people aged 65 years and over are of particular concern because of their frequency” (Hunt, 2017, p. 410). At the defined age of 65 years, therefore, a person becomes problematic through a sudden propensity to fall over. Hospitals and ARC facilities are particularly concerned with preventing falls in people aged 65 years and older and it is an auditable measure to monitor the standards of care in a hospital (Ambrose, Paul, & Hausdorff, 2013; Health Quality and Safety Commission New Zealand [HQSC], 2016). Drawing on a functional decline discourse, a blanket statement is made that age is the reason for someone to fall over rather than factors such as environmental hazards. This issue then deploys an ageist discourse by assuming that having a fall is associated with older age and is commonplace in the older person because of loss of functional capacity manifest at 65 years of age (Swift, Abrams, Drury, & Lamont, 2016).

Identifying older people as more likely to experience a fall, or have poor oral health deploys a sub discourse, a safety and at-risk discourse that objectifies the older body as extra risky. Deployment of these aforementioned experiences has the totalising effect of constructing all older people as risky subjects (Gilleard & Higgs, 2010). These excerpts exemplify the pervasive power/knowledge nature of making truth claims in textbooks that assume all older people present similar risk. The pervasiveness of such truth claims was evident in the essays written by my student nurses, as introduced in Chapter One as a reason for my research question on ageing in Aotearoa New Zealand. Many essays featured poor dental health and a high rate of falls as representative of being older.

Continuing with the notion of the older person being at risk as a sub discourse of a functional decline discourse is a report on a recent phenomenon in New Zealand, the establishment of Acute Care of the Elderly (ACE) wards. An ACE ward is for the acutely unwell ‘elderly’ medical patients with the aim to “improve care for complex elderly patients aged 85 and over by creating a multidisciplinary acute geriatric unit” (Weaver & Gavin, 2014, p. 16). Here the older person is clearly defined as 85 years and over, with a variety of challenging healthcare needs that require intervention. The group was identified as not receiving adequate care in mainstream medical wards where “there were vulnerable frail acute medical patients in need of rehabilitation spread across medical wards” (Counties Manukau Health, 2015, p. 7).

The introduction of a speciality unit for medically unwell over 85-year olds was in response to the assumption of risk. This manifested on multiple levels. The older person was at risk from inadequate care in the mainstream wards; conversely younger patients were also considered at risk of a lesser level of care if frail older people occupied beds and strained limited resources (St John & Hogan, 2013; Warren, 1948). There was also risk to the multidisciplinary team of care providers and financial risk to the hospital if inadequate care resulted in older person staying in hospital longer (Moreau, 2017). Deployment of an at-risk sub discourse enabled the development of a speciality unit that divided the frail older person off from the mainstream population based on age and biomedical characteristics such as frailty.

An ACE ward is another example of dividing practices produced by a biomedical discourse, based on a particular classification (Rose, 1994) that set up the binaries of non-aged/aged, independent/dependent, non-frail/frail perpetuating a functional decline discourse. This positions the frail older person as being more vulnerable than the mainstream population, requiring different care practices. Although an example of a dividing practice that is applied to those at the margins of society (Foucault, 1983, 1994), the ACE wards do have benefits for the frail older person as "the multidisciplinary team intervenes early to reduce patient deterioration during the acute phase of illness" (Counties Manukau Health, 2015, p. 17). To provide a service directed specifically to a particular older demographic is not inherently ageist, assuming the services provided are fully resourced and funded. Nevertheless, for the student nurse who may have a clinical placement in this area, this type of designated ward can serve to reinforce any stereotypical ageist attitudes already held by a student nurse (Swift, Abrams, Lamont, & Drury, 2017).

Once again, separating a group of people into a special area draws on a functional decline discourse, and produces a particular type of nurse. With a stated focus on rehabilitation and supportive care rather than acute care, the nurse is produced as having different skills, which as discussed earlier, are not as valued as acute care technical skills. The dividing practice of separating the older person from the mainstream population based on pathology seen in the geriatric wards of the last century, appears to still be operating, and it is a biomedical discourse that continues to produce these divisions.

The above examples of commentary associated with oral care, co-morbidities, ACE wards, and falls risk typify how the indiscriminate use of age-based characteristics as the cause of a physical change are produced as truth statements in nursing texts. All-encompassing

statements that privilege one partial and ill-defined truth about being older have the discursive effect of positioning all people named as older as problematic, based on a single measure of chronological age. Another effect sees the frail older person become marginalised from the mainstream population and positioned as dependent on the nurse to provide personal care. These are examples of tactics deployed with in nursing texts that position the older person as different to the mainstream hospital population.

### *The older person who needs managing*

The role of family and or carer is also referred to throughout the texts studied. The notion of working in partnership with family is indicative of a holistic approach to care, yet, I would argue, is problematic. Inclusion of a suggestion to consult with family members or a carer, deploys a functional decline discourse and produces the older person as not trustworthy to make their own decisions. The need to consult with others impinges on notions of self-determination and autonomy in decision making. Older people have reported a loss of autonomy when health professionals have not consulted with them when making decision about their health and well-being (Minichiello, Browne, & Kendig, 2000). There is a proclivity to conflate a person because they are older, with a person experiencing declining mental and physical capabilities and capacity: "By working in partnership with an older person and their family or carers, the aim is to increase the quality of life for the older person and assist in minimising their functional decline**"** (Hunt, 2017, p. 396).

In my opinion, the above statement is paternalistic and draws on an ageist understanding that automatically positions all older people as needing help from others as the statement assumes all older people have family or carers involved in their everyday life. The statement then positions the older person as a child, who is dependent on others for necessities of life. The use of the phrase 'to increase quality of life' extends this reliance on others, inferring that a particular way of living is valorised by the health professional and to achieve this standard help from others is necessitated. This serves to moderate the older person's account of what may constitute quality of life. Furthermore, a functional decline discourse produces the older person as a subject to be cared for by others, diminishing their ability to self-manage as the nurse assigns the carer of family some power over the older person.

A nurse/education discourse produces a student nurse who is now given the right and afforded the subject position of legitimacy to negotiate care decisions with the family or carer, potentially by-passing the older person. Assuming involvement of the family member

or carer is necessary to plan care adds further to the loss of agency for the older person (Phelan, 2010). The above statement from Hunt (2017) alerting the student nurse to 'minimising their functional decline', discursively infers all older people are at constant risk of functional decline and are unable to negotiate their own healthcare decisions. A functional decline discourse that constructs older people with particular care needs appears to be a putative truth repeated throughout the text under various guises (Maben, et al., 2012).

Age-based characteristics, as a product of discourse, are highlighted as a factor of difference in the older person not evident when promoting care of a younger demographic. For example, when alluding to the mainstream population Brotto (2014) cautions, "family members or friends should be taught to give injections in case the client becomes ill or physically unable to handle a syringe" (p. 840). Hence, for a younger person, an inability to manage self-care is directly attributed to temporary physical change. But for the older person, potential challenges are attributed to an assumption of physical and cognitive decline, in statements such as: "Sensory alterations, mobility limitations and physical co-ordination problems affect the capacity to learn" (Burton, 2014a, p. 227). The loss of ability to learn and remember is reiterated by Hunt (2014): "Information contributed by a family member may be needed to supplement the older adult's recollection of past medical events" (p. 450). In both these examples, a functional decline discourse operates connoting a pervasive ageist generalisation that all older people lose the capacity to learn. Older people are therefore offered the subject position of diminishing capacity attributed to age and not any other factor.

An important discursive practice associated with a functional decline discourse evident on admission to hospital, is surveillance. As a disciplinary tactic, surveillance can take many forms, including assessments and specific care practices (Crisp et al., 2017; NCNZ, 2012). Foucault (1995) posited surveillance as an apparatus of power. It is through surveillance that the individual, not as a representation of self, but as a deviation from the norm is individualised. In modern society there is constant surveillance; within the hospital environment, this is intensified. As a part of routine care, the nurse is required to constantly monitor a patient, alert for signs of deviation from the norm (Brown et al., 2015; Jarvis, 2016). But for the older person, the nurse is required to deploy different and additional tactics during assessment which constitute the person in a functional decline discourse.

Tactics to be deployed when working with older people are outlined in the texts. "During the assessment process the nurse may find it necessary to 'allow' rest periods or to conduct the assessment in several sessions because of the reduced energy or limited endurance by some frail older adults**"** (Hunt, 2017, p 406). Use of the word 'allow' assumes an unequal relationship and enactment of knowledge/power in favour of the nurse. Another example perpetuates an ageist myth that older people are forgetful (Eliopoulos, 2014). The text states that, "memory loss is common in the elderly and the client may miss doses or take the drug again" (Brotto, 2017, p. 779). This statement instils and perpetuates an ageist stereotype which infers memory inherently declines with age and is challenging. Repeating that a change in cognitive function as a normal part of ageing places the older person at risk of being labelled with the age-related stereotype without justification (Lamont, Swift, & Abrams, 2015). The reality is that while memory loss in older people without a diagnosis of dementia is statistically greater than the younger population, it is not as common as not having memory loss (Belleville et al., 2006). Yet through the act of learning to surveille and to be alert for changes in cognitive function, deploying a functional decline discourse, the student nurse is becoming disciplined as an agent of the state (Holmes & Gastaldo, 2002).

That a functional decline discourse is valorised when gerontology textbooks include hospital care for the older person is exemplified in the following examples taken from two Australasian gerontology textbooks targeted at undergraduate nurse education: *Care of Older Adults: A Strength Based Approach* (Moyle et al., 2014) and *Healthy Ageing and Aged Care* (Bernoth & Winkler, 2017). Beginning with *Care of Older Adults: A Strengths Based Approach*, the following two excerpts relate to care of the older person in an emergency department of a public hospital. In the first example the student nurse is cautioned to:

> Provide separate and quiet areas in the ED department for older people and provide equipment that is age friendly (e.g. large faced clocks) and treatment and care that respects the dignity and privacy of older people.
>
> Provision of age friendly care and assessment that incorporates the family carer and is openly communicated and streamlined.
>
> Awareness and assessment and treatment that is age appropriate; that is regular mobilising of the older person to the toilet, decubitus ulcer assessment, hydration and skin moisturisers. (Moyle, 2014, p. 140)

Here, functional decline and nursing discourses intersect as the student nurse is encouraged to provide physical care for the older person, based on a raft of stereotypical understandings about people named as older (Elioloupus, 2014; Minichiello et al., 2000).

These discourses produce a place and a role for the student nurse as a carer, who is cautioned to attend to older people with different care practices to those afforded younger people. These differences include expectations that all older people have poor eyesight, need help to walk to the toilet and have different privacy needs. These are not covert, but rather very explicit statements that construct older people as frail and dependent, and as a population to be divided from the mainstream population because they are different and fall outside 'normal' practice. These statements make truth claims about ageing that appear to relate to a very small section of the population of older people; those who by categorisation belong to the 'fourth age' defined as a time of dependency and frailty leading to death (Baltes & Smith, 2003; Twigg, 2004). For people identified as in the fourth age, the above interventions have value, but the interventions do not apply to all older people- a distinction which is not made apparent.

The second text reviewed, *Healthy Ageing and Aged Care*, presented similar understandings about care practices considered appropriate for an older person in an emergency department. The introduction reminds the student nurse reader "all older people are adults and individuals who deserve respect, whose pathologies present differently and often present as cognitive impairment" (Bryant, Montayre, & Bernoth, 2017 p. 266). In this statement, there is a truth claim of expected cognitive impairment and biomedicalisation of ageing as a pathological process, that manifests as different from the younger demographic. For clarification, the following excerpts relate to emergency department protocols for an Aged Care Services Emergency Team (ASET). This team targets older people admitted to the department "with complex medical and care needs" (New South Wales Ministry of Health, 2014, p. 1). Hence the authors are not referring to all older people, but a context-specific sub population. Nevertheless, the discursive effect is merging all older people with those who have complex needs and may be frail. The chapter continues providing guidance on communication and education around exercise for the older person with complex care needs. Drawing on a nursing discourse embodied as a person-centred care dynamic the student nurse is encouraged to:

> Always lower your voice just that little bit and say 'How is your hearing?' because not all older people are deaf. Ask, have you got some hearing aids tucked away in there under your hair?

When considering a discussion on promoting exercise on discharge:

> They need to walk every day. They can have rainy days and Sundays off. You add a little bit of humour and it helps them to remember the instructions.

Finally:

> Realise these people have been practising living with memory loss for years and covering it up so they are not devalued or perceived as not able to live independently. (Bryant et al., 2017 p. 272-274)

Overt stereotypical commentary infiltrates these comments and draws on the most common assumptions that older people's physical and cognitive ability inevitably declines, hence, they are no longer competent to managed their own lives (Swift et al., 2017). The use of the term 'these people' draws on a discourse that differentiates and places older people outside the mainstream population.

In both the above excerpts, knowledge of an older person who is independent and does not fit a discourse of older age appears as either subjugated knowledge or is not rendered visible to the student nurse at all. A discursive subject who is independent and agentic becomes marginalised and not operationalised when constructing the older person. Notwithstanding the overt deployment of a functional decline and a societal difference discourse founded on age, an encouragement to use paternalistic language (Marsden & Holmes, 2014) when communicating with older people further diminishes their opportunity to self-determine and positions them as dependent on the student nurse. The suggested use of humour to help the older person remember, I propose is demeaning and ageist, no matter how well intentioned.

Another statement from *Healthy Ageing and Aged Care* reads, "older people can be intimidated by assessment tools. Multiple questions, which are often repetitive, can be confronting and confusing" (Bernoth, 2017, p. 252). This statement could ordinarily apply to all people but by aligning it with age confers a meaning that all older people are somehow less able to apprehend commonly used assessment processes. A complex assessment tool becomes discriminatory, as older people are positioned as the problem rather than the assessment tool or person conducting the assessment (Ng, 2007). Many people, who enter the health system, are challenged by the level of health literacy required to navigate that space, and this has little to do with age (Jessup, Osborne, Beauchamp, Bourne, & Buchbinder, 2017). In all these excerpts, a functional decline discourse is evident that encourages the student nurse to assume the subject position of a protector and being in charge of the older person founded on their frailty and dependence on others.

The above examples from nursing scholarship, therefore, serve to reinforce construction of the older person to the state known as the fourth age, best associated with frailty (Laslett, 1996; Pickard 2014). A different set of rules and care practices apply deploying dividing

practices. For the student nurse, older age is constituted in terms of loss of bodily function and associated problems. This limited representation of an older person constrains the student nurse to view an older person through a biological deterministic lens producing functional decline as inescapable. The recommended nursing interventions convey an inevitability of older age that is hearing impaired, with loss of memory and needing assistance from others during the decline towards death. In all the above examples, a nurse/education discourse, intertwining with a functional decline discourse, affords the student nurse a subject position of a paternalistic carer.

In the final section of this discussion of the hospital as site for the student nurse to interact with older people, I introduce a statement from the Healthy Ageing Strategy (MOH, 2016b). Healthy ageing is the goal of the strategy but for those who may require the services of a public hospital, a form of exclusionary practice is implicit:

> Ambulance services and emergency departments are generally the first services to deal with acute and potentially life-threatening situations. But **they may not be the best place for older people** [emphasis added] whose conditions could be managed at home or by the local primary health care clinics or aged residential care. (MOH, 2016b, p. 18)

This statement is reminiscent of the policies of the beginning of the last century, as discussed in Chapter Four that categorically excluded older people from acute care, instead recommending they be managed in separate institutions. It does however, offer a resistance to the dominant biomedical discourse and suggest there are other ways or places to provide care. If read literally, and incorporating an understanding older people are those 65 years and older, it could be construed as suggesting that for anyone over 65 years of age, hospital may not an appropriate place for them to receive care (D'Souza & Guptha, 2013). A reading of this statement while applying a Foucauldian lens raises the question does it refer to all older people, or a particular category of older person who maybe frail with multiple comorbidities, the person in the fourth age perhaps? With ARC facilities providing more hospital level care in an attempt to decrease admission to hospital (Manchester, 2013), the statement could be referring to residents of ARC. Miller (1987) presented an argument that older people are less likely to be offered treatment in a hospital. Earlier discussion established the hospital as a place of risk for the 'some' older people so is this comment to protect some older people from the dangerous hospital, or is it more congruent with a financial discourse of cost containment (Moreau, 2017; Papoutsi et al., 2018)? The above excerpt does demonstrate potentially discriminatory rhetoric

against a certain group based on their chronological age that could seek to deny a group of people hospital level care (Angus & Reeve, 2006).

To conclude, within a public hospital environ, a shared understanding as to who might be the person named as older is open to debate. It appears gerontology knowledge and the older person as objects of discourse in a hospital are not uniform nor stable, yet a biomedical and functional decline construction of older age are privileged. The power/knowledge effect of these discourses resides in spatial arrangements in hospital that separate, categorise and divide some older people from the mainstream population based on the increased need for support related to functional decline. Interview data from some participants suggest gerontology knowledge becomes visible in areas such as rehabilitation wards. Similar to placement in ARC, the first-year student nurse or the student nurse who is unable to perform to the standard expected in an acute care ward is preferentially sent to areas with a predominance of frail older people. Research has demonstrated how the frail older person and people with dementia are more likely to receive care from an inexperienced nurse or carer, hence not as valued (Dewing & Dijk, 2016; Neville, 2005). This discursive practice draws on a number of discourses that constitute the older person as an object of different care practice to the mainstream population. To the student nurse this promotes a homogeneous view of the older person and what constitutes gerontology knowledge. The older person who is not considered at risk of functional decline is assimilated into the milieu of mainstream hospital population and not categorised as gerontology knowledge, and is therefore less visible to the student nurse as an older person.

## The community as a contested site for gerontology knowledge

Student nurses are required to complete a community placement (NCNZ, 2015b) and thereby interact with older people in a variety of settings including the home. Few participants mentioned the student nurse and interactions with the community dwelling older person; likewise, content relating to community experiences was light in the New Zealand nursing journals. This observation draws on Foucault's principle of exclusion, "not another prohibition but a division and a rejection" (Foucault, 1981, p. 53). This principle directs analysis to consider that knowledge of the community dwelling older person does not have currency with what is considered appropriate knowledge for the student nurse (van Iersel, Latour, de Vos, Kirschner, & Scholte op Reimer, 2018). As will be presented in the following section, participant comments did offer a more heterogeneous view of the

older person, yet continued to construct the older person as requiring different care practices to the mainstream population. This section begins with a resistance to the functional decline discourse played out in the previous section.

### *Resisting a resistant discourse*

As articulated by Foucault, where the technologies of power/knowledge operate there is also resistance (Kendall & Wickham, 1999; Pickett, 1996). Sydney, a nurse educator, recounted how within one paper students go into the community to meet with older people who live independently. Mindful of the negative perception and attitudes student nurses may have toward older people, Sydney drew on a nursing discourse that promotes the notion of holism. Sydney also discursively constructed older people in what I identify as a wellness and independence discourse that positions the older person as not requiring immediate healthcare, and self-determining. This is a position associated with the third age (Gilleard & Higgs, 2002) as will be discussed in Chapter Seven. These discourses were evidenced by ensuring student nurses see the hospitalised older person as a unique individual and associate them with the community dwelling volunteer they interviewed earlier in the programme. A holistic approach includes not only the biological but also the psychosocial and spiritual dimensions of a person (Watson & Smith, 2002). In referencing this discourse, Sydney was offering resistance to the techniques of power/knowledge (McHoul & Grace, 1997) evident in educative processes that, I argue, continually situates the older person in a biomedical discourse and draws on ageist accounts about ageing and risk:

> *…and that's around getting them [student nurses] to recognise that there is a real kind of range in regards to ageing. But also, that the older person in the hospital bed who is now in a hospital gown and in that kind of disempowered position, could have been that volunteer you talked to. And they [older person] have just had the misfortune of falling, fracturing a hip and here they are*. (Sydney, p. 7)

Although attempting to personalise the older person within a wellness and independence discourse, Sydney, by using the example of a hip fracture, also operated a biomedical discourse to construct of older age as different to the 'normal' younger demographic. A fall resulting in a hip fracture is strongly associated with older people (Kieffe, Rennie, & Gandhe, 2013). Interestingly, this example illuminates how easily nurse educators, despite best intentions to promote the heterogeneity of ageing, enact a tendency to construct an older person as being at risk within both a biomedical and functional decline discourse. The comment draws on a taken-for-granted knowledge that older people have a propensity to have 'a fall' and fracture a hip bone, as opposed to a younger demographic who 'fell over'

and are not automatically considered at risk of such an injury (Ambrose et al., 2013; HQSC, 2016). However, by introducing student nurses to well independent older people, Sydney's recognised the difficulty in avoiding functional decline and biomedical discourses that offer older people limiting subject positions.

Continuing with an independence and wellness discourse, Sydney discussed how the central tenet of a paper on older people is the well independent older person living in the community. Gerontology knowledge is deployed in a nursing discourse that values the psychosocial aspects of life:

> *They [student nurses] have a specific older person's health module which is four weeks, they have one week of theory. Again, in the past that's been very much focussed around older people in the community, very much a wellness type of focus, but also complexity.* (Sydney, p. 10)

Counter to previous commentary on the older person, Sydney drew on the notion of independence and wellness, enacted through the older person living well in the community. This construction offers the older person the subject position of a self-managing individual. A discourse of independence and wellness, however, is modified by other discourses. A nurse/education discourse imbues value to engaging with the older person and presenting a holistic understanding yet draws heavily on a biomedical discourse and the assumption the older person will be living with pathological conditions that add complexity to their life. Hence value is added to the student nurse's engagement with the older person by deploying a biomedical discourse explicating an older person as having a range of health conditions.

In the aforementioned course module on community placement, the student nurse is required to demonstrate "analysis of the pathophysiology, co- morbidities and ageing changes when performing skills of physical assessment" (Tertiary Institute Curriculum Document, 2017, p. 35). While the student nurse may find out about the psychosocial aspects of the person's life, the inferred function of this assessment premises an older person will exhibit some range of physiological changes and pathological states ascribed to being older. This constructs the older person within a biomedical discourse with the tacit assumption the older person will have age related co-morbidities. The older person is objectified as a complex pathologised body. A biomedical discourse creates a tension with an intended wellness and independence discourse and dominates to produce a subject position for the older person of complexity because of aged related changes. By applying the biomedical gaze (Foucault, 1994) the student nurse becomes the biomedical detective

mandated with revealing physiological changes in the person being assessed, and so confirming the stereotypical view that older people decline physiologically. The goal of the module positions the older person within an independence and wellness discourse, while concomitantly a biomedical discourse serves to conflate the knowledge of the older person with being at risk of functional decline.

Extending a discourse that constructs the older person as healthy and capable of living independently, participants Kerry and Robbie also discussed how student nurses visit older people in the community. In this instance the older people live in retirement villages. Kerry attributed the introduction of these visits to a lecturer who has a keen interest in older people and a determination for student nurses to see older people as living well in the community:

> *So, she was really clear that she wanted students to be aware that you can be old and independent. So that's how we've developed the Fridays. They spend, I think it's about 3 hours, they go in pairs to somebody's homes.* (Kerry, p. 5)

Kerry clarified that to meet the independent older person the student nurse goes into a retirement village:

> *So, we are aware there are safety issues that we have to consider. So, they [student nurses] generally go to any of the retirement villages. So, they go into a person's home within the set-ups you know where they've got their own little villa.* (Kerry p. 6)

Robbie provided a further example of student nurses visiting older people who live in retirement villages, but in this instance the goal was health promotion:

> *Some of them go into the college and do health promotion there and some of them go out to retirement villages and do health promotion at a retirement village. So, so they're all doing the same, task but different students will have different opportunities for targeting those different groups.* (Robbie, p. 6)

Although the rationale for the student nurse visiting the older person appears different, with Kerry promoting the notion of independence and Robbie focusing on health promotion, both examples of student nurse engagement with an older person are limited to those who live in retirement villages. By attending to health promotion in the retirement village there is an assumption the residents require some guidance to maintain health, drawing on a sub discourse of at-risk. A nurse/education discourse produces a retirement village and the people who inhabit this space as an ideal site for student nurse visits. This utilisation of retirement villages for student nurse visits is, I contend, founded on

convenience as retirement villages have a readily accessible population of older people in a geographically small area (Crisp, Windsor, Anstey, & Butterworth, 2012; Maxwell, 2018).

Drawing on a nurse/education discourse, the retirement village thus is constructed as a convenient space occupied by the targeted population. Use of a retirement village introduced an independent, well, older person to the student nurse and serves to resist a functional decline discourse. Nevertheless, this engagement with older people fails to capture their heterogeneity as there are admission criteria for retirement villages, and the cost of purchasing a dwelling, further limits who can live there (Maxwell, 2018; Ryman Healthcare, 2019). In this setting, the older person visited by the student nurse is more likely to be retired from paid employment as the student is visiting during standard work hours (Statistics New Zealand, 2019). Retirement villages, drawing on Foucault's notion of governmentality, are an efficient means of managing a particular population by combining them in one space. While becoming increasingly popular in the current socio-economic and cultural environment, having communities solely for the one group of people defined by their chronological age harks back to communities set up in earlier times that separated the people on the edges of society from the rest of society. "There was the great confinement of vagabonds and paupers; there were other more discreet, but insidious and effective ones" (Foucault, 1995, p. 141). The examples of student nurses visiting older people in retirement villages, resisted a functional decline discourse through positioning the older person as independent in the community, however, the older person continued to be constructed as different to the mainstream population.

### *Community and a functional decline discourse*

In preparation for interacting with health consumers, student nurses are required to attend a number of clinical simulation laboratories that replicate real life situations (Waxman, 2010). Pat provided an example of how simulation is used to prepare students nurses to visit older people in their home:

> *For example, we've got a simulation in Year 3a, in the family, whanau, community paper where the student goes in for a home visit with a district nurse and there's an older woman there who's got; there's all sorts of things in the room as triggers like a collection of newspapers and empty wine bottles and there's a nosy neighbour sitting in the interview. So, we have simulations that are directed towards older adults as well.* (Pat, p. 10)

One of the purposes of nurse education is to produce a safe nurse, constantly on the alert for changes that may cause disruption to a person's health (NCNZ, 2012). The health of the population evokes Foucault's notion of biopower (Foucault, 1978). For economic and social

purposes, the government or state wants a healthy productive population; to achieve this a government seeks to control biological processes such as encouraging people to be healthy (Gastaldo, 1997). Through on-going surveillance and interventions, the nurse becomes an agent of the state ensuring the political objectives of a heathy population are achieved (Holmes & Gastaldo, 2002: Perron, Fluet, & Holmes, 2005). The student nurse hence needs to be trained into how to surveille when visiting someone in their home. The student nurse is encouraged to be always alert with heightened surveillance for changes that may go against behaviour mandated as healthy by the state, particularly if the person is older. Through simulation scenarios, a nurse/education discourse objectifies the older person living alone in the community as a risk to the state through the potential to self-harm.

Pat recounted above how the student nurse was being trained to be competent at surveillance. The target of this particular skill is the older woman in the simulation scenario, who is offered the subject position of a troublesome older person as she is endangering her own health through her actions. On one level this simulation generates critical thinking but also has the discursive effect of positioning an older woman as being problematic. Potentially the older person needs to be managed, requiring some form of intervention from the health professional to improve her/his life, and hence requires special attention from the student nurse (Gilleard & Higgs, 2010). These actions have the potential to perpetuate the notion of older age as a time of declining function and buy into a stereotypical view of ageing serving to construct all older people as needing to be treated differently (Leedham & Hendricks, 2006). As with the other sites identified, in a simulated environment the older person is constructed within a nurse/education discourse as problematic, as they deviate from acceptable 'normal' behaviour (Kagan & Melendez-Torres, 2015). The student nurse cannot escape the material effects of once again being offered a homogeneous construction of an older person that perpetuates a view of being unable to manage their own lives in a manner that is considered acceptable to the observer.

McMurray and Clendon (2015)'s community nursing textbook dedicates a chapter to the older person, titled 'Healthy Ageing'. A definition of 'healthy ageing' parallels other contemporary terms such as 'positive', 'successful' or 'active' ageing (Rowe & Kahn, 1987; WHO, 2002). The emphasis is on older people continuing to participate in the world as they age (Swift et al., 2017). The onus of the chapter therefore, is on healthy ageing and the stated goal for the health professional is to "provide community supports that enable the highest level of health and capacity possible" (McMurray & Clendon, 2015, p. 322). The

beginning section presents a heterogeneous version of an older person who may be actively engaged within the community, producing the older person within a wellness and independence discourse. Hence the text draws on other discourses to convey multiple facets of ageing and resist the dominant functional decline discourse.

This changes progressively through the chapter as a discourse of functional decline begins to be deployed. The student nurse is directed to consider safety for an older person as "safety is a priority in the home, community and residential care" (McMurray & Clendon, 2015, p. 331). The binary of safe/unsafe constitutes the older person, wherever they live, as at risk of being unsafe. The risk to an older person's safety becomes paramount and legitimises active and perhaps unwanted surveillance. "Home visits can be an opportunity for surveillance of the immediate home environment and the neighbourhood" (McMurray & Clendon, p. 331). Through the act of surveillance, the nurse exerts power/knowledge over the older person: the nurse is the authority, and through surveillance activates that authority (Foucault, 1995). As an agent of the state (Holmes & Gastaldo, 2002), the nurse has a mandate to act on unsafe behaviours such as failing to self-manage (Gilbert, 2006).

Deploying a safety and at-risk sub discourse justifies many practices that afford older people less power than others and accept behaviour that may not be tolerated in a younger demographic (Gawande, 2016). Again, the older person becomes objectified in a nurse/education discourse and draws on a safety and at-risk sub discourse as an older body is at risk because of their age and functional decline. The act of heightened surveillance reinforces an expectation that age-based characteristics are detrimental to an older person's health and further serves to marginalise the older person (Hockey & James, 2003). Drawing on a safety and at-risk sub discourse generates the assumption that an older person needs guidance and support to mitigate behaviours that put them at risk of functional decline, justifying a heightened surveillance.

The requirement for a student nurse to be alert to physiological changes and behaviour that may endanger an older person's health and wellbeing, is a recurring tactic identified in the literature that deploys a functional decline discourse. One textbook alert's the reader to the problem of malnutrition in the older person: "Prevention and correction of malnutrition in this age group is vital to optimise mobility and function" (Marshall & Roberts, 2017, p. 1035)**.** Without a codicil, the use of 'this age group' attributes the problem of malnutrition indiscriminately to all older people. This is disingenuous, as most

older people's way of life is not putting them at risk of malnutrition (Kaiser et al., 2010; Statistics New Zealand, 2017).

Older people are also positioned in the literature as not having reliable self-knowledge. A gerontology nurse practitioner who works in the community, cited in an earlier study commented: "Seeing someone in their own home also provided the opportunity to talk to other family members about the person's health history" (Manchester, 2016b, p. 19). Inherent in this statement is a sense that the older person is not trusted to make a decision for themselves. Other people's knowledge is privileged over the older person's own self-knowledge. In another example, a functional decline discourse, intertwined with a safety and at-risk sub discourse is also deployed, justifying a paternalistic attitude when nurses are called upon to offer protection to older people that they would not offer to a non-marginalised younger population (Pickard, 2014). McMurray and Clendon (2014) remind student nurses that "protecting older people from harm throughout ageing begins with attention to the community environment" (p. 331). Valorising the need to protect older people infers they do not have the capacity to self-manage.

As I have shown, statements from both nursing texts, and interviewees delimit and constrain how the student nurse may constitute the older person. The commentary perpetuates multiple subject positions for the older person including requiring protection, and having the responsibility for health and wellbeing assumed by family and carers. Deploying discursive formations, the statements constitute the older person necessitating some form of management for behaviour that is not accepted as it would be in a younger person. The older person is produced in a functional decline and nurse/education discourse as being a subject at-risk, whose agency is negated as demonstrated by the oversight of the nurse. The student nurse when engaging with older people is afforded the subject position as an agent of the state to be constantly vigilant for signs of behaviour that puts the older person at risk, and is empowered to intervene. The low risk older person continues to be largely invisible to the student nurse.

Additional evidence of how a functional decline discourse imbued with ageism is operating is provided in a statement comparing older people with children. "Like children, older adults are often dependent on others and this does not always offer them a voice at the policy table" (McMurray & Clendon, 2015, p. 348). In this statement of truth, the older person has been tacitly compared to a child; one of the main discursive practices of ageism is associating older people with child-like behaviour known as infantilisation (Butler, 2005;

deVries, 2013). Use of the word 'often' then suggests this applies to a large number of older people, which is inherently not correct, as most older people are not dependent on caregivers with many in paid employment, or themselves caregivers (Bascand, 2012; Malinen & Johnstone, 2013; Statistics New Zealand, 2017). However, the text confirms a stereotypical myth that older people are dependent and disempowered. This is further played out at central government, as the Minister for Seniors is also the Minister for Vulnerable Children (New Zealand Government, 2019). The concept, 'common-sense reality' is employed by Angus and Reeve (2006) as a means of explaining how stereotypical assumptions continue to be perpetuated in the socio-political field. In defence of the comment it does however draw attention to frail, dependent, disempowered older people who do not have a voice (Gilleard & Higgs, 2010). The problem is conflating all older people with frailty and dependency, while comparing them with children is an example of infantilisation (de Vries, 2013).

### *Heterogeneous representation of the older person*

Gerontology knowledge is not limited to the pathologised older body, however, the older person as a psychosocial being, living well and independently in the community rarely featured in the data. To conclude this analysis, I introduce other representations of older people which provide a few exceptions, and serve to resist the dominant biomedical and functional decline discourses I have shown to infiltrate nursing scholarship. For Foucault, resistance was aimed at a "technique of power rather than at power in general" (McHoul & Grace, 1997, p. 86). One technique of power is the generation and reinforcement of a particular type of knowledge that excludes and limits other ways of thinking (Foucault, 1981). This technique was played out in the literature available for this research.

Data search revealed only three articles that resisted the aforementioned discourses and produced the non-pathologised older body as the object of a wellness and independence discourse. This suggests a disinterest in the well, independent older person from a nursing research perspective. One study interviewed women over the age of 85 years who lived alone (Foster & Neville, 2010). In this article self-knowledge was valued over biomedicalised knowledge of the ageing body and research centred on psychosocial aspects of life as an older woman. Another study: 'Health education and health screening in a sample of older men' (Dallas & Neville, 2012), was interested in the healthcare needs of older men in the community. The final study in this small group was a review of three earlier New Zealand studies investigating independence and well-being in later life (Neville, Keeling, & Milligan, 2005). All these studies acknowledge the heterogeneity of older

people, offering a counter discourse to the functional decline discourse that pervades nursing literature.

Similarly, chapters in the gerontology textbook *Healthy Ageing and Aged Care* (Bernoth & Winkler, 2017), resist a biomedicalised and functional decline account of older age, including chapters on: "Leisure activities and recreation in the lives of older people" (Dionigi, 2017, p. 204) and "Volunteer relationships and older people in the workforce" (Evans- Barr & Winkler, 2017, p. 180). These chapters brought into play other discourses such as a healthy ageing discourse and constructed older people as living well and independently in the community. Such a representation is associated with the 'third age' that values a psychosocial understanding and constructs older people as active participants in the wider social field (Baltes & Smith, 2003; Gilleard & Higgs, 2002).

Foucault (1978) asserts, "we must not imagine a world of discourse divided between accepted discourse and excluded discourse or between the dominant discourse and the dominated one; but as a multiplicity of discursive elements that come into play in various strategies" (p. 100). To relate this assertion to nursing scholarship, I argue that in the current healthcare environment, nurses are not needed when older people are healthy and well. Nursing services are only sought when there are pathological changes, or to prevent such changes. Mandating this particular type of knowledge has the discursive effect of shutting out one form of knowledge about older people but opens up sites where student nurses do engage with older people such as ARC and hospitals. Again, drawing on Foucault, this suggests that gerontological knowledge that positions an older person as well and independent is "disqualified as inadequate to their task or insufficiently elaborated: naïve knowledges, located low down on the hierarchy, beneath the required level of cognition or scientificity" (Foucault, 1980b, p. 82). As nursing is not generally concerned with the well and independent older person hence wellness and independence become subjugated knowledge in undergraduate nurse education.

## Conclusion

Drawing on interview and textual data, a Foucauldian discourse analysis of how gerontology knowledge and the older person is constructed by nurse education at sites of student nurse practice including hospital and community settings, has been presented. Analysis from interview data revealed the hospital, a site of learning, as producing an unstable and conflicting understanding as to who could be categorised as an older person, hence identified as a gerontological subject. Some participants resisted categorising all

older people as the proper focus of gerontology knowledge, while others identified older people as a segregated population, visible and named in rehabilitation and orthopaedic wards. In the main, interview data supported the assumptions and stereotypical views revealed in Chapter Four and Five. Equally, in textual data a discourse of functional decline dominated and represented older people as having different care requirements to the younger population. The student nurse who works with older people in areas more associated with care of older people is offered the subject position of being less skilled in the technical aspects of nursing

In both hospital and community sites, a functional decline discourse operates and affords the older person the subject position of being at risk of becoming frail and dependent. The community setting introduced the student nurse as an agent of the state, and taught special surveillance skills to assess the older person for signs of risk of unsafe behaviour and functional decline. Together these discourses have the power/knowledge effect of limiting understanding of gerontology knowledge, and support an ageist view of older people that perpetuates all the stereotypical notions of older age. In both areas, the older person was rendered visible to the student nurse within a multiplicity of discourses including biomedical, and functional decline discourses interwoven with a safety and at-risk sub discourse, hence eliding other possible ways of constituting the older person and gerontology knowledge. This now concludes my analysis chapters as in the next chapter I will draw my analysis together and offer my thoughts on how to proceed in the future.

# Chapter 7: So What? And the Future!

## Introduction

This final chapter reviews and discusses the findings from analysis Chapters Four, Five and Six while offering consideration to the implications for the future of nurse education and gerontology knowledge. I now seek to address my third aim: to problematize the capacity for nursing education to prepare graduate nurses to meet the health and wellbeing needs of older people. This project was undertaken in response to a personal sense of disquiet that as nurse educators we are failing to prepare student nurses with the capacity and capability to meet the healthcare needs of an older demographic. A critique of New Zealand nursing literature accessed for this study, identified no effective options to address this issue. Saliently, a general disinterest in the older person, particularly from a psychosocial perspective, appeared entrenched in the power/knowledge functions of nurse education. This position is reflective of a wider social condition that marginalises and devalues the older person (Jönson, 2012: Palmore, 1999). It was apparent that nurse researchers, while able to identify and decry student nurses' disinterest and negative perceptions of working with older people, were still not contesting the contingencies and contemporary practices that contributed to this phenomenon.

Underpinning this research has been a critique of the material conditions and discursive practices that have contributed to the contemporary understanding of gerontology knowledge in undergraduate nurse education. In this chapter, I draw together the analysis chapters and provide an overview of my findings by troubling the current understanding of gerontology knowledge as identified from my analysis. Although not mandated in a Foucauldian discourse analysis (Cheek, 2000), I offer some suggestions as to ways future accounts of gerontology knowledge could change. Finally, the limitations and options for future study will be discussed ending with my concluding statement.

## From the beginning

The first aim of this research was 'To reveal the discursive practices that have predetermined, sustained or hindered gerontological knowledge in contemporary undergraduate nursing curricula'. As stated at the outset, a driver for this project was to illuminate how it came about that student nurses choose to write about older people in Aotearoa New Zealand drawing on and privileging a functional decline discourse that produced an array of ageist and stereotypical views. Alongside this aim, another original

intention was to extend gerontological knowledge among student nurses by first critiquing the current pedagogy. However, what transpired through my research journey completely changed my own understanding of how we constitute older people and gerontology knowledge within undergraduate nurse education and the nursing profession. This revelation left me with more questions than answers. Appropriating Foucault's writing and situating my research through a postmodern and social constructionist perspective, proved to be a compatible methodology to achieve my research aims. This approach allowed me to utilise Foucault's understandings of the relationships between power, knowledge and discourse, in order for my research to take a different journey to that ascribed by a modernist approach predominant in nursing scholarship (Porter & O'Halloran, 2009). Central to the process of fulfilling the research aims was interrogating the contingencies that have led to the modern-day understandings of older people in nurse education, hence the first analysis chapter, Chapter Four, provided a historical perspective utilising Foucault's archaeological and genealogical tools.

As aptly stated by Foucault (1980), "each society has its regimes of truth, its general politics of truth: that is the types of discourse which it accepts and makes function as true" (p. 131). Consequently, there is a societal truth about older people that is accepted and operationalised through social and state practices. Claims of truth about ageing and older people in nursing come into being through social, cultural and political expediency (Foucault, 2000a; Rolfe, 2000). Emerging in the nineteenth century, charitable institutions for the indigent aged continued on to evolve into ARC facilities. Then, in the 1950s, geriatric wards were introduced into hospitals to counter the problem of too many older people occupying acute care beds. In these sites, older people became visible to the student nurse through a biomedical discourse that pathologised understandings of older age as being synonymous with physiological changes, and a functional decline discourse assuming decreasing functional capacity (Powell et al., 2006; Saville Smith, 1993; St John & Hogan, 2013). Such wards were the antecedents of the continued and accepted practice of institutionalising older people who are unable to self-manage. In hospitals and community settings different care practices were introduced for the older person identified as at risk of functional decline but drew on similar discourses of frailty and dependence.

My critique of the contingencies contributing to the contemporary account of older people and gerontology knowledge in undergraduate curricula led me to some surprising findings. A biomedical discourse operated in combination with a functional decline discourse,

restricting access of older people to hospitals which favoured treatment for acute and curable conditions. This understanding was extended further as data revealed how older people were also seen as an obstacle to the younger demographic receiving care. Nursing curricula and textbooks at the time perpetuated a singular biomedical pathologised view of older age, reinforced with the establishment of geriatric wards to separate the older person from younger patients. The apprenticeship training model ensured student nurses, a necessary part of the hospital workforce, worked in all areas of the hospital; however, for many years there was a requirement to have an explicitly set number of hours in a geriatric ward (NCNZ, 1973; NMB, 1958).

A shift occurred by the end of the twentieth century as student nurse training/education changed from an apprenticeship model to a tertiary education model (Christensen, 1973; Papps & Kilpatrick, 2002). Geriatric wards were disestablished and the term 'geriatric', became less commonly used. A new branch of older persons health was introduced, 'gerontology', that came to represent knowledge and care practices that included a more holistic approach to care, incorporating psychosocial aspects of an older person's life (Eliopoulos, 2014; Tabloski, 2014). These two events could have provided educators the tools to change how older people were constituted in education. Yet as it transpired, nurse education continued to promote a biomedical construct of older age, deploying a functional decline discourse that delimited and constrained how the older person became visible to the student nurse. Material practices with roots in the nineteenth century that divided the older person from the younger demographic and viewed them as different, continued to be enacted into the twenty-first century. Institutional care of dependent older people remained, while in hospitals, geriatric wards were replaced by rehabilitation wards and more recently the ACE ward (Counties Manukau Health, 2015).

## Gerontology knowledge and functional decline discourse

This study's second research aim was to illuminate the power/knowledge relationships and discursive practices in contemporary undergraduate nurse education which construct gerontological knowledge and the older person in a particular way. To achieve this aim, I attuned my research focus to the three areas in which student nurses may potentially engage with the older person: ARC, the hospital and the community. Textual data to support analysis were drawn from New Zealand nursing journals, commonly used undergraduate nursing textbooks and textbooks with a singular focus on care of the older person, and supplemented through interviews with nurse educators in managerial roles. A

foundation of this study was the need to examine the mechanisms of power relations and discourses brought into play that produced legitimate truth statements about older people for the student nurse (Foucault, 1978). From my analysis presented in Chapter Four, I gained insight as to how within nurse education the older person became produced by a biomedical and a functional decline discourse. As my analysis progressed to the present day, it became clear that there had not been a pedagogical shift in how the older person was produced by a nurse/education discourse. As I noted in Chapter Five, there was a move to a gerontological rather than a geriatric construction of older age, combined with a socio-political decision to focus on wellness and healthy ageing, however, this change did not filter through to nurse education (MOH, 2002, 2016b; Rowe & Kahn, 1987).

Options available for older people in New Zealand society have altered in the years since Foucault (2003) wrote, "before the war [second world war] families shoved the elderly into a corner of the house, complaining of the burden they placed on them, making them pay for their presence in the household with a thousand humiliations, a thousand hatreds" (p. 78). When Foucault produced this statement in the 1970s, New Zealand had a mandatory retirement age of 65 years (MOSD, 2015a). Retirement is no longer mandatory, with many people working beyond 65 years of age. Current figures indicate the employment rate for people aged 65 years and older is 24 %, similar to other western countries (Organisation for Economic Development, 2017; Statistics New Zealand, 2019). Popular culture and scientific endeavours promote an anti-ageing narrative, challenging the perceptions of diminishing functional capacity and ability as an inevitable part of biological ageing (Vincent, Tulle, & Bond, 2008). Thus, drawing on Foucault's comment, many people named as older do not fall outside the capacity of activity and remain economically and socially productive in society. Nurse education appears not to have recognised these societal changes and continues to keep in play a functional decline construct of older age. This thesis has exposed the strategies and phenomena that present an intertwining of a biomedical and functional decline discourse at the forefront of a student nurse's construction and understanding of older people.

### *Who is the subject of gerontology knowledge?*

Integral to this study is the term 'gerontology knowledge', a social construction which represents a westernised understanding of older age. Gerontology knowledge has proved to be an unstable, contested, and at times a contradictory term that is not uniformly recognised nor adopted by those within nurse education. In Chapter Six I illustrated how

participants did not present a unitary understanding of to whom gerontology knowledge referred. Gerontology knowledge lays claim to knowledge of the person named as older, in all aspects of existence. Gerontology knowledge in nursing is applied in theory to ensure older people "achieve wholeness by reaching optimum levels of physical, psychological, social and spiritual health" (Eliopoulos, 2014, p. 77). This definition does not operate a binary of independent/dependant, non-frail/frail, nor able/disabled- yet my analysis has shown that nurse education lays claim to knowledge about older people as situated in the inferior position of the binary. Notwithstanding the intent of the definition, my research uncovered a proclivity among the nursing profession and educators to pathologise older people in their consistent use of a functional decline discourse.

In most instances, participants and the New Zealand nursing journals constructed gerontology in reference to ARC or the frail and disabled older person. This observation is illustrated in a comment in *Kai Tiaki* from a writer identified as a gerontology researcher. In reference to the negativity around working in ARC, Montayre (2017) argues that to overcome this situation, gerontology needs to be holistically integrated into nursing curricula. Similarly, nurses themselves do not subscribe to the title 'gerontology nurse' unless working in an area identified as caring for frail and disabled older people. Hunt (2014), when outlining "working with older adults – gerontology as a specialty area" (p. 441), asserts that "most nurses who work with older people identify themselves in a specific care context, for example rehabilitation, community care, or residential aged care" (p. 441). Both authors deploy a functional decline discourse that sets gerontology as a disciplinary knowledge separate from acute care areas such as surgical and medical wards. The independent, well, and self-managing older person does not fall under the purview of the gerontology nurse.

The difference between the self-managing older person and the older person who needs care sets up competing and contradictory discourses. Gilbert (2006) calls these two trajectories, and argues it is the second trajectory into what might be known as the fourth age, a euphemism for frailty and dependency, that attracts the attention of gerontology knowledge. This stance is also supported by Leedham and Hendricks (2006) who suggest there is a division between the non-productive older person and the productive older person. It is knowledge of the non-productive older person that is privileged in nurse scholarship and draws the interest of gerontology researchers. Findings from my analysis concur with the aforementioned observations. I argue the relationships between power

and privileging a particular type of knowledge about older people mean nurse education is complicit in the construction of older people within a discourse of functional decline. Throughout the three years of education, student nurses encounter many older people, both in the hospital and community, yet educational practices privilege biomedical knowledge, emphasising pathological changes associated with an ageing body. Through concentrating educational practices on a deteriorating body characterised by degenerative changes, nurse/education discourse focuses on a form of biological determinism that renders the older body visible to the student nurse in very limited ways. This biological determinism serves to typify the older person in a functional decline discourse, hence constraining and subjugating knowledge about health and wellness.

This study has illustrated how privileging a functional decline discourse pervades and dominates gerontology knowledge and the construction of the older person within nurse education. As noted by Mills (2003), "truth is kept in place by a network of strategies" (p. 76)**.** These strategies were manifest in textbooks that enacted dividing practices constituting people named as older as different to the younger adult population. The textbooks directed the student nurse to adopt different care practices founded on 'scientific facts' about the physiological changes to the older body. Textbooks have power/knowledge effects as statements of truth about older people due to their being written by those considered an authority. However, the texts serve to construct a particular version of truth statements about being older and negate or marginalise other understandings of ageing, such as personal experiences and psychosocial accounts.

Another strategy supported by nurse education that aligns gerontology knowledge with a functional decline discourse is the use of ARC and clinical areas where older people require extra assistance with ADLs. These practices circulate and perpetuate a common sense reality about older people that they are different to the mainstream population. The use of these two areas for the beginning, or the less capable student nurse, also reinforces a regime of truth about older people as having less value than the mainstream, younger and more independent adult population (Maben et al., 2012). Sayers and Brunton (2019) argue that ARC facilities are "places of exclusion from social norms" (p. 17). Hence ARC facilities operate to keep dependent older people and those who work there hidden away from the general population, further devaluing those who live and work within these facilities.

The older person in acute care areas of hospital brings to light a tension in what constitutes gerontology knowledge and exemplifies the contested and contradictory positioning of

older people as defined by gerontology knowledge (Baumbusch et al., 2014; Bryant et al., 2017). The previously well, independent older person having some form of acute biomedical intervention is not typically identified as a candidate for gerontology knowledge. This reflects findings from other authors who claim older people are embodied as belonging to the fourth age, representing frailty and dependency (Baltes & Smith, 2003; Pickard, 2014). As described in Chapter Six, one participant confirmed that in the State Final Examination, questions relating to gerontology concerned older people recognised as belonging to the fourth age. This interpretation of gerontology could be considered as a resistance to a functional decline discourse that in some literature conflates all older people with declining functional capacity. However, the comment highlights the varied interpretations of gerontology. My analysis certainly confirms an unstable recognition of what constitutes gerontology knowledge, in not only undergraduate nurse education, but also wider nursing scholarship.

Apparent contradictions as to what constitutes gerontology knowledge drew me back to the works of Foucault and the notion that discourse is productive: it produces objects and offers subjects positions within the discourse (Foucault, 1972). I thought about the discourses I had revealed and named that circulated around the older person and how an older person may be constructed by one discourse or another. My thinking led me to consider what discursive devices were enacted that identified an older person for the student nurse, and gerontology as being produced in a particular discourse.

Writing as a person shortly to be named as older, I began to question when I would become categorised and constructed by nursing as an older person. Am I claimed by gerontology on my 65$^{th}$ birthday? Legislation dictates I will receive superannuation at 65 years of age, and therefore will then be categorised as an older person (MOH, 2016b; MOSD, 2015a). Once so categorised, will I, if admitted to an emergency department, be placed in a special room with a large faced clock and assumed to be unable to provide information about my condition as my memory has become unreliable (Bryant et al., 2017; Moyle, 2014)? Will the student nurses I have been educating (I teach pathophysiology on a bachelor of nursing programme) about the physiological changes associated with ageing, assume I will be incontinent of urine and offer to walk me to the toilet more frequently, or worse put me in a full incontinence product? I doubt it. So, the question remains, when and how does the student nurse construct someone 65 years and older as person with special needs, attracting different care practices, as ascribed to gerontology knowledge?

As first posited by Laslett (1996), and further expanded upon by Gilbert (2006) and Gilleard and Higgs (2002), independence is attributed to the 'third age' and dependency and frailty to the 'fourth age'. The boundaries between the third and fourth age are ill defined and not assigned chronologically (Twigg, 2004). How is this division then determined and enacted? There exists a contestable and unstable zone between a wellness and independence discourse, recognised as the third age, and a functional decline discourse, ascribed to the fourth age. Both discourses are mingled within a biomedical construction of older age, enacting relationships of power/knowledge. I suggest between these two discourses available to the student nurse to construct the older person exists a space, an interstice, occupied by a sub-discourse of safety and at-risk in which the older person is objectified as a risky body to be surveilled in a way that is different to how a younger adult person is seen. Foucault's (1978) rule of the tactical polyvalence of discourses directs the researcher to understand there is never just one accepted discourse operating but "a multiplicity of discursive elements that come into play in various strategies" (p. 100). Hence multiple discourses are available to the student nurse to constitute the older person in a particular way that may, or may not, be claimed by gerontology knowledge.

Through disciplinary techniques such as assessment, the student nurse is trained in the art of surveillance, to be alert for evidence of functional decline or of self-management. The student nurse is hence recruited as an agent of the state and versed in disciplinary techniques, including surveillance, thus learning how to maintain a well and healthy population of older people for the benefit of the state (Holmes & Gastaldo, 2002; Foucault, 2000a). A chronological marker, or terms such as 'older person' or 'elderly' alert the student nurse, deploying an age-based safety and at-risk sub discourse (McMurray & Clendon, 2015; HQSCNZ, 2016) to activate heightened surveillance. A safety and at-risk sub discourse produce a taken-for-granted truth about older people that either claims the older person within a functional decline discourse (the fourth age), or continues with a wellness and independence discourse (third age) (Gilleard & Higgs, 2002, 2010; Pickard, 2014). Once claimed by a functional decline discourse, the older person appears to be constituted by gerontology knowledge and nurse education, henceforth requiring differing modes of practice technologies from the rest of the adult population. For some older people a change in physical condition may legitimately necessitate the student nurse utilising different care practices, however the danger is conflating all older people founded on age-based characteristics.

I argue that once recognised through a functional decline discourse, stereotypical assumptions about older people infiltrate both education and practice, offering the older person an unasked-for subject position of frailty and dependency, and as I have discussed, a loss of agency (Baltes & Smith, 2003). A functional decline discourse draws on multiple stereotypical assumptions about ageing that permeate the social milieu and renders the older person as visible to the student nurse. By constructing older people through a functional decline discourse, nurse education deploys apparatuses of power/knowledge that constrain and shut down other forms of knowledge about the older person. A secondary effect is reinforcement of negative perceptions about working with older people who are frail and dependent. There is little interest from nurse education in well-being, with focus on those who exhibit signs of dependence, rather than wellness.

Adding to the discussion, I have coined the phrase 'mind flick' in recognition of an action that appears to be operating when older people are mentioned. I first identified this 'mind flick' in myself when I conflated gerontology knowledge with care of older people who resided in ARC. I recorded my thoughts in my reflexive journal as I realised what I had been doing:

> **Reflexive Journal entry 12th October 2017**
>
> The term gerontology, is widely used and can mean anyone over 65, yet when I use the term my 'mind flicks' to someone exhibiting signs of becoming frailer and no longer part of the work force, it shouldn't but it just does.

This observation had been supported by most participants who assumed my questions on gerontology knowledge related to student nurses working in ARC. This 'mind flick' indicates the hegemonic nature of a functional decline discourse that produces older people with declining functional capacity and perpetuates stereotypical assumptions of ageing. Evidence of the 'mind flick' resonated throughout my thesis and I think sums up how socio-cultural norms perceive older people (Lamont, et al., 2015; Nelson, 2016). This 'mind flick' is, I contend, reinforced by the continued use of the term 'elderly' in contemporary textbooks and some journal publications, as highlighted in Chapters Five and Six.

### *Language and ageist practices*

Authors from a variety of health disciplines question whether ageism, either overtly or covertly continues in healthcare practice. I suggest based on my findings, an inherent ageist discourse permeates all aspects of nurse education, produced through choice of clinical placements, to educational content and textbooks. Palmore (1999, 2005), a frequent

commentator on ageism, regards ageism as a social disease which like racism and sexism, does great societal harm. Overt sexist or racist language is no longer tolerated in nursing scholarship, yet contrarily ageism, in a cloak of social acceptability, remains almost unchallenged (Coleman, 2015; Kagan, 2012; Palmore, 2005; Richardson & Carryer, 2005). Nursing scholarship in New Zealand has acknowledged that ageism, racism and sexism affect care delivery and has introduced an obligation to demonstrate culturally safe practice, as central tenet of nursing in Aotearoa New Zealand, (NCNZ, 2012; Richardson & Carryer, 2005; Wepa, 2005).

To prove culturally safe practice, a student nurse or a nurse must "Practice[s] nursing in a manner that the health consumer determines as being culturally safe" (NCNZ, 2012, p. 13). An indicator on how to demonstrate cultural safety states "avoids imposing prejudice on others and provides advocacy when prejudice is apparent" (NCNZ, 2012, p. 13), thus determining a nurse's actions will not infer prejudicial behaviour. Wepa (2005), appropriating Gadamer's interpretation of prejudice, finds there are enabling and limiting prejudices in nursing. An enabling prejudice could be "a willingness to provide assistance to those in need" (p. 62). On the other hand, a limiting prejudice is "fearing or avoiding contact with difference" (p. 62). Referring to a limiting prejudice I now argue that age-based prejudice is not always called to account in nurse education.

The covert acceptance of ageist attitudes in a nurse/education discourse was apparent when in Chapter Six, two participants referred to student nurses' reluctance to work with older people. The student nurses exhibited ageist attitudes, yet just as noteworthy was the accepting response of participants to the comments. Had the student nurse said 'I don't want to look after Indians, or transgender people, this type of commentary would most certainly incur some form of disciplinary action based around professional standards, whereas an ageist observation was accepted with wry acknowledgement as an occasional occurrence. Throughout education disciplinary tactics are deployed (Foucault, 1995) to ensure practice meets cultural safety standards (NCNZ, 2012). Contrarily, the threshold of acceptable cultural safety standards does not appear to capture commentary that promotes prejudice toward older people. Statements from participants are indicative of the pervasive nature of ageism among the nursing profession despite years of promoting culturally safe practice, and are generally not understood as prejudicial, or drawing on an ageist discourse (Nash, Stewart-Hamilton, & Mayer, 2014). Accepting a student nurse's dislike for working with older people reproduces and supports truth statements

perpetuated within a nursing discourse that caring for older dependent people is less valued and a low status area in which to work (Maben et al., 2012; Palmer & Eveline, 2012).

Language used in textbooks also has a role in disseminating ageist and functional decline discourse. The use of language and terminology has a social purpose; thus, the deployment of various words have effects that may reproduce or modify social practices (Allen & Hardin, 2001). Consequently, it is through deployment of discourse a student nurse may apprehend a common-sense reality about the older person. The use of the word 'elderly' to describe the older person was apparent in both *Potter and Perry Fundamentals of Nursing* and New Zealand journal publications. For example, one statement says "use of OTC [over the counter medications] is common in the elderly and may put them in danger of adverse drug reactions" (Brotto, 2017, p. 779). Then demonstrating how the terms 'elderly' and 'older adults' are interchangeable is exemplified by a heading "Pain in older adults' followed by the statement "elderly clients commonly under report pain" (Douglas & Schoenwald, 2014, p. 1327). The continued use of 'elderly' in contemporary nursing texts is salient as the term is no longer sanctioned by the United Nations nor New Zealand healthcare policy documents (MOH, 2002, 2016b; United Nations Committee on Economic Social and Cultural Rights, [UNESCO] 1995). The word 'elderly' draws on tacit assumptions about ageing and exists as a metaphor for decline, dependency and diminishing responsibility, and is a term used to classify a group of people recognised as such (Avers et al., 2011; Neville et al., 2019). The use of 'elderly' in conjunction with 'older person' has a homogenising effect, constructing all older people in a functional decline discourse and positioning them as problematic.

Surfacing in Chapter Four, were commentaries on how the older person was constructed in nursing textbooks. For example, "the older patient is slower in his movements and responses than a younger one. Attempts to make him hurry often result in confusion, irritation and accidents" (Smith et al., 1971, p. 42). A different construction of older age exists in the twenty-first century that promotes independency, wellness and healthy ageing (MOH, 2016b) and yet it appears not all assumptions have changed or taken up this counter-understanding of older age. Stereotypical assumptions of older age were operationalised consistently in almost all contemporary textual and interview data analysed.

A nurse/education discourse produces a student nurse schooled to detect explicit cues in all older people that reflect societal stereotypical assumptions of older age (Lamont et al,

2015). For example, a student nurse is directed to ask an older person "How are your waterworks going? Have you got any urgency or frequency or have you got a bit of dribbling?" (Bryant et al., 2017, p. 274). The older person is explicitly constructed as different and requiring different care modalities to the younger demographic. Knowledge of a deteriorating body centred on pathology and degenerative changes is repeated and privileged in textbooks and journal articles. Educators then are mandated to divide the older person from the younger adult population and educate the student nurse about what can go wrong with the older body, operating through a deficit model of care. The power/knowledge effect elides and marginalises other possible ways of constructing knowledge around the older person. As a collective, nurse education needs to consider the rules that make these particular constructions of older age repeatable (Foucault, 1972). Nurse educators and authors of nursing textbooks and studies must be directed to critically question the power/knowledge functions that continually constitute older people in respect to pathology, chronicity, functional decline and risk, rather than health and wellness?

## Future options: Everything is dangerous

In a critique of Foucault's work and its application to nursing practice, Cheek and Porter (1997) claim that "a Foucauldian analysis can tell us a lot about what is wrong with where we are, it can tell us very little about where we should go" (p. 113). This thesis has exposed how gerontology knowledge is produced and legitimatised within a nurse/education discourse by biomedical and functional decline discourses. Privileging such discourses, the power/knowledge function is to engender limited and homogeneous accounts of ageing that perpetuate stereotypical notions of older people. Educators and scholars alike regularly call for more gerontology knowledge to be introduced in nurse education, to ensure student nurses are prepared for the ageing population of baby boomers (Bednash et al., 2011; Ironside et al., 2010). If this request is directed at including more knowledge on caring for the frail and dependent older person then the discursive effect is to further delimit and constrain other accounts of older age. Powell et al. (2006) note that for the majority of older people, correlation between declining functional capacity and increasing dependency is not evident until the age of 75 years and beyond. Is this then the demographic gerontology knowledge privileges or do nursing scholars intend to include more knowledge about the well and independent older person?

Such a solution provides an illusory solution at best, as in the current environment a student nurse requires knowledge in the care of the frail, dependent older person to meet the healthcare needs of the institutionalised older person. Gerontology knowledge ostensibly accounts for all older people yet foregrounds the frail and dependent. If age-based indicators were to be removed from textbooks, there is a risk that they might fail to address the very real physical and psychological needs a frail older person may have? I therefore acknowledge that a biomedical discourse is a valid, valuable and credible form of knowledge and responds to our societal desire to maximise our health. However, it is the primacy that a biomedical discourse commands by coalescing with a functional decline discourse that subjugates other equally valid knowledges, particularly in the way student nurses may come to know the older person. A nursing discourse that embodies person-centred care has the capacity to cater to specific needs of all people regardless of age, and yet seemed to be a marginalised discourse in my analysis. Perhaps a solution is for nursing to do what it says it does, and make the person, older or otherwise, the centre of any care decisions.

Foucault (1983) offered a simple solution to this dilemma which is congruent with a postmodern perspective:

> No, I am not looking for an alternative; you can't find a solution of a problem in the solution of another problem raised at another moment by other people. You see, what I want to do is not the history of solutions- and that's the reason why I don't accept the word 'alternative'. I would like to do the genealogy of problems, of problématiques. My point is that not everything is bad but that everything is dangerous, which is not exactly the same as bad. If everything is dangerous, then we always have something to do. So, my position leads not to apathy but to a hyper and pessimistic activism. (p. 231-232)

Utilising this insight from Foucault, the purpose of this project is not to suggest an alternative to the contemporary nurse education system and what transpires as gerontology knowledge. Rather the study's objective is to make visible the discursive constructs of gerontology knowledge that continue to preserve stereotypical views of ageing, and present a homogeneous perspective of becoming an older person. Through illuminating the past and contemporary conditions, it is possible to open up a space where dialogue can occur between nurse education, scholars, gerontology advocates and policy makers to decide what action to take for the future. For direction, Foucault (1983) suggests guidance by an ethico-political choice to ascertain what, in fact, is the main danger. It is outside the scope of this work to offer a solution to the social construction of older people

in western democracies, however the analytical process recounted here has prompted some considerations of options to begin a future dialogue within nurse scholarship.

### *A future path for gerontology knowledge and nurse education*

This doctoral process has brought to the fore many surprises as I applied a more critical approach to taken-for-granted practises and language used in nurse education regarding the person named as older. The continued use of the term 'elderly' in both New Zealand nursing journals and textbooks keeps in place taken-for-granted assumptions about the older person and conflates all older people with a particular understanding of what being old means. Similarly, the paternalistic language that is evident in a number of texts led me to question whether nursing construction and understanding of older people has changed from the overtly paternalistic attitudes of the past. Nursing scholarship needs to take some ownership for the continued and legitimatised use of a limited construction of older people that endures in nursing literature, despite a political will to disavow prejudicial practices and language on a global scale (UNESCO, 1995; WHO, 2017). Removal of terms such as 'elderly' from nursing literature is feasible, although paternalistic attitudes are more ingrained in social practices (Laslett, 1996) and will be harder to shift.

Threaded throughout the project was the contested and contradictory understanding of gerontology knowledge and what particular type of older person it produces. The overt focus on the physiological changes associated with ageing and the care needs of the frail older body inherent in nurse education, requires a more critical stance from nurse education and the wider discipline. Many older people are not constructed by gerontology knowledge: and does that actually matter? Perhaps gerontology should construct the frail, dependent person and not differentiate based on age categorisation. Care practices based on chronological indicators fail to capture the heterogeneity of older people and, I argue, are obsolete as they indiscriminately produce older people within functional decline and biomedical discourses. Age categorisation has a homogenising effect across the whole population of heterogenic older people (Blytheway, 2005). The dependent frail person who requires a particular type of care may be 45, or 85 years of age; age does not dictate need. By truly operationalising and valuing the espoused person-centred approach to care, nursing practices will not be defined by age but by the individual at the centre of their care, hence change may occur. I now offer a suggestion as to a future change that may restore value to foundational care practices through fundamentals of care.

In the time since I began this thesis, a new/old model of care has gained attention in nursing scholarship. The Francis Report (2013) commissioned to investigate poor standards of nursing care in a British Health Trust, reported nursing had lost the core values of caring, compassion and kindness. The report highlighted how nurses and student nurses were not attending to patients' fundamental needs such as hygiene cares, and assistance with food and fluid (Francis, 2013). In response to the report, the International Learning Collaborative group was established with the mandate to investigate what caused this failure in nursing care (Kitson, 2018). Research concluded that nurses had become more concerned with completing technical tasks than taking time to interact meaningfully with patients (Feo & Kitson, 2016). Several issues relating to undergraduate education were identified that lead to a de-emphasis on fundamental cares. First, fundamentals of care were not prioritised nor valued in nursing curricula, tending to be taught in the first year of education and not revisited (MacMillan, 2016; Thomas et al., 2012). Second, to learn fundamentals of care, in respect to physical care needs, student nurses are often paired with health care assistants as nurses complete more technical and administrative work (Annear et al., 2014; Chapman & Clucas, 2014). Third, the subliminal messages student nurses receive during education suggest fundamentals of care are not important and have less value than technical skills (Darbyshire & McKenna, 2013; MacMillan, 2016). All these points are congruent with my research findings, so what is the potential for change?

Arising out of the International Learning Group was a new model of care, the 'Fundamentals of Care' framework (FOC). Core to the effectiveness of the FOC framework is the nurse-patient relationship, founded on delivery of quality fundamental care (Kitson, 2018). As well as the relational aspect of care, the FOC framework directs the nurse or student nurse to attend to routine physical needs of a patient such as keeping someone "safe, rested, clean, mobile, warm and fed" (Kitson, 2018, p. 101). The FOC framework has been piloted in a nursing programme in Australia and found to be an effective way of introducing fundamentals of care to nursing students but also of highlighting the value of both the relational and physical aspects of care (Alderman et al., 2018).

In practice, the basic physical needs of patients in acute care hospitals and residents in ARC are in the main attended to by health care assistants under the direction and supervision of nurses. This situation is not about to change in the current healthcare environment. However, the relational aspects of fundamental care that draw on a nursing discourse valorising care, compassion and the psychosocial imperatives of the patient, needs to be

kept visible across all areas of student nurse education. I recently completed observed structured clinical examinations (OCSE's) with year two student nurses to ensure they are safe to go out into clinical practice. While assessment and technical skills such as safe drug administration were assessed, empathetic interactions were not. My suggestion to a different future, therefore, is for nurse education to value and promote fundamentals of care that define what it means to be a holistic practitioner, particularly when relating to older people requiring care in either the acute care or ARC setting. If nurse education privileges fundamental care equally, or more controversially, above technical and administrative tasks, then working in areas with a greater number of older people who do not require acute levels of care may become valued. Nurse education has the potential to lead change.

Another suggestion for the future in alignment with valuing fundamentals of care, is for nurse education to recognise the heterogeneity of the older population. To value difference in an age-based demographic by recognising older people are not just produced in biomedical and/or functional decline discourses. I propose nurse education promote discourses that construct older people in other ways, such as those focused on wellness. Opening up to other discourses constructs a heterogeneous account of older age that promotes the different and equally valid needs of the person named as older.

At the end of *History of Sexuality Volume One,* Foucault (1978) writes how the future may look back at this time and wonder how it was that things were how they were. The ageing population is considered by many commentators as having economic and political significance. Katz (1992) writing of this economic and political concern, identified a discourse he labelled an alarmist demography. More recently terms such as the 'grey tsunami' have been used by commentators to produce the older population as problematic (Ryan et al., 2018). Statistically, there will be increasing numbers of frail and dependent older people, but also the productive and healthy. Nurse education must reflect on its pedagogical practices and ensure that it presents a heterogenic representation of the older person. Equally important is to position fundamental care of a dependent person, regardless of age and care requirements, as a valued part of nursing work and to promote care of the dependent frail older person as a career option for all student nurses.

### *Limitations and options for future research*

For a research project to be manageable there must be limits to data sourced for analysis. A reading of Carabine (2001) warns researchers that a Foucauldian genealogy could require

reviewing vast amounts of potential data taking a number of years to navigate. Appreciating there were numerous international journal publications and textbooks referring to the older person and ageing I necessarily imposed limits on the literature to be considered data. As a result, research was limited to the New Zealand context, hence reflects only one nation's undergraduate nurse education system. Confining data to the New Zealand context is my first limitation and there are two other areas that I perceive as limiting.

My decision to foreground the three practicum areas in which student nurses could potentially engage with older people meant I used textbooks primarily about experiential learning and nursing practice. As a consequence, I did not include sociology textbooks that referred to theories on ageing and changes across the life course as they were not specific to nursing practice. This may have limited the discourses that are in play in nurse education.

The third limitation relates to the actual content in lectures and tutorials in undergraduate education. Interview participants were in managerial roles, so provided a programme overview. Notably, my interview questions did not seek to discern specific teaching content. A critique of lecture and tutorial content and interviews with lecturers who include knowledge of older people in her/his teaching could have added to the analysis.

Acknowledging that there are limitations to my study, I have stayed true to postmodernism and Foucauldian perspectives by revealing the conditions that exist that led to a certain way of thinking maintaining prominence in nurse education. The hope is by disseminating my findings, the nurse education profession may debate and change the way older people are constructed in nurse education.

The potential for future research is up to the next generation of nurse researchers. Already there is an extensive body of literature about the issues faced by older people when interacting with the healthcare system. Saliently, scant research has traced that critical analysis back to nurse education and the influence of, in the words of MacMillan (2016), the 'hidden curriculum' that determines what student nurses actually learn about older people. Future research should investigate specific teaching and learning practices that occur in lectures and tutorials. For example, what is taught in sociology about the social determinants of health, or chronic health conditions: are student nurses taught to critically analysis the impact of their actions on healthcare consumers? Use of ageist language still

exists. Recently, I heard a colleague directing first year student nurses to consider the social determinants of health of the 'elderly'. The pervasive use of such ageist language needs to be called to account. Nurse education must further research how pedagogical and experiential learning practices perpetuate stereotypical assumptions of older age. To prepare students nurse to meet the healthcare needs of all older people in the future, nurse education must look critically at current practices.

Earlier in this section I introduced the Fundamentals of Care framework and the imperative to return to core nursing practice and values. This initiative warrants further development and research in New Zealand nurse education, in particular with student nurses working in ARC. Finally, I suggest more research that recognises the heterogeneity of older people and ways to introduce student nurses to other narratives of ageing that do not operate from a deficit model. Change in the present construction of older people in undergraduate nurse education is unlikely to occur unless educators become aware of how current pedagogy and experiential learning practices impact on student nurses' perception of working with older people, particularly in ARC. My research findings need to be disseminated so debate and dialogue may begin. I intend to share this study with the wider nurse education community through presenting at national and international nurse education conferences. I will also publish my research findings internationally to gain a wider audience.

### *Concluding statement*

Foucault neatly sums up a potential outcome of a discourse analysis when he suggests researchers consider that while we know what and why we do things, we do not necessarily know what that doing does (Dreyfus & Rabinow 1983). I began this project with a realisation of what the doing does, brought to the fore by student nurse essays on ageing in Aotearoa New Zealand. Drawing on a social constructionist and postmodern approach and utilising Foucault's concepts of discourse, power and knowledge, this thesis brought to light a range of discourses that operate to produce the older person and gerontology knowledge in a particular way in undergraduate nurse education.

Of the array of discourses revealed there were two that privileged a student nurses' construction of people named as older; a biomedical discourse and a functional decline discourse. These discourses legitimise what is considered appropriate knowledge about the older person and marginalise other ways of constructing older people such as through health, wellness, and psychosocial accounts. Deployment of discourses offered older people diverse subject positions, yet the ones that dominated were subject positions of

dependency, frailty, disempowerment and diminished value as a consumer of healthcare. Analysis exposed how the dominant discourses also served to conflate all older people with those who required assistance with ADLs. Likewise, an ageist discourse was evident that has kept in play a raft of stereotypical assumptions about how a person named as older may conducted her/his life. My summation is that the older person continues to be constructed by nurse education in a way not dissimilar to the exclusionary practices evident in the beginnings of the twentieth century.

Throughout this project I have felt, to draw on a biblical analogy, like David opposing Goliath. Every day in the media, in conversation and in my work environment I have been confronted with a social construction of older people so embedded in our cultural practices and norms that change may be slow. I have developed a heightened sense of awareness of language and ageist stereotypical views that permeate all aspects of socio-cultural understandings. However, change is occurring through government policies and a more empowered baby boomer generation, who will soon all be categorised as older people. What difference therefore can this thesis make? The answer is that by troubling, questioning and shedding light on what we do and what it does, I have revealed previously hidden and taken-for-granted truths about older people. Now revealed, and once more widely disseminated, my goal is to generate dialogue so others may also question the current pedagogical practices and effect change in curriculum development. The future direction nurse education takes in addressing the healthcare needs of people named as older must recognise the heterogeneity of this population, and to value the psychosocial aspects of life and to challenge the dominance of the biomedical and functional decline discourses. To conclude this thesis there can be no more apt words than Foucault's (1995) call to arms "we must hear the distant roar of battle" (p. 308).

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# Appendices

## Appendix A: **Ethics**

**AUTEC Secretariat**

Auckland University of Technology
D-88, WU406 Level 4 WU Building City Campus
T: +64 9 921 9999 ext. 8316
E: ethics@aut.ac.nz
www.aut.ac.nz/researchethics

26 April 2017

Stephen Neville
Faculty of Health and Environmental Sciences

Dear Stephen

Re Ethics Application: **17/92 How is gerontological knowledge integrated into teaching in New Zealand undergraduate nursing curricula?**

Thank you for providing evidence as requested, which satisfies the points raised by the Auckland University of Technology Ethics Sub Committee (AUTEC).

Your ethics application has been approved for three years until 26 April 2020.

As part of the ethics approval process, you are required to submit the following to AUTEC:

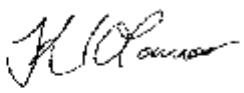
- A brief annual progress report using form EA2, which is available online through http://www.aut.ac.nz/researchethics. When necessary this form may also be used to request an extension of the approval at least one month prior to its expiry on 26 April 2020;
- A brief report on the status of the project using form EA3, which is available online through http://www.aut.ac.nz/researchethics. This report is to be submitted either when the approval expires on 26 April 2020 or on completion of the project.

It is a condition of approval that AUTEC is notified of any adverse events or if the research does not commence. AUTEC approval needs to be sought for any alteration to the research, including any alteration of or addition to any documents that are provided to participants. You are responsible for ensuring that research undertaken under this approval occurs within the parameters outlined in the approved application.

AUTEC grants ethical approval only. If you require management approval from an institution or organisation for your research, then you will need to obtain this.

To enable us to provide you with efficient service, please use the application number and study title in all correspondence with us. If you have any enquiries about this application, or anything else, please do contact us at ethics@aut.ac.nz.

All the very best with your research,



Kate O'Connor
Executive Secretary
Auckland University of Technology Ethics Committee

Cc: pam.foster@toiohomai.ac.nz; Barbara McKenzie-Green

## Appendix B: **Participant/nurse educator information sheet**

# Participant Information Sheet: Programme Area Leads

**Date Information Sheet Produced:**

1st April 2017

**Project Title**

How is gerontological knowledge integrated into the teaching in New Zealand undergraduate nurse curricula?

**An Invitation to participate**.

My name is Pam Foster and I am a graduate student enrolled in a Doctor of Health Science degree through the Auckland University of Technology. I have practiced as a registered nurse for 30 years and currently employed as a senior nurse lecturer and PASM in the undergraduate Bachelor of Nursing degree programme at Toiohomai Institute of Technology (formally known as Waiariki). I am undertaking a research project focusing on gerontology and its inclusion in undergraduate education. My interest in this project arose out of a concern that few undergraduates consider a career in gerontology nursing.

You are invited to participate in this study that reflects on historical and contemporary gerontological teaching in an undergraduate degree that leads to nursing registration. This study will involve interviewing senior nurse lecturers on undergraduate degree programmes who have an overview of the curriculum content. Further details on the research method can be provided should you express an interest in participating in this study. Full disclosure may reveal a conflict of interest and should you no longer wish to proceed you are free to withdraw at any time with no disadvantage to yourself.

**What is the purpose of this research?**

Reports from the Ministry of Health state that 42% of the health care budget is spent on people over 65 years of age. However, contemporary research indicates graduate nurses are reluctant to work with this population, particularly in aged residential care. The purpose of this research is to analyse the development and current status of gerontological knowledge in undergraduate nursing curricula in New Zealand. Of particular interest is how visible is the teaching of gerontology in curricula. My intention is to interview a representative from each institution providing a qualification that leads to registration as a nurse.

Results from this research, once may potentially inform curricula change to better prepare a graduate workforce that meets the health care needs of an ageing population. During, and on completion of my research I intend to present at relevant conferences, for example Australasian Nurse Educators Conference, and to publish my findings in scholarly nursing journals. Data from this research will only be used in academic publications and conference presentations

**How was I identified and why am I being invited to participate in this research?**

You have been identified by your role as a programme area lead or senior academic member of staff. In considering the most appropriate person to invite to participate in this research I concluded a programme area lead or senior academic would be most likely to have a sound overview of how gerontology is taught. I accessed your details from your organisation's web site.

**How do I agree to participate in this research?**

If you wish to participate in this study please contact me via email or phone as per details provided below. Before proceeding to interview you will be required to complete a consent form. This form will be completed in person before the interview takes place, or if the interview is via skype then a consent form will be forwarded to you to be signed and returned before the interview.

Your participation in this research is voluntary and whether or not you choose to participate will neither advantage nor disadvantage you. You are able to withdraw from the study at any time. If you choose to withdraw from the study, then you will be offered the choice between having any data that is identifiable as belonging to you removed, or allowing it to continue to be used. However, once the findings have been produced, removal of your data may not be possible.

**What will happen in this research?**

Your contribution to this research will involve a commitment to a 30 – 45 minute interview. The interview will focus on the gerontological content of your undergraduate degree programme. I will also seek general information on the academic preparation and practice experience of teaching staff in relation to gerontology. The data from the interview will form part of my thesis and may be included in any future publications and presentations.

- The interview will take place at a mutually agreed time and at the venue of your choice. There is also the option to conduct the interview via skype.
- With your permission, the interview will be audiotaped and later transcribed by a professional transcriber who will sign a confidentiality agreement. The audio tape and transcript will be stored in a locked filling cabinet and separate from the consent form. On completion of the study the audiotape and transcript will be stored for six years in a secure location and then destroyed.
- To ensure confidentiality, the term 'senior academic member of staff' will be used, and place of employment will be referred to by a generic term.

Please be aware that due to the limited number of people in your role your contribution may be recognised by a reader. I am unable to guarantee complete confidentiality but would take every opportunity to minimise this risk. This would include using the term 'senior academic member of staff' and a generic term of indicating your place of employment.

**What are the discomforts and risks?**

- A potential risk of participating in this study is that your contribution and your employer may be identified by a reader.
- Another potential risk is the loss of valuable time that you use to contribute to this study.
- As this study involves an analysis of your organisation's current programme there is potential that the discussion could cause discomfort as the intent of the study may generate concerns of criticism.

**How will these discomforts and risks be alleviated?**

I will take all measures possible to minimise risk of identification, including use of generic terminology to situate role and employer. However, the possibility of identification cannot be completely negated due to the small number of education providers in New Zealand.

To minimise the use of your valuable time I intend travelling to you for the interview, or if mutually agreed use a skype platform. Interview times will be arranged to suit your timetable and minimise the disruption to your schedule.

To alleviate any concerns of criticism a brief overview of the research analysis will be provided verbally. All questions will be welcomed.

At any point during the study you have the right to:

- Decide not to participate
- Refuse to answer a specific question
- Ask any questions relating to the study
- Provide any information on the understanding your name will not be used
- Ask for the audio tape to be turned off
- Withdraw from the study up until the time that the analysis has commenced
- Be given a summary of the findings from the study at its conclusion.

**What are the benefits?**

There are no direct benefits to contributing to this study but you will have the opportunity to present your programme's gerontology content. Participation in this research allows you the opportunity to reflect on the future direction of gerontology education within your programme

**What are the costs of participating in this research?**

There are no financial costs associated with participating in this study. The main cost is the time required to be interviewed. The time of the interview will be arranged to cause minimal disruption.

**What opportunity do I have to consider this invitation?**

I will be contacting you via phone or email within the next two weeks to confirm if you consent to participate in this study. In preparation for the interview I will send you a list of potential questions for the semi structured interview. If you have any questions concerning this research please do not hesitate to call myself or my supervisor (details listed below).

**Will I receive feedback on the results of this research?**

On completion of the study, should you request it, you will be given access to a summary of the findings.

**What do I do if I have concerns about this research?**

Any concerns regarding the nature of this project should be notified in the first instance to the Project Supervisor, Associate Professor Stephen Neville: Stephen.neville@aut.ac.nz phone 07 921 93779

Concerns regarding the conduct of the research should be notified to the Executive Secretary of AUTEC, Kate O'Connor, *ethics@aut.ac.nz* , 921 9999 ext 6038.

**Whom do I contact for further information about this research?**

Please keep this Information Sheet and a copy of the Consent Form for your future reference. You are also able to contact the research team as follows:

***Researcher Contact Details:***

Pam Foster at 0800 86 46 46 ext 8790 or email at pam.foster@toiohomai.ac.nz

***Project Supervisor Contact Details:***

***Associate Professor Stephen Neville at 09 921 93779 or email at*** Stephen.neville@aut.ac.nz

**Approved by the Auckland University of Technology Ethics Committee on *26th April 2017*, AUTEC Reference number *17/92*.**

## Appendix C: **Participant/ NCNZ information sheet**

# Participant Information Sheet Nursing Council

**Date Information Sheet Produced:**

1st April 2017

**Project Title**

How is gerontological knowledge integrated into the teaching in New Zealand undergraduate nurse curricula?

An Invitation

My name is Pam Foster. I am conducting this research to complete my Doctor of Health Science degree through AUT University, Auckland. I am a registered nurse and currently employed as a senior nurse lecturer on the undergraduate Bachelor of Nursing degree programme at Toiohomai Institute of Technology (formally known as Waiariki). My nursing back ground is 30 years in acute care but for the last eight years I have been working in undergraduate education. I have a particular interest in gerontology and its inclusion in student education. My interest in this project arose out of a concern that few graduate nurses consider a career in gerontology nursing.

You are invited to participate in this study that reflects on historical and contemporary gerontological teaching within an undergraduate degree that leads to nurse registration. As a member of Nursing Council of New Zealand, I am interested to gain your perspective as to what strategies are being employed to ensure the health care needs of older adults are being addressed in BN curricula. I will provide further detail as to the analytical process should you express an interest in participating in this study. Full disclosure may reveal a conflict of interest and you no longer wish to proceed. You are free to withdraw at any point in the process.

**What is the purpose of this research?**

Figures from the Ministry of Health state that 42% of the health care budget is spent on people over 65 years of age. However, contemporary research indicates graduate nurses are reluctant to work with this population, particularly in aged residential care. The objective of this research is to analyse the development of gerontological knowledge in undergraduate nursing curricula from a historical to a contemporary context. I am also interested in the how gerontology knowledge is assessed in the state final exam. Results from this research, once disseminated, may potentially inform curricula change to better prepare a graduate workforce that meets the health care needs of an ageing population.

I am undertaking this research to meet the requirements for completion of a Doctorate of Health Science. During, and on completion of my research I intend to present at relevant conferences, for example Australasian Nurse Educators Conference, and to publish my findings in scholarly nursing journals.

**How was I identified and why am I being invited to participate in this research?**

You have been identified by your role as education officer in Nursing Council of New Zealand. In that capacity you have an overview of all curricula content and may be able to provide information related to how NCNZ is ensuring a graduate work force prepared to meet the needs of an ageing population.

**How do I agree to participate in this research?**

To participate in this research, you are required to complete a consent form. This form will be completed in person before the interview takes place or if the interview is via skype then a consent form will be forwarded to you to be signed and returned.

Your participation in this research is voluntary and whether or not you choose to participate will neither advantage nor disadvantage you. You are able to withdraw from the study at any time. If you choose to withdraw from the study, then you will be offered the choice between having any data that is identifiable as belonging to you removed or allowing it to continue to be used. However, once the findings have been produced, removal of your data may not be possible.

**What will happen in this research?**

Your contribution to this research will involve a commitment to a 30 – 45 minute, semi structured interview.

*Please be aware that due to the limited number of people in your role your contribution may be recognised by a reader. I am unable to guarantee complete confidentiality but will take every opportunity to minimise this risk.*

*You would be identified as a member of the Nursing Council of New Zealand (NCNZ). However, should you request it your job title, Education Officer would be used.*

The interview will take place at a mutually agreed time and at the venue of your choice. There is also the option to conduct the interview via skype.

With your permission, the interview will be audiotaped and later transcribed by a professional transcriber who will sign a confidentiality agreement.

The data from the interview will form part of my thesis and may be included in any future publications and presentations.

The audio tape and transcript will be stored in a locked filling cabinet and separate from the consent form. On completion of the study the audiotape and transcript will be stored for six years in a secure location and then destroyed.

**What are the discomforts and risks?**

A potential risk of participating in this study is that your contribution and your employer may be identified by a reader.

Another potential risk is the loss of valuable time that you use to contribute to this study.

As this study involves an analysis of your NCNZ's current position there is potential discussion could cause discomfort as the intent of the study may generate concerns of criticism.

**How will these discomforts and risks be alleviated?**

I will take all measures possible to minimise risk of identification, including use of generic terminology to situate role and employer. However, the possibility of identification cannot be completely negated due to the small number of registered nurses employed by NCNZ.

To minimise the use of your valuable time I intend travelling to you for the interview, or if mutually agreed use a skype platform. Interview times will be arranged to suit your timetable and minimise the disruption to your schedule.

To alleviate any concerns of criticism a brief overview of the research analysis will be provided verbally. All questions will be welcomed.

At any point during the study you have the right to:

- Decide not to participate
- Refuse to answer a specific question
- Ask any questions relating to the study
- Provide any information on the understanding your name will not be used
- As for the audio tape to be turned off
- Withdraw from the study up until the time that the analysis has commenced
- Be given a summary of the findings from the study at its conclusion.

**What are the benefits?**

There are no direct benefits to contributing to this study but you will have the opportunity to present your NCNZ position on gerontology in undergraduate education. Participation in this research allows you the opportunity to reflect on the future direction of gerontological education within New Zealand.

**What are the costs of participating in this research?**

There are no financial costs associated with participating in this study. The main cost is the time required to be interviewed. The time of the interview will be arranged to cause minimal disruption.

**What opportunity do I have to consider this invitation?**

I will be contacting you via phone or email within the next two weeks to confirm if you consent to participate in this study. In preparation for the interview I will send you a list of potential questions for the semi structured interview. If you have any questions concerning this research please do not hesitate to call myself or my supervisor. (details listed below).

**Will I receive feedback on the results of this research?**

On completion of the study, should you request it, you will be given access to a summary of the findings.

**What do I do if I have concerns about this research?**

Any concerns regarding the nature of this project should be notified in the first instance to the Project Supervisor, Associate Professor Stephen Neville: Stephen.neville@aut.ac.nz phone 07 921 9999 ext

Concerns regarding the conduct of the research should be notified to the Executive Secretary of AUTEC, Kate O'Connor, *ethics@aut.ac.nz* , 921 9999 ext 6038.

**Whom do I contact for further information about this research?**

Please keep this Information Sheet and a copy of the Consent Form for your future reference. You are also able to contact the research team as follows:

***Researcher Contact Details:***

Pam Foster at 0800 86 46 46 ext 8790 or email at pam.foster@toiohomai.ac.nz

***Project Supervisor Contact Details:***

***Assoc Professor Stephen Neville at 09 921 93779 or email at*** Stephen.neville@aut.ac.nz


**Approved by the Auckland University of Technology Ethics Committee on *26th April 2017*, AUTEC Reference number *17/92*.**

# Appendix D: **Confidentiality agreement**

TE WĀNANGA ARONUI O TĀMAKI MAKAU RAU

## Confidentiality Agreement

*Project title: Gerontology knowledge in undergraduate nurse curricula*

*Project Supervisor:* ***Associate Professor Stephen Neville***

*Researcher:* ***Pam Foster***

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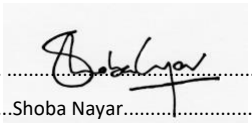
- ✓ I understand that all the material I will be asked to transcribe is confidential.
- ✓ I understand that the contents of the tapes or recordings can only be discussed with the researchers.
- ✓ I will not keep any copies of the transcripts nor allow third parties access to them.



Transcriber's signature: ..... .....

Transcriber's name: .....Shoba Nayar.....

Transcriber's Contact Details:

Email: snayar19@gmail.com.....

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Date: 3rd August 2017

Project Supervisor's Contact Details (if appropriate):

Associate Professor Stephen Neville.....

Email: Stephen.neville@aut.ac.nz.....

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***Approved by the Auckland University of Technology Ethics Committee on 27th April 2017 AUTEC Reference number 17/92***

*Note: The Transcriber should retain a copy of this form.*

## Appendix E: **Consent form**

# Consent Form

*Project title:* ***Gerontology knowledge in undergraduate nurse curricula***

*Project Supervisor:* ***Associate Professor Stephen Neville***

*Researcher:* ***Pam Foster***

- ○ I have read and understood the information provided about this research project in the Information Sheet dated dd mmmm yyyy.
- ○ I have had an opportunity to ask questions and to have them answered.
- ○ I understand that notes will be taken during the interviews and that they will also be audio-taped and transcribed.
- ○ I understand that taking part in this study is voluntary (my choice) and that I may withdraw from the study at any time without being disadvantaged in any way.
- ○ I understand that if I withdraw from the study then I will be offered the choice between having any data that is identifiable as belonging to me removed or allowing it to continue to be used. However, once the findings have been produced, removal of my data may not be possible.
- ○ I agree to take part in this research.
- ○ I wish to receive a summary of the research findings (please tick one): Yes○ No○

Participant's signature: .....

Participant's name: .....

Participant's Contact Details (if appropriate):

.....

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.....

.....

Date:

***Approved by the Auckland University of Technology Ethics Committee on*** ***type the date on which the final approval was granted*** ***AUTEC Reference number*** ***type the AUTEC reference number***

*Note: The Participant should retain a copy of this form.*