Ageing at Work

The phenomenon of Being an older experienced health professional

Ann Paddy

A thesis submitted to Auckland University of Technology
in partial fulfilment of the requirements for the degree of
Doctor of Health Science (DHSc)

2010

School of Healthcare Practice

Primary Supervisor: Liz Smythe

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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, it contains no material previously published or written by another person (except where explicitly defined in the acknowledgments), nor material which to a substantial extent has been submitted for the award of any other degree or diploma of a university or other institution of higher learning.

Signed ………………………………….

Dated ………………………………...

Abstract

This study explores the phenomenon of experienced health professionals ageing at work asking: *What is the meaning of being an older experienced health professional*. The aim was to open up the taken for granted aspects of being an older health practitioner. While much is known about older nurses; for instance that they have intellectual capital and knowledge of the organisation, that their experience benefits healthcare organisations and enhances care of patients, there is little writing that shows what it is to be an older experienced health professional including their own and their managers' perspective.

The philosophy underpinning the research is hermeneutic phenomenology which draws on the work of Martin Heidegger and Hans-Georg Gadamer to uncover meaning. Of the 14 participants, purposefully selected, 10 were older experienced health professionals, from five different professions, and four were managers. The method involved individual interviews with each of the 14 participants. Stories from the interview transcripts were crafted to tell of the lived experience of health professionals ageing at work, and of managers interacting with them.

Four overarching themes that emerged from my interpretation of the participants' stories form the study's findings. They show the way that 'Being the past future and present' constitutes older practitioners' lives; that through the 'announcing of change' older health professionals' bodily ageing is revealed; that their experience of 'being-with others in the world of work' is full of contradictions, of being respected or not. The impact of being experienced and older as they entered 'into the heart of practice' reveals growing in practice wisdom. Yet being an older experienced health professional does not have a single meaning.

Older practitioners and their experience differ; for many the call to care stays with them, for others it does not. The surrounding world is increasingly complex. Older practitioners' ability to adapt and change to meet the ongoing physical demands of practice and their shifting workplace environment determines in part whether they will be valued at work and remain in their roles or whether they will leave. Both managers, particularly those who are younger, and older health professionals need to communicate in respectful ways across generational divides. If health services

are to retain older practitioners, managers too need to make adjustments to their views of older practitioners, recognising the values that underpin their practice, negotiate ways to capitalise on their practice wisdom and organisational knowledge, and in some cases, make accommodations for their ageing bodies.

This study too, recognises and acknowledges the double jeopardy of external and internal change that transforms the lives of older health professionals at work. The meaning of being an older health professional is contained within their years of experience.

Chapter One: Introduction to the Study

Years are not empty containers: important things happen in that time. Why must these years be trivialized? They are the stuff of which people's lives are made. (Andrews, 1999, p. 309)

Introduction

This study's focus is the experience of older health professionals. Older people are not in fact young people in old bodies (Andrews, 1999). They have learned, they have changed, they have gained a container, full to the brim, of experience along the way. This study acknowledges the importance of those years for it is to their ageing and the meaning of their years of experience that this study turns. I came into this research project inclining towards a specific phenomenon. As an experienced health professional I was becoming older. In making the choice to turn away from the world of practice as an occupational therapist to immerse myself in academic study, the question of what it was like to continue practicing towards the end of one's career caught my attention. My interest, that of being an older health professional, leans in to me, calling for me to stay with it and reveal its significance, holding my gaze.

> We are capable of doing only that we are inclined to do… we truly incline towards something only when it inclines towards us, towards our essential being, by appealing to our essential being as what holds us there. (Heidegger, 1993, p. 309)

The call, "to get something underway" (Heidegger, 1993, p. 386) has resulted in this study. In order to draw the meaning of the experiences of older health professionals away from assumed understandings that can cover and hide the phenomenon, I chose the philosophy of interpretive hermeneutic phenomenology to underpin the study. Within this philosophy I have turned primarily to the work of Martin Heidegger [1889-1976] and Hans-George Gadamer [1900-2002].

The Study and its Purpose

At the centre of this research project is the question: *What is the meaning of being an older experienced health professional?* This study offers me the opportunity of questioning and exploring "what something is 'really' like" (van Manen, 1990, p. 42). Do older health professionals add value to service provision? How difficult is it for them to work with the degree of techification now part of practice? Do they

perform with the same energy and competence as their younger colleagues? How easy is it for them to continue to immerse themselves in the busy world of practice? Do they bring to their current practice, values from their clinical education and past practice? Are older health professionals a gift, a liability or both? What is the loss to an organisation when they leave? While these were not the specific questions in my study, they were the prompts behind my thinking, as the participants shared their own stories. The phenomenological nature of this research gives the opportunity to show the difference between the clarification of a theory and the way "theorizing is… made true in real life" (van Manen, 1990, p. 42). To that end, 10 older health professionals were interviewed for this study. Four managers were also included to give a perspective of how others viewed and valued the older worker within a range of health care settings in New Zealand. Why does the study matter? The argument for this study has evolved during the process of carrying out the research.

The Significance of the Research

From the stories of older experienced practitioners, and their managers, this study brings a fresh perspective to an issue that is of wide interest in today's world; having sufficient health professionals to provide healthcare to a rapidly ageing population. Older practitioners live and work in a time of constant change and increasing complexity (Carden, 2007). Consequently there has been an evolving argument for carrying out this research. This study's significance comes from a number of perspectives.

The first perspective concerns the retention and valuing of the expertise of experienced older health professionals. It builds on the argument that as a country, New Zealand cannot afford to have health practitioners leave their professions prematurely, as a consequence of feeling undervalued or dissatisfied. I argue that when health practitioners have built up years of experience and expertise, they are needed as mentors and role models for younger clinical staff and by clients as expert practitioners.

Until recently the numbers of active health professionals, post middle age, in many clinical areas in New Zealand has decreased rapidly. Alpass and Mortimer (2007) have outlined, in a New Zealand Labour Department paper, the way the "Primary Healthcare and Community Nursing Workforce Survey show an older overall

workforce than the general workforce" (p. 22). By implication, this means that more health practitioners will retire each year as the health workforce ages. Similarly in the United States, Buerhaus, Staiger and Auerbach's (2000) research paper "suggest that a fundamental shift occurred in the RN [registered nurses] workforce during the last 2 decades" (p. 2953). With young women having greater career options, fewer become nurses, leading onto an aging nursing workforce. There are indications of a potentially serious shortage of active health professionals in the next 20 years (Ministry of Health (MOH), Occupational Therapy, 2005; MOH, Physiotherapy, 2005).

Yet, recent statistics demonstrate the tendency for some older health professionals to continue on at work beyond what was once considered the retirement age of 65 (Equal Employment Opportunities Trust (EEO), 2009). Despite this, there is a current shortage of dieticians in New Zealand and predicted skill shortages in the long term of dieticians, nurses and midwives, occupational therapists, pharmacists, and physiotherapists (EEO, 2009). The health workforce demographics raise questions about New Zealand's ability to provide healthcare to the increasingly aging population of the future. How do we then set out to retain older health professionals in active practice for as long as is realistic? Health care leaders and researchers (Perkins, 2004; Youngson, 1999) cite a more inclusive style of leadership within health services following the health reforms of the 1990s as one of the answers. The Magnet programme (Carryer, 2010) developed within nursing aims to recruit and retain nurses within health services. But will changes and initiatives such as these slow the tide that draws practitioners away from active practice within their professions?

A second, broader perspective derives from the ageing workforce. The gradual rise in the number of older workers in all Organisation for Economic Co-operation and Development (OECD) countries is demonstrated by workforce demographics (Batini, Callen, & McKibbin, 2006; Canadian Census, 2001; Carden et al., 2007; NOWCC, 2005). As a large number of workers from the Baby Boomer generation (Sherman, 2006) approach retirement, the steadily increasing reduction of workers in some age groups, in a range of professions and in health care services, such as nursing in particular, is also documented (Impact, 1998). Agencies such as EEO

Trust (1999) and the New Zealand Institute for Research on Aging (Davey & Cornwall, 2003) along with the Department of Labour (2002) stand out as leading the way in seeking to clarify the importance of the issue of the ageing worker in New Zealand. Researchers working within areas allied to health, such as educational facilities, are also highlighting and drawing policy makers' attention to a trend. That is, the loss of older staff along with a decline in the number of younger staff coming through, which has the potential to dramatically change the shape of New Zealand's future workforce. Alongside this is the suggestion that "society could no longer afford the costs of early exit" (Loretto, Duncan, & White, 2000, p. 281).

A further perspective comes from societal attitudes towards older people. Such attitudes carry through into employment practices. We live in an era where youth is valued over age with Wilson, Parker and Khan (2007) saying, in a research based study, that because of ageist stereotyping older workers are seen as less employable than younger workers. International research shows that older workers are more likely to be made redundant (Alpass & Mortimer, 2007; Wilson et al., 2007) and are less likely to be up-skilled and/or retrained (Wilson et al., 2007). This discrimination against older workers sits alongside a change in New Zealand law the Human Rights Act (Human Rights Commission, 1993) that should stop such ageism yet "age discrimination continues" (Alpass & Mortimer, 2007, p. 30). From a mandatory retirement age, the Human Rights Act has allowed people to decide when to retire. At a time of labour shortages, New Zealand needs its older workers to remain in employment and it is now deemed unlawful for employers to act in an ageist manner (Human Rights Commission, 1994). But how successful are such Acts when put into practice in the workplace? Evidence from a New Zealand and a British study (McGregor & Grey, 2002; McVittie, McKinlay, & Widdicombe, 2003) reveals that ageist stereotypes, of both a negative and positive nature, still exist and are generally 'bought into' similarly by both workers and their employers. Clearly making ageist discrimination unlawful does not necessarily change workplace attitudes and culture.

Congruent with this change in age of the workforce, is the acceleration of aging of New Zealand's population generally. A number of factors can be seen contributing

to the resulting imbalance; increasing life expectancy and the decline in the birth rate (Statistics New Zealand, 2007), along with the Baby Boomer generation. Significantly, as people grow older, more health professionals will be needed to work with the increasing number of ageing people requiring health care services. This study brings the personal to the general; the voice of experienced older health professionals saying what it means for them to be working at their age within healthcare. Hearing their stories and the meaning drawn from their experience gives the potential to reveal at a deeper level the issues that employers need to understand in order to develop inclusive workplace cultures within healthcare services. Inclusive workplace cultures are needed, now, and in the future to assist in the retention of older health professionals within healthcare practice.

Unpacking the Research Question

The research question brings to the fore a number of diverse elements of language, where every word indicates something; yet, each person will bring his or her own perspective to their possible meaning. The following section opens up those understandings, articulating my intention behind the use of the specific words.

Being Older

I begin with the word **old** as defined in The Oxford English Dictionary Volume X (Simpson & Weiner, 1991a). To be old, auld in Old English, is "to nourish, bring up [to be a] grown up adult" (p. 759). Though the word **elder** is still used, it has been "superseded by **older**" (p. 759). Old signifies "having lived or existed a relatively long time [as] opposed to young" (p. 759). Thus, old is also a word that "distinguishes the thing spoken of from something of the same kind newer or more recent" (p. 761). In using the word older I am distinguishing the participants from those who are younger, working in the same fields of clinical practice, rather than indicating that they are better or worse. The Oxford English Dictionary points out that **old** can be used disparagingly. Along with the words old and older is that of **ageing** used in Volume I of the Oxford English Dictionary (Simpson & Weiner, 1991b), as in "the unfortunate effects upon us of ageing" (p. 247) and "becoming aged, showing signs of advancing age" (p. 247). This brings me to wonder about comparisons between young and older practitioners; whether the signs of being older that inevitably come with ageing are viewed as a positive or a negative attribute in terms of a health professional.

So it is that the older practitioners, 50 years and more, are advancing in age, further from their beginning and rather closer to their end. The older health professional participants in this study were 50 plus, in age, at the time of interviewing. While they are older they do not fit into the category as 'old - beyond working age'. While two of the older practitioners were on the cusp of retirement many of the others intended to continue working into the future at the time of the study.

Being Experienced

In order to ensure that participants had a depth of clinical experience the inclusion criteria of 10 or more years was a requirement for the recruitment of older practitioners. Being experienced is an integral aspect of what it means to be an older health professional in terms of this study. Coming originally from the Latin word *experientia* (Harper, 2001) the word **experience** is defined in The Oxford English Dictionary Volume V (Simpson & Weiner, 1991c), as "to make trial or experiment of; to put to the test; to test try" (p. 563). In this way, the practice of older health professionals will have been put to the test in their practice encounters. Over the course of years, they will have undergone a repetitive process of meeting the same or similar situations, providing a layered foundation on which to build, a foundation that has the potential to strengthen practice. **Experience**, also meaning "to be informed or taught by experience" (Simpson & Weiner, 1991c, p. 564) is relevant, as clinical experience, along with the learning the skills of practice and life experience, enlighten and teach the health practitioner. So the meaning of the word experience relates to being put to the test, to meet with, to feel, suffer, to undergo. Experience then is both an acquiring and learning; but it is also felt in relation to senses and emotions.

Returning to The Oxford English Dictionary Volume V (Simpson & Weiner, 1991c), we find that **experienced** means "of persons, their faculties and powers. Having experience; wise or skilful through experience" (p. 364). Here experience alludes to wisdom and skill. How do qualities such as wisdom and skill show themselves, are they observed in practice or can it be assumed that years of practice automatically bring these qualities with them?

Being a Health Professional

I have used the term health professional to describe the older participants in this study who work in clinical roles. The participants came from a range of health professions within nursing, midwifery and allied health. I elected to include this group of health practitioners as there are similarities between their qualifications and employment conditions. While there is some diversity there are also commonalities. As 20 years was set as the minimum number of years since completing their clinical education, unlike the current cohort of recently qualified health practitioners, none of the practitioners were able to qualify for an undergraduate degree as health undergraduate degrees were not then a part of the health education system in New Zealand. Whereas now, all these health disciplines are required to have undergraduate degrees in order to register for practice. While I generally refer to these participants as health professionals, I find this term unwieldy when used repeatedly and have therefore chosen to use the terms health practitioner and clinician.

The Inclusion of Manager Participants

Initially I planned to interview only older health professionals as it was their experience that was at the core of the study. It was as I developed the research proposal, and considered where understanding and insight within the research project might come from, that I recognized that a wider view of the meaning would open up other ways of seeing. Thus, I included a manager group of four participants. Their voices offered a perspective of how older health professionals are viewed by others.

Coming to the Philosophy

To decide to use Heidegger's writing to underpin a research project is to open up 'a can of worms' where what seems within grasp remains elusive, where understanding becomes layered, complexity abounds, where all the while the questioning comes back to fundamentals regarding what it is to be human. Yet choosing the philosophy was an easy decision. I came to have some understanding of Heideggerian notions during the thinking and writing of my Masters thesis (Paddy, 2000). On reflection this engagement was of a relatively light, playful kind. Even so there were struggles to get to the deeper level of analysis, to write in a way that connected linguistically with the philosophy of interpretative phenomenology.

Interacting with work centred on the writing and thinking of teachers such as Nancy (2001, 2009) and John Dieklemann (2005, 2009), Liz Smythe, Melinda Swenson and Sherry Sims (2006) drew me in, further opening up the richness of the philosophy. Since then, my engagement with interpretive phenomenology has deepened. Yet it continues to be a challenging journey.

> Heidegger was constantly 'on the way'. Never at the end of a lecture, book or essay by Heidegger do we feel that we now know what he believes. His answers to questions invariably raise deeper questions… He is working out problems as he goes along. (Inwood, 2006, p. 1)

It seems too that I am always 'on the way' to understanding but have not yet arrived; thinking, 'so this is what it means to engage with Heidegger, to never reach an ultimate answer, to always be puzzling, facing new challenges to understanding'. True to the methodological approach, I find myself immersed and situated within this study, rather than as an objective outsider, looking in at the data. Van Manen (1990) said that "a real understanding of phenomenology can only be grasped by actively doing it" (p. 8). The philosophy looks to raise questions that relate to meaning rather than what happened or why something happens. While no ultimate truth is arrived at, the human experience being explored is opened up to deeper engagement and greater understanding through the deepening questioning. Just as coming to the philosophy has been part of a personal journey, another aspect has been the evolving development of understanding the subject area.

My Horizon to Understanding

My prior understandings about what it is to be an older experienced health professional have been formed within a number of my work roles. Many of those roles significant to this study link to health care provision. They are: over a 10 year span, being initially a younger and then later an older community occupational therapist, working with older health practitioners, alongside being part of multidisciplinary teams consisting of practitioners spanning a range of ages. In my late forties, I began what became 6 years of working in a split role consisting of managing a team of occupational therapists that included older practitioners, along with a clinical role as a community occupational therapist. Later as a professional leader in an occupational therapy advisory position, by then in my late fifties and early sixties, I worked with occupational therapists of a wide range of age groups. At times older practitioners were my colleagues, people who reported directly to

me, and my friends. These evolving relationships, and ages, added to the complexity of my work.

Sitting alongside judgements coming from work roles are the personal values and beliefs that come from my experience of being-in-the-world. My life experience gives a horizon to my understanding (Gadamer, 2004). One of the tensions in coming to a study of this nature is that rather than knowing too little about the phenomenon of interest, is perhaps that I know too much (van Manen, 1990). Thus assumed understandings can get in the way of what is less obvious. I acknowledge that they are part of what brings me to the study, making me mindful of their possible influence. Congruent with the chosen methodology, where an openness of attitude is required, I was interviewed by a fellow doctoral student, Valerie Wright-St Clair, prior to starting the research. I found this useful in bringing to the forefront of my mind the prejudgements and presuppositions that I hold as the researcher. During the approximately hour long interview I was asked about what drew me to the research, and the thinking that could impact on the study and interpretation. My responses included the following.

My Prejudgments

Experience is Valuable

The first pre-understanding I held is that experience has value that it is important to the role of health professional; that practitioners who brought experience to their practice had something significant to offer health care services, and had an advantage over less experienced practitioners. However, working with older practitioners who continued to practice in purely clinical roles led me to believe that they, and their experience, may not be valued by managers and younger practitioners within their work world. Despite this, older practitioners who stayed for longer periods at work held institutional knowledge, and frequently provided 'the glue' that held the place together as younger workers moved on through the system. Remaining in clinical roles seemed to relate to caring passionately about the clinical aspects of being a health professional. I wondered if their longevity in their roles was equated by others with lack of ambition or progress. One of the insights from this reflection was that the potential that experience offered may not always

have been drawn on in practice. Like any attribute it can be used positively or be neglected.

I questioned what lay behind the seeming reluctance of some District Health Boards (DHBs)[1], to reduce full time hours, or to create part time roles that offered older practitioners the option to work longer. It seemed that older clinicians had at times chosen to leave their roles prior to retirement, to work in less physically demanding jobs. My hope then is that this research will add to the call to value and acknowledge the wisdom that practitioners' age and experience can bring to healthcare practice.

Older Experienced Health Professionals Create Barriers to Change
A pre-judgement I have regarding older health professionals is that when unhappy or weary of work, they became reluctant to accept or be involved in new initiatives. Those who feel most disillusioned consequently avoid interaction with decision makers in management, leaving them unable to influence the way change or progress occurs. Paradoxically they can also be outspoken critics of any change, causing ambivalence amongst younger practitioners about older practitioners' negativity. Communication failures seem to occur between older practitioners and others. On reflection I need to maintain my awareness of my belief that older practitioners' attitudes can be a barrier to change and the way this may impact on my interpretation of participants' stories.

Older Practitioners bring Differing Beliefs and Values from those of Younger Staff
Another of my assumptions was that older practitioners brought values from both their personal background and their clinical education, that for many of them came from the distant past. As a consequence they could be viewed as holding out-of-date ideas and values. Such value and belief systems did not necessarily fit within the new world of healthcare and could result in conflict in the healthcare environment when the 'old fashioned, hands-on care' of the past was exchanged for streamlined systematised evidence-based practice. The changes that were a consequence of the New Zealand health reforms of the 1990s, with their focus drawn away from clients to a focus on budgetary constraints had, I believed, further alienated older

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[1] District Health Boards (DHBs) are responsible for providing, or funding the provision of health and disability services in their district. There are 20 DHBs in New Zealand and they have existed since 1 January 2001 when the New Zealand Public Health and Disability Act 2000 came into force.

clinicians. Many of the older practitioners received their clinical education in the 1960s when helping others, altruism, was frequently seen as a driver. This then may have altered their expectation of what should happen in the workplace. I expected that there would be a differing focus in the recent education of health professionals that shaped how graduates expect to practice. I need to maintain my awareness of my belief that the education and subsequent values of older health professionals differ from other practitioners.

Older Health Professionals Struggle with Modern Technology
During my years of practice I have been aware of older practitioners sometimes struggling to work with the systems that modern technology brought to their workplace. Sometimes they mastered the new systems, or learnt the skills, but it took time as, unlike younger practitioners, they were unfamiliar with this technology in other aspects of their life. It seemed that management became impatient with the time that it took older practitioners to adapt to changes and systems, and did not always allow sufficient time and opportunities for older clinicians to 'keep up' with evolving systems. This raised the question, was my belief that older practitioners struggled with the new technology influenced by a general perception of older workers?

Ongoing Education Impacts on Older Practitioners Disproportionately
My understanding from past experiences as a clinician and professional leader was that at times there was a bias against older health professionals accessing ongoing education and skills-based courses. Because of their age, they may have been seen as unlikely to stay in the service long enough for there to be a future benefit. Paradoxically the new competency requirements for all New Zealand health practitioners demand that all practitioners maintain and upgrade their professional skills in order to stay current with health care practice. I came into this study believing that these two conflicting interests provide a tension in healthcare services that has not been resolved.

While these fore-structures to understanding accompanied me throughout the study, my awareness and understanding of their potential to impact on my approach to interviews and stories was raised. Through their heightened visibility I remained

mindful that they were 'already there', likely to influence my thinking, as I listened and interpreted the experiences of participants.

Overview of the Thesis

This study sets out to explore the experience of being an older health professional. I recognize that my history and beliefs accompany me throughout, that I am a part of the research process, as a researcher and older health professional. When I came to write up the research, I began with the stories that form the four findings chapters, the other chapters followed. Here the ten chapters of the thesis have been placed into a logical sequence. The following layout of the whole of the work begins with an opening, and ends at the conclusion, allowing for an easier read, easing the reader into the complexity of an interpretative phenomenological study. While each chapter stands alone they all interconnect, building upon each other.

Chapter One: The introduction has set the study in its context. It has laid out the approach to the project, leading the reader into the study, providing a path to follow in terms of my own understandings and the philosophical approach taken. My pre-suppositions and beliefs have been outlined.

Chapter Two: The context of this study is further explored by setting out the aspects that surround the focus of the research, the changing world of health care and other issues that impinge on or are significant to the study focus of older health professionals.

Chapter Three: The literature review examines literature relevant to the research question. The stories that are told through research, by demographics, and in other sources such as newspapers are drawn on to show the differing perspectives regarding the focus of the study, being older and experienced as a health professional and worker.

Chapter Four: The methodology brings the reader to the philosophy underpinning this work and shows how the study is informed by the work of Heidegger [1889-1976] and Gadamer [1900-2002]. The major hermeneutic phenomenological notions congruent with the study are explored. This enables the reader to become familiar with the philosophy that becomes more apparent in the findings chapters.

Chapter Five: The research design is outlined providing the step by step process of doing the research to the reader. It shows the links to the methodological approach and the recruitment and interviewing process, connecting the various aspects of the method finishing with an outline of the study's trustworthiness.

Chapters Six, Seven, Eight and Nine: These four chapters make up the findings chapters. Within each chapter participants' stories guide the writing and analysis as they are structured into themes.

- **Chapter Six:** Being the past, future and present, revolves around Heidegger's notion of lived time as integral to being an older experienced health professional.
- **Chapter Seven**: The announcing of change, explores ageing at work for older practitioners.
- **Chapter Eight**: Being with others in the world of work, reveals the meaning of older health professionals' interaction with others.
- **Chapter Nine**: Into the heart of practice, goes to the core of the work of older practitioners, their clinical practice.

Chapter Ten: The discussion and conclusion draw the significant findings from each chapter into a whole, linking the parts and revealing their significance. These findings are discussed in relation to the relevant literature. Recommendations for health care managers and professional leaders and for older practitioners are shown. Limitations of the study and implications for future research are also outlined.

This study opens up the issue of the valuing of health practitioners as they age at work. It aims to show the lived experience of older practitioners within health care settings, making visible the meaning of their experience along with the meaning of managers' experience of working with them.

Chapter Two: Context of the Study

Understanding is essentially a historically effected event.
(Gadamer, 1975/2004, p. 299)

Introduction

Older health professionals in New Zealand are faced with a rapidly changing world. Much as it occurs elsewhere, in OECD countries, change comes at them from all sides. It is to that background of change that this study now turns. In order to understand what they are confronted with in the world that surrounds them today, we need to understand something of what brought them to this point in time. Yet, Gadamer (1975/2004) tells us that "we are always already affected by history" (p. 300), so that our looking back brings its own understandings to the reflecting. Hence, our context matters, for we are all part of the world we live in and that world assists in making us who we are. Heidegger (1927/1962) says that part of our Being is that we have a world. Exploring that world allows the phenomenon of being an older health professional in New Zealand to be seen more clearly through its historical roots. Such a context draws on the past future and present.

Looking Back

Through looking back we consider the influence the past has had on those older health professionals still practicing today. In order to situate older practitioners in their context, we turn back to get a glimpse of what it was like for health practitioners leading up to the 1960s, when the oldest of the study participants received her clinical education, and to consider the flow on effect. The 1960s and 70s were very different times for novice health professionals to practice than the first decade of the 21st century has been for newly qualified clinicians. Just as there is a majority of older women practitioner participants in this study, the health workforce also has such a gender imbalance. This along with the health reforms of the 1990s will be explored, showing the continuing impact of the past.

A Past World

Detailed in a social history, The Legacy of Occupation (Gordon, Riordon, Scaletti, & Creighton, 2009) are stories dating from the 1940 to 1972. These stories open up the past of a New Zealand health care profession, occupational therapy. Noeline

Creighton (cited in Gordon et al., 2009), who entered training to become an occupational therapist in 1955, describes the social milieu of that time:

> New Zealand in the 1950s was prosperous and comfortable. World War II was over, rationing was a thing of the past and there was full employment. School leavers walked into jobs and students who were studying for careers, including teaching, nursing and occupational therapy were paid to train… Hotel bars closed at 6 o'clock at night. There were few restaurants… Young women and their mothers made their clothes… We wore hats and gloves when we went out [and] few married women were in paid employment. (p. 143-144)

It is likely that this was a time when the world seemed ordered and safe. With the end of the war New Zealand came into a time of relative prosperity, a time when the nation could afford to pay nurses and occupational therapists, as well as other health professionals, to receive their clinical education (Gordon et al., 2009). Congruent with this were the rigid boundaries about when alcohol could be drunk, and when, for some, appearances counted, as young women, wearing homemade clothes, set out to give an impression of being 'ladylike'. It was also a time of formality when women wore hats and gloves for important events, when social traditions and mores influenced behaviour impacting on people's choices and decisions. While this description of students in that time and context may align with a middle class perspective, the many stories outlined in The Legacy of Occupation (Gordon et al., 2009) depict the student context during that time.

Ellen, a participant in an Australian family history study (Wicks & Whiteford, 2005), with participants born between 1924 and 1935, tells what happened for her:

> I decided to go nursing… I was not going to have children until I had… lived my life. But I did get married, at twenty, but I had to keep that secret for my nursing… I did start to have a child. And it was evident, of course, I had to give up nursing. (p. 205)

Despite her best intentions, life events took hold of Ellen's existence. These events meant her giving up something important. Then, priorities were obvious and were clearly understood with the social expectation that when the time came, women would put husbands and families first, leaving their careers behind them. In this way many young women were lost to their careers as health professionals.

A Workforce Out of Balance

Workforce surveys show that within the health workforce there is a predominance of women in 'hands on' clinical roles other than medicine (MOH, 2005). There is much philosophical and sociological writing on the gendered[2] division of labour and how this arose, reaching well back into history.

Both the Industrial Revolution, beginning in the late 18th century in Britain, with its breaking up of the family economic unit, and the first and second World Wars which caused labour shortages in industry, altered what happened in terms of women's roles. In the first instance, women came to work more within the confines of the home; with their economic role restricted and controlled to a greater degree by men who went out to work (Bradley, 1994). In the second instance, the labour shortages brought women into working areas and roles previously allocated to men; such as family business, retail, and farm management in the First World War and during the Second World War into industry. At war's end there was an expectation, from men in particular and society in general, that women would move out of these work roles and return to the private sphere of the home. Frequently this did not happen (Frontier of Dreams, 2005). While women were now working in broader fields of employment there seems to have been little alteration to the pervasive belief that linked women to the private sphere of home (Bradley, 1994).

Though many women had come to be employed outside the home, with the doctrine of separate spheres of work still dominating, work that was suitable for women then needed to be defined (Bradley, 1994). Women frequently entered the workforce as part time workers with responsibility for the care of their children. They also entered professions that were seen as compatible with their 'main' role in life, as wife and mother. Frequently those were roles within education and health care. Bradley (1994) notes that women's workplace culture still exists in traditional female professions saying that, "hospitals and schools mirror family relationships and in them women practice their 'inbuilt' feminine skills for the public good" (p. 155). Following the second world war, there was also the stress of living with different demands at a societal level; that New Zealand women would stay at home

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[2] Gender refers to the social division and cultural distinction between men and women, rather than their natural or biological differences (Jackson & Scott, 2002).

full time involved in domesticity, including looking after children, and the conflicting need for them to be in paid work outside the home, in order for their families to take advantage of the new prosperity (Du Plessis, 1994).

As the power relationships between men and women relates to the society they live in, gendered patterns vary in time and place (Wicks & Whiteford, 2005). Coming from the perspective that "gender influences the way life is experienced" (Wicks & Whiteford, p. 198), I ask the question, how much did those gender related practices impact in New Zealand on the period this study is set in. Did gender, for instance, constrain the options of individual women when making a choice regarding education or work? How much of this choice was influenced by familial and societal expectations of their time? A quote from a personal narrative group, in 1989, suggests one answer to these questions: *Women make their own lives, but do so in conditions not of their own making* (Wicks & Whiteford, p. 198).

It seems that even when women believe that it is their choice of career or work, the context to those choices can channel them into making particular decisions. Given that "the definition of certain occupations as 'male' or 'female' is not just a matter of personal choice; [that] institutional mechanisms perpetuate these mechanisms and the distribution of people into jobs" (Du Plessis, 2004, p. 101), it was not surprising to find women falling into certain occupations. Similarly, beliefs and expectations in the 1950s regarding what was suitable for women impacted on the range of career choices for girls. In some educational facilities, in 1952, science subjects were still seen as boys' subjects and were not available to girls. This would have narrowed the options for people like Jeanette Vesey:

> My Ashburton High School education led to limited openings at a time when girls were unable to take science subjects. We had to do home science. Vocational guidance suggested I do occupational therapy. I liked people and crafts. (Gordon et al., 2009, p. 24)

In the 1950s, with the perception that 'liking people and crafts' were significant attributes to becoming an occupational therapist, the lack of science subjects would not be the same barrier to entry that they would be for prospective students in future eras. Such subject restrictions will have impacted on the choices of young people

entering health care professions; the people who are now older health professionals and possibly participants in this study.

A study by Middleton (1988), that explored gendered education with participants who were born in the late 1940s, revealed the dual expectations for young women in academic classes. On one hand it was assumed that young women would prepare themselves for careers as professionals; while on the other, they were also being prepared for lives as unpaid housewives. At that time "compulsory lessons in clothing and cooking were to remind young women that their true vocation was in unpaid domestic work at home" (Du Plessis, 2004, p. 108). The dual demands of their life to come were already there in their education. Squires (2008) discussed the experience of nurses in relation to social change. As the participants in Squires study were all women 60 years and over, in their twenties and thirties during the 1960s and 70s, they would have "experienced the second wave of feminism" (Squires, p. 83), when the world around them was thrown into new configurations that both examined and questioned the exploitation of women through roles traditionally defined for women. It was a time when returning to the workforce was not something that happened easily because of the lack of structured support for their families. Some of the nine women older health professionals, in this study, will have had experiences that aligned closely to the older nurses in Squires' study.

There are a number of reasons why the proportionately heavy numbers of women are significant in today's health workforce. Women are more likely to work part time and have leave of absence during child rearing years; therefore, they do not have the same opportunity as men to build wealth (Buchan, 1999; Hugman, 1999). Women also tend to be paid less in the roles they work in (Du Plessis, 2004) and have less ability to put money away for their retirement (Buchan, 1999; Hugman, 1999). Because of their lesser earning ability, women have little to lose by moving into alternative careers away from their health practitioner roles. Women live longer than men. This means that the money they have put aside is less likely to last throughout their retirement. As a consequence, women tend to be worse off financially during retirement and in danger of becoming marginalized. Hugman's (1999) Australian study shows that women's access to the medication needed in old age, along with good housing and transport, can be put at risk. Writing about

ageism, Rosenthal (1990) says that "for women as they age, the intersection of ageism with sexism can be devastating, in circumscribing their activities and controlling their self image" (p. 1). Thus for women as a group, remaining in their professional roles as long as they are able and willing to continue practicing will not only benefit healthcare organizations, it can also benefit them. One aspect of remaining in work roles is that of being caught up in the sweeping changes that occur at intervals in the world of healthcare.

The Impact of the 1990s Health Reforms

During the 1990s New Zealand followed a trend in developed countries of attempting to pare back escalating health costs. The escalation came as a consequence of new technological and medical advances that were causing healthcare costs to spiral out of control (Carden, 2007). Believing that a commercial approach would reduce costs, the New Zealand Government took a radical reform approach (Easton, 2009) with the intention of privatising New Zealand's Public Health Services (Easton). Funding was split between four Regional Health Agencies (RHAs), the funders that would purchase health services from twenty three Crown Health Enterprises (CHEs). The CHEs role was to provide health care services throughout the country. The intention was for decision making in health to move away from clinical management to commercial management. Early in the reforms, the working environment was experienced by health professionals as having deteriorated, resulting in low staff morale (Ashton, 1999). Cost cutting was such an implicit aspect of the 1993 reforms that clinical staff felt pressured by an expectation that the previous service would be provided on less money. In their paper on the value of dignity in the work life of nurses, Lawless and Moss (2007), drew on the work of Beil-Hildebrand (2002), Hofmeyer (2003), and McCloskey and Diers (2005) when referring to "the move to a cost control focus in many health environments in the late 1980s and early 1990s, which fundamentally changed the way nursing work was organised and valued" (Lawless & Moss, p 232). Consequently turnover of clinical staff in the health services was at historically high levels (Gauld, 2001) due to the constant and rapid changes imposed on clinicians. Perkins (2004) described clinicians needing to be involved in decision making as this would give them control and a connection to what was occurring in the service.

Following the reforms, with a tension between clinical values and commercial values, antagonistic relationships developed between managers and clinicians which later improved (Ashton, 1999; Youngson, 1999). Health professionals also had concerns that the new systems compromised patient safety (Ashton, 1999). There was also considerable secrecy regarding commercial sensitivity as a consequence of health services initially adopting a competitive commercial style. This organisational secrecy contributed to the sense of isolation of health professionals (Ashton, 1999) and would have impacted most on older practitioners. Their past experience, prior to 1993, will have been that of working in health care cultures where communication across services was of a more cooperative and collegial nature.

The impact of the loss of clinical advisors (Youngson, 1999), with their depth of clinical knowledge and professional leadership strengths, will have added to the uncertainty felt by older health professionals. Professional advisors would have been the people frequently relied on to maintain stable working environments providing a buffer between clinicians and management driven change.

Challenges to Health Professionals as 'Expert'

By the 1990s health professionals found themselves in a changed environment where their professional authority, their sense of being 'the expert' (Benner, 1984) in the client/practitioner relationship was being challenged on all sides; by client and their families, by caregivers and by consumer advocates (Youngson, 1999). At times challenges would have come from health care clients as a consequence of their familiarity with advancing technology, the ready transmission of information, along with their desire to use those advances for their own benefit. For some practitioners such relationships will not have presented as a challenge. At other times older practitioners will have risen to the challenge of practicing differently, in a more reciprocal manner. Globalisation offering increased access to cheaper goods would have also impacted on what clients saw as available to them. Alongside this, what was available in one part of the world was now recognised and desired world wide. Advocates increasingly came to support consumers in their expectations of health care services. While this change was beneficial and enabling for clients, at times clients' wishes and demands would not have fitted with what health professionals could provide, creating a tension. For older practitioners this would

have meant a changed relationship, with a need to work differently with clients, and at times feeling they had less to offer.

Other challenges were arising for health professionals. An impact of the emerging consumer rights and disability rights movements saw a number of Acts that supported healthcare clients brought into law by New Zealand governments. The Privacy Act (1993) designed to protect clients, tended to make communication more complex and challenging for practitioners. The introduction of the internet also dramatically changed the power relationship between clinicians and patients as patients came to gain total access to information about their health conditions. While younger health professionals would have been a part of those changes, older practitioners would have found themselves in a different world. For older health professionals these questioning relationships, with challenges to their expertise, are likely to have been experienced as threatening. In the past health professionals will have been accustomed to working from a different perspective where the clinician was regarded as the 'expert' directing the care on the basis of their knowledge and clinical expertise. When the client expected to be treated equally, with their expertise respected, this would have challenged, undermined even, the health professional's perception of themselves as 'expert'.

Health Care Clients as Consumers

With the advent of the Code of Health and Disability Services Consumer Rights (Health and Disability Commission, 1994a), the client was officially no longer someone who things were 'done to' by health practitioners, but became a consumer of health services with rights, such as 'the right to respect' which is described as the "key to the code" (Health and Disability Commission, 1994b, p. 4). Patients as consumers were expected to be treated with dignity, valued as individuals and given choices. Patients had the right to complain about health professionals' communication and the quality of their care (Health and Disability Commission, 1994b). It is probable that patient choice, while seen as necessary for the patient (Ham, 1997), was also demanding and testing for health professionals. A new way of working was required and while some older workers will have risen and faced up to the changes, for others there will have been tensions in the changed relationship. It is likely that older workers were horrified, for instance, by managers' use of the term 'consumers' to describe 'their' patients/clients. With the introduction of

professional codes of ethics and an act that protected consumer rights, along with expectations of greater accountability to healthcare services (Allen, Oke, McKinstry, & Courtney, 2005), clinicians may have found their relationships with clients even more challenging.

Threat of Deregistration

Youngson (1999) described many health professionals as having felt under threat by the multiple changes during the 1990s with challenges to their professionalism. The intention of professional codes of ethics was to "promote or guide moral values" (Wright-St Clair & Seedhouse, 2005, p. 21); yet, they are more likely to simply guide judgements (Wright-St Clair & Seedhouse). However they do have some authority as health professionals have been deregistered by their professional boards for not meeting their profession's Code of Ethics. Other practitioners have experienced complaints being made by patients or their families to The Health and Disability Commissioner. In instances where discrimination by a health professional or manager has been the focus of the complaint it can be passed on to the Human Rights Commission (1993) which upholds the Human Rights Act. For older health professionals these challenges and perceived threats from professional boards and new government Acts, coming after what must have seemed like many years of independent professional practice, are likely to feel onerous and possibly unnecessary.

Shifting Perceptions of Professionalism

During the 1993 reforms there was a major shift in power. At the time of the health reform the New Zealand government took away some of the situatedness of medical decision-making of doctors where decisions had tended to be based on bringing their knowledge and understandings to the patient in front of them (Feek, 1999). With the government concerned with a more equitable distribution of health resources across society and economically driven choices needed to be made. Previously, where much of the power was held with medical staff, this now opened up for other health professionals and for the patient/client to be involved in decision making (Perkins et al., 1997). Youngson (1999) describes a new approach in clinical leadership, which is the place where much clinical decision making and thereby power resides. This was inclusive of a range of health professionals and occurred in a multidisciplinary approach. If changes of leadership in the New

Zealand health care settings came from clinical leaders who were familiar with local conditions those changes are likely to have been more closely linked to health professionals' beliefs and to have a sense of relevance for them.

A further challenge to professionalism has been the advent of evidence–based medicine[3], "a movement strongly orientated to positivist methodologies" (Whiteford, 2005, p. 36). For health practitioners generally, evidence-based practice linked closely to evidence based medicine (Whiteford, 2005) has pervaded workplaces with a turning back to scientific truths. Yet Whiteford described "some very real tensions between practice-generated knowledge and research driven knowledge" (p. 37). Older health professionals, accustomed and familiar with practice-generated knowledge, are likely to struggle to orientate themselves to the search for the 'right way' with their client-related interactions. No longer will they be able to assume that interventions successful with clients in the past can continue to be used. Jones and Higgs (2000) comment with regard to evidence based practice:

> For some health professionals whose decisions traditionally go beyond pathophysiological considerations, this shift in what is deemed evidence [to evidence that is restricted to information available from select quantitative studies] could create very real dilemmas concerning 'credible' practices. (p. 309)

When evidence that supports practice is regarded as valid only when it comes from scientific studies, there is an undermining of other ways of knowing, arising both within qualitative studies and from knowledge about practical choices (Polkinghorne, 2004) that comes with experience.

In the Present

Our world embraces us with a rapidly evolving context. Older health professionals experience this changing context; they live and work in a world that rushes forward, with much of the change occurring through technification. Carden (2007) says "the sheer complexity of our lives even in a space of a single generation has been astonishing" (p. 28). It is "a complex crazy world" (Carden, p. 25) in which nothing is certain, where "an avalanche of information wouldn't be a problem if our brains

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2. Evidence based medicine is the process of systematically finding, appraising and using contemporaneous research findings as the basis of clinical decisions (Rosenberg & Donald, 1995).

could handle it. Unfortunately they can't" (Carden, p. 35). We know so much more about what is happening on the other side of the world than was readily available a generation ago. For instance, like other parents with an adult child living overseas, I use SKYPE to talk to my son and his wife living in London and to 'see' our new grandchild recently born on the other side of the world. We exchange conversational emails, send digital photos through cyberspace, and frequently 'talk' by telephone, or text. The world has shrunk in terms of communication, with the sharing of knowledge and information seemingly bringing people closer together. The impact of the technification of the health workplace will be explored along with how recent legislative change has impacted on and shaped practice. Another important factor, referred to earlier is the 'graying' of the population of New Zealand. This study's links to the baby boomer generation will be discussed, along with the intergenerational perspectives that are a part of older health professional work world.

The New Technology in Practice

> Caregivers are now being encouraged to follow scripts and program outlines, with the objective of making their practices technically based rather than judgement based. (Polkinghorne, 2004, p. 47)

Within their immediate work world the high level of technification and systems change of the health care environment impacts on older health professionals. Locsin (2006) says that a definition "that fits nursing well is Heidegger's (1977) who described technology as a means to an end, an instrument, as well as a human activity" (p. 121). While younger practitioners today have been "reared in a culture that values technical solutions" (Polkinghorne, p. 94) this is unlikely to be true for older health professionals. They come from past eras where they "depended on their practical knowing [that] draws on personal experience in the action of practice" (Polkinghorne, p. 94). Yet a high degree of modern technology is now part of the workplace environment encountered and engaged with, effecting the daily work of all health practitioners. Polkinghorne (2004) says that technification alters practice:

> Technification has a tendency to discard former ways of knowing and practicing. In a drive for complete dominance, it eradicates areas that are not technified. When alternative ways of thinking and problem solving are summarily dismissed as being inefficient, irrational, or not scientifically validated, a culture becomes one dimensional. (p. 47)

When older practitioners' former ways of thinking and practicing are dismissed as out-dated, in workplaces where practice is "technically based rather than judgment based" (Polkinghorne, 2004, p. 47), the loss of practitioners' practical decision making may have a negative impact on clinical interventions. I argue that the negative effect of the dominance of technology is considerably greater for those practitioners who received their professional qualification when healthcare was considerably less 'high tech'. That was a time when case notes were hand written into patient files, when communication was primarily face to face or by telephone, letter and memo rather than by text, email and electronic files. Health professionals today spend many hours working with a computer in front of them, complying with systems designed to streamline their practice and involvement with clients. When "the technical-rational approach" (Polkinghorne, p. 108) takes over from the ability of practitioners to work with whatever comes forward in clinical situations, there is likely to be a loss of the situated meaning particularly in complex situations (Polkinghorne, 2004). For older practitioners, being confronted with a highly technical and systematized workplace is likely to be experienced as inability to draw on the resourcefulness they have built up over many yeas of practice. Further their practice has become increasingly shaped by technology.

> Recovery of the wisdom from past traditions can help us overcome the limitations of our present technical understanding of the world. (Polkinghorne, 2004, p. 98)

Traditions from the past can bring wisdom into future practice. Never-the-less health care managers have become reliant on systems that came along as part of technification of healthcare provision. Exemplifying this approach, Wayne Brown, former Chairman of Auckland DHB, speaking about waiting times for treatment said:

> We've brought very much a production – orientated approach to the running of the hospital. Making it like a big factory as much as we could. We've tried to remove the emotion, just run it as a production unit. (Klong, 2007, p. A4)

Legislation that Shapes Practice

Following a trend in other OECD countries the New Zealand Government enacted legislation, the Health Practitioners Competence Assurance Act (MOH, 2003), which aimed to ensure that all health practitioners working in this country

maintained their practice, keeping abreast with new developments in their field. Such a programme assists with "external scrutiny of practitioner activity as well as [to] satisfy the professions need for self determination" (Allen, Oke, McKinstry, & Courtney, 2005, p. 90). During the years prior to this legislation a major issue impacting on consumers of health services became apparent. Increasingly publicity drew attention to errors by health professional; errors that resulted in, for instance, well people being diagnosed and treated as terminally ill and vice versa, along with people being denied access to treatment or services to which they were entitled. The public began to lose confidence in its public health services (Allen et al.) at a time when there was an increasingly higher expectation by the public of health care services and when the complexity and variety of services were already putting health services under pressure (Allen et al.).

Legislation such as the Health Practitioners Competency Assurance Act has shaped practice. Now health practitioners must show their competence to practice by complying with the activities set by their registration board. For older health professionals this has meant a number of things; enforced learning programmes that may seem meaningless, a sense of being demeaned by having to constantly prove their competence, time spent on showing their competence that takes them away from clinical work when they are already under time pressure. Yet there will also be positive outcomes from complying with competencies, such as being able to attend training courses that the health service may not have been prepared to fund in the past and that of making staff members, who have fallen behind in their practice, current.

Linking to the Baby Boomer Generation
This study links closely to the baby boomer generation. At the point of interviewing, the older health professionals, whose experience is the focus of this study, ranged in age from 50 to 66 years. This means that they were born during or within approximately 11 years following the second World War (1939-1942) and are situated within the broader context of population ageing and the imminent retirement of the baby boomer generation. The name 'baby boomers' (Smith, 2009) was given to the large number of babies born in countries including New Zealand, Australia, the United States, England and Canada, following the cessation of the second World War; a boom that started in 1946 and had slowed by the 1960s

(Smith). Much has been written about this defined group, in part because they make up such a large population group and because they stand out as differing from the generations that followed, the so called X and Y generations[4] and also the generation before them, the matures.

Demonstrating the prominence of the baby boomer generation in the media, issues concerning them blaze forth in magazines and newspaper headlines: "Elderly baby-boomers take over America" (Harris, 2007, p. A12), from an article that informs us that the country is bracing itself for the retirement of its post war generation. Another article headlined "Older workers are ready willing and able – they just need a chance" (Newsweek, 2007, p. 30), tells us that it is time for employers to stop their ageism and preference for younger workers that results in older workers being pushed out for younger cheaper staff. Other headlines such as, "Newsflash: Why 70 is the new 50" (Black, 2009, p. 16-17) focus on the reasons why people choose, or choose not, to work longer. In that article a former 69 year old nurse describes why, after 50 years of nursing, she "threw in the job" (p. 17). Although she had loved being a nurse, now "the endless attention to rules, regulations and paperwork has taken pleasure out of the job without, in her opinion, improving the care of patients" (p. 17).

McCrindle and Pleffer (2008) talk of Baby Boomers being 'sandwiched' between responsibility for caring for their ageing parents and their adult children, coming about as their children remain financially dependent and their parents live longer. In addition Baby Boomers are likely to stay at work longer than people their age once did. It seems that Baby Boomers will take over some societies through the sheer strength of their numbers; at the same time, they are described as being prejudiced against because of their ageing. Yet older health professionals, such as nurses, are still regarded as vital to the workforce (Klug, 2009). Being a Baby Boomer means being at the apex of a recognized, yet new, phenomenon, at the forefront of public comment, with individuals subsumed by an oncoming wave of mass ageing.

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[4] The X generation; born 1965-79, are believed to have values of work life balance, independence and putting family before work. The Y generation; born 1980-94, are believed to have values of fun and enjoyment, tolerance of diversity, social awareness and friendship. The mature generation was born 1909 – 1945.

Intergenerational Perspectives - Youth versus Ageing

When looking at the qualities that differing generations bring to their work world, it is easy to make assumptions, to generalize about what constitutes a baby boomer, an X or Y generation person. But it is not easy to talk about groups without generalizing, as these categorizations have become an accepted way of differentiating between generations. "Human life is movement" (do Rozario, 1988, p. 199) and the young inevitably become the old if they are fortunate to live long enough. Throughout life we are in motion, moving through differing stages and phases, coming into this world as helpless dependant infants, becoming for the most part independent youths; progressing into such social categories as adults of middle age and eventually old age. Although ageing is a normative physiological process, the consequent changes can disrupt how we view ourselves. Throughout this movement there will be "turning points" (Gattuso, 1996, p. 104) where we assess and redefine who we are and the way change impacts on our identity, or life story, "our self narrative" (p. 104). This movement through life takes us from the positive sense of what Bollnow (1962/1970) called the morningness of youth; the mood of the young coming to each day with a trusting freshness and openness to life, to a different perspective on later life. Gattuso (1996) says that "the common view of ageing is that it is a wasteland" (p. 108). Not all elderly people see it that way. Casals (2008) at ninety three years old said, "I do not think there is a day in my life in which I fail to look with fresh amazement at the miracle of nature" (p. 370). Yet it is possible through these differing perspectives to see the disjuncture between youth and old age, where one is full of freshness the other, at times, despair.

In a Listener magazine article, Australian social researcher Mark McCrindle discussed with Ralston (2010) the problems and conflicts that can be associated with up to six generations, working or living together when they do not understand each other's values. A number of nursing articles draw attention to such tensions existing in the health workforce. Weston (2006) describes advantages in that intergenerational teams offer opportunity to use differing perspectives, learning from each other and that "supporting nurses who want flexibility is the wave of the future" (Weston, p. 7). Sherman (2006) says that nursing leaders should anticipate that while generation X and Y nurses want flexibility in their leaders, Baby Boomers mostly want meaningful work. With the health workforce likely to remain

diverse in the years ahead, recognizing and managing those differences can lead to an invigorated team of health professionals that incorporates the wisdom that older health practitioners can bring to their roles.

The Future

> At the beginning of the 21st century, it is argued that we are witnessing the emergence of a new age of uncertainty for human services in health and disability for which we need new theories, new forms of practice and an associated language. (Corker & Shakespeare, cited in Chapparo & Ranka, 2005, p. 52)

With the pace of work within healthcare creating as much uncertainty as it does, how will older practitioners manage into the future? Sinclair (2005) says that "practitioners in the world must be flexible and resourceful in order to promote effective partnerships focused on developing relevant services and changing methods of service delivery to meet health needs of communities and society" (p. 123). Will older practitioners have this flexibility and resourcefulness needed in the new world? Alongside this, Carden (2007) tells us that technological advances will continue to accelerate at an ever increasing pace. For older health professionals faced with the accelerating change and pace of work, flexibility in their roles may not be enough. For managers working within healthcare, ways of managing these changes will be essential in order to retain older practitioners who will be particularly vulnerable in an uncertain or chaotic health environment.

Summary

An historical, social, legislative and technologically evolving backdrop informs the present and future of being an older health professional in New Zealand today, for older health professionals carry their past with them. The following chapter places the study focus within the literature that highlights the aspects that matter in this enquiry. Both the context and literature build a picture, giving a depth to the issues that make up this exploration.

Chapter Three: Exploring the Horizon of the Literature

> Horizons are permeable; they can be broadened to take account of other people's meanings and beliefs, even without those meanings and beliefs being adopted… However in puzzling through these unfamiliar views, the inquirer also achieves some estrangement from the things he or she hitherto took for granted and failed to question. (Abbey, 2000, pp. 162-163)

Introduction

Exploring and coming to recognise what matters in the diverse literature underlying and surrounding the research focus can constitute a fusion of horizons to understanding (Gadamer, 1975/2004). For as I draw closer to seeing something new, accompanying me is that which is already understood, my fore-understandings, coming up against that which is new or different. In this way my understanding is challenged, opened up, broadened. From this insights come. Abbey (2000) refers to a fusion of horizons where one's own horizon to understanding, coming from cultural and social beliefs and historical understanding, encounters another, be it historical text or the language and views of another. In this way thinking is surprised, stimulated, and opened to seeing something differently. At the same time we can find ourselves feeling distanced from, or letting go of, once firmly held beliefs and assumed understandings.

> Thus the hermeneutic conversation begins when the interpreter genuinely opens himself to the text by listening to it and allowing it to assert its viewpoint… It is precisely in confronting the otherness of the text – in hearing its challenging viewpoint… that the reader's own prejudices (i.e. his present horizons) are thrown into relief and thus come to critical self-consciousness. (Gadamer, 1976, pp. xx-xxi)

In this way, "literature acts as a dialogical partner to provoke thinking" (Smythe & Spence, 2009) rather than the review of the literature offering a set format in which a particular structure is adhered to.

The Search for Meaning

My approach taken in turning to the literature is one of seeing all writing, such as biographies, newspaper articles, philosophical writing, along with research articles and other texts, as having the potential to offer insights into the research focus; providing a matrix within which the study is situated. Here there will be voices that

I need to attend to, voices that could illuminate the research focus or show its significance through its absence.

This writing brings together different aspects of meaning that surround the research focus, diverse parts that already show the text in a certain way. My quest in drawing those parts together is to present them in a way that no longer takes for granted; in a manner that questions and seeks to uncover other ways of seeing. Van Manen (1990) tells us that in describing the phenomenon we are not trying to dispel the mystery of meaning but rather to bring it into presence. Presenting the phenomenon of being an older experienced health professional through the medium of literature is not to take away from that meaning but rather to reveal it. Yet, "meaning is multi-dimensional and multilayered" (van Manen, 1990, p. 78); like understanding, it too is elusive and slips easily from our grasp (Arendt, 1978). This exploration of the literature considers aspects of the broad context of being older and experienced as a health practitioner all the while "recognising that these activities are always partial, always situated and always on-going" (Smythe & Spence, 2009, p. 3). In this way I acknowledge that uncovering the available text can only ever show aspects of what is there, that both I and the text are a part of our situated and historical context. For my attention will be drawn to some aspects and not to others; and no matter how much literature I seek out and uncover, there will always be more awaiting discovery.

As I begin the process of exploring the literature further, I find that I have come to this aspect of the project with many ideas and thoughts about what is likely to be 'out there' and what of it matters in terms of my research. And while I come with ready made beliefs and understanding, the authors of the texts encountered also come to me with barely concealed interests both "conscious and unconscious" (Gadamer, 2007, p. 241). Alongside these considerations I am reminded about the nature of thinking:

> We never come to thoughts they come to us.
> That is the proper hour of discourse. (Heidegger, 1971, p. 6)

While I read and think and await "the splendour of the simple" (Heidegger, 1971, p. 7) the thoughts that do eventually come, a discourse with the literature slowly begins.

<center>**Turning to the Literature**</center>

Where do the studies emerge that begin to show what it means to be an older health professional? What became apparent during this search was a very particular focus where research and other literature, much of it originating in the United States, highlighted issues regarding older nurses along with the looming shortage of nurses in many OECD countries. Little research regarding other older health professionals came to hand. Alongside the focus on a specific health care profession and specific country sits the wide horizon of literature that relates to 'the older worker'. This literature, covering as it does people who work across many industries and countries is global and all encompassing providing a backdrop to the more specific focus on healthcare provision. Yet a wealth of material sits within these areas along with insights drawn from other fields. It is from these fields, ideas and thinking significant to the research, that focus can be drawn. Themes from within these areas will begin to uncover some of the beliefs about what it means to be an older practitioner.

Experiencing Being an Older Nurse

> We are old nurses. But we still have something not found in the new nurse, something worth more than being swift; we have experience. (MacInnis, 2003, p. 31)

Older nurses bring experience to their practice but how do they experience working in their professional roles; do they for instance have the perception that they are valued? It seems that there are many positive aspects to the way older nurses see themselves. I have begun by drawing on themes from two research articles by Letvac (2003a, 2003b), to illustrate older nurses' experiences. These studies consist of: research that looks at the experience of 14 perioperative nurses, over 50 years of age, (2003a); and, the experience of being an older staff nurse, of 11 staff nurses (2003b), both set in a southeastern state of the United States. Both studies were guided by a feminist perspective. Combining with Letvac's findings are further insights from Squires' (2008) Masters thesis, set in a New Zealand city, which used a social constructionism methodology to research the experience of 11 nurses over 60, who work in a range of specialty areas. Older staff nurses describe themselves in Letvac's (2003b) study as feeling confident in their abilities and clinical skills; and in Squires (2008) research, full of knowledge and experience, with work not only providing structure to their lives but also giving them a sense of identity while

challenging them intellectually. What keeps some of these older nurses from retirement is "loving what I do" (Letvac, 2003b, p. 50) and a sense of specialness, "We are not just nurses, we are OR [operating room] nurses and we love what we do" (Letvac, 2003a, p. 639). The feeling they were important to patients mattered, with patients saying such things as "what are we gonna do when you older nurses leave?" (Letvac, 2003b, p. 50) and "just last week a woman commented, 'finally a nurse with grey hair. I know you know what you're doing'" (p. 52). On occasions it was managers who indicated to nurses that they were valued:

> I received very positive feedback from my manager. She is always making little comments such as, you aren't getting ready to retire. Period. You can forget it. And that thrills me. I'm glad she feels that way. (Letvac, 2003b, p. 52)

Some older staff nurses had a sense that "we don't have to prove our ability – we know we're good" (Letvac, 2003b, p. 50), their self worth clearly linked to their work role. Though they had some specific concerns, older nurses generally expressed satisfaction with their roles (Ingersoll, Olsan, Drew-Cates, DeVinney, & Davies 2002; Letvac, 2003a). However, Letvac (2005) cites the National Sample of Registered Nurses (USA) which found that only "68% of RNs (registered nurses) were at least moderately satisfied with their jobs" (p. 66); compared to this 90% of all professionals are satisfied with their jobs" (p. 66). Thus, while smaller samples of RNs give one perspective on satisfaction the larger National Sample shows RNs having less satisfaction when compared to other older professionals.

Despite the earlier affirming comments, visible in the literature were the many negative feelings encountered by older nurses. Moseley and Patterson's (2008) review of literature, with a focus on retention of older nurses, draws attention to Kupperschmidt's (2006) paper (cited in Moseley & Patterson) where older nurses felt negatively perceived by younger nurses and management. At times, older nurses also believed that management wanted to get rid of them (Letvac, 2003b), while others considered themselves witch hunted, bullied, and experienced feelings of persecution (Letvac, 2002a).

Letvac's (2003b) study, brought to the surface the strong sense of disgruntlement felt by some older nurses who complained of no longer being able to do a stretch of nights when it was expected of them; at the end of a 8 hour shift, feeling "ready to

fall off my feet" (p. 53); operating room nurses being stressed by on call scheduling and being up all night, "we can't stay up all night and work half the next day with no sleep" (Letvac, 2003a, p. 644); and being paid little more than younger, relatively new, nurses (Letvac, 2003b). For the nurses 60 years and over, participating in Squires' (2008) New Zealand qualitative study, there was the challenge of the huge amount of new leaning and being unsettled by the changing nature of their work. Alongside this were negative interchanges with management, with a staff nurse saying "I get very little respect. I think they want us out of here because we make too much money" (Letvac, 2003b, p. 53). Another older nurse felt unappreciated regarding her manager's inability to understand the value of her experience:

> My manager asks me all too often when I'm going to retire. I think my experience intimidates her. She may have the degree but I have the experience and skills and the nurses look up to me. I'm gold in her pocket and she doesn't see it that way. (Letvac, 2003b, p. 53)

Some studies show older nurses feeling they were appreciated and needed while others felt under pressure to leave. What can we make of these contradictory findings? The nurses participating in these studies work in a broad range of settings from district nursing, acute hospital wards, to hospital night shifts and being on call for operating room duties. Some of them do work that is complex, highly technical, and work for others is physically tiring and exhausting. Just as all work places vary, health care settings will have affirming managers who 'look out for' their older nurses, and others who will not. For some nurses there will be negative experiences from working in neglectful, unsafe environments, others will have supportive experiences with colleagues and managers that allow them to continue to meet the demands of their working environment and role. In optimum circumstances, what can older nurses offer?

What are the Attributes of Older Practitioners?
What is the advantage of trying to extend the time that older health professionals remain in the workforce? After all, they are growing older and will retire in the not too distant future. Along with referring to the previous studies, I turn also to the Robert Wood Johnson Foundation white paper, Wisdom at Work, (Hatcher, Bleich, Connolly, Davis, O'Neil, Hewlett, & Stokley Hill, 2006) that seeks to outline the importance of the older experienced nurse, with the need to retain them at work as

long as possible. This paper describes how 13 experts, skilled with experience in a range of health care leadership and management roles, were interviewed, giving their opinions on the attributes of "older, seasoned nurse" (p. 27). These 'sages', held a positive view of contributions of older nurses (Hatcher et al., 2006). Though their ages and length of experience is not given, it is reasonable to assume that, because they were chosen for their skills and experience, some were older which may have influenced their perceptions. Older experienced nurses were seen as:

1. Calm in emergency situations and able to promote an atmosphere of calmness.
2. Accomplished, dedicated and experienced
3. Committed to the profession over profit
4. Hard working, knowledgeable and committed
5. Able to display a "been there, done that" attitude
6. Intuitive and accomplished in decision-making skills
7. "Salt of the earth" team players (Hatcher et al., 2006, p. 27).

Adding to the above list of older nurses' contributions, there are a number of further attributes outlined in a range of studies. Moseley and Patterson's (2008) literature review draws from studies that describe older nurses' experience as beneficial to healthcare organisations, in that they bring intellectual capital and knowledge of the organisation they work within, as well as enhancing patient care (Squires, 2008). Supporting aspects of the 'sages' list of attributes (Hatcher et al., 2006), Moseley and Patterson's work depicts older nurses as not only loyal to the organisation but providing stability. Many studies portray older nurses as mentors and role models (Letvac, 2003b; Moseley & Patterson, 2008; Santos et al., 2003) and as bringing maturity and wisdom to their roles (Squires, 2008). Is this all too good to be true? If, potentially, older nurses bring so much to their work within healthcare settings, why do some feel as though their managers cannot wait for them to leave? We now turn to look at what the literature says about older nurses' performance at work.

Differing Perspectives on Performance
While there is much writing about the performance of older workers in general, there is less regarding that of older health professionals. Clearly the ageing process takes its toll, with eye sight, hearing and other physical attributes declining (McGregor & Grey, 2002); yet, these New Zealand researchers say that "most scientific literature… reports little consistent relationship between age and work

performance" (p. 165). Bass and Caro's (1996) work on productive aging found that performing most physically and mentally demanding work is possible for many older workers who can also learn new skills. The Robert Wood Johnson Foundation's white paper (Hatcher et al., 2006) describes older nurses as making fewer mistakes than younger nurses, while Moseley and Patterson (2006) saw them as valuing hard work, with their recall and memory just as good as it was when they were younger (Letvac, 2003a). It has also been suggested that the challenge and stimulation of their nursing roles slows ageing (Squires, 2008). Why might there be differing views on ageing in relation to work performance? McGregor and Grey (2002) propose that "various modifying factors and compensating factors are pointed out in response" (p. 165) to older workers' losses. Similarly the Robert Wood Johnson white paper (Hatcher et al., 2006) suggests that older workers compensate with increased job knowledge and skills for a decrease in retention. In part this is confirmed, and yet disputed, by findings coming out of a number of studies and other literature.

Refuting the suggestion that the recall of older workers is just as good as those who are younger, Papalia, Camp and Feldman's (1996) writing on adult development and ageing outlines the way that reaction times decrease along with a reduction in ability of the long term memory to process information and access information in older workers. Further, Papalia et al. say that older workers' slowness with computer work may impact on getting tasks done. Another area impacted by ageing occurs when older workers attempt to give their undivided attention to work amidst distractions or time constraints. Contradicting the earlier positive view of the performance of ageing workers, Moseley and Patterson (2006) depict older nurses becoming more fatigued at work than younger nurses; and as a consequence, being unable to do the same amount of shift work. While they may be more stable, participants in Letvac's (2003a) study of older perioperative nurses were described as finding the work harder, and labour intensive, and as having less endurance. Older nurses working in theatre said they were more tired after 8 hours work than they were when in their twenties; yet, they were still able to meet the physical and mental demands of their work (Letvac, 2003a). More specific problems of ageing such as weak bladders cause problems for older nurses when they are unable to take timely breaks (Letvac, 2003a). It seems that for all nurses, disengagement increases

with time in the job, showing itself in aloofness and withdrawal from fellow workers (O'Brien-Pallas, Duffield, & Alksnic, 2004). It may be that the effects are exacerbated for those nearing retirement, particularly if they have been in the same position or institution for many years (O'Brien-Pallas et al., 2004). For some participants it is the physical demands of their roles that provoke stress such as lifting or being on call: *The call is a killer. Twenty years ago people would switch with you all the time. Now everyone is out for themselves* (Letvac, 2003a, p. 644).

What Moyers and Coleman (2004) said in a review of literature exploring the adaptation of older workers to occupational challenges, was that "older workers' ability to adjust to workplace changes are dependant on individual, organisational, and environmental factors" (p. 72). Alongside the questions regarding the level of older practitioners' ability to perform in their work role, is that of their interpersonal skills. How does the literature describe their ability to manage relationships with managers, fellow clinicians and patients?

Questioning Interpersonal Skills

Older nurses were portrayed in some research (Hatcher et al., 2006; Squires, 2008) as vitally important in difficult or complex situations involving patients and families, such as connecting with dying patients or emotionally charged work. In another study (Letvac, 2003b), management was described as appreciating "the experiences we older nurses bring. We are the stability in the unit" (p. 52). Further, Santos et al. (2003), in a study that explored baby boomer nurses' burden of care, confirmed the element of provision of stability from older nurses presence, with a participant saying "Nurse managers look to them to… keep the unit going" (p. 248). Older nurses were also sought out as good communicators, as mentors and leaders who would orientate new graduates, and as people who would not let down patients or their peers (Santos et al., 2003). Letvac's (2003a) study on the experience of older perioperative nurses had a participant describing older nurses as "more team players… there for each other" (p. 645). Yet that same study highlighted some of the negative aspects with regard to older nurses' interpersonal skills.

Stress and Strain at Work

Different generations of nurses in a United States four-site hospital based study were scored according to their stress, strain and coping (Santos et al., 2003). The

total number of RN participants was 694, of which 368 were baby boomer nurses. In one area the Baby Boomers "had significantly more interpersonal strain than other cohorts" (Santos et al., p. 247). Such strain shows in "frequent quarrels" or "excessive dependency" (247). In part the strain was put down to "competing demands for their time" (p. 248) such as juggling work responsibilities while still supporting family members outside work. In four of the six scales, "baby boomer nurses had significantly higher or more negative, stress scores than their colleagues" (p. 245). Criteria they were measured against included role overload, role insufficiency, role ambiguity and role boundaries. While these scores demonstrating such negative aspects are concerning, nurses from other generations had poorer scores than baby boomer nurses in other aspects of the questionnaire. Despite signals that Baby Boomers struggled to cope with their work, the study also described nurse managers seeing them as the people who would mentor others, orientate new graduates and keep the place running, and "the formal and informal leaders" (p. 248). Such additional responsibilities may be a factor in the high levels of baby boomers' stress and strain.

In Letvac's (2003a) study, operating room nurses, aged 50 to 62, struggled in their relationships with operation room technicians. A change in culture with increasing presence of technicians in operating rooms, up from approximately 20% to 50%, along with inequities in education and income, appear to have set up "big rivalry" (p. 645) between the two groups. Another major difference was the experienced nature of the operating room nurses, many of them fitting within the baby boomer generation. The 'techs', were described as having "generation X attitudes… they don't want to be told how to do anything" (p. 645). Conversely, Letvac (2003b) in her study, on older staff nurses, refers to copious amounts of literature where X generation workers see older workers as "self–righteous, set in their ways, rigid and workaholic, whereas the older generation claim younger workers are slackers, whiners, unwilling to pay their dues, and possessing negative attitudes" (p. 51). Clearly Letvac's (2003a, 2003b) studies signal a generational divide possibly triggered by other work role differences. Yet stress arising within older workers' roles and work setting stands out in a range of studies.

An Australian nationwide survey of nurses asks who will be there to nurse when the baby boomers retire, citing unrelenting and excessive workload as a "major cause of stress and dissatisfaction" (O'Brien-Pallas et al., 2004, p. 299). Also indicated is that the increased acuity of care makes providing the level of nursing required near impossible. Supporting this notion, a further study (Santos at al., 2004) suggests that the tension of coping with inpatient work that is physically demanding makes it hard for baby boomer nurses to keep up with the physical and psychological pressures of in patient nursing. Along with this is the turnover of staff, including "their own personal stress associated with these factors [of acuity of care], which are sometimes compounded by lifespan issues" (p. 248). This study brings to light the way baby boomer nurses can be seen bearing the burden of care in some inpatient settings. Such findings, demonstrating the strain baby boomer nurses are under, are not necessarily reflected in absence from work and frequency of sick leave.

Is Injury Illness and Absenteeism an Issue with Older Workers?

One of the disadvantages, often referred to, of having older workers on the staff is absenteeism and a greater rate of injury (Alpass & Mortimer, 2007). Despite this, it seems that while older people have more chronic illnesses than those who are younger, they have fewer sick days for acute illness (Letvac, 2002a). The Robert Wood Johnson Foundation paper (Hatcher et al., 2006) describes older workers as having improved health (than older workers previously did), saying that technological advances have made it possible to extend work life beyond 65 years.

Contrary to the above findings, a study exploring the implications of the ageing registered nurse workforce within the United States (Buerhaus, Staiger, & Auerbach, 2000) described higher injuries amongst older nurses; while a further study (Santos et al., 2003) has shown greater incidence of orthopaedic problems. Letvac's later work, focusing on older nurses, expands on some of the earlier points regarding nurse injuries and illness. When looking at the health and safety of older nurses Letvac (2005) documented almost a quarter of older nurses in her survey of 308 participants, from the Southeastern United States, as having "experienced a job related injury within the past 5 years, and over a third experienced job-related health problems" (p. 66). For those older nurses working in hospital settings or doing physically demanding work, more job-related injuries were recorded. Yet older nurses were also found to have better physical and mental health than the national

norm and to have rates of back injury that were comparable with other nurses (Letvac, 2005).

However, Trinkoff, Brady and Nielson's (2003) research in the United States, into the prevention of musculoskeletal injuries in all nurses, stated that "nurses have one of the highest rates of back and other musculoskeletal injuries amongst all occupations" (p. 153) and that absenteeism associated with back injuries only decreased when there were fewer nurses doing lifting. While this study does not separate older nurses from those who are younger, such injuries would seem to inevitably lead to absence from work, and early retirement, for older nurses. O'Brien-Pallas et al.'s (2004) study that looked at the loss rates of nurses in New South Wales, Australia, suggests "an almost perfect correlation between sick time and overtime" (p. 299). What comes through in the literature is the complexity of looking at work place injuries, illness and absenteeism. There is no clear picture of whether these research findings show disproportionate amounts of older nurses taking sick leave or leaving their nursing roles due to harassment, illness or injury though the possibility remains high. What then are the work conditions which in an ideal work environment keep older practitioners at work?

Ideal Job Conditions as Perceived by Older Practitioners

Amongst the studies on retention of older nurses there was a recurring theme. This revolved around the need for health workplaces to change in order to retain older nurses in particular. From Moseley and Patterson's (2008) study came the call for fewer shifts; older nurses found shift work particularly exhausting. In addition older nurses also wanted less pressure from their heavy workloads with fewer demands being made on them. At times older nurses asked for reassignment to less physically demanding jobs (Moseley & Paterson). Within the work world of perioperative nurses there was a strong wish to not be 'on-call', in order to avoid the long stretches of work entailed with being called back into theatre on top of days already spent working there (Letvac, 2003a). In addition, from this same study, nurses asked for management to be cognisant of their concerns with regard to safety within the theatre. Just as in Levac's (2003a) study, older nurses in O'Brien-Pallas et al.'s (2004) research also wanted relief from what can be excessive and unrelenting workloads. Older nurses expected to be rewarded for the work they did and wanted additional leadership roles with control over such things as practice and scheduling.

Turning to older workers generally, such things as "improving the quality of the working environment, redesigning and reassigning jobs" with flexible employment options being offered, such as part time work and job sharing are some of the accommodations proposed by Davey and Cornwall (2003, pp. 59-60). Options such as these would enhance the opportunities for older health professionals to continue as active members of the health workforce.

So what does motivate older practitioners to continue? Letvac's (2002a) paper, drawing on the work of Sterns and Alexander (1988), says that older workers aged 50-59 came to see enjoying work and being useful as more important than money, while younger workers between 40-49 saw money, and enjoyment as more motivating than usefulness. Moseley and Patterson (2008) described respect, recognition and acknowledgement for a job well done as important; in contrast, older staff nurses in another study of Letvac's (2003b) saw money as a form of recognition for their experience. From Mosley and Patterson's (2008) review of the literature came a number of recommendations about what motivates older nurses: being listened and responded to, receiving honest and respectful performance appraisals that were free of age bias, working in a participative environment - taking control of issues that affect their everyday practice, control over what types of shifts they are given, having positions of authority linked to decision making and influencing patient care, having a sense of community and belonging, and being challenged by their work to avoid stagnation (Moseley & Patterson, 2008). Motivating factors for younger and middle aged nurses were not explored. It is possible that what motivates other nurses both differs yet is similar to those of older nurses.

Amongst Letvac's studies that focus on older nurses came the following suggestions for motivating nurses: healthy relationships that are mutual and growth enhancing (Letvac, 2003a), good interpersonal relationships with co-workers (2003a), being respected and having positions of authority in the OR (Letvac, 2003a), being challenged by the younger generation (Letvac 2003b), and that they continue to work because they continue to care (Letvac, 2003b). A sense of autonomy and independence was also put forward by Squire's (2008) study as making work enjoyable.

Repeatedly, in nursing research articles, there was a call for greater or continued access to ongoing education. What is the position for older health practitioners with regard to professional development? Are they seen as worthy of having their knowledge and skills maintained and updated or are such requirements disregarded with the unspoken agenda being that they will shortly be retiring, are too old to learn new skills, or are not worth putting resources into?

Keeping Up to Date

The importance of ongoing education and training for older workers is a significant issue of divergence evident in studies pertaining to older workers and their employers. This appears to have, in part, arisen as a consequence of the negative stereotypical perception that older workers cannot learn, as in 'you can't teach old dogs new tricks'. In McGregor and Gray's (2002) research, employers were shown to be more likely to believe the stereotype that older workers were difficult and less willing to train; whereas older workers saw themselves and their contemporaries as "willing and able to be trained" (p. 170). Unwillingness of older workers to train was also a view held by employers in a working paper on older workers working in industry (Stoney & Roberts, 2002). Stoney and Roberts (2002) describe the way access to training decreased with age for older workers, with the employer loath to train them. Trew and Wyatt Sargent's (2000) guide to managing older workers provides an interesting scenario, "offering training opportunities to younger workers qualifies them to move on. Offering training opportunities to older workers enables them to stay" (p. 89). Alongside this Davey and Cornwall's (2003) study said that "the need for life-long learning, driven by technological change, has been recognised internationally as economically important for business" (p. 44) and that "not only are older workers willing to retrain and upgrade their skills, they are just as capable of learning new skills and applying them productively" (p. 31). Clearly the issue of training and education is an area where the stereotypical views employers have of older workers impacts on their ability to keep up with practice trends and changing technology in their workplace, thereby reducing their value to the organisation.

In the midst of articles and studies about older workers, a number of studies provide insights into attitudes regarding professional development for older health practitioners. For the main part, the literature appears to support the notion of access

to ongoing professional development (Letvac, 2002b; Moseley & Patterson, 2008; Squires, 2008). Letvac (2002b) depicts older nurses as having more desire for continuing education while Moseley and Patterson (2004) describe the importance of all nurses attending professional development and being given release time, and equal access to do so. Both Letvac (2002b) and Moseley and Patterson (2008) go on to say that professional development is more important for older nurses, than for younger nurses, because of the way increasing technological change impacts on their capacity to do their job. Drawing on the work of Spetz (2005), Moseley and Patterson describe the most useful learning method for older nurses generally; that is through case histories or experiential learning, or in the classroom environment. For nurses born between 1946-1964 being part of participatory groups is preferred while for those born between 1925-1945) one-to-one coaching is the better learning style (Sherman, 2006; Weston, 2005).

Letvac's (2003a) research on perioperative nurses describes older operating room nurses as being more likely to be up to date than others, and wanting more ongoing education (Letvac, 2003b); but also worrying about who will educate younger operating room nurses (2003a). Similarly in Squires' (2008) research, on older New Zealand nurses, she portrays some study participants as finding that in-service education, along with practice and encouragement, meant they coped well with learning the new skills needed to manage biomedical technology. Squires also suggests that the quality of their work was increased by the ongoing education they received in order to maintain their competency for registration. It is possible that a major outcome of New Zealand's Health Practitioners Competence Assurance Act (MOH, 2003) has been to ensure that health services promote and encourage all practitioners, including those who are older, to participate in programmes that assist in maintaining and improving competency. It seems inevitable that myths and stereotypes have promoted and reinforced beliefs that older people cannot learn. This, in part, proved a barrier to them accessing new learning. Reflecting on the impediment, attitudes regarding older workers and ongoing education caused me to question the impact that a range of myths and stereotypes about aging generally and older people, have on older health professionals.

The Ambiguity of Myths, Stereotypes and Ageism and Older Practitioners

Many myths have developed about ageing. Such myths have an impact on older workers as they show themselves as stereotypes that become labels, or typecast, the way older workers are seen. When this occurs, the negative attitudes and at times prejudicial actions towards older workers become what is known as ageism[5]. The label of 'older worker' carries with it many stereotypes (Davey & Cornwall, 2003) that impact on how older health professionals are perceived by others. Such labelling is difficult to combat as, for instance, while not all older workers have problems with new learning, some will struggle. Thus the stereotyping and the consequent ageism is reinforced, though some younger workers will also experience difficulty with new learning. Much of the writing about stereotypes refers to the general population, with Loretto, Duncan and White's (2000) United Kingdom study on ageism and employment suggesting "that negative stereotypes underlie employer attitude and practices, endorsing a deficit model of ageing" (p. 283).

Even when not recognised, stereotypes are there in the workplace as outlined in a book, Ageism: Stereotyping and Prejudice against Older Persons:

> All humans, to varying degrees, are implicated in the practice of implicit ageism... We define implicit age stereotypes… as thoughts about the attributes and behaviours of the elderly that exist and operate without conscious awareness, intention, or control… Ageism unlike racism does not provoke shame. (Levy & Banaji, 2002, p. 51)

The frequently unacknowledged myths and stereotypes that have not yet been covered in this chapter are laid out, so that they can be shown in relationship to those impacting on older health professionals.

Common Myths about Older Workers

- A common myth is that older workers are unwilling to do new things or learn new skills (Letvac, 2002a; Loretto et al., 2000) whereas Robert Woods Johnson Foundation white paper (Hatcher et al., 2006) states that 88% of those between 45-77 years of age said "the opportunity to do new things would be essential to their jobs" (p. 13). In addition, Letvac's (2002a) article that looked at the myths about ageism and nursing suggests that age is no deterrent to meeting new demands.

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[5] Ageism is a word used to describe the systematic stereotyping of and discrimination against people because they are old (Loretto, Duncan & White, 2000).

- A further myth is that older workers do not adapt easily to computer technology and are resistance to change with the majority of employers and older workers in one large New Zealand study (McGregor & Gray) holding such negative stereotypes. A British paper (Loretto et al., 2000) exploring myths about older nurses reinforced this belief. In contrast, a further survey showed that more older workers than their younger counterparts were willing to learn new technology (Hatcher et al., 2006).

- Another myth is around older workers being less cognitively sharp than younger workers, as cognitive decline begins at age 25. Letvac (2002a) reports that most longitudinal studies indicate that the majority of individuals maintain "stable intellectual functioning well into their seventies" (p. 1102) and less than 5% of people between 65 – 69 have moderate to severe memory impairment (Hatcher et al., 2006).

- A further myth is that older workers are expensive to employ. However the cost for holidays and pensions are outweighed by the low turnover that avoids the costs involved with recruitment (Hatcher et al., 2006). While older nurses may be seen as expendable, the availability of new graduates to take their place in the near future has been refuted in many studies (Palumbo, McIntosh, Rambur, & Naud, 2009).

- Older workers are seen as less creative than younger workers. The Robert Wood Johnson white paper (Hatcher et al., 2006), however, states that creativity can occur at any age and that in science and medicine age can be an advantage, since cumulative wisdom is often necessary for a breakthrough.

- One positive stereotype held about older workers related to dependability. The majority of employers and older workers in McGregor and Grey's (2002) study "was consistent with overseas research… older people were seen as more loyal and reliable" (p. 174).

Stereotyping that brings a Double, if not Greater, Jeopardy
Ageism, like sexism and other prejudices, labels and works against those being stereotyped. With the majority of health professionals being women, there can be a range of labelling occurring concurrently. Loretto et al.'s (2000) research looked at younger people's perceptions of older workers. The findings "support the notion that women are faced with the double jeopardy of age and sex discrimination, at

least in the perception of these students of an early decline in job performance" (p. 296). In addition, for older workers who have a disability, there are issues of retention of employment for those at the receiving end of a "combination of biases against age and disability" (Kampfe et al., 2008, p. 339). Potentially "older people with disabilities may face as many as four types of employment related discrimination, or negative stereotypes (ie. age, disability, racial/cultural and gender)" (Kampfe et al., 2008, p. 339). At risk of discrimination in their employment are the many older health professionals who are women and for others, based on their ethnic or racial background. Discrimination can take the form of lower promotion rates, lower benefits and salaries, and shorter retention rates. Though these biases have been described by Kampfe et al. (2008) as referring to older people with disabilities, they may equally befall others being stereotyped.

Do older health professionals accept their lot or are they motivated to speak out about what they want? Letvac's research brings out the voice of older nurses:

> Nurses have historically had very little voice. At age 62, the oldest nurse in the study stated, "As nurses, my generation was always accepting of whatever we got, which was a huge mistake. None of us had the courage to stand up." We are now all challenged to have the courage to stand up for the older nurse – who is both the present and future of nursing. (Letvac, 2003b, p. 55)

From within the literature the voice of older workers and older nurses in particular, can be heard speaking out about their work world and the load that they carry. Researchers and commentators concerned for the ageing health workforce join the chorus. But who is listening to, and hearing, what is said? And as a consequence has anything changed?

How have Health Services and Management Responded to these Issues?

During this review of the literature I have read considerable numbers of research and opinion articles on being an older nurse, on intergenerational differences, and the retention of older nurses. Almost without exception their findings and conclusions make visible the large numbers of nurses across several OECD countries that leave nursing prior to what has frequently been considered retirement age (Bauerhaus et al., 2004; Boyle, Bott, Hansen, Wood, & Taunton, 1999; Hatcher, 2008; Ingersoll et al., 2002; Kovner, 2009; Letvac, 2002a, 2002b, 2003a, 2003b; Moseley & Paterson, 2008; O'Brien-Pallas et al., 2004; Palumbo et al., 2009;

Santos., et al., 2003; Sherman, 2006; Weston, 2006). This highlights the current dilemma; healthcare organisations either have few of the policies and procedures in place that invite and encourage older nurses, as well as other older practitioners, to remain in their clinical roles, or they have failed or been slow to implement them; despite the fact, that nurses are becoming a scarce commodity and the population will require more health professionals not less.

Successive New Zealand Governments have reacted to the evolving and increasingly complex world of health care provision, along with the protection of individual rights by enacting legislation such as; the Code of Health and Disability Services Consumer Rights (Health and Disability Commission, 1994a); the Employment Relations Act (Department of Labour, 2000); the Health and Disability Commissioner Act (Health and Disability Commission, 1994b); the Health Practitioners Competence Assurance Act (MOH, 2003); the Human Rights Act (Human Rights Commission, 1993), Human Rights Commission Act (Human Rights Commission, 1994) and the Privacy Act (1993). These Acts will have assisted in assuring the public of their individual rights as healthcare recipients. However, the question key to this study is, 'do health care policies and management strategies assist in keeping older health professionals working within healthcare provision?' Letvac's (2002b) research asked hospital and nursing home administrators in an American state about "specific policies in place that addressed the needs and issues surrounding an aging workforce" (p. 389). Only 6% had policies and 5% had intended to address the issue in the next 6 months. The administrators said that most of the issues asked about were the individual nurse's responsibility and while most were concerned about nursing shortages clearly little was being actively done to retain their older workforce.

On a positive note, a recent New Zealand development came out in a newspaper article (Borley, 2008) of encouraging nurses back to work, by paying for their registration and/or the courses to update them. The strategy was launched by the three Auckland District Health Boards to fill vacancies. While this scheme does not directly target older nurses and has, to date, enticed relatively small numbers back into the health workforce, it does point to a progression in health management actions. Kovener, Brewer, Cheng and Djukic (2009) in an American study that

explored older nurses work attitudes in 29 states, said that while older nurses had greater commitment to their organisations than the younger nurses surveyed, 9% of older nurses surveyed left in the year between the first and second survey. Their study called for health organisations to do more to retain and recruit older nurses back into the workforce as "organisations often will not hire RNs who have been working outside nursing back because they lack current clinical skills" (p. 117). Further the health organisations failed to entice older nurses back to work who have retired. Failure to entice older workers back to work occurs in other industries that also require strategies that will delay retirement (O'Brien-Pallas et al., 2004).

In relation to income, health organisations penalise nurses for working outside healthcare, despite having developed work skills that are transferrable. Kover et al. (2009) argue that nurses should be compensated when they stand to lose retirement benefits. This aligns with my experience of working for a DHB in New Zealand where, when older staff members retired and qualified for a gratuity due to them for length of service, as recently as 3 years ago they were prohibited from returning to work in their profession, at the risk of losing their gratuity. Because of the protocols around gratuities, the lengthy and valuable experience of those health professionals was then lost to healthcare despite some of them being interested in continuing further in part time roles. Adding to such bureaucratic restrictive protocols is the reluctance of individuals such as a past DHB Chairman, Wayne Brown, to retain 'expensive' older staff, saying at a New Zealand parliamentary select committee "one of the ways to keep the staff costs within future funding growth percentages is to, where possible employ younger people" (Berry, 2006, p 1).

In contrast the Robert Woods Johnson Foundation white paper (Hatcher et al., 2006) outlined a number of individual healthcare organisations in the United States that were judged as offering "successful models in heath care systems" (p. 44) for older workers. Yet these organisations were few in a healthcare system that is huge. In addition the Magnet hospital program, "while not specifically designed to address the older nurse" was put forward (Hatcher et al., 2006, p. 46) as likely to be a factor in the retention of older staff. The Magnet hospital strategy (Carryer, 2010) has primarily focused on attracting nurses to health care institutions. However, the concept is equally useful in retaining staff, including older workers, as it includes

many of the work conditions that older practitioners have been requesting that may also be similar to what younger nurses want. This suggests the possibility that the there may not be a big difference between what older nurses and younger nurses want. One might reflect on why such a scheme has remained restricted to nursing rather than extended out to other health professions and why only a limited number of New Zealand healthcare organisations have adopted the scheme. In choosing to adopt the Magnet scheme, hospitals implement policies and protocols likely to improve work conditions for older practitioners by turning them into positive actions. In an era when younger health professionals in some OECD countries are supported by such benefits as increased parental leave and crèches for their children within their work settings, it is hard to consider the lack of action aimed at retaining older health professionals, made visible in its near absence, as anything other than ageism. Alongside this the research indicates what older nurses and, by association, older practitioners want and need from their managers and workplace environments. I recognize that older nurses and older health professionals are not synonymous. Disciplines such as nurses and midwives can be expected to provide 24 hour care, may be on call, or working at night. Despite that, there are still similarities that mean that understanding of one profession informs the others: they are different yet alike.

Summary

The review of the literature has provoked me to question my taken-for-granted understandings of the older health professional (Abbey, 2000). It becomes clearer that being an older health professional today is complex and set in a time of great change and tensions within healthcare provision. The literature review in looking out to the horizon has pushed aside some previously held understandings. At the same time the literature has drawn attention to much of what seems to matter and placed it within its context, emphasizing important issues while putting forward contradictions. On the one hand we see how much is known about the need for retention of older health practitioners, while on the other, the actions undertaken to resolve the issue of loss of experience and expertise is barely visible in the literature. The methodology of hermeneutic phenomenology follows.

Chapter Four: Methodology

There is tradition, a body of knowledge and insights, a history of lives of thinkers and authors, which taken as an example, constitutes both a source and a methodological ground for present human science research practices. (van Manen, 1990, p. 30)

Introduction

From the lives of thinkers and authors, from those who have come before and whose work has built into a body of knowledge, comes a tradition that offers a methodology for hermeneutic phenomenological research. Stating that the methodology has a tradition may seem to imply that it is static, fixed in time, with a set of rules or techne as a guide. Yet much of the time the methodology comes forth creatively (Gadamer, 1975/2004) from the thinking and reflecting that occurs within the research project. Smythe, Ironside, Sims, Swenson, and Spence (2008) remind us that "who one is as-researcher is fundamental to the thinking of the research, for thinking does not happen as a mechanistic process divorced from being in the world" (p. 1390). With the combining of the philosophy with a creative approach, the methodology in this study emerges.

This chapter explores the philosophy inherent in the use of the methodology and the way that it closely connects to, and underpins, the method and the findings chapters; indeed all the chapters of this thesis - for congruence and coherence across the thesis matter, thus, giving the work its integrity (Smythe, 1998). The way that Heidegger's approach to phenomenology, and Gadamer's to hermeneutics, link to the research is outlined.

Putting this chapter together was in the nature of the hermeneutic circle; all the parts inform the whole while, at the same time, the whole of the circle expands understanding of the parts. So that the reader can see what matters, it is necessary in this chapter to write down and put the parts, significant to this study, into some sort of order. Yet there is no logical and right order. The reader is about to engage with a number of pieces of writing which show, as best I can, the way that the methodology influenced many aspects of this study.

The Inquiry

Coming into this inquiry means to arrive with a question about meaning (Heidegger, 1927/1962). In order to be able to ask a question is to already understand something of the background to the question (Gadamer, 1976/2004). My question, *what is the meaning of being an older experienced health professional* arose from my experience of being an older practitioner, from working with older experienced health professionals. Turning to my question came from concerns that have stayed with me, concerns that are current within health care provision and are central to the research focus. Coming to the precise question involved a considering of what lay behind the focus of the research project, for the question does not come out of nowhere, it always has understandings behind it. My historical consciousness (Gadamer, 1975/2004), that is the layers of historical, cultural, and social beliefs and values that are a part of understanding, played a role in locating the right question. Alongside this van Manen (1990) reminds us that "from a phenomenological point of view, to do research is to always question the way we experience the world, to want to know the world as human beings" (p. 5). In this study the human world explored is that of older experienced health professionals situated within their work-world of health care provision, the place where their inter-relating with others and things such as technology occurs. The subjectivity of my approach was previously detailed when exploring the presuppositions I brought to the study.

The Philosophical Underpinnings

While deciding to use the methodology of hermeneutic phenomenology to underpin this research project was a straightforward choice, the consequences have not been. For many students coming to understand 'the how' of phenomenology is not an easy route (Caelli, 2001; Koch, 1996; Smythe, 1998). Just as each researcher needs to find his or her own way through the maze of ideas and notions integral to the philosophy; I too struggled with how aspects of it fitted together within the whole. Alongside this there has been the need to ensure that I had grasped the philosophical notions of Heidegger and Gadamer that underpin the study. While coming to understand has not been easy, in many senses it has been worthwhile as I have found my understanding and interpretation frequently expanding, reaching a deeper level, as I brought the philosophy to participants' stories. It seems that the

philosophy drew forth deeper meaning, illuminating what lay there, waiting to be revealed.

Turning to the Philosophical Origins

The evolvement of the philosophy and its relevance for this project becomes clearer in briefly turning to the earlier philosophers with whom phenomenology originated, then to the thinking and philosophies of Heidegger and Gadamer. As a movement, phenomenology arose through a number of early philosophers, Hegel [1770-1831], Breneto [1838-1917] and Carl Stumpf [1848-1936], with some of their ideas still having relevance within phenomenology today (Cohen, 1987; Spiegelberg, 1994). However, Spiegelberg (1994) says that it was one of their students, Husserl [1859-1938], who was the philosopher who introduced phenomenology as it is today, with Moran and Mooney (2002) calling Husserl "the founder of phenomenology" (p. 57).

From Husserl to Heidegger and Gadamer

Despite Husserl's influence, it is to the philosophy of Heidegger and Gadamer that I have turned. Why have I moved away from Husserlian phenomenology? My understanding is that Husserl deemed it possible to humanize science by reinstating "the everyday world as the foundation of science" (Dahlberg, Drew, & Nystrom, 2001, p. 44). As part of developing phenomenology he considered that scientists or researchers could take an objective stance and remove personal bias by taking "into account the scientist's relationship with research projects, thereby assuring the objectivity on which the science is founded" (Dahlberg et al., 2001, p. 44).

Why does this matter? In contrast to Husserl's phenomenology, my belief is that the prejudgements that I hold regarding the research focus will be with me throughout the research, therefore my understanding aligns with Heidegger's philosophy in that I acknowledge that it is not possible to 'bracket' such beliefs out, putting them to one side, in order to be a neutral presence in the research process. I also believe that in research of this nature, as in many human aspects of coming to understand, it is important to bring prior understandings to assist in interpretation (Abbey, 2000). This attitude towards the research impacts on how I come to question and the possibilities I choose to follow. Throughout the research process I will maintain awareness of how my beliefs and prejudices may 'colour' my understanding and interpretation. Gadamer 1975/2004) says this is complex "since the fore-having that

determines my own understanding can go entirely unnoticed" (p. 271). Gadamer, like Heidegger, asserts "that the important thing is to be aware of one's own bias, so that the text can present itself in all its otherness and thus assert its own truth against one's own fore-meanings" (p. 271). Awareness of our own prejudice matters as, without the insight this offers, it would be impossible for what we look at to present itself fully.

The presuppositions explored in an interview prior to starting the research project, and detailed in chapter one, have heightened my awareness of my biases, making me attentive to the otherness in participants' stories. Throughout the study I show that the perspective I bring to this research is not a neutral and objective one, by presenting how my "social and historical position interacts with the text" (Allen, 1995, p. 175) as I have analysed and interpreted the data.

Hermeneutic Phenomenology

As stated, this study is situated within the philosophical approaches of both hermeneutics and phenomenology. While differing, both have distinctive "rich traditions" (Dahlberg et al., 2001, p. 42) that provide "a foundation for human science research" (p. 42). Hermeneutics has ancient roots, involved with the interpretation and understanding of texts, "such as theology, literature and law" (Allen, 1995, p. 176). While "phenomenology appeared as a concept in philosophy during the 18th century" (Dahlberg et al., 2001, p. 42), Heidegger turned to Ancient Greek arguments about the meaning of Being, drawing on Greek words such as 'phainonenom' (phenomenon), to show itself, in order to create meaning (Palmer, 2006). Gadamer's "philosophical hermeneutics" (Palmer, 2007, p. 227) also returned to elements of Plato and Aristotle. From this perspective it becomes apparent that philosophers' quest for the meaning of Being is an ancient one.

Gadamer's hermeneutic philosophy, based in language, "is an interaction between a historically produced text and a historically produced reader" (Allen, 1995, p. 175). Hermeneutics' relevance to this study lies both within the use of language and the historicity of the work. The narrative to be analyzed comes from older practitioners and managers, talking about their embeddedness within a defined social, cultural period of time.

The Complexity of the Language

Central to Heidegger's philosophy are the words, phrases and method he brings to opening up "the mystery of Being" (Polt, 2003, p. 25). Yet the very way he chose to lay open and address the meaning of Being becomes, for some, a barrier to understanding. For those who do not speak German, there is the hurdle of grappling with translated words and interpretation. Then, Heidegger's approach to words is so innovative and steeped in meaning that understanding only comes after endless reading and re-reading. Inwood (2006) says that "above all words matter to Heidegger. Words matter as much as meanings" (p. 2) and that he sought to retain "connections to the language of the marketplace" (p. 2). I frequently found that in order to understand the words, when referring to the philosophy of Heideggerian hermeneutic phenomenology, I needed to refer to the work of other scholars (Harman, 2007; Inwood, 2006; Krell, 1992; Polt, 2003; van Manen, 1990) who have written about Heidegger's philosophy; in order to gain access to his thinking, writing and philosophical notions, before once again returning to Heidegger's work. And as I have read, it becomes apparent that others too share this struggle. For many people, it seems that the tension with Heidegger's use of language comes because he is reaching out to show what lies behind the everyday world, one that we do not usually take notice of and do not have a language for (Inwood, 2006). As Heidegger believed that the words used in traditional philosophy did not suit his new approach, new words, new thinking and language were called for:

> The broad outlines of the everyday world, and many of its details, are inconspicuous to us. We have thus developed no vocabulary adequate for describing it. If called upon to do so, we tend to resort once more to the language of traditional philosophy. (Inwood, 2006, p. 2)

Both Heidegger and Gadamer brought new ways of looking at and naming interpretation and meaning. Gadamer's major contribution to hermeneutics comes through language. In saying that "Being speaks" (Gadamer & Grondin, 1996, p. 90) Gadamer is telling us that "only through language can Being be understood" (p. 90); yet, he also acknowledges a limitation, that not everything is language and that "what cannot be understood can pose an endless task of at least finding a word that comes a little closer to the matter" (p. 91). I found this was how it was for me in my search for meaning. While Being spoke out from the language used in participants' narratives, always there was the search to grasp the deeper level of meaning that showed the experience in a new way through other language, other words.

I acknowledge the importance of the new vocabulary that Heidegger, in particular, brought to the philosophy of phenomenology. Throughout this thesis I have used many Heideggerian words and notions to show meaning. Gadamer's notions have also informed the research project and interpretation within it. At the same time I am conscious of the need for the work to be intelligible to readers, including those not familiar with Heidegger or Gadamer's work. Within my writing I have tried to walk a pathway that strikes a balance between showing the way that Heidegger and Gadamer's philosophy underpins and opens up my interpretation and that of speaking clearly and understandably to readers.

Like others before me, I have had to discover for myself whether the insights gained from Heidegger and Gadamer's language make the effort worthwhile. Wrathall (2005) poses this question about Heidegger, why "is he worth striving to understand?" (p. 5). He answers by saying that:

> Heidegger did more than any other thinker of the twentieth century to develop a coherent way of thinking and talking about human existence… [and]…has challenged us all to rethink our place in history and the direction in which we as a scientific and technological culture are moving. (pp. 5-6)

Despite the frequently challenging language and complex philosophical notions that Heidegger used to outline his philosophy, there are many insights about human existence to be gained from coming to understand. And while for many people the difficulty puts them off reading Heidegger (Wrathall, 2005), I have found that, despite experiencing those same difficulties, the philosophy and philosophical notions, in speaking of the covered-over meanings lying within stories of lived experience, brought to life the phenomenon being studied. When Harman (2007) draws attention to the way life is always a part of the context it is situated in, he says that "life is thisly" (p. 28), for it is "this particular life and no other" (p. 28). The historicity, and situatedness, key to this philosophical approach is one where participants talk about particular moments and events in their lives. This both links to and underpins the happenings of the findings chapters. There the participants talk about their work and recall what matters from their past and consider their present and future. While I am convinced of the need to understand Heidegger's language, there still lies the complexity of grappling with the political stance he took.

It would be remiss of me to complete this explanation of Heidegger's philosophical relevance to this study without referring to his involvement with the National Socialism (Nazi) party. For some people his connection to the Nazi party discredits his philosophy and raises questions about its use and whether Heidegger the man can be separated from Heidegger's philosophy. I have explored explanations of Heidegger's past through readings that refer to those years (Dreyfus, 1991; Harman, 2007; Polt, 2003; Wrathall, 2005) and I am reminded that always there is the inexplicable in amongst the understandable for "our origins open a 'clearing', an open space within which things are revealed to us - but this clearing is always surrounded by the dark woods, the realm of the concealed and inaccessible" (Polt, 2003, p. 9). While Heidegger's decisions and actions lie within the inexplicable, his personal background and the historical context he lived through would seem to make the way he lived more accessible.

In turning to consider Heidegger's early life I acknowledge that "our beginnings both illuminate and hide our world, opening up certain dimensions in life at the same time as they close off others" (Polt, 2003, p. 9). Heidegger's upbringing in a small town brought with it a strong sympathy for the German countryside and his belief in being situated concretely within his world, a place where he could turn away from modernity (Polt, 2003). As a man, Heidegger "could be a bully; intimidating gifted students such as Gadamer" (Harman, 2007, p. 14) and is further described in Polt (2003) as:

> An intense man who by nature longed for extremes and hated everyday conventionality and comfort; at the same time he had been raised in a provincial, Catholic environment… In a time of crises Heidegger was poised to become one of the many 'revolutionary conservative' intellectuals who supported Hitler. (p. 113)

In 1933 Heidegger joined the Nazi party and supported the National Socialist German Workers Party in what has been described as "Heidegger's darkest year" (Harman, 2007, p. 10). When, "attracted by the party's anti-modernism" (Wrathall, 2005, p. 84), he agreed to become the National Socialist Director of the University of Freiburg his colleagues, such as Arendt, were appalled by his involvement with Nazism (Polt, 2003). Heidegger was not only an enthusiastic supporter of the Nazi party but also failed to support Jewish colleagues who were in danger (Harman,

2007); yet for many what rankles most, and may have been most damaging to his reputation in the longstanding debate about his involvement with Nazism, was his later silence and his seeming lack of contrition (Polt, 2003; Steiner, 1987). Wrathall (2005) says that "it is downright distressing to see how poorly Heidegger behaved in the circumstances" (p. 86). His silence has also been seen as a choice to not defend his actions for "silence does not necessarily conceal" (Inwood, 2005, p. 198) as "silence is one of talks way of being and as such is a definite way of expressing oneself about something to others" (Heidegger, 1925/1985, p. 368). Silence in such situations can be seen as the call of the conscience (Inwood, 2006).

In using hermeneutic phenomenology it was to Heidegger the philosopher that I turned; rather than Heidegger the man. It could be argued that the two are inseparable; yet, others say that there is no sign of his politics in his philosophical writing (Dreyfus, 1991; Polt, 2003). What should I, as a student using Heidegger's philosophy focus on? Polt (2003) says that "for the student the main concern should [be] his thought" (p. 113). Throughout this study Heidegger's thinking and questioning led to an opening up and expanding of my thinking and questioning, for to use his philosophy is to question. And while much of the questioning is focused on my own interpretation within the study, alongside this sits a questioning and reflecting on Heidegger's philosophy.

> For those influenced by Heidegger, it is not his misadventures with Nazism or his self-importance that is paramount in interpreting his philosophy, but his originality as a thinker and the scope and profundity of his thought itself. (Wrathall, 2005, p. 2)

While it is the thinking and philosophy of Heidegger and Gadamer that primarily inform the methodology used, other philosophical sources, from within hermeneutic phenomenology and from without, are drawn from. The philosophical notions significant to this study are now offered.

The Philosophical Notions key to this Study

Heidegger's (1927/1962) notions were frequently of his own invention as he constantly tried to explain things that are difficult to put into language (Inwood, 2005), and "to tell about the most fundamental things of our existence" (p. 3). In order to bring understanding to the reader, within the following writing are the notions of Heidegger and Gadamer that feature most prominently and support the

interpretation within the findings chapters. While further explanation is given as the philosophy comes to draw meaning from stories, the following notions, that are fundamental to the study, give the reader an overview of what lies ahead.

The Philosophical Notions

Dasein/Being- Being there
Being, or Being there, is translated from the German 'das Sein', a word that means existence, but also literally means being-there (Large, 2008). Being is seen as Heidegger's most universal concept as "Being is always the Being of an entity" (Heidegger, 1927/1962, p. 29). But what is Being? For Heidegger "being *is* Being", for "all being is in Being" (Steiner, 1987, pp. 25-26). What Dasein describes is "the way human beings are rather than what they are" (Large, 2008, p. 109). Heidegger's focus on Being came from a "fundamental concern with ontology: What does it mean to be a person" (Leonard, 1989, p. 42).

Within this study, in the research question, in my philosophical approach and in my interpretation, I turn towards a focus on **how** older experienced health professionals experience their world and away from the question: **what** is an older health professional. This requires me, for instance, during participant interviews to draw meaning from participants' stories that disclose them engaged in their everyday work world, interacting with things and others, rather than focusing on what or why they are who they are.

Being-in-the-world
In setting out to explain 'everydayness' Heidegger moved away from terms that he believed had limited ability to show normal existence, such as "rational animals" (Polt, 2003, p. 36), to a new way of looking at existence. The term being-in-the-world makes explicit the way that people are always a part of a world, that they are always situated within a context rather than standing alone. World and worldhood are words used by Heidegger (1927/1962) to describe all that is present in the world, a place where we work, as well as where Dasein lives. It can also be used to name both the public world and the everyday domestic kind of world with worldhood indicating the totality of what is significant in the world.

This study links into the situatedness of study participants in their work-world. Within this world older health professionals live out their everyday existence.

Impacting on how they experience their world will be their encounters with the ordinary everyday things that they work alongside. I am mindful that such situatedness matters, that I need to pay heed to how the participants engage in their world as health practitioners and managers. Alongside this I need to be careful of readily made assumptions as "the world is ambiguous, or two faced" (Harman, 2007, p. 2), a place where things hide from view or may present themselves in oversimplified ways.

Being-with
An aspect of being-in-the-world (Heidegger, 1927/1962) is that in everyday existence we are always with other people; for even when physically absent, they can be present in our thinking and revealed in their absence. Heidegger tells us that "the world of Dasein is a *with-world* [Mitwelt]" (p. 155). In terms of being-with-one another, we are "essentially for the sake of Others" (p. 160); yet, according to Heidegger, "by 'Others' we do not mean everyone else but me… they are rather those from whom, for the most part, one does *not* distinguish oneself − those amongst whom one is too" (p. 155). Because of our constant concern with how we compare to and differ from others, an "inconspicuous domination by others" (p. 164) can take Dasein over.

Heidegger (1927/1962) talks of the "dictatorship of 'the They' " (p. 164). These are the frequently invisible people who make the rules and set the pattern for what is right and what is wrong. For "Being-with-one-another concerns as such itself with averageness, which is an existential characteristic of 'the They'" (p. 164). As a consequence of averageness a levelling down occurs where Dasein is controlled in 'the They' dominated everydayness. It seems that this is how Dasein comes to feel at home, as Dasein is not answerable or responsible for decisions made by the They.

Throughout the findings chapters, older health practitioner and manager participants can be seen being drawn into a tension between their resoluteness and the influence of 'others' and 'the They', pressures that sway them away from their self-constancy (Polt, 2003). In their particular world of health care provision, older health professionals will constantly be comparing themselves, and their actions, with others, wanting to fit in with others. For just as we are all influenced in life by

those around us, for the study participants *Being-with* others and surrounded by the frequently faceless 'They' in the world of work, will impact on their actions and reactions.

Being Authentic (Eigentlich)

For Heidegger being authentic is neither good nor bad (Polt, 2003), just as being inauthentic is neither one or the other. Rather, authenticity relates to when we are most ourselves, as frequently, being authentic comes when we are jolted from our casual everyday mode of being-in-the-world into an awareness of who we are, our potential future, and possible well being (Polt). From Heidegger's (1927/1962) perspective this awareness comes as recognition that we are always Being-towards-death. Authenticity is revealed when we make our own choices and own our existence (Large, 2008). We fall back into an inauthentic mode of being as we carry out everyday aspects of our lives where we let others make choices for us. Falling under the influence of 'the They' tends to be linked to being inauthentic, in contrast, being resolute and owning one's decisions relates to authenticity (Heidegger, 1927/1962).

Stories from the study participants reveal them in both authentic and inauthentic modes of being in the world. At times in the everydayness of the world, they go along and fall in with decisions and choices that are made either for them, or made under the influence of others; whereas in other situations, they refuse to follow the crowd and choose their own possibilities. As older practitioners, looking towards what the future holds, study participants can be seen in an authentic mode weighing up their future possibilities, and considering the diminishing years left to them.

Phenomenon

A phenomenon signifies "that which shows itself in itself" (Heidegger, 1927/1962, p. 51). Yet Heidegger also reminds us that phenomenon can seem to be one thing yet be another, a seeming, or "semblance of something" that in reality is not (p. 51). Alongside this we can be deceived when a phenomenon indicates something that does not show itself, but is giving only "an appearance of being something" (p. 52). The phenomenon, therefore, can be something in some way hidden that may be revealed.

Heidegger (1927/1962) asks, "what is it that phenomenology is to let see" (p. 59)? He then answers, "that if phenomenology is letting something show itself, what phenomenology deals with must be something not already obvious" (p. 59), that "it is something that proximally and for the most part does not show itself at all: it is something that lies hidden" (p. 59). In this way I come to understand that the phenomenon that I am investigating will not be one that is readily apparent; for the phenomenon to be worth investigating, I come to this study with the belief that the phenomenon of focus will not be 'just this or that' but is something not clearly seen, something that I will need to search for. I am mindful when analysing participants' stories that I need to stay close to the words from stories, in order to explore words and phrases whose meaning is not initially open to my understanding, to not be taken in by a mere semblance of what I am looking for.

Time

It seems time is not concrete or predictable and is there "already at work in our environment before we have noticed it at all" (Harman, 2007, p. 26). Yet, time is "grasped as an event" (p. 26); for life has a threefold structure – the past, the future and the present, which Heidegger sees as a truer representation of the meaning of time than linear clock time (Harman, 2007; Heidegger, 1927/1962). Time has an elusive, shimmery, slippery quality, like quicksilver, it slides out of our grasp plunging us forward with its movement. The future is something we are thrown into, finding ourselves in a new moment of time, in a new experience, in a new era as time gains momentum. Yet all the while we hold close to moments from the past, memories that anchor and sustain, rescuing us from the new unsettledness of the present. In the present when we think we have a grasp on time, we find ourselves falling into an unannounced future. Time plays tricks; the present, dreamlike, slides by, the past full of gritty detail assaults us in the present as alive today as yesterday and we must deal with it, while anticipating the future may bring feelings of hope, fear, possibilities into the present moment of time.

With their age advancing, time for older health professionals, with its threefold structure, gains increasing significance in their lives. So much of their life has already been lived, and would seem to lie in the past; yet memories stay with them, throwing them into the future. Caught in the ambiguity of living with the past and future, older health professionals may sometimes struggle to be there in the present.

Outwardly and inwardly they are marked by the movement of time and throughout the findings chapters, participants' stories show the way the movement of time impacts their thinking, possibilities and actions.

Thrownness
Thrownness describes an aspect of Being-in-the-world where we find ourselves coming from the past into the future (Harman, 2007), "delivered over to circumstances beyond our control" (Wrathall, 2005, p. 35). Heidegger (1927/1962) tells us that as part of being-in-the-world we are thrown from our past into our future to a place, or circumstance, that we do not necessarily choose; but to which we must respond.

Coming into this study I have been aware that the older health professionals who participated will have found themselves thrown into a vastly differing world of health care provision, a world poles apart from the one they encountered in their early work as health practitioners. In this 'new world' values may differ from those of the past, advances in technology will have changed their work and their workplace since their early clinical work. They may find themselves in a work-world where the clinical qualification that has been a badge of honour is no longer honoured in the same way and where being older may be valued differently than in the past. For the participants, the very thrownness (Heidegger, 1927/1962) of finding themselves in a particular world opens up possibilities and choices; yet, these future possibilities may not eventuate.

Coming to Understand
Interpretation is grounded in understanding (Heidegger, 1927/1962) and "in interpretation understanding does not become something different. It becomes itself" (p. 188). In contrast to the modern scientific approach with its objective way of gathering facts and formulating theories, knowing is based on our already Being-in-the-world and interpreting it. This is integral to interpretation, coming from our shared understandings and presuppositions. When we see something, we see it *as* something (Inwood, 2005).

Presuppositions regarding the focus of interpretation involve the following: My *fore-having*; "the general understanding of the entity to be interpreted and the totality of involvement… in which it lies" (Inwood, 2005, p. 107). My *fore-sight;*

when "I set my sights on something I want to interpret" (Inwood, 2005, p. 107). My *fore-conception* or *fore-grasp;* that "I can only interpret things in terms of concepts at my disposal" (p. 107). In addition, Gadamer (1975/2004) coming from a hermeneutic perspective, saw understanding as bringing that which we seek to understand into the open.

Such ways of interpreting in the study that I have undertaken are there as I engage with the texts from participants. What I bring to the study are insights coming from my experience of having been immersed in a clinical world of work in a similar time span to many of the participants; our histories link and overlap. This brings me into the study with a *fore-having*, an embodied sense of knowing what it is to be an older health professional in their work world. The *foresight* I bring will mean that I understand the participants and their stories central to my study from my perspective as a student researcher, as a health professional or simply by being human. My *fore-conception* means that I will have grasped certain aspects of their work world, such as tensions and generational differences between dissimilar staff. I am reminded that what I have grasped may be flawed, but with further interpretations this can be altered. However:

> That which we seek to understand will always be in flux between what can and cannot be seen, between what 'is there' and what disappears just as we sense a hint of what we have not yet grasped. (Smythe, Ironside, Sims, & Spence, 2008, p. 1391)

Horizons to Understanding

Heidegger (1927/1962) talked of a horizon as being the place, or vantage point, from which one can see certain things that we can then question. At a later point he saw horizon as relating to the differing perspectives from which the world could be viewed (Inwood, 2006). What underpinned the idea of a *situation* for Gadamer (1975/2004) was that of *horizon,* something we cannot stand outside of, relating closely to Heidegger's early writing about the meaning of horizon. Gadamer says that the "horizon is a range of vision that includes everything that can be seen from a particular vantage point" (p. 301). This notion is associated with another of Gadamer's (1975/2004) ideas, that the range of vision we have can be gradually opened out, expanded, by new ideas, new thinking, in a fusion of horizons; that we are never bound to one point of view, for our horizon moves as we move:

> 'To have a horizon' means not being limited to what is nearby but being able to see beyond it. A person who has an horizon knows the relative significance of everything within this horizon, whether it is near or far, great or small. (Gadamer, pp. 301-302)

In addition:

> The task of historical understanding also involves acquiring an appropriate historical horizon, so that what we are trying to understand can be seen in its true dimensions. If we fail to transpose ourselves into the historical horizon from which the traditionary text speaks, we will misunderstand the significance of what is required… Understanding tradition undoubtedly requires a historical horizon. (Gadamer, pp. 302-303)

I am aware with the undertaking of this research project that I come with my own horizon to understanding. My personal and professional background gives me a way to see what is before me. While the insights I bring from my vantage point will bring certain known things to my attention, I need to be constantly aware that to only see what is clearly visible could mean neglecting to take notice of what is really there. Yet, as Gadamer reminds us, it is through grappling with new thinking that our horizons expand and grow. Understanding comes when a 'fusion of horizon' (Gadamer, 1975/2004) occurs, as my own horizon merges with another horizon.

Older experienced health professionals, through the integration of their past experience and beliefs into their working lives, bring their history, their historical horizon, with them into their practice. Their stories in this study reveal this history and its impacts on them and their work. Understanding aspects of this and how their past is an integral facet of them, both as people and as practitioners, matters in recognising what it means to be an older practitioner. In attempting to understand their traditions, I need to "transpose myself" (Gadamer, 1975/2004, p. 304), to bring myself into the situation as a part of it, to see the wider horizon. Yet, Gadamer warns that it is "constantly necessary to guard against overhastily assimilating the past to our expectation of meaning. Only then can we listen to tradition in a way that permits it to make its own meaning heard" (p. 304). I am reminded that in listening to stories, and moving forward with my analysis of them, I need to situate myself within the process, all the while taking care that the meaning I am seeing is not solely coming from my assumed understandings.

Being in the Hermeneutic Circle

More than 200 years ago the hermeneutic circle of interpretation was cited by Schleiermacher [1768-1864] as both a theory of understanding and as a "systematic method for interpretation" (Dahlberg, Drew, & Nystrom, 2001, p. 71). The circle shows the way that initially we understand in advance "only in a vague, partially defined way, and not yet as the vigorous concept that we seek" (Harman, 2007, p. 58). While Heidegger (1927/1962) acknowledged the importance of pre-suppositions in coming to understanding within the hermeneutic circle, his concern centred on "the possibility of the most primordial kind of knowing" (p. 195) hidden within the circle, believing that "we genuinely grasp this possibility only when we have understood that our first last and constant task in interpreting is to never allow our fore-having, fore-sight and fore-conception to be presented to us by popular conceptions" (p. 195).

Understanding, in hermeneutic phenomenological research, is described as coming from the movement between the parts and the whole of the circle (Gadamer, 1975/2004) that expands and grows, in a fusion of horizons, as we bring what we do not yet understand to what we already know. When I came into the circle with a question about the meaning of being an older health professional I had some initial presuppositions of what that could mean. My pre-understandings of the research focus brought me into the circle and continued to influence my thinking.

Within the circle, as my ideas and interpretations were challenged by new thinking, my understanding expanded. At the same time I needed to be constantly alert to the possibility of sliding into obvious ready-to-hand interpretations that came initially from my fore-having (Heidegger, 1927/1962). In order to find the interpretation that best fitted the stories I needed to repeatedly turn towards what the study participants were saying, or not saying, that was significant to the research focus.

The Circular Nature of Analysis

Analysis of the research data occurred in a constant interweaving of the parts with the whole, just as in the hermeneutic circle. The parts initially consisted of the crafting of the significant individual stories while being open to the meaning within. Each story came back into the whole of each participant's offering of stories, opening up new insights. Through writing, thinking, and reading, the circle of

understanding grew; bringing new thinking and shape to the whole. Yet, the whole brought deeper reflection and refining of individual stories. It was in my immersion and the movement backwards and forwards, circling and recircling between the parts and the whole that I found the insights came, with movement between what was known and meaning that lay waiting to be uncovered (Diekelmann, 2001). Much of being in the play, the to-and-fro (Gadamer, 1975/2004) of working with the data, meant learning to trust that insight would come (Smythe et al., 2008).

Summary

Within the methodology there is much to lay before the reader, much to tell. I am aware that I have needed to confine myself to what matters, in bringing understanding to the foundation that underpins the study, giving insights to why I have conducted the study in the manner I have. My intention has been to show the way that hermeneutics and phenomenology come together, inter-twined within the research, to openly present the philosophies I have drawn on to guide this work. A brief description of the origins of hermeneutics and phenomenology led to a discussion on Heidegger's involvement with the Nazi party. The question of whether Heidegger regretted his links with Nazism remains unanswerable. In detailing the philosophical notions key to this research, my purpose is to bring the reader into the circle of understanding that has been so critical to the interpretation of participants' stories. The following chapter explores the path I have followed in the unfolding of the method.

Chapter Five: The Method – On the Path

Everything here is the path of a responding that examines as it listens. Any path always risks going astray, leading astray. To follow such paths takes practice in going. Practice needs craft, stay on the path, in genuine need and learn the craft of thinking, unswerving, yet erring. (Heidegger, 1971, p. 186)

Introduction

When coming to write and show the method used for this research project I am conscious that the path I have followed, while seemingly ordered and circumscribed, still lays open before me, still unfolding. For while I adhere to the path, in listening and responding, I find myself reflecting and learning, falling into hidden traps and ways of thinking, taking me another way. Much of the way of doing hermeneutic phenomenology research is an unfolding (Diekelmann & Diekelmann, 2009) where the method is endlessly intertwined with the search for meaning. This then is a method that draws on phronesis, the wisdom in action, "that resists being pinned down, refuses to be a set of steps, is enacted differently by each of us, and yet shares a common quest" (Smythe et al., 2008, p. 1390). The moment of doing the research, in the way of all lived experience, lies in the practice of always being 'in play' (Gadamer, 1975/2004); which, with its to-ing and fro-ing through the choices that continuously open up, can take off in any direction (Smythe et al., 2008).

There comes to be a tension in writing about a method that, through immersion in the research process, seems to just happen. Yet the challenge here is to clearly show the reader that this is the method. Despite the ambiguity of describing a method that seems to just arise from engagement with the study, this chapter sets out to show how this research project came into being, along with its evolvement and the drawing together. And while the method, as it is laid out, may give the appearance of being straightforward, it was not. Much of the meaning and importance of aspects of the journey were only revealed as I went along. Gadamer (1975/2004) reminds us of the complexity of using the method of hermeneutic phenomenology:

> In a serious sense there is not really a 'method' understood as a set of investigative procedures that one can master relatively quickly. Indeed it has been said that *the method of phenomenology and hermeneutics is that there is no method.* (cited in van Manen, 1990, p. 30)

Though there will not be steps or investigative procedures clearly outlined, I suggest that the reader will be able to grasp how, as the researcher, I was able to navigate the path that guides the method of this study (Caelli, 2001).

Starting Out on the Path

The Study Context

It is my belief that an understanding of the situatedness of this study, its time and place, will assist the reader to recognise what matters in the research, how it came to be and why. Hence, I will briefly lay out the influences that matter as part of this context. I came to this course of study having previously completed a Masters of Health Science thesis that drew on hermeneutic phenomenology as the methodology. There had been much new thinking and learning that excited me in the complexity of using a philosophy based method and methodology. I came to value the teachers who had so expertly mentored and guided me along the way. Some years later, after working in clinical supervisory roles and as a professional advisor, I once again returned to study with a question about meaning. This search for meaning also led me into using an approach that is about "drawing on who one is and who one is becoming" (Smythe et al., 2008, p. 1391). Along the way I would come to not only understand the focus of my research more deeply, but as part of the lived experience of engaging in the project find that it would insinuate itself, becoming a part of me and my ways of thinking.

Where did I stand in terms of this research? True to an approach underpinned by Heidegger (van Manen, 1990) I understood myself as an older practitioner, having worked with older health professionals, to be always situated within the context of my study. Yet alongside my involvement in the research focus there was my need to be open to seeing the newness in participants' stories, and the thinking coming from them, allowing the interpretation to unfold as I wrestled with the possibilities before me (Smythe et al., 2008). As my place within the research and pre-understandings of the research focus has been explored in depth, in chapter one, I will turn here to the issue of ethnicity.

The setting for this study is Aotearoa[6], New Zealand, a bicultural[7] country. New Zealand is also home to a successive wave of immigrants from Asian and Pacific Islands that followed the early European settlers. Although this research project did not set out to specifically address issues related to Māori[8], research participants might have identified as Māori. As I am Pākehā[9], to ensure that my approach to Māori participants would be inclusive and respectful, I met with Livia Marsden, at that time the General Manager of Te Puna Hauora Primary Health Organization, prior to commencing the research. She asked me about the focus and approach of my research and supported the inclusion of Māori as possible participants in this study. I was appreciative of the guidance offered as to how to ensure that my engagement and interaction with Māori participants was appropriate; for instance, ensuring that potential Māori participants fully understood that their stories would be recorded and that their words could be reordered.

Considering Potential Participants

As my focus was on exploring what it meant to be an older health professional, my initial intention was to interview only older allied health professionals. However, in the process of planning the research, I came to realise that the inclusion of another group, managers who worked with older practitioners, would give greater depth to the study. As such, I decided to also interview a smaller group of managers. The intention was not to make a comparison between the stories from these two groups; rather, that people from both of the participant groups would have an interest in what it means to be an older practitioner. I decided early on in the study to avoid the uneven ground of interviewing people who worked together, where one might be in a position senior to the other. My intention in making that decision was to assist in the development of a trusting relationship between myself and the participant and of their being able to consequently trust in the research process and its outcome.

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[6] Aotearoa was the name given to New Zealand by Māori prior to the arrival of European settlers.
[7] Biculturalism is a term used in New Zealand to describe the partnership of two cultures inherent in the Treaty of Waitangi signed in 1840 by Māori and the British Crown. Biculturalism reflects the sharing between two cultures of the land and an exchange and acceptance of cultural values and practices.
[8] Māori are the indigenous people of Aotearoa/New Zealand.
[9] Pākehā is the word used by Māori for people who are European or have fair skins.

Ethical Approval

Ethical approval was gained through the Auckland University of Technology Ethics Committee (AUTEC) (See Appendix A). Maintaining confidentiality and the anonymity of participants was an important ethical aspect of this study. While older health professionals working in clinical roles may not be seen as vulnerable people, at times they would be talking about their interaction with people in positions senior to them. For this reason I felt concerned to ensure their anonymity, through measures detailed under 'Protecting Participants' (refer p. 80).

Inclusion Criteria

The elected setting for the study was the upper North Island. The field of potential participants was wide; therefore, it was important to determine inclusion criteria prior to starting the study. However, one year into the study I elected to alter the inclusion criteria to include people who had worked as managers for any length of time, as I perceived that new managers may be more threatened by older workers. The revised approval (see Appendix B) was granted by AUTEC (2nd October 2007) and the amendment made.

For older health professional participants, the criteria included those of any ethnic group aged 50 years and over, who worked in clinical settings where their roles were primarily of a clinical nature or a mix of clinical with some management or professional leadership function. The age criteria of 50 plus was selected after reviewing literature where ages defining the older worker ranged from 45 years to 60 years. In addition, I specified that practitioners would have 10 years or more experience, as 8 to 10 years work experience, post graduation, has been used by New Zealand District Health Boards and unions to define an experienced clinician. Further, participants who have trained 20 or more years ago were chosen. These numbers of years were selected to ensure practitioners are older and experienced, an issue central to the research focus; as opposed to choosing less experienced, older practitioners, who entered their professional education as mature students. The participants selected were articulate and able to tell their stories in English.

For healthcare managers, the initial inclusion criteria were those who had been in management positions for 4 years or more, and whose primary role was management; yet, they remained close to clinical work and had experience of

working with older health professionals. I further specified managers who were articulate and able to tell their stories in English and came from any ethnic group provided they met the other inclusion criteria. One year into the study I became aware that only including managers with 4 or more years of managerial experience could limit the range of stories. As a consequence the criteria was changed as described under the subheading Inclusion Criteria.

Accessing and Recruiting Participants

Approval was granted to recruit up to 18 participants, a maximum of 13 older health professionals and 5 managers. Setting the maximum participant number, rather than a fixed number, gave me flexibility around deciding when sufficient data had been gathered. The numbers were determined as a decision was required regarding "quality versus quantity" (Kvale, 1996, p. 103) and I needed to ensure that the overall scale of the research fitted within the size of the project.

Many of the participants, both health practitioners and managers, came to the study through my informal professional networks, my own knowledge of people who met the study criteria and the informal professional networks of my two supervisors. As the study progressed, the specific purpose for recruiting certain participants became apparent as I heard and analysed the experiences of the earlier participants. Sometimes the initial approach to potential participants was made through an intermediary; at other times, directly by telephone or email. Information sheets (Refer Appendices C and D) were then given, or emailed, to people who had indicated their interest and were left with them for a week or more to consider. The majority of people who were informed about the study contacted me directly. Two potential manager participants did not respond to a message from me after initially expressing interest. As they had my contact details I assumed this meant that they no longer had the time or were no longer interested in participating. I therefore elected not to pursue further contact. People needed to be involved in the study of their own volition and interest, rather than from external pressure to participate. On occasion, people did not go on to become participants, as they did not meet the inclusion criteria.

Recruitment took place over 19 months. This was a lengthy period, which allowed me to fully immerse myself in the initial narratives, as each was transcribed, and

initial analysis began, before recruiting further participants. Accordingly, I began by interviewing 6 older practitioners over a 4½ month period. Then all 4 manager participants were recruited and interviewed over 5½ months. I purposively selected (Morse & Field, 1995; Whitehead, 1994) primarily younger managers, as there were indications of possible generational differences or tensions between older health professionals and younger managers coming through in practitioners' stories. Later, after considerable work had been done with their interview narratives, four additional older health professionals were recruited and interviewed over 9 months. This ordering was intentional to enable me to bring additional insights to the later interviews. During the latter part of the recruitment process, when I had a stronger sense of what was coming forward in stories from the older health professional participants, I chose, following discussion with my thesis supervisors, to be quite specific about the participants still needed. Thus, the last two practitioner participants selected were working in roles likely to place greater stress on people as they age, such as being involved in night work and the physically demanding work of theatre nursing. This specific strategy followed up on earlier participants' accounts of being physically tired and finding it harder to cope with broken sleep, and was used with the intention of capturing the breadth of experience of ageing as a health professional.

The Study Participants

The following outline of the research participants is deliberately general in nature. A number of participants expressed concern about their anonymity and that of the people they talked about. Therefore a decision was made early in the study to give demographic data collectively but not individually. Rather than focusing on participants' professions, readers are encouraged to focus on hearing the meaning in the participants' stories in relation to ageing. Fourteen people participated in the research. That number does not represent the full range of health professions or health services that exist, nor do they represent the ethnic diversity of New Zealand.

Older Health Professionals

There were 10 older health professional participants; 9 women and 1 man. The discipline mix was 2 midwives, 3 nurses and 3 occupational therapists, 1 physiotherapist and 1 podiatrist. There was one older practitioner who identified as

Māori and nine as Pākehā or of European descent. They came from a major city and a rural area in the upper North Island of New Zealand.

The older health professionals' ages ranged from 50 years to 66 years with a slight majority being 60 plus. One participant was on the edge of retirement and another, while still working when recruited, chose to be interviewed following retirement. They worked for a range of organisations; two DHBs, two private hospitals, two private clinics, in independent practice and contracting to Accident Compensation Corporation (ACC) from private practice. Participants carried out their professional work in community mental health, forensic psychiatry, in the theatre of a private hospital, a community physical health setting, from a community based midwifery practice and as an assessor contracting to ACC. One participant worked in two different roles, as an older health practitioner in one and as a manager of a service in another.

The years since graduation, at the time of interview, were between 29 and 41 years, with the majority having graduated 38 or more years ago. For the majority of participants there had been changes of work place and role along with lengthy periods employed in particular roles. At times all their work was on a full time basis; at other times there was a mixture of part time and full time work. Almost all participants had periods where, since graduation, they had not worked in their profession. As the majority of this group of participants were women, it is likely this related to time spent in child rearing.

Manager Participants
Of the 4 manager participants in the study, two were women and two men. One manager participant identified as Māori/New Zealand European and 3 as Pākehā or of European descent. They all worked in a major North Island city. Their ages at the time of interview ranged from 34 to 50 years. The majority were in their mid to late 30s.

The manager participants had worked in management roles for between approximately 1 year and 16 years, though for the majority it was up to 6 years. One participant had recently left the management position but I believed the amount of recent experience the manager had was ample for the purposes of the study. The

participants managed a multi-disciplinary team, hospital services, a community service and a private hospital/clinic. These services where part of two DHBs and a private hospital.

When is Recruitment Finished?

How did I know when I had enough participants? It was always tempting in the process of interviewing, having data transcribed, pulling the stories together and glimpsing the meaning, to keep adding participants from professions that I had not yet included. It was also tempting to include a manager who was suggested to me later in the recruitment process. But I was mindful of the quantity and quality of the data that I had already received from participants and wanted to do that justice, for the depth and quality of the narratives given can be as important as the numbers of participants in research of this nature (Sandelowski, 1995). In addition I was coming to the realisation that there was not only sufficient data for this study but that also, despite the diversity, there was an increasing similarity in terms of stories and the meanings arising from them. Recruitment stopped at that point.

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Phenomenological Interviewing

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Interviewing in a hermeneutic phenomenological study has been described as conversational and unstructured with the intention of discovering a rich description of the phenomenon being studied (Benner, 1994; van Manen, 1990), all the while remembering in the interview the question fundamental to the research (van Manen, 1990). When using a phenomenological approach, the purpose is to get as close to the everyday experience being studied as possible by gathering the stories that participants relate about their embodied experience. These stories tend to come from being specific, rather than general, in asking participants to talk about how interactions happened, about when or where, and how they felt (van Manen, 1990). At other times the dialogue can be more hermeneutic in nature, when participants are asked about their understanding of something they describe. I also brought to each interview thoughts about some of the experiences I wanted to have the participants talk about. During the individual voice-recorded interviews, such ideas were used as conversational guides; whereas on other occasions when participants talked at length, there was a sense that the interview was guided by the participant's stories.

Coming into Interviews

Participants were asked to nominate a meeting place of their choice. I also suggested two possible rooms outside their workplace: a meeting room at Auckland University of Technology and a meeting room at the Northern Region Stroke Foundation's office. Six participants chose to come to 1 of those 2 venues; 4 elected to be interviewed at their home, and 4 participants asked to be interviewed at work for their convenience. Of the latter group, 3 were managers and 1 was a practitioner who worked in both clinical and management roles. Some of these interviews were outside work hours. Clinicians seemed less comfortable about making the choice to be interviewed at work.

With the intention of keeping the interview informal I took food to eat before or during the interview and ensured that a hot drink was available at the interview site. A discussion about the study prior to the interview provided an opportunity for me, as the researcher, and the participant to gradually orientate ourselves to the interview process (Johnson, 2002). Consent forms were then signed (Appendix C) highlighting the participant's ability to withdraw from the study. As a digital voice recorder was used to capture participants' stories for later transcribing, and re-listening, I reminded participants that the interview would be recorded and that the recording could be stopped at any point they chose. Participants were also assured that any demographic data they shared with me would only be used in a general way in the research method to outline the nature of those participating in the study. Those participants who indicated that they would like to receive a summary of the findings of the thesis were assured this would be provided following completion. Each participant was asked to choose a pseudonym.

Older Health Professional Participants

The interviews sometimes began at a slow pace, with the participants taking awhile to fully relax. In Dickinson's (2004) doctoral thesis, she notes that health practitioners (rather than the patient/family participants in her study) took "longer to get the dialogue underway" (p. 95). The conversation guide I used is presented in Appendix C. After hesitant beginnings participants soon became more open to sharing stories of their experience. Two participants were initially concerned with anonymity. They became more confident when reassured in greater detail about being able to ask for removal of aspects of the recording, and being able to review

the stories and have details withdrawn or altered as they chose. At times it seemed as though participants were seeking to give the 'right' response when there was no right way. In order to bring their focus towards a specific time or place (van Manen, 1990), I initially opened the interview by asking participants to talk about what it was like for them working in the team/group they currently worked with, in terms of their age. While this resulted in some stories relevant to the study, by the fourth interview, I decided to change the 'opener' to encourage more specific data. So I began asking how they saw themselves, as an older worker or in some other way. This initial conversation starter seemed to promote the flow of stories of the specific pre-reflective nature that I was seeking (van Manen, 1990). Yet, Gadamer (1975/2004) reminds us of the complexity of conversing:

> The way in which one word follows another, with the conversation taking its own turning and reaching its own conclusion, may well be conducted in some way, but the people conversing are far less the leaders of it than the led. (p. 345)

At times it seemed that the participant and I conducted the interview; on other occasions it was as though the conversation led us. And so it was that no two interviews were the same; yet, some resembled others. There were many occasions during interviews when I recognised 'little gems', words that revealed something of the experience of being older, or experienced, as health professionals. These were exciting moments. A number of participants had a lot they wanted to talk about. It was as though they had been waiting to tell someone about their experience. These lively interview conversations sometimes occurred in response to my prompts and comments in the form of "How did you feel when that happened?" and "That's interesting". Participants' seldom seemed conscious of the interview being voice recorded. When participants talked of events that did not seem to relate to the research question, it was a difficult balance knowing when to wait and when to interrupt to seek further clarification. As participants began to sound as though they had said what they wanted to say, I asked about things that we had not yet talked about such as where they saw themselves being in 5 or 10 years time. Enquiring if there was anything further they wished to add frequently initiated the telling of a further story. I found that it was important not to turn the voice recorder off too early.

At the end of each interview a kōhā[10] of a $10 petrol voucher was offered, and accepted. This was intended to cover transport costs of getting to and from the interview, and as acknowledgement of my appreciation of the gift of their time. The older health practitioner interviews lasted from 50 minutes to 75 minutes. Although I had made provision for it in the ethics application, I came to believe a second interview was not needed with any participants. I had the sense that they had finished relating their experience. Telephone conversations took place with three of the participants when I asked them for further detail regarding something they had already talked about.

Manager Participants

The initial interview was with a younger manager who had brief management experience and showed the tensions relating to generational differences between the manager and older health professionals. Because of what this interview revealed I chose to remove the number of years managers needed to be in their role to meet inclusion criteria.

For the most part, manager participants were open and confident during the interview process. With them I came with a different approach to the conversational dialogue (Refer Appendix D). Initially I asked managers to focus their minds on an older health professional they worked with, to picture them, think about them and then to tell of a time when something happened that impressed them regarding that person. This process was used in an effort to focus their thinking and responses on what lies at the core of the study, their experience of working with older practitioners. From some participants, this strategy immediately brought forth stories about their experience of working with older practitioners. Despite this strategy, one manager participant spoke at length about older people on the team; yet when I enquired, these people were administration staff rather than health professionals. These were hard conversations to halt and sometimes it took until there was a break in the narrative for me to attempt to refocus the interview. Later, I asked for them to again picture an older practitioner and tell of a time when they had an issue with a specific older health professional. Many stories came from these two conversation openers. As with practitioner stories there were times when I

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[10] Kōhā is the Māori word given to a gift, present, offering, donation or contribution.

understood that I was hearing something significant, a word, or idea that revealed something of the phenomenon at the heart of the study. Towards the latter part of the interviews I asked about areas that had not been discussed, such as older practitioners' access to ongoing education. I again had the sense that a second interview was not needed as participants had fully explored their experience.

A kōhā in the form of a $10 petrol voucher was given to each manager participant as an acknowledgement of the time they had given me and to cover possible transport costs. The manager participants' interviews were between 60 to 75 minutes long. A number of further telephone conversations and emails came as follow-up with one participant around issues of identification and further clarification of her stories. Another manager participant assisted with recruitment and sent me helpful articles linked to my research as she encountered them. The primary difference between the practitioner and manager interviews was the confidence that the majority of managers participants showed early in the interviews, as well as feeling free to be interviewed at their work site. No incidents of any significance occurred during interviewing.

Transcribing the Interviews

I began by transcribing the initial two interviews from the voice recordings. While this was useful in coming to have a close relationship with the text, it is also a lengthy process. Other than removing some of the halting stammers of a normal conversation, the interviews were transcribed verbatim. When a fellow doctoral student said she was available to do paid transcribing I happily gave that task over to her for the following interviews. Although this had the potential to put a distance between myself and the data, there were ways to compensate. I listened carefully to the recording as I read the transcript, initially changing or putting in words that were intelligible only when I recognised the conversation. Highlighting aspects of the transcripts in my initial reading drew my attention to my early reactions regarding significant words and phrases. Later, as I was putting stories together, I listened to the recordings and again when I had received comments back from participants.

Protecting Participants: Confidentiality and Anonymity

I employed strategies to protect the identity of participants from being known. The transcriptionist who typed twelve transcripts signed a confidentiality document

(Appendix H). As she was also conducting doctoral research I had complete confidence in her maintaining confidentiality. Throughout the transcripts and stories all names of participants, family members, and co-workers were removed. When another person besides that of the participant featured prominently in a story, they were also given a pseudonym. At times geographic and work place names were altered and in certain stories further changes, such as to gender, were made when the participant believed the story could identify them or other people. The stories crafted from each participant's narrative were sent back to them to read and they were asked to comment as they chose; then deletions and amendments were made as requested. Many of the changes were minor and revolved around ensuring anonymity for the participant and those people they talked about. At times sections of some stories, that were potentially identifying, were removed when their removal did not alter the meaning inherent in the story and when I came to see that they were not central to the research focus.

Confidentiality has been ensured by the storage of transcripts and other research material in a locked cabinet in my office. The recording of each participant's interview was deleted late in the project. Protection of participants was an important aspect of the study throughout the research process. Alongside AUTEC approval was my own sense of valuing what I had been given in the way of participants' stories and how I came to use them, and my awareness of the trust inherent in those relationships.

Hermeneutic Phenomenological Analysis

Crafting Stories

Caelli (2001) discusses the need to craft stories from transcripts in order to not only send something understandable back to participants but also to develop rich deep stories that resonate when read. While she named these crafted stories "narratives of experience" (p. 278), I have preferred the word *stories* on the understanding that readers recognise that they were drawn from the data, reshaped using participants' words, thereby becoming *crafted stories*. Crafting the stories from participants' narratives began by looking at each participant's transcript one at a time. As I looked at each narrative, words, phrases and paragraphs, leapt up from the page. Some of these words had stood out during the interview process; others were new and exciting discoveries. I highlighted these words and began to craft stories. Some

came almost intact from the transcript. More often, parts of the stories were in one place while other aspects were in another, as a participant circled back to conclude what they had begun talking about earlier. Much of the interview narrative was the muddled mixture of everyday conversation that, left as it was, would confuse and hide 'the gems' lying within. While some words were left out, others were added to increase coherence. Grammar was altered to enhance the meaning that was already there. Caelli (2001) describes the way both Patricia Benner and Max van Manen used this method of crafting in stories they presented at a symposium. Van Manen, speaking at a workshop (cited in Smythe, 1998), said "that a transcript was merely the means of capturing meaning, it was not an end in itself" (p. 113). This led me to have confidence that I could take the story inherent in participants' transcripts and in coming to understand what I found through reading, listening to the audiotapes, crafting and re-crafting stories, have a story that spoke of something significant; that illuminated an aspect of the experience being studied.

Revealed here is the paradox that in stepping out of a participant's story, from having been immersed in the words and flow, the researcher can come closer to showing the story more fully. For in bringing coherence to it, by removing duplication and grammatical errors, the story is revealed in a new way allowing it to shine and stand out in a way that it did not as part of the raw data. When I had completed this early phase of crafting and polishing the stories that most closely related to the experience being explored, I gave each story a name in order to identify it more readily during later analysis. Inevitably many stories where left behind. They were the ones that either did not relate to the focus of the study or where other stories showed the phenomenon more clearly. At such times it was hard to let them go. I mourned their not being included in the report of the study.

Seeking Participants' Input

In order not to burden participants with reading and commenting on vast amounts of their written interview data (Caelli, 2001), a decision was made early in the study that their crafted stories, rather than their full transcript, would be sent back to each participant. Transcripts would be offered back to participants if requested. Just as interviewing took place over many months so too did the process of sending out the stories. Participants were asked to comment within approximately 4 weeks. I asked whether they had a sense that in crafting the stories I had stayed true to the

interview narrative they had given me. Eleven participants responded to the stories sent to them. A number of studies using this methodology discuss the lack of response from some participants following receipt of their narrative or stories (Caelli, 2001; Paddy, 2000; Smythe, 1998) as, subsequent to engaging in the interview process, they have become immersed again in their daily lives. Therefore I saw receiving responses from 11 of the participants as very positive.

With regard to the three non-responding participants; in one case I was assured by the person who had recruited the participant that they were still residing at the same address. As I had both posted and emailed the stories to them I elected to not pursue further contact. I met a further participant who commented that they were happy for me to use their stories unchanged in whatever way I chose. Unsure if they had received their stories, I rang the third participant who had not responded. Her reaction to the stories had been one of shock, which led to her not reading the majority of what had been sent. We discussed at length her concerns. These included her perception of the ease of being identified, also her negative sense of having talked about herself and her ideas at great length. Many of the words that could potentially reveal identity had been removed but following that conversation I further altered geographic, organisational and service pointers within the stories. Those changes did not alter meaning. The corrections, made at a participant's request, again confirmed for me that changing words in the data, as long as it was carried out in a way that safeguarded meaning, treating the narrative respectfully, was part of an authentic aspect of editing written work in a study of this nature (Smythe, 1998). At the time of the telephone call, I was also able to reassure this participant that all the study narratives showed participants talking about their own experiences, as that was what I was seeking and what I had asked of them. This was completed to the participant's satisfaction and the participant affirmed her consent following this interchange. This conversation added to and increased my awareness of the extent to which participants open themselves up, exposing themselves to vulnerability in what they reveal in the trusting interview process.

A number of participants asked for minor changes to their stories which were carried out as requested. Once the stories were amended they were sent back. I also

undertook to send the stories that were likely to be part of the finished work when it was still in draft, rather than complete form.

Listening for the Voices

As each cluster of stories came into being from individual participant's data, I came to question to whose voice I was attending. There was the voice of the older practitioners speaking out through their stories. Alongside this were the voices of health care managers speaking, amongst many other things, of older health professionals they worked with. Always in the background were the voices of philosophers, theorists and other researchers, expert in the methodology I was using, showing how to do it; this way, or that way? There was also my voice, the voice that I clearly needed to use and show throughout the research process. I came to see that while the participants' narratives were theirs, the voice interpreting stories, in a process of analysis of crafting and re-crafting, was mine. While the manager participants spoke of many things, what I needed to turn my attention to was the focus of the study; their experience of being with older practitioners. This sometimes meant turning away from wonderfully insightful stories of people and experiences that were not central to the study. These were hard choices to make; yet, they became clearer as I went along. The voices of philosophers and fellow researchers have been used throughout my analysis. At times I tussled with where they fitted and I frequently found myself altering what had once seemed just right. New and deeper reading added to what had already informed my thinking and growing insight into Heidegger's philosophy expanded my thinking, giving me a stronger voice. Nevertheless, it was always the data itself that directed my thinking and reading.

During the regular meetings with my supervisors I took notes of our discussion that I later typed, in order to draw and reflect on them, as I came to make choices and decisions about which way to go, which path to follow. These notes and the insights coming from them expanded my thinking and reflection. Consequently the voices of my supervisors, who walked with me on the path, also sit within this study; invisible yet important in my learning as part of "an oncoming converging conversation – a listening dialogue with the conventional practices, which humans conduct because they already understand" (Diekelmann & Diekelmann, 2009, p. xx).

Furthering the Search for Meaning

In searching for what is significant in participants' stories, in questioning "how does the text speak" (van Manen, 1997, p. 345), I was drawn to a number of language features described by van Manen (1997). These are: "lived-throughness" (p. 351) that shows a phenomenon placed concretely in the life-world so that it can be recognised and related by readers to their own lives; "evocation" (p. 353), provoking images through language's vividness; "intensification" (p. 355), in the way of giving key words their full value; the "tone" (p. 359) of language which allows the text to speak to us appealing to our non-cognitive way of knowing; and "epiphany" (p. 364) that comes with a perception or intuitive grasp of the life-meaning of something. These aspects of language both linked to the way I crafted stories and to my ongoing analysis in drawing meaning from the text.

Initially in trying to access what was not obvious in stories I used a number of approaches to open up my thinking. I began by writing about what the story was telling me, asking "What is happening here?" Then I looked for what the story seemed to be saying about the meaning of being an experienced older health professional. I then found myself searching for universal themes, turning to philosophy and the way it could reflect meaning in a new way, seeking to take away everyday assumptions that hide the phenomenon from view. This stage of moving to a deeper level of analysis was exhilarating, but also a struggle. Sometimes I wrestled with a piece of analysis endlessly, at other times I learnt to trust in the thinking that just comes (Smythe et al., 2008). This was thinking that seemingly came out of nowhere; when waking in the morning, out walking, when a phrase caught my attention while reading something unrelated to the research, and at times in the endless writing, thinking and rewriting of the research. I came to see that this grasping of something significant came primarily when I was in a mode of deep immersion in the data, yet frequently happened when I had ceased working and relaxed, or at times when I was caught up 'in the flow' of ideas. Pamela Ironside (Smythe et al., 2008), talking about interpreting data wrote, "If I try to force it, it doesn't work. I don't know how to make it happen but I know when it does. It's exhausting but exciting at the same time. And when it happens I don't want to quit" (p. 1394). Ironside's words resonate with my sense of slowly learning to trust in the

thinking and meaning that just comes. I came to relinquish any thought that each part of the process would simply follow another.

At that point there comes the question "Can one understand the narrators better than the narrators understand themselves?" (Diekelmann & Diekelmann, 2009, p. xxi). The search in writing and interpreting was to see in the narrative that which was hidden. Analysis represents the complex mix of ideas and thinking that I brought to the research, much of the thinking growing from my reading of others' writing, but also seeking to go beyond those words. For in phenomenological interpretation:

> We do not seek to clarify and evaluate already known interpretation, but neither do we discard them out of hand. We seek rather to reveal hidden meanings in order to bring them to the light – not stopping at what the authors of the narratives tell, but going behind the text to ask what is not being said and perhaps what the narrators could not, would not, or do not say. (Diekelmann & Diekelmann, 2009, p. xx)

It was in seeking what the story could not, would not, or did not say, that analysis deepened and as early ideas gave way to more complex ones, my writing evolved, from turning to the story in the context of a participant's narrative to later bringing phenomenological notions to interpretation.

As I worked with participants' stories I came to see emerging patterns which led to evolving themes. I then began to place stories into loose groupings and to be able to describe to others important aspects of the data. This did not mean that the stories and analysis could not or would not later fall into a different pattern; rather, that it allowed for a sense of fittingness as the meaning of the data unfolded. While I had begun with fourteen folders holding each participant's stories and my initial tentative analysis, these evolved into eight folders, holding stories that seemed to represent the data and analysis, naming the emerging themes that spoke of significant things in the data.

Themes

Another way of showing what makes up participants' experience comes through taking hold of and showing themes as "themes may be understood as the structure of experience" (van Manen, 1990, p. 79). Van Manen (1990) also tells us that "grasping and formulating a thematic understanding is not a rule-bound process but

a free act of 'seeing' meaning" as "themes give control and order to our research and writing" (p. 79). Without the use of themes to see and show meaning, the findings chapters would be merely a sea of words.

The study's over-aching themes fell into four findings chapters. Having spent many months immersed in the detailed aspects of my work, as I began to write within themes the bigger picture became clearer. At times, stories moved to another level of analysis as I came to rework them within the developing argument. Frequently I was led astray by new thoughts and ideas and I had to refocus and remind myself of the research question. It was through being immersed in this thematic writing that I came to see that some aspects were alike and could be merged. In such a way, the clarity of my argument developed, and in further rewriting was refined. Van Manen (1990) says that this is how "essential themes" come into being (p. 107).

In this manner the four findings chapters developed. I started with little idea of the ordering of these chapters, yet I had begun with what came to be the first, followed this with the second, then the third, finishing with the fourth and final findings chapter; they had ordered themselves in my thinking.

Trustworthiness of the Research

Coming to the trustworthiness of this study has been a returning to the parts of the study. For it was within the parts that those aspects were revealed. In order to show the reader the trust inherent in this work, I have elected to use a framework of expressions of rigour that is firstly congruent with the methodology that underpins this work, and secondly assists in pointing to the path that I followed. De Witt and Ploeg's (2006) proposed framework for people using interpretative phenomenology seemed to most closely align with the process and outcome of this study. In addition aspects of Annells (1999), Koch and Harrington (1998), Smythe et al. (2008) and van Manen's (1990, 1997) writings have been drawn on. Koch (1996) says that one of the basic tenets when using this philosophical approach is "that a dialogue takes place between researcher and text, or reader and interpretations, acknowledging that the researcher and reader bring to the analysis her or his own preconceptions" (p. 92). It is my belief that this chapter shows how this occurs.

Balanced Integration

De Witt and Ploeg (2006) write about the necessity of balanced integration as a measure of trustworthiness in a hermeneutic phenomenological study. Integration shows in the way that the parts of the study come together to make a cohesive whole. The research question, one that inquired into the meaning of being an older experienced health professional, fitted well with the chosen methodology; one central to Heidegger's (1926/1972) philosophy, that is focused on Dasein, that looks to unravel the meaning of Being. Throughout the research process and findings chapters, ways of Being and other philosophical notions central to hermeneutic phenomenology sit within participants' stories, and link closely with much of my interpretation. Readers can see and judge for themselves whether the bringing together of the fundamental philosophy, the meaning in participants' stories, and my analysis, is congruent and has been integrated and made understandable (Annells, 1999; Koch, 1996). At the same time, each aspect while intertwined is balanced within the whole of the work (de Witt & Ploeg, 2006).

Openness

My orientation to the phenomenon of interest was presented early on in this study, visible initially in my presuppositions interview, where the notions I had about being older as a health professional were explored. These understandings have not been bracketed out but rather I have shown that I see myself as an integral part of the study, using my personal experience as the beginning point (van Manen, 1997). Visible too are the voices coming from others who have influenced the decisions made (Koch & Harrington, 1998). I have shown throughout each chapter the path that I have followed, the turns taken, and the adjustments made, and the choices and decisions that happened along the way (de Witt & Ploeg, 2006). The trail followed has been put forward in this chapter with examples of how decisions occurred, for instance by asking for the original inclusion criteria to be altered when new ideas came from an early participant's interview. I believe that the reader can recognise how and why these decisions came to be made.

Lived-Throughness

Rather than use the word concreteness chosen by de Witt and Ploeg (2006), the term "lived throughness" used by van Manen (1997, p. 351), to similarly indicate the need for participants' stories to be grounded in their experience, is preferred. This

assists in allowing readers, in bringing their own prejudgements (Koch, 1994), to recognise and connect to such things as the historical and cultural situatedness of the story (de Witt & Ploeg, 2006). The study situated older health professionals in their work world where the nature of being older as a practitioner most reveals itself. While crafting and choosing stories for the findings chapters I have endeavoured to show those that capture most closely the experiences that reveal such situatedness, staying as close to the words and meanings as possible during my analysis. In doing this I have sought to assist the reader in identifying with and appreciating experiences that link to one's own lived experience (de Witt & Ploeg, 2006; van Manen, 1997).

Resonance

De Witt and Ploeg (2006) refer to resonance whereas van Manen (1997) uses the word "epiphany" (p. 364). Both terms refer to having a sudden grasp or perception of meaning. This also aligns closely with Gadamer's (1975/2004) 'fusion of horizons' when understanding comes. Resonance is apparent in the way I have shown my attunement to the data throughout participants' stories and my analysis. The surprise of such understanding came during my research at such times as presenting my work to professional colleagues, doctoral students and teaching staff. Following a seminar where I had presented a participant's story along with my analysis, I heard from the participant who had been in the audience and whose story had been part of the presentation. She said that she had recognised something significant about her situatedness and her future possibilities through hearing the story and analysis, being alerted to things that she had turned her thinking away from. She had grasped the meaning of being experienced and of being older as a health practitioner that came from both the story and analysis, and consequently about the possibilities before her. This illustrated for me the way the phenomenon of ageing as a practitioner was embedded in its context and that my choosing "to do it this way" (Smythe et al., 2008, p. 1391) resonated with listeners. At presentations of my research, health practitioners saw themselves in others' stories evoking a depth of feeling and a sense of knowing what was coming to be revealed by the research. This contributed to my sense that the research had a worthwhile focus.

Actualisation

Actualisation speaks of the future expectation of resonance of the study (de Witt & Ploeg, 2006). Amongst other theorists, in writing about findings of a phenomenological study, Sandelowski (1986) says that readers of hermeneutic phenomenology will continue to read and interpret the study into the future. Although I have shown that the findings of this study resonate with audiences who have listened to them, it seems actualisation will come about through readers of the future. Throughout the process of doing this research, I have been aware that many aspects of the findings ring true not only for older health professionals but for other older workers. This potentially brings a much wider audience than older practitioners.

Summary

The path I have followed in carrying out the study is detailed in this chapter. Outlined, are the ways that participants were recruited to the study, with participants having been presented in a general manner that assists in maintaining their anonymity. Also detailed are the ongoing measures I took to protect those participating in the research. Alongside this, the nature of phenomenological interviewing, transcribing, crafting stories, analysis and the development of themes that gave meaning to the data in this study have been described. The framework that de Witt and Ploeg (2006) proposed for use in a hermeneutic phenomenological study has been used to show the trustworthiness of the project.

The narratives providing stories from the fourteen participants gave the rich text for the study. So much of what occurred was a process of keeping to the path, trusting yet erring, always 'in the play' of doing the research. I see this chapter as a starting point of the 'how' of this study, providing a route that leads into the four findings chapters. There, participants' stories, combined with my analysis, lead into themes that reveal what lies hidden, within the experience of being an older practitioner.

Chapter Six: Being the Past, Future and Present

Life always has a three-fold structure of past future and present. At any given moment life does not choose the state in which it finds itself. There is no erasing our current situation, no matter how glorious or miserable it may be; our current life is there before us, as the hand we are forced to play. The most we can do is to try to work with the situation as we find it and every moment, no matter how dull or how horrible, has its possibilities. This is the threefold structure of life which Heidegger sees as a truer form of temporality than clock time. (Harmon, 2007, p. 28)

Introduction

Just as we all do, older health professionals live in the moment of time with no escape from their present living and working situations. Heidegger (1964/1993) reminds us that we are unable to alter what is happening to us in the moment. Whereas the past assists in making us who we are, the future opens up possibilities of change. For Heidegger, *"Being is time"* (Harman, 2007, p. 1), we are our past, future and present: yet, we tend to take time for granted. Time remains invisible, that is unless it is clock time, dragging on as we wait, pressing in as we run late. In exploring what it means to be an older health professional the interwoven structure of time reveals itself; for older practitioners, like all of us, are caught up in the to-ing and fro-ing of time past, future and present.

Time past reveals itself in stories that show the older practitioners looking back to where they have come from, and considering in the present how their past has affected them. Time past shows in the way they talk about their expectations, anticipating a changed future, while acknowledging uncertainty about that future, with possibilities not yet at hand and which may never be (Polt, 1999). In order to understand what it is to be an older health professional working towards retirement, it is necessary to look back at how it was for them at the start: for the beginning influences the ending of the journey. This chapter explores the way in which the past and future of older health professional participants reveals who they are and where they hope to be.

The Past is Now

The past remains deeply intertwined with older health professionals' work in the present. It influences who they have become and how they practice. Alice, a midwife with many years working experience, reflects on what she has brought

from the past into her current work. She talks about her sense of the changing values around her:

> *I do think the values from when you trained matter. We were trained in really basic old fashioned principles that aren't always included in modern training. Just the simple things like bed sponging, making someone who's very ill as comfortable as you can, that sort of old fashioned, general nursing care, basic hands on stuff. I don't think it's there the same now. Although you don't get the same call for it in midwifery, there are times when you can make someone more comfortable because you have those old skills. When I was doing general nursing and you had someone who was terminally ill and they were miserable and uncomfortable, and you'd leave them washed and cleaned, and combed, with clean linen, there was something highly satisfying about that.*

From her past clinical education, Alice values the old fashioned principles, such as providing comfort, using them first when nursing and now in her practice of midwifery. Some of the intrinsic values of care from health professionals' clinical education, of years past, will be carried forward and used when working across diverse settings and client groups.

In the intimate relationships between midwives, nurses, and their clients, 'old fashioned' values and principles from the past are pulled into the future. Hands hold, soothe, and smooth, providing comfort when comfort is needed. Hands, the tools 'fashioned of old', the first tools going back through the millennium, tend those in need of care from the emerging of new life, at birth, to the cessation of life, at death. They bring to their work of care, their own ingrained memory of how to touch, how to soothe, how to hold. The understanding of the importance of the care given, its meaning, and how to provide care, is in the doing of it rather than in the thinking (Wrathall, 2005). Care 'fashioned of old' carries past tradition forward into future practice. For Heidegger, our hands connect us to our world and to others within that world; revealing in the universal role of hands, their connection to our being and doing:

> The hand reaches and extends, receives and welcomes – and not just things: the hand extends itself, and receives its own welcome in the hands of others. The hand holds. The hand carries. (Heidegger, 1993, pp. 380-381)

Hands, frequently conveyers of care in the past, have an important role along with the other ways we use our bodily presence in expressing care. Yet, they are

frequently silenced, overlooked, and taken-for-granted, their appeal to us deafened by the noise of the latest process or technology (Polkinghorne, 2005).

The previous story takes us forward into the present yet it has the past imbedded within it. Now we come to look back at how the participants came to their professional role and the significant ways in which those early choices remain a part of them still.

<div align="center">**Reaching Back in Time**</div>

How people come to make the choice, or neglect to make a choice, of a career varies widely; yet, available choices are also a part of the context of the day. At times, influenced by family expectations or the words of someone they admire, people have a picture of themselves from a young age in a certain role. Societal values, in terms of work, frequently impact on people, yet, may remain unrecognised and invisible.

The Call

While people may feel individually destined to follow a certain calling or career, according to Heidegger, (1927/1962) destiny comes not from individual decision, or individual fates, but through our being alongside others in the world, and from "the way in which a group draws on a shared heritage and works out a shared fate" (Polt, 2003, p. 103). While Heidegger (1927/1962) talks about the two notions, fate and destiny, that seem to indicate that decisions are out of our control, there will be choices to be made. Each of those choices which we are free to make will have its own load for us to carry:

> We are free, but our freedom is necessarily limited; our possibilities have to be drawn from our own heritage, and we are always faced with the possibility of having no more possibilities... We share moods, concerns and decisions, and our history tends to follow the movement of generations. (Polt, 2003, p. 103)

Decisions, while feeling freely made, will still be influenced by our context. For some participants in this study becoming, for instance, a physiotherapist, a podiatrist, a nurse can just feel right. This sense of fate could be described as the resoluteness that comes with being authentic (Heidegger, 1927/1962). Authenticity shows when participants' stories tell of them feeling very much at home and settled in their choice of work. It seems that others will feel called to work in roles,

particularly those associated with having a sense of vocation, that involve caring and reaching out to help others. Heidegger (1927/1962) talks of the call in this way:

> The call dispenses with any kind of utterance. It does not put itself into words at all; yet it remains nothing less than obscure and indefinite … while the content of the call is seemingly indefinite, the direction it takes is a sure one and is not to be overlooked. (Heidegger, 1927/1962, p. 318)

Following the call there can seem to be a predetermination, a sureness to what follows, shaping their lives. Many of the older health professionals had a clear sense of what drew them to their clinical discipline. However, others appeared to just fall into something and at times people found themselves thrown into a career they had not anticipated. Kate, a podiatrist, describes making her career choice:

> I was looking for a career and was more interested in helping people ... I saw occupational therapy, decided it was not me. Then the podiatry director, who was looking for students because there was nobody going through the course that had only been opened two or three years, hijacked the whole bus load of us and dragged us across to the clinic. I walked into a clinic and it was just me, I just knew it, it was just one of those revelation moments. Podiatry I think is a calling. It's a vocation to do this work. I think you really need to have a vocation to do the palliative stuff really well. If you've not got the empathy with patients, they can tell the difference.

While Kate sees her arrival at the choice of podiatry as a revelation and calling, Heidegger (1927/1962) used the word thrownness to show the way that we find ourselves thrown into future situations that are not of our choice or making. Kate's bus load of students were high-jacked, finding themselves already there in what "is and has to be" (Inwood, 2005, p. 219). Yet, even being thrown into something holds the possibilities of choice along the way (Harman, 2007). For Kate, making a choice from those possibilities means coming to work with a client group that she feels aligned to and concerned with. Other participants also felt a sense of vocation. Genevieve, a midwife, tells about how she came to be drawn to her future profession:

> I had a calling when I was young about seven. I wanted to be a nurse, I don't know where that came from, but I always wanted to be a nurse. There were none in the family, but I just knew. Then when I went to be a nurse I didn't like it at all, I found it very depressing. And I had cold hands, and so men would shriek every time I touched them, and I was very young and naïve. They could make me a blush at the drop of a hat so I was easy meat for embarrassment. And I didn't like all the death and dying. It was definitely wrong and I got depressed. So I was a nurse when I had a baby and that was traumatic. Then when I was overseas, recovering, I had the thought that I actually want to be a midwife. I was going to stay there but then I thought 'it gets dark too early, I'll

go back to New Zealand'! I arrived back in December and rang up the midwifery school and they had a spare place on a course starting January, so off I went. I was amazed. And I never looked back. I had a calling that's all I can say it was, it sounds mad but it's true.

Genevieve has known from an early age what she wants to be when she is grown up; yet, she quickly recognises that nursing is not right for her. The picture held in her mind, and what she anticipates as her future, alters when she finds herself in her youthful vulnerability confronted 'in the there' with death and dying. Genevieve finds herself delivered over into a situation that she must somehow deal with. Yet she must also consider other opportunities. It is through experience that new possibilities open up, with the source we draw on coming from the legacy of our past heritage. Our future plans come from somewhere, rather than being plucked out of nowhere, when considering our future (Polt, 2003). Heidegger (1927/1962) talks of such possibilities coming from a shared inherited past, from role models, while Polt describes "the interaction between our past and future" (p. 103) as allowing us to make resolute choices in the present.

When it Just Happens

For some older health professionals there was not so much a calling to a profession; rather, that it just happened. Yet there was an eventual feeling of rightness about their choice. Elizabeth, an occupational therapist, tells her story of getting started, of feeling pushed forward on the road ahead:

It just happened, I thought I might apply and then I got accepted. I don't remember thinking 'I'm so passionate about it, what a wonderful career this is going to be', I just did it. It was all very matter of fact. Now I wouldn't have done anything else, then it was just like, okay, this is the next step but it wasn't like I was driven. I remember focussing on the practical. That's what I liked about occupational therapy, it was very practical...and how wonderful the training was, it taught you so many different things that you could turn your hand to anything. I didn't think much about the patients, they were pretty scary really. I wasn't there to cure people. Fixing people, helping them 'no, no', I don't remember that being part of why I did it, it was just very practical.

There was no call to a vocation of looking after or 'fixing' people, no sense of wishing to 'do good', rather Elizabeth found a career that seemed okay to her, one that suited her practical nature. *Then* it was just the next step, whereas *now* she would not have done anything else. At times, swept along by the need to move into the next phase in their lives, participants describe finding themselves in lifelong careers. Yet looking back on their career choice health professionals can come to

see the consequences of that choice as their destiny. While destiny could be regarded as fate or providence, there can also seem to be a fallingness and thrownness (Heidegger, 1927/1962) into future possibilities. Thrownness involves being thrown into the midst of where one finds oneself (Inwood, 2005); yet, this leads on to Elizabeth and Kate's sense of having discovered the 'just right' career for them, showing a resoluteness that comes from their authentic sense of rightness in their choice.

The Allure of a Role

Sometimes potential careers exude an appeal that is centred on the appearance of the role. However, what looks exciting can be dull; a glamorous looking role can hide the gritty reality present in the everydayness of work. Coral, a physiotherapist, was drawn in by an allure attached to a professional role prior to beginning her clinical education:

> *I probably went into it with the same idea that 90% of physio students have, they want to work for the All Blacks[11]. But I remember my first placement as a physio student was down in the old outpatients department of Dunedin hospital. My first treatments were with these young, males who came in, who I described as a pack of wusses, with their smelly feet. I thought I don't want to work with people like this and I changed directions. It didn't take much at all! I still don't like smelly feet!! The strange thing is that in my early years as a physiotherapist, I think the most interesting people I ever met were some of the older people and I think that's probably why, in the end I, continued with neurology because I found that they were interesting to talk to, they worked hard for you. They wanted to get better.*

Working with 'The All Blacks' is envisaged as an exciting experience for Coral, yet what looks fascinating from the distance changes when she is thrown into a placement in close proximity to her potential 'idols.' She has an unexpected and revealing experience, one of seeing the phenomenon of men who play rugby close at hand. Instead Coral finds she enjoys working with older people. For being a physiotherapist in the world of work is 'thisly' (Heidegger, 1927/1962), this life in this situation.

Tom, a nurse working in forensic psychiatry, finds there is also a clear intention for choosing his pathway:

> *At high school my schooling was very much physics, maths, and sciences. I wanted to have a formal qualification. Coming in to mental health was a real*

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[11] All Blacks is the name given to New Zealand's National rugby team.

turn about where there were a lot of challenges, getting away from absolutes, and accepting all the shades of grey. That's probably the adjustment that happened through the formal part of my nursing training. In those days you got well paid as a student nurse and so they were some of the drivers that led me here.

Tom experiences a different call from that of some participants. His career choice brings with it the possibility of financial independence; an opportunity to turn aside from the pathway he is on, a chance to reassess his way of looking at the world, to see it from a different horizon. As this new lens from his immersion in the world of clinical education shows him a different perspective, absolutes modify and become pliable; the world softens, and takes on new colours, black and white become grey. As part of being-in-the-world we stand situated within that world (Gadamer, 1982). Yet, despite their differing contexts, people can move beyond their own vantage point to a 'fusion of horizons' when they are open to new ideas from texts or people (Grenz, 1996). Reaching this new point of seeing and understanding where things in that world change colour and absolutes open up transforms Tom's world. While some participants were clear about being drawn to a specific career, for others the influences on their choices and possibilities remain less visible.

Part of its Context: Different World

We come from communities that share a heritage that shifts across different times and places for "our history tends to follow the movement of generations" (Polt, 2003, p. 103). The traditions from our past assist in making us who we are for "we are *historical*…we inherit a past tradition that we share with others, and we pursue future possibilities that define us as individuals" (Polt, 2003, p. 5). In decades past, there were traditions that deemed certain pathways suitable for one gender but not the other. Just like the air we breathe, societal beliefs of the day are essential elements of our world though are not necessarily overt. They frequently sit in the background sustaining the approach of educational institutions, school career advisors, and the mentors who lead younger generations to their future pathway. Coming into health care education or pursuing limited career possibilities was part of a tradition, the context that people found themselves embedded in. For young women in the 1960s through to the 1980s the roles deemed 'suitable' were frequently those involving the caring and nurturing of sick and elderly people, as well as teaching and where family relationships are mirrored (Bradley, 1994). While

it could be said that much of past traditions regarding gendered career pathways have altered, by how much is still debatable.

Older health professionals, in this study, describe making choices, though the possibilities before them were narrow. Hilary was not resolute about the best option of career for her. She talks about what it was like in 'those days':

There weren't many other choices, unless you were someone exceptional. In my year at school they had all these bright, bright girls and hardly any of them went to university. You had to be quite a lateral thinker to go to university. In those days, when I was thinking about what to do, you were either a nurse, a teacher, or a secretary. I put my name down for nursing, but did some nurse aiding and decided that wasn't for me, then did shorthand typing and got fed up. My cousin said "what about occupational therapy" because I'd always liked making things. So then I went off to a guidance person, and it all added up.

Of course in those days it was about 'helping people', that was about that particular time; little girls, it was 'nice' to help people, because you needed to have people's approval as a little girl and as a big girl too. Approval was terribly important. Probably true then in general for women but quite a lot for me. Because being a nice person was important, nice people probably helped other people.

When considering her own future possibilities, Hilary understands that choices are limited as even the bright girls didn't often go to University. At the point of finishing her secondary school education she finds herself falling into a world where her options are primarily focused on what could be called the helping professions; professions where girls may feel they are 'doing good' as they help and assist others. It is as though there is a recipe for 'nice girls,' in Hilary's environment, a recipe created from past traditions carried through into the present. Approval comes from those around us, and the influence of 'the They', consisting of parental pressure, societal norms of the day, and institutes of learning. Such pressures exert their frequently invisible authority to pull us towards what is seen as normal. The more we relax into this being, our usual way of Being-in-the-world, the more vulnerable to their influence we are. For Heidegger (1927/1962), part of Dasein's being-in-the-world is that we are always with others, so that we are always trying to keep up; 'the they' take away our choice thus "it is not I who decides, no one does, it's just what *one* thinks and does" (Inwood, 2006, p. 212). Polt (2003), tells us that "we are free, but our freedom is necessarily limited; our possibilities have to be

drawn from our own heritage…" (p. 103) and it is in looking back that we understand who we were, the ways we were influenced, and who we now are.

Looking Back

In looking back on her clinical education, Elizabeth, an occupational therapist, reveals how much 'of its time' it was as she describes the rules surrounding her:

> *It was definitely a girls' career. I wouldn't have had any sort of feminist thoughts at that stage, a couple of guys came in the last year that I was there, a bit of an oddity really. The rules were quaint, you weren't allowed to get pregnant, you weren't allowed to have boyfriends, and it was all very archaic. You weren't allowed to get married but a couple of girls got pregnant on the course, they just did it. We called Miss Rutherford [the school principal] Miss, and called each other Miss.*

Immersed in her 'girls' career' the rules may well have been accepted by Elizabeth as part of being caught up in the every-dayness of her training. Because she is present in her specific situation, with no time for feminist thoughts; this is just the way it is. Within her training environment everything is connected, the 'rules' and expectations have meaning that came from within the tradition they are part of (Harman, 2007). It is in looking back on the social context of her clinical education that Elizabeth now sees how different those times were; quaint and old fashioned, highlighting "the inescapability of personal history" (McIntosh, 2010, p. C7) and tradition. Christian names are seen as too familiar, occupational therapy a profession for girls was at the threshold of accepting mixed gender classes, with the training school appearing to believe it was 'parentus locum', responsible for students in the absence of their parents. The world described is a different world from that of today, in an age when the context of women's lives meant they followed certain patterns (Wicks & Whiteford, 2005).

Despite the seemingly narrow opportunities of a career open to her, Hilary, another occupational therapist, found herself 'caught up' in her clinical education:

> *When I started training I found I absolutely loved anatomy, physiology, and psychology and psychiatry, I loved them, loved all the subjects. I just loved it all. They all fitted in. Craft work I wasn't so keen on and I've never looked at craftwork since.*

Hilary's subjects just fitted for her, she found herself loving them. Her engagement is not with the craft work that initially made occupational therapy, seen then as a career for girls, attractive to her. It is the subjects that capture her, making an

education choice that she falls into, rather than feels called to, special. She is moved out of the everydayness of an unthinking, unquestioning, plodding existence and finds herself present, being-in-a-world that has become heightened and where the parts fit together. It is through being open to future possibilities that we can find ourselves, find who we are; yet in part this comes from "[what] we were" (Polt, 2003, p. 96).

Having a Sense of Values

The principles, ethics and standards that come to practitioners through their clinical education can become a part of the ideals that underpin health professionals' work. Through our heritage, values become embedded in the way we work. For the standards and norms that surround older health professionals, though conveyed to them through the 'theys' of their world, may also come to them in the form of mentors and role models. Such values from their heritage of clinical education can be held onto and instilled as ready-made notions. Genevieve, a midwife, talks about what she values from her training:

> *Where I did my midwifery training at St. Helens Hospital, though it was only six months, it was a very, very, comprehensive hands-on six months of intensive work. And the matron who ran the hospital was very old school so you learned to do things properly and you learned to do them well and you had a lot of practice with them and that just carried on right through. So my value system has never changed in terms of 'you do the job properly and you do it as well as you can and you get help when you need it and you tell the truth. So I feel like I had a very, very good grounding, plus it was a midwifery training school and I stayed there for around 15 years. So every 6 months we'd get a new lot of students and we'd teach them, so as you grew, they grew, and as they grew, you grew.*

The very comprehensive 'hands on' clinical education Genevieve received in the past remains with her in the present. While the matron may have seemed old school then, the lessons stayed with Genevieve; doing things well, being honest and knowing when to seek help. Having been shown the 'right way' Genevieve continues on, repeating the lessons learnt in her past, lessons learnt from her mentor, she continues on mentoring others. This is her legacy, "because the past is still with us serving as our heritage" (Polt, 2003, p. 101). The lessons of the past are brought to the present and future, giving a sense of resoluteness.

A number of other older practitioners talked about the lessons coming from their past into their future practice. Coral, a physiotherapist, brings a very specific belief

from her clinical education to her work. She says, "*I still believe that one of the essential parts of physio, is what I call 'the laying on of hands', and that is the actual contact*". Jessie, a community nurse, too has values that are deeply embedded in how she lives in the world of work and the world outside, "*There are the skills and the principles of assisting, supporting and helping each other, a little kindness is a circle, and it goes round though it won't necessarily come back to you*". It seems that Jessie's values have become a moral compass that guides her as a practitioner through her everyday practice.

As a manager, Jack considers an older staff member in his team who no longer seems connected to values, or the call to care, that may have once been part of her working life:

> *By the time I started managing her she was pretty switched off at work. Initially she showed willing and there were a series of times when I asked her to be involved in projects but her heart wasn't really in it. She was just going through the paces coming to work, becoming disillusioned as time went on. She acknowledged that she hadn't been as involved as she could have been, and expressed feelings of regret about that.*

The older health professional is there in the moment at work; yet, while her body is there, her spirit and energy are missing. Much as the light fades, when the power to it fails, she has 'switched off'. She has fallen into the present, moving through what confronts her in her daily work world, but lacks the energy and decisiveness to really be there. What seems to have diminished is the older practitioners call to care. In "the there" (Polt, 2003, p. 103), in each moment of time, we participate in events as they occur and confront us; yet, we have choices to make about the possibilities before us. While we are free to select our preferences it is our heritage that we draw them from. The choices we make matter and our past can be drawn on in the future as highlighted in Polt's (2003) writing:

> The past is a storehouse of opportunities to exist authentically… for the past is still with us, serving as our heritage… His notion of repetition does not mean aping the past, but appropriating it freely and creatively. (p. 101)

Looking to the Future: Towards Oneself

For all of us an aspect of being caught up in the movement of time is that at any point while in the present we carry both the future and past, for we *are* our past, our present and our future. Older health professionals will be influenced in their every-

day-world by their plans and expectations of the future which may influence their decisions in the now. Stories from the older practitioners show that their preparations and thinking varies widely. Some plans seem very real and motivating in the present moment, others hint at concerns about what the future may hold and how they themselves are shaped and their lives controlled by their present work context. While some participants focus on the present, for others moving forward was paradoxically about going back to an earlier passion. The freedom ahead to make choices can seem quite daunting for those whose routines and working lives have revolved around service provision and systems. Liberations from health practitioner roles could be seen to offer greater choices with more time to engage in other roles and occupations but potentially bring the tension of 'how will I manage' and who will I be when I have discarded or let go of my profession. Frequently there were thoughts about who am I without my work role.

Questioning Identity

Older health professionals think about what is coming towards them from the future. They weigh up the possible opportunities as they contemplate changes to their health professional role, changes that can enable them to retain or reclaim their identity; an identity that has shifted and moved along with the movement of time in their lives. Believing they are important, that they matter, will for some health professionals centre round their work role. Letting go of a work identity will impact how long they stay on in a professional role as well as the plan they make for their future. Genevieve is an older midwife. She links her future identity to both work and things outside work and considers other possibilities, other identities:

> *I have been a midwife for a lengthy period, but I'll be at it another three or probably five years. There's a plan, we have this land at the beach where we're going to live and that will change things. My husband will be able to work from there, coming to town a couple of days a week, whereas I'm not taking my midwifery role there because that's my paradise up there, that's where I recuperate and recover, de-stress, and relax. And I don't want to bring that 'on call' mad life into up there. When we do move up I will 'go to pasture', doing three days or nights a week, three 12 hour shifts a week at the birthing unit at the hospital.*

Genevieve looks into her future and sees that as she ages she needs to allow herself a less demanding life. She describes herself as 'going to pasture', and while this usually implies letting go of former demanding roles, she still continues to hold to her work role and identity as a midwife in her contemplated, and hoped for, future

world. The possibility of working reduced hours offers her a chance to continue to contribute as a practitioner while making changes in how she sees herself as an individual.

Prior to retirement Hilary, an occupational therapist, comes to see the meaning of her work in the whole of her life as she reflects on what her professional role gives her. She sees what retirement can mean in terms of how others see her and how she views herself:

> *This last year has been so up and down, it's been such a weird time thinking about actually leaving the job and my loss of my role. I didn't understand loss of role and it's enormous. It really makes me think that it's just occupational therapy in this little wee country, but when it's been my whole life I then think of myself as an OT. That's who I am. I work full time so that takes up a major part of my life. That's going to be gone and then who will I be? How weird. I should be who I have always been, which has made me think 'how much has work made me feel who I am'. I didn't realise how work has defined me as much as it obviously has even in my eyes.*

Contemplating finishing work feels strange to Hillary as she comes to realise that her identity has been caught up with being an occupational therapist and that her work role has defined her to others and to herself. It is who she will be in the future that Hillary comes up against. The upcoming transition, throwing her into a different world, from health practitioner to member of the public, brings to the surface her pending loss. Yet at her core Hilary's Being will remain as she sheds the outer covering of being a health professional; much as taking off a coat reveals more clearly the shape of the person beneath, Hilary will become who she already is. This will be her new identity, the same person who has been there all along, changed and swayed by her role but always present, never absent.

At critical points in our lives, such as facing retirement, we wake up and recognise an aspect of our life that lifts us out from the everydayness, reminding us that this is our life, not just any life. This is a time when we may come to understand what our work means to us as well as the life we have that we have been thrown into (Polt, 2003). A professional identity gives a label, one that can have positive repercussions. It is the others, those who surround Hilary, who may view her differently and whose opinion she anticipates. To them she may become simply one of the masses, 'an invisible older person'. The loss is likely to be connected to the

good opinion of others. We are all subject to the opinion of 'others', people just like us, and the judgement of the 'Theys'. While having gained a new status as older, possibly as beneficiary, we lose our previous mantle of contributing active worker. The choice of any future vocation for older practitioners may well be determined by the social view of ageing returning them to the very societal influences that impacted on them at the start of their professional journey.

Older health professional participants ponder their future. They think about what they will miss, they think about who they will be. Their alignment with their working role at times feels as though it is at the core of who they are; at other times, more a role they chose to inhabit that they can shed at will.

The Personal and Professional Future

Some participants talk in positive terms about their future and also hope to fulfil alternative lives they have not had time to fully explore. There is an appearance of tentative acceptance of 'what is to come' and 'hoping for the best', yet alongside this is the alternative possibilities that still lie in the future with a postponement of facing the unwanted. Laura, an occupational therapist, looks forward at the differing possibilities and potential tensions:

> *My hopes for the future are for health, security, enjoyment with friends, and some adventure; I want to travel. But I also want fulfilment with my music. I think I will find it very hard to become dependent, that's if I do become dependent, because I've always been very independent. It's not a fear yet, it's more a worry about what sort of disability or illness am I going to have to face. But I'm putting that off for about ten years!! I'm also getting on with doing the things I want to because who knows.*

In discussing retirement Laura hopes for the best, for health, security, the pleasure of being with friends and the excitement of travel. Laura's hope will help her build these possibilities and open up her world. The worry is the 'what ifs'; what if I become dependent on others, what if I become too unwell to follow my hopes and dreams? For those older health professionals whose work has centred primarily on clients, who are in the midst of illness or have a disability, there is an underlying, not always visible, awareness of the worst that can happen. It may be that health professionals view of what can befall them has been distorted by their work, which gives an additional reason for detailed planning. Although they may turn away from its possibility, preferring to hope for the best, the fear of the worst sits nearby, for in

the hope lies uncertainty, part of the same dichotomy, for one underlies the other. Alongside this, planning well in advance can cause plans to be outmoded; by the time we are financially or emotionally ready to make the commitment the time for such things may have passed.

Another participant, Tom a nurse working in mental health, brings his own approach to planning the more distant future. He carries hope with him, transporting himself from the everydayness of his work world to where he would like to be in the future:

> You can become so routinised in this sort of work that you put aside the thought of change and find yourself working for no other reason than you work today because you went to work yesterday. So I want to avoid getting into that situation and I motivate myself towards retirement by envisaging a rather rosy time of retirement. Whether that's realistic or not, I don't know, but it does help with the motivation. It's around family time, I had my first grandchild just a month ago, so that's a whole new kind of experience and one that I'm really enjoying, so retirement brings with it that role of a grandparent. I have family who are overseas and so the idea of travel, that sort of thing, so you know they're just those everyday sorts of thoughts.

Pulling himself up out of the routine and familiarity of his work to avoid it becoming a mere ritual is helpful to Tom. He envisages a time in the future where the habits of work are left behind, where work is in the background and other things, family and travel are in closer proximity. Tom conjures up a picture, where by looking through rose tinted lens he brings into focus the idealized life he hopes for. Once again the future is seen in an idealized form. The darker side of future possibilities is turned away from, remaining unexplored and dormant. Perhaps in hoping for the best, rather than making fixed or exact advance plans, there is an underlying recognition of the uncertainty of each person's future, a future that even with the best of preparation will remain uncertain and unknown; an aspect of being human. For other study participants there is a focus on what looms ahead and a trying to pin down the elusive future. Elizabeth brings her future possibilities more clearly into focus:

> As an occupational therapist I think we have a lot of strings to our bow, it's just choosing which one. It doesn't have to be in the health service, I could see myself running some relaxation classes. There's the community centre, or hopping on the wellness band wagon or doing some historical stuff, working in a shop, helping out at a centre, there's voluntary work, there's a retirement village down the road, there's no end of things to do. So I don't anticipate being bored.

> *The main reason why I would stop doing things, would be health, my biggest fear is losing health. There are all those things that you face as you get older, your partner getting unwell, going deaf. My next door neighbour died unexpectedly, a 60 year old lady, so you know it could be anything. Mortality and health really are the biggest things. If those stay fine then the potential is unlimited, I don't see any need to stop your life.*

Elizabeth finds herself nearing the end of her time in her current long term work role. She considers retirement in the future, envisaging herself having many possibilities. These plans draw on her past interests. As she explores and considers what will be available to her she glimpses the thrownness of all life; if her next door neighbour, younger than she, can die unexpectedly then what is awaiting her? It is as though Elizabeth has had a wake up call, being brought face to face with the uncertainty of all life by her neighbour's sudden death. When such things happen we are pulled out of our average everydayness; the frequently unthinking way that we live in our world. And we face up to the finiteness of life. With our mortality brought more clearly into focus we see that *this could happen to me*. At such times, Heidegger (1927/1962) says that we become our authentic selves; that the way our understanding is distorted to cover up and 'close off' our unsettledness about our condition and the unknowness of the future is pulled away, that "by seeing and showing our unsettledness about the future we own up to Dasein's authentic way of being" (Dreyfus, 2002, p. 27) as being-towards-death. With no definite plans and unsettled about her future, Elizabeth, in realising Dasein's inability to predict the future, becomes her authentic self. Though plans may be made, there is an understanding they may not be acted on, for while we continue to prepare for the continuity of life, it may be life that suddenly no longer continues with us.

Alongside consideration of the uncertainty of life is the paradox showing in a number of participants' stories; that as they reach a stage in life when time will be in plentiful supply for either exploring alternative lifestyles or developing much anticipated hobbies further, they may be short of the money, cognitive ability and necessary health to take part in them. There will be some things for which time is running out.

Grace, who works as a theatre nurse, is waiting until more is revealed before she really makes plans. In the mean time she weighs things up:

I even talk about opening a bed and breakfast for goodness sake and then just working part time to supplement my income I don't know, I just have to wait. My main concern is with my son and in four or five years I think I'll be free to make a decision that will suit me then. So it's kind of a waiting game. If I can still cope with it I'd like to still do it, if I'm still physically able and haven't gone do-la-li, I would like to.

The waiting game involves Grace delaying decisions, of considering her future health and contemplating what may happen with others she is close to. As with other study participants, Grace sees the need to think about a different future while conversely waiting to see how life unfolds, and in doing so, avoids fully facing the future. Allowing coming events to assist in guiding one's way forward and waiting for the future to open out happens, for participants, more frequently than at first shows itself.

Other participants, looking ahead, see a future for themselves beyond their current clinical role, a future that brings them full circle, back to where they came from, back to their roots. For Jessie this means a return to her place of birth, the environment and family that formed her in the beginning, prior to becoming a nurse:

I come from a very isolated village. It's 14 miles out of the nearest town, and I've built a cottage down in the bay off the road, with the beach and the lagoon and all the things that I did in my childhood there. And it's very much family, it was my Grandmothers' land. A he ka means to burn, to burn brightly, it's about reigniting family, family name. That's the process with being Maori; you identify that reigniting of family values, spiritual beliefs, all of that by my building back on my Grandmothers' property. So I'll be back there soon. And I will be living closer to my daughter and son.

It's quite nice to get out of the rat race and you don't have to worry about things. There are different worries with being in the city to being in the country. My hopes are that I will be able to look at a new direction, that it will be a new challenge, a new journey for me. I've got a lot of friends and people who've been supportive and generous and I'll be leaving my friends, the people I've been close to. The hardest thing for me is going to be leaving my home, the pain of leaving this address. You know I have discussions with my [deceased] husband about leaving this place. He was always a very kind person.

Jessie plans ahead for her retirement from her role in nursing, to leaving the 'rat race' of living in the city. She looks forward to going home to a place, and a past, that hold so much for her. Yet in turning away from the present and going back to her family's land, there is deep pain in thinking about the loss of her current home and the memories it keeps alive for her. *Here* she is close to the more recent past, to

friends and a husband who meant so much to her. *There*, in her returning, are possibilities of a different life with new interests close to family and her tribal roots. Turangawaewae is the word used by Maori that means "a place to stand, a place to belong to, a seat or location of identity" (NZ History, 2010, p. 3). While both places are locations that Jessie belongs to that hold and strengthen her identity, her current home being her social turangawaewae, the call to return to her tribal turangawaewae remains stronger.

For many older health professionals this is what it is like to plan for retirement; always a tension between what could be lost of the old and treasured times and what may be gained by starting again, or reconnecting with a previous life. Yet the future brings the past ahead of it and in the present lies the past and future, where memories and hopes are kept alive for "what we call the beginning is often the end and to make an ending is to make a beginning. The end is where we start from" (Eliot, mcmlix, p. 221). The end of a health professionals' working life holds the beginning of the new life.

While it may be assumed that planning is a good thing, for some, there is recognition that life cannot be pinned down with ready-made boundaries, or treated like a commodity. Frequently life just happens in all its unexpectedness. It seems that for the older health professionals, everything becomes more dependent on other things. In contrast to the freedom young people may feel, with much of their life in front of them, with possibly fewer dependant family members resulting in a greater ability to make unhampered decisions, older health professionals' lives will have become deeply enmeshed in their work, entangled in their social settings, and ensnared by their economic situation. Even continuing to work can become more contingent, on such things as good health, finances and others in their world.

Summary

In their stories older health practitioners describe themselves as both called to their professions and falling into them. The choices and the decisions made were part of their historical context, one that is unavoidable. This then is a past that they come to draw on in their practice, that gives them perspective and values that underpin who they are. While at times it seems they direct their choices, on other occasions, they become lost in 'the They' directed world of everydayness. Yet in looking back and

considering where they have come from, their professional heritage has provided an identity and become a legacy that they carry with them. We can see how older practitioners draw on their traditions to be resolute yet open to newness of what the future holds as they move towards a time when they will no longer be in paid employment. This chapter has shown the way time past influences the future, what follows is an exploration of older health professionals ageing into their present.

Chapter Seven: The Announcing of Change

> Thus appearance, as the appearance 'of something' does *not* mean showing-itself; it means rather the announcing-itself by something which does not show itself, but announces itself through something which does show itself. Appearing is not showing itself. (Heidegger, 1927/1962, p. 52)

Introduction

The older health professionals, in this study, have revealed how the beginning of their time as a practitioner leads to the end of it, in that the beginning informs the end. In terms of their body and of their professional role, it is during their latter years at work that they come to understand that change is upon them. Ageing as a phenomenon comes to show itself for the participants through an announcing of change. One moment they are working in the taken-for-granted mode of being in their world of work when change comes, sometimes suddenly, at other times gradually. Other people, or signs, point to outer changes that signal getting older, at times catching them unawares, sometimes confirming a suspicion or revealing to them what was previously hidden in their possible future. Their bodily ageing both reveals and conceals what it is to be an older experienced health professional.

Heidegger tells us that it is while we are in the present moment that entities become present to us (Polt, 2003). Merleau-Ponty says that what is central to us in the present is our 'lived body' as "an examination of experience reveals that it is the body that first 'understands' the world" (cited in Leder, 1984, p. 31). Becoming older announces itself, to others and to the older health professionals in this study, in multiple ways. While appearance throws some light on older health professionals ageing, it connects to something outer, on the surface, that is easily seen; a mere appearance of the experience of aging. For the experience of bodily ageing is frequently obscured, hidden from the casual observer, concealed, at times misinterpreted as something other than it is, as a mood rather than physical or emotional weariness.

While ageing brings with it an altered body, alongside this change, there is a further impact of ageing for older health professionals. That is, their anticipation of their future, the recognition of the coming end of their working life as a health professional. This chapter looks at the announcing of the ageing body of older

health professionals, how this is perceived by them and by those they interact with, along with their hopes and fears for the future.

The Visible Observed Body

Older practitioners' stories tell of being seen and judged by their 'aged' appearance and possibly their value. For some it is an unthinking remark that points to their ageing, while others perceive that their worth or identity is being evaluated and even altered through the response of others. Occasionally it is a participant, such as Tom, who observes and takes note of the change he finds himself undergoing as an aspect of bodily ageing. He says: *I'm conscious, in my fifties that I'm fumbling for my glasses.* At times the study participants resist being placed in a category according to how others view them, while others show concern for their future.

Resisting being Categorized

Hilary, who anticipates approaching retirement, considers what it will be like not working as a health professional, causing her to reflect on how she is treated now by others and the impact on her of others' judgements:

> *I see myself joining the grey haired population who people in shops talk down to "yes dear". If people talk down to me now, I think to myself 'this is my lunch time I've got a busy job' so it doesn't affect me. It doesn't affect me because I know who I am, so when that's gone I'll have to gain a new persona.*

Hilary knows who she is; she has an identity, for she has a busy role as a clinician. This enables her to push away the unwanted assumptions of others. It may be that the role of older health professional provides an assumed 'social mask,' a notion described by Biggs (cited in Ballard, Elston & Gabe, 2005), behind which it is possible to avoid the ageism that surrounds them. Roles can assist people in resisting how they are categorized by others. As public ageing occurs visibly it seems that 'ageing' is then monitored and commented on by others (Ballard et al., 2005). Currently, Hilary has a 'World' (Heidegger, 1927/1962), that includes her work-world and this world gives her "a meaningful set of relationships, practices, and language" (Leonard, 1989, p. 41). But who will Hilary be in the future when that role, and that world, has gone?

Genevieve, a midwife in her sixties, is defiant about the way others see her:

> *The only thing that puts me off getting older is the way other people treat me. It's not at work but if I go into a shop and buy something and someone says "is that too heavy for you" I'll say "bugger off"!! Or "can I help you ma'am" I hate that! I think, 'they think I'm old'! I find it revolting. I think for god's sake, I must look wrinklier than I think I look. My mother said when she was 50 or 60, she still felt like she was 14 but I don't feel 14. I might feel about 30 perhaps.*

There can be a difference between how others observe the outer signs of ageing and the picture we hold of ourselves. While Genevieve at times feels around 30 this is not how she is seen by others. The announcing of her outer ageing comes to her from people she does not know, providing a disjuncture between how she feels and sees herself and how others perceive her. Defiance of visible ageing may be the consequence of how aged people are treated in society by others. Who wants to be seen as 'older' when the outcome is being spoken to in a belittling or patronizing manner. Laura, too, senses a change in how people see and interact with her:

> *I'm finding as an older person that people in shops and taxis try to put one over me in terms of change and costs and things like that. And they find out that I'm not doddery yet! That sort of thing comes. I told my 87 year old mother and she said, "wait until people talk down to you".*

It seems that Laura's chronological ageing is increasingly being equated by others with a change in her mental astuteness. While Laura may show outward signs that signify ageing, she responds sharply to attempts to belittle her mental capacity.

The difference between outer appearances of ageing and an inner sense of being unchanged is outlined in a study by Cunningham-Burley and Backett-Milburn as a "mind-body dualism" (cited in Ballard, Elston & Gabe, 2005, p. 171) where there is a sense of alienation between the two with the outward appearance masking the more youthful person beneath. Andrews (1999) draws our attention to what she calls the duality of ageing; "we tell ourselves that if our bodies must grow old… we can at least retain our useful spirit" (p. 301). However, this may be a way of tricking ourselves into believing that 'I'm only as old as I feel" (Andrews, p. 301), which means avoiding old age, as we learn that old age is something to avoid and fear. Ballard, Elston and Gabe (2005) describe how one's mother can become a reference point for people when considering their appearance of ageing. What a number of participants in this study relate back to is not any similarity in

appearance, but their identification with their mother's insights about the disjuncture between how they feel compared to society's view of them.

Assumptions of Appearance of Ageing

Elizabeth's external sign of ageing is announced by her son when he is pointing her out to friends:

> *I had grey hair and I used to pick my son up from school, he'd catch the bus home because he went to school just across the road from where I was working and I remember him shouting out down the bus one day, "that's my mother the one with the old hair" and I would have been all of 43 or something similar.*

Her age is not one usually regarded as 'older'. This is a mere appearance (Heidegger, 1927/1962) of 'being old' rather than the 'real thing'. And while public ageing, identified by such things as wrinkles and graying hair (Ballard et al., 2005), can be associated with changes in the way older health professionals look and are viewed, conversely private ageing, such as increasing tiredness, is much less visible, hidden from many of the people that older health professionals associate with. Genevieve describes an aspect of her public ageing:

> *At the hospital they're all quite horrified to think I turned 60 recently and one of the charge midwives said "you know what I call you" and I said "what" and she said "frisky old thing"!!. It's still got old in it but frisky was good, I liked frisky, I took it as a compliment anyway.*

To be called frisky implies on the one hand the energy of the young, whereas old, signifies visible outer ageing. Never-the-less Genevieve is happy to be described in this way. It seems that in her thinking the word 'frisky' outweighs that of 'old' and this perception then assists her in transcending her ageing (Andrews, 1999).

Working with retirement in mind seems to assist Laura when she is visibly ageing in her role: *What I wanted to do was work as hard as I could and save as hard as I could until the point when I retired and that's sort of what I did*. Such judgements made about her age are balanced by her impending retirement and anticipation of the potential freedom of a changed life:

> *In my role I was occasionally called a consultant. I didn't take much notice of that because people usually said that when they wanted me to approve something. You've had this certain status, you've got a role, but you're about to become just an old woman. How much does it mean because you're going to lose that. I'm so ready for no more of those stressors, that it didn't mean much. But, once last year I was making the second of two home visits to a*

client, I knocked on the door and a little girl of about seven answered the door, opened it, and I could hear the person I had come to visit whisper, "who is it". And the little girl said, "It's the old lady"! And, I didn't really mind but if I hadn't already known, I was told.

Though outwardly it seems Laura is impervious to both descriptions of herself as 'a consultant' and 'the old lady', it is never-the-less brought home to her that she is revealing signs of being older, that ageing is announcing itself. Laura's expectation is that old age will come suddenly rather than creep up on her. In the process of losing her identity and status as a practitioner she expects to tip over into a new identity as 'just an old woman'. It seems that working is equated with providing a veneer of youthfulness while retirement strips the veneer away showing another identity, that of being old. Still, the loss of the status and identity that a work role can give may be balanced by the desire to escape the increasingly stressful aspects of being in the world of work as an older practitioner.

Moving beyond Ageing Appearance

Bodily ageing is sometimes so apparent that it causes apprehension for those who work with older practitioners. Jack, who manages a team of clinicians working with older adults in an inpatient setting, talks about the ageing of some of the staff he works with and the way workplace ageing can move beyond that of mere appearance:

Some older therapists had started 12 years before I arrived and are still there and they'll probably move from being staff to being patients. They're in their late sixties now. One of them fell over and hurt herself while she was at work and I thought that she would in fact become a patient but she didn't.

In this world of work bodily ageing goes beyond the surface appearance of growing older. It announces itself in a highly visible recognizable manner, frequently associated with old age, with a fall. Jack has cause to think about whether the staff member will become a patient in the service. Though hospitalization does not happen, this time, it prompts him to consider the longevity in work roles of some of the older staff members he works with. Here is a picture of ageing therapists who are working with, and caring for, older patients; people who generally are beyond working. Yet, at any point these therapists could be lost to their therapist role, becoming patients themselves, finding themselves in a 'geriatric' bed, and cared for by those they previously worked alongside. Revealed is the possible collapse of the

fine line that divides staff and patient and the uncertainty of being employable in the future, particularly for older health professionals.

Much as Jack feels a sense of unease regarding the ageing therapists he works with, Coral, a physiotherapist, has concerns for her future that visible signs of ageing might signal to others an increased debility:

> *Perhaps one of my greatest fears is becoming so old and doddery I might have to go in with my walking stick! That's a bit scary, but I don't think that will happen, I think I'll see the light before then. I have seen some older physios who have got so stuck in their ways that other physios talk about how it is time for them to move on, though they don't actually say it to them.*

Coral fears the announcement of her bodily ageing to her work colleagues, that highly visible walking stick that could support her when she's old and doddery, yet still working. Alongside that she fears not knowing and understanding that she has become one of those physios that others talk about, stuck in their ways and past it, not up to being in their role. As a physiotherapist Coral's work could at times involve her in doing walking assessments and supplying walking aides to clients. In her dreaded scenario it is as though she has become a client of the service when still working there; yet, doesn't recognize this incongruity. There is a dilemma for older health professionals; will they see the light and recognize when it is time to retire. When Joy, a manager, has concerns similar to Jack and Coral about the physical aging of health professionals within their workplace she talks with Nancy, one of the nurses at the clinic:

> *We had a conversation and she said to me, "if I stop performing, or I look too old to work here then…" Well we've got a pact that I will tell her that she looks too old to be still working and then she's going to retire. We've got that agreement. I just think she's wonderful.*

It will be the appearance of ageing and of her physical performance that alerts Joy, the manager, that Nancy needs to not just cut back her hours but to retire from nursing. This suggests that Nancy has passed this 'recognition of ageing' over to her manager because it is beyond her ability to judge. It seems that the appearance of ageing may sometimes take precedent over the ability to meet practice requirements for older practitioners working within health services. For Jessie, a community mental health nurse, the decision ahead, is also passed over to her manager:

What I've said to my boss, who has known me for many years, is that when he feels that I'm not up to my job and not working to my full capacity then he needs to tell me to leave. He said, "Yes, I will definitely do that! Yes I will definitely do that". I say to him, "well, I'm going to leave" and he says "when will that be?" I say, "next year" and he goes "oh yeah, that will never come as well". So there you go.

Jessie fears a time in the future when she will not be able to perform at the level required of her. For some participants there is a sense that with increasing age they may not know and understand when they have moved physically, or mentally, beyond the point of good practice in their work role. According to Buytendijk, (cited in van den Berg, 1952) "though our body is the thing most known and close to us of all things, and while it is undoubtedly belongs to us" (p. 25), early studies by Wolff (cited in van den Berg, 1952) have shown that we do not recognize it when we look at it intently. Van den Berg (1952) explains that through the work of Sartre (1947-1965) we understand:

> That the qualities of the human body... can only become apparent when the human body is forgotten, eliminated, passed over in silence for the occupation or landscape for whose sake the passing is necessary. *It is only the behaviour that explains the body.* (pp. 65-66)

While others may recognize when our body is no longer able to function in the way it needs to, in order to carry out a role, it can also be that through the regard of others, we can come to feel vulnerable, with our body comprised through being with the other and our awareness of their regard.

Managing a team that includes a considerable number of older staff brings Joy face-to-face with the impact of an ageing workforce:

> *I've got a whole crowd here of older health professionals that are in their late 60s and one in their 70s… many of them have been here for 15 to 20 years. They're wonderful nurses, wonderful… I am now concerned with Nancy working and what she's going to do if she suddenly retires. I do think down from four days to nothing will be a bit of shock to her. So I have talked to her this year about taking one day off, leave without pay, every second week, that means some weeks she works three days so that then she gets used to being at home with the husband.*

Joy is concerned for the older nurses at the clinic. She worries about how they will manage sudden change with a reduction of hours at work causing destabilization of their work and home lives. These nurses are observed by their manager who values them, and as they gradually reveal signs of being unable to cope with their work

load or their working hours it seems she adapts the system to suit them as individuals.

The Unobserved Body

Mood, or state of mind, links to and reveals how a person's body and mind are functioning. At times, it will be this outer more visible, observed, aspect of how a person is doing in their world that others see. While "mood discloses being as a whole: as mood is a way of being in the world" (Harman, 2007, p. 68), for older practitioners the physical impact of working while their body ages remains partially obscured by other ways of describing it, such as irritability or intolerance, not always recognizing bodily felt weariness. Yet mood reveals; "they show us something…" (Polt, 2003, p. 66). Heidegger (1927/1962) describes one thing appearing as another, when it shows itself as a thing it is not, rather than what it actually is, as a semblance. He also says that "a mood makes manifest 'how one is, and how one is faring'" (Heidegger, 1927/1962, p. 173). Older practitioners may appear to be still working much as their colleagues are doing, yet for some study participants, there is a gradual difference appearing, an alteration in mood disclosing change to 'how they are faring'.

When Mood Reveals Itself

Genevieve, a midwife, describes how her tolerance to inconvenient phone calls has changed over time:

> *Now that I am starting to get a bit older, there are times that I'm a little bit more irritated if people ring me at 10pm Sunday. I'm less inclined to say "yes I'll be your midwife" if people call me at that hour or if they call me at 8 on a Saturday morning. It depends on your mood, sometimes the minute you hear someone's voice on the phone you instantly think 'no', for whatever reason. Or if they start saying they're interviewing midwives then I think 'oh forget it', I can't be bothered.*

Genevieve gets irritated more easily and her mood affects her decisions. Whereas when she was younger, she may have tolerated the intrusiveness of being rung at inconvenient times, now she finds it produces a barrier in potential relationships. At the same time she protects herself from women who may not understand the unspoken rules, who do not consider her as she would hope to be considered. When we find ourselves 'thrown' into a situation to which we must respond, our mood helps us come to grips with our world; will we respond this way or that way, our mood helps us decide.

> For Heidegger (1927/1962) a mood is not something psychologically 'inner' that our minds impose on the outer world. Instead a mood is a way of being-in-the-world. And Heidegger takes a special interest in bad moods which cover up the environment in which we exist. (Harman, 2007, p. 68)

It may be that Genevieve's mood of irritation covers and disguises the impact of her tired body on the way she interacts with others in her work-world. A 'bad mood' in part reveals the imposition of ready accessibility for clients that in some situations can cause older health professionals to lose their precious private time. And private time is likely to be highly prized by older health professionals, working in what can be demanding full time roles, with their need to recover from the physical or mental fatigue that such work can bring. Another older clinician is also described as having a negative mood. Joy, a manager, says:

> *Deidre sometimes gets a wee bit grumpy around life in general, that's just her personality. She is 63 and talks about working for another couple of years and I've got absolutely no problem with people working over 65.*

It is possible that Deidre's tiredness around still being in her role is seen as part of her persona, as the negative mood of grumpiness, rather than connected to her advancing ageing. Yet there is likely to be a close connection between what shows up as her outer mood and her felt body. When Hilary makes plans to leave her work-world she is conscious of the impression she will leave behind when she has retired:

> *I want to leave on a good note. I've done a hang of a lot of thinking about it and it's been about coming to terms with things. I do want to leave on a good note I don't want to be bitter. I think I've had periods in this last six years that I've been quite bitter and angry. I've stopped moaning, I haven't moaned for the last two years pretty well.*

As she plans to leave, Hilary becomes very aware of her public self, the way she is viewed by others. For "in public we become public figures. But in private we become the individuals we are" (Oates, 2004). It is one thing to feel disgruntled out of the public eye, another to have such moods and feelings on display at work where it is expected that she will be "fitting, suitable, correct" (*stimmen*) (Inwood, 2005, p. 130). Her past mood of anger and feelings of bitterness may well have been the outer sign of Hilary's weariness, showing as a mere semblance of what is really occurring; as moaning, complaining, challenging and grumbling are likely to

signal to others a change in emotional state rather than the weariness that lies hidden beneath.

The Body Visible as Mood

There are times when a combination of decreased stamina impacting on emotional resilience affected the older health professionals' ability to do their work. Grace, a theatre nurse in her fifties, reflects on how both the physical and emotional demands of her work role affect her:

> *I get more tired, more frustrated, definitely more stressed and it's probably due to age. In some ways I find the job quite physically demanding and some days I find it emotionally draining. Physically there's a lot of lifting involved, there's a lot of moving around of equipment. For example to do a total hip joint [replacement] there are up to 15 crates of instruments which can weigh 10-12 kilos each to drag around. And then with patients up to 200 kilos, we've got to move them round the bed and off the bed. We also do incredibly long hours at the private hospital that I work in because we just go until the lists are finished and we can often work 10 to 12 hours a day. At the end of 10 hours at work I feel absolutely had it, absolutely had it, and then I have to go turn around and go home and do dinners and take care of kids and things.*

The demands and consequent frustration linked to Grace's role may well show outwardly as her being irritable, yet, is physical and emotional weariness. Grace thinks about her current work and understands her bodily ageing in terms of it. Her work involves heavy lifting, long days, and is consequently both physically and emotionally draining. She is weighed down by it for "bodiliness cuts through the sense to perception. It is the whole of an individual's sense perception and feelings… it is here and now" (Heikkinen, 2004, p. 567). In the here and now Grace's work consumes her time, energy and emotions, leaving little for her personal life, for family. Completing the list is the overriding priority, while individual personal priorities fall away. When the lists are finished the staff feel finished, as it is not possible for them to manage or control their work environment. It seems that for Grace her family gets what she has left over to give.

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The Invisible Felt Body

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External and internal appearances and signs of ageing are aspects of being in the world, for we are all, at all times, growing older. With the health professionals in the study, aged between 50 to 66 years of age, their stories in part reveal how the changes that are aspects of the phenomenon of ageing affect and shape their work. They also reveal how their working impinges on them both physically and

mentally. Their felt body, frequently invisible to others, is in contrast increasingly felt by them.

Being Weary

Genevieve, an older midwife thinks about how ageing has impacted on her liveliness:

> *When I look around at the hospital, there are still women of my ilk or way older. I do feel it physically more than I used to, getting up in the night and not springing up quite as readily. About once a month I kind of think 'oh god, I'm up'.*

Bodily felt weariness has crept up on Genevieve, whereas once she leapt from bed, now springing up lies in the past. She is simply relieved to be up at all. A gradual change has crept up on her. When your body lets you down, does not do what could be expected of it, much as when a piece of equipment fails, it has become un-ready-to-hand (Heidegger, 1927/1962), and is highlighted and brought to our attention through its unavailability. Joy, a manager participant, talks about what she sees happening for theatre nurses as they age:

> *The only ones I worry about are the older ones in the operating rooms because one of the reasons I went into management was that my leg was starting to ache with long procedures. And while I loved it, and I got huge job satisfaction, I worked out that in 5 to 10 years, my body wasn't going to be able to cope as well as it did when I was 20. And then I started squirming my way into management.*

Joy understands that there is a limit to what a theatre nurse can expect from their body, that some work roles demand more strength or stamina than others. So she is concerned for the future of the staff she works with, worrying about their ability to continue.

When Bodiliness is Everything

When work impacts on practitioners' bodily ability to carry out their role, it is as though their body is announcing something that they may not wish to take notice of. Genevieve gauges how her body is responding as she continues to work in a role that requires that she does night work and frequently stand while working:

> *My legs ache. So if my feet ache more than half way up my leg, then I know that it's been a long time on my feet. And if it's one birth after another then it's always my feet that feel it worst. If I get tired and get in to bed and lie down and I think 'oh my god, thank god I'm lying down', it's my feet that are complaining most. But getting up if I'm tired, I can feel it physically mostly as achy and sore shoulders and sore back and generally, just physically tired.*

Sometimes you get a run, one birth after another, you get pile ups. Standing on my feet, that's hard, it's a long time. It's the long hours and the standing, because mostly you're standing, leaning against the birthing bed or sitting at a desk writing notes or standing at a desk. Standing on my feet so long, it's hard.

Genevieve's body conveys demanding messages to her, reminding her of its presence and the need to heed what it communicates to her. Feet aching and protesting announce to Genevieve her bodily felt ageing. In contrast to the Cartesian view that "this self *possesses* a body" (Leonard, 1989, p. 41), from a phenomenological perspective, "rather than having a body, we are embodied" (p. 48). Thus it is through our bodies that we interact with and reflect our world as "it is the body that first grasps the world and moves with intention in that meaningful world" (p. 48). Unlike a tool that is ready-to-hand, a thing that is useful and available for use, Heidegger (1927/1962) describes one that is unavailable or unable to do what we want or need it to as unready-to-hand (Dreyfus, 1991). Instead of being fluid, and carrying out tasks in an assumed unobserved way, a person's body too can become unready-to-hand unable to function in the fluid unnoticed mode of the past.

It seems that 'bodiliness' (Heikkinen, 2004) has become the whole of this older clinician's experience in the present moment of time. At such times the body becomes a burden; yet, within the burden a message is carried, a message that Genevieve may prefer not to hear. Her body is revealing that it is time to stop working as a midwife in this particular role. The hardness of the physical impact of some work roles will, in part, determine how long an older practitioner can remain in their role. While the older clinicians interviewed talked generally of tiredness and weariness related to aspects of their work it was particularly stories from midwives that revealed the necessity and hardness of working at night. Here Alice tells about a midwife colleague:

There is that obligation to do night shift. With one woman that I was talking with, she was saying that she physically cannot cope with night shift anymore but for her to work in midwifery she's obligated to do a certain amount. That's just the deal. It's always been a struggle for her and now it's getting worse and worse as she's going through menopause. She feels that she's not safe when she's sleep deprived and the impact on her physically is huge, she just cannot deal with it. You question whether it's possible for her to get an exemption on health grounds. Otherwise it may mean that she will leave the profession and go to somewhere like A and E where she doesn't have to do a

night shift. It's ridiculous. I can see the dilemma if you say one person is exempted from it. On the other hand you're cutting off your nose to spite your face. She's such an able practitioner and she'd be a really big loss. Some people say to her "oh harden up" not taking in to account that she's had some significant health problems. She's pretty over hearing that. It's a refusal to look at her as an individual. It's like conform or get out.

Having weathered the storm of disruption that ill health brings, the midwife in this story must continue on, safe or unsafe, frequently sleep deprived, exhausted. For there is an expectation from the organizations that midwives work for, that they will do night shifts. It seems that no one is exempted from this, including people who do not function well on broken sleep or when under duress caused by health issues. For the midwife in this story there is a tension, to struggle on in her professional role that she has vast experience in or leave to go to a different role. She finds herself having been thrown into a world where she has little control over what she must do, for the world she works in demands physical coping with shift work, regardless of the impact on her. Now she must conform to the rules, or leave, there are no exemptions, just one rule for all. As a midwife Genevieve explains about the dangers of working nights and how stressful it is for her:

> *You don't know about nights, you have no idea. If I have a run of nights then I just expect to work at night. So if you have a day time birth you don't quite know what to do with yourself, you're home at five in the evening and think it's a bit strange, it feels like you've been a bit spoilt. But working nights is just part of the job, you just do it. Afterwards I'm very keen to get into my bed I can tell you that much. And sometimes that is all you can think about, 'how the hell am I going to get out of here and get to bed as fast as I can', which is generally the time that you'll slip over and hurt your back, leave the car keys up in the room, or forget where the car is. You have to be careful with the tiredness.*

When one night of work follows another, the tiredness causes desperation, a pervasive need to lie down to sleep, keenness to be in bed. The desperation causes danger when carelessness slips in, yet even more dangerous is the impact of invasive recovery time. Alice, also a midwife, describes her work conditions, reinforcing the impact of working nights:

> *I'm getting to be one of the longest stayers in this particular field of independent practice because there's quite a lot of wear and tear involved. A lot of practitioners, as they've got older, have found it disruptive to sleep, which becomes more difficult to cope with.*

The 'longest stayer' sees others come and go. People around her, particularly those who are older, at times depart exhausted from interrupted sleep and the wear and tear of being on call. This is how they experience their professional life. Wear and tear may reveal itself in a variety of ways; for some there will be accidents, for others exhaustion or irritability. It is possible that the wear-and-tear on Genevieve from her working hours as an older midwife will show itself in the care she takes of herself and how that presents itself to others:

> Tiredness for me depends on what time I get woken up and how often. When I first started working like this I always had clean hair, I always had the clothes laid out in case I had to get out and I probably went to bed anticipating getting out. Now I just think 'as long as I vaguely know I've got some knickers on and some trousers on and a clean top and know where my shoes and the keys are then I just crash into bed and 'what is what is'.

> If you haven't got up at night for a few weeks, then the anticipation of getting woken up at night again is stronger. But if you know that you've got all these women due and the month's running out and you want them to get on with them then you don't mind. You're quite pleased when the phone rings. But if you're overtired, you've just got in to bed and it's 10 o'clock and you're dreading a call and then an hour later the phone rings, then you think 'oh crap'.

The tired ageing body announces itself. It is there in the letting go of former dressing rituals, it is there in the crashing into bed fatigued, there again in the acceptance of 'what will be' for there is no will to fight the tension, just an anticipation, a willing the work to be done with. The body can also be of "primary familiarity" (van den Berg, 1952, p. 70) when altered or changed by injury or illness or when the reliability of the body's youthfulness deserts us. Older health professionals Genevieve, Hilary and Laura describe a deep sense of familiarity with their weary and at times unreliable bodies, altered by ageing and a loss of youthfulness.

When Equilibrium is Lost

For some older practitioners a loss of equilibrium is implied in their stories. Work impinges on them, and their time, to such a degree that they find it hard to maintain a sense of having a life outside their professional work. Hilary is a therapist who does not work at night but is nevertheless exhausted by her work role. She reflects on how she has adapted in attitude to her work environment, to her public life. But this adaptation has involved Hilary making many compromises in her private life.

She tells about these compromises, and consequent loses, impinging on her life outside work in order to complete the days, weeks, even months until retirement:

I don't know if it's psychological, but it happened dead on 60, I noticed that I got heavy and more tired. I thought 'that's ridiculous, it must be psychological' but I've talked to so many other people working full time who've found the same thing. It's when you get home; you've used up all your energy at work and there's none left when you get home. I need to go to bed so early and then it takes all weekend to recover for the next week. I don't actually want to do much in the weekend and I don't particularly want to go out all that much during the week. Life closes in and just becomes work, because that's when your best energy is. It must be work because I haven't got any energy left over.

Now when I have a student I get absolutely exhausted and I find that my other work goes because I can't get myself together to do it. All my attention is on the student, what they need to know, what I need to tell them. Latterly it's been very, very tiring. So yes it is exhausting.

I used to always go to night school and sometimes I'd have two different classes. And this year I made a big effort to go to some computer courses, and when I missed the first one I was so glad because there weren't very many of them. I thought, 'I just don't want to do night school any more.' Yet I've always done it in some subject or other. Also the family are now so busy that I don't see them so much in the weekend. But it works in quite well, because I don't want to do a whole lot of things then. I need the whole weekend just to recover to just sort of, gather myself together, have a bit of time at home to have the energy for the next week. Weird isn't it?

Suddenly at 60, work takes all Hilary's oomph, leaving little for the rest of her life. Her heavy body tells her to slow down and it is a relief to let other things and people go, pushed aside by her need to conserve her precious energy for work. Time at home becomes recovery time, time she now spends sleeping, gathering herself together, in readiness for the new work week. When energy is flagging and exhausted, we tend to focus on the most important, or dominating, aspect of our life; for some older health professionals, needing to continue in full time work until they can retire, that focus will be their work role. Because Hilary gives her best energy to work she is likely to offer to her work a semblance of a competent functioning health professional. But beneath the semblance lies another truth that which she describes in her story, of a depleted and weary way of being in the world. The bodily burden of weariness from ageing can remove the balance in life, taking away pleasure and leaving just the demands of work. While in the public area of work the older health professional may continue to look capable, 'together', with

work getting their 'best energy'. In contrast, through their withdrawal into a quiet undemanding space, their private life becomes a shadow of what it formally was. Clearly this is not a way of life that could be maintained with no hope or plan of approaching retirement to rectify such an imbalance. It seems that we can "encounter the recovery of equilibrium in exactly the same way as we encounter the loss of it, as a kind of sudden reversal" (Gadamer, 1996, p. 36). This loss of balance comes when there is a striving and exertion that tips the balance away from what is being strived for (Gadamer, 1996).

Like Hilary, Laura too finds that balance seems to be missing in her life, as work increasingly impinges on private time:

> It hasn't been regular hours and in the last couple of years I've been very tired by Friday! The evening's the best time to catch people to make [work] appointments. Then occasionally you have to make an after hours or a Saturday visit. Though it's quite rare you have to do it because people aren't available any other time. You've got to do your invoices and all the other things associated with a private business, not as bad as for a shop, but there are additional duties. I have my accountant, but he wasn't doing it regularly and I have a secretary I can rely on. So I was tired on Fridays and I enjoyed it more when I was a bit younger, than say the last five years.

Work is gradually taking up more of Laura's private time. Though she has others who support her work, she has come to feel physically wearied by her role. Like Hilary, it seems Laura has lost the balance in her life, with work making so many inroads into the time that she might use for recovery. Hilary notices that as she ages, becoming wearier and needing more sleep, time has taken off, paradoxically both speeding up and slowing down in a way that leaves her bemused:

> It seems like a hang of a long time ago that I was 50, on the other hand the last few years have gone so quickly, and this year's just ridiculous. So the years seem to be going awfully quickly yet when I look back to 50 I can't even think who I was at 50, my God, it's so long ago. It's weird isn't it, it's the opposite. It seems a long time ago yet it's gone so quickly. In this later part of my life I go to bed early, I sleep so much, that I'm losing a bit of time. I'm having more sleep than I used to. Whereas when you are young and have children life just seems so slow because you are living every minute in a way. When I had young kids we didn't go to bed until 11 pm whereas now I'm often in bed by 9 pm, 9.30 pm. I get up at ¼ to 6, such a lot of sleeping. It will be interesting to see what happens when work stops.

In her youth time crept by slowly, now as she ages it is rushing by; however, Hilary now spends much more of this valuable time asleep. Yet she has to sleep more, for her body demands it. Other participants are also concerned with sleep. Genevieve's

inability to 'catch up' on her sleep accelerates as she ages, increasing her struggle to manage working at night:

> *It used to take me a day to get over an all night birth, we'd do three all night births one after another and I'd be fine. Now it takes me a week to get over one all night birth. I find that more often it's really a result of tiredness. But if I have a run of births then I don't get the time off. I'll notice I'm tired for a week. I used to be able to bounce back; the night work wouldn't bother me. I would be tired, but now I find I get slightly more vulnerable physically if I'm overtired. In the last five years I didn't have the bounce back that I used to have. It's just come gradually with age. But then other things have gone on in that five years that would have probably been part of it as well. I've had lots of people dying and my husband getting sick and those life things that add to the burden or the struggle.*

Now is different from how it *used to be*. Genevieve's bodily changes are announcing themselves to her, changes that have crept up on her over time. Whereas once she recovered physically in a day from a night time labour, now it takes more than a week. She has lost her ability to rebound; her bounce back has left her. Such changes impact on her, and those close to her, bringing them up against what they hope for and the un-hoped for. For this is a time of life when bodily ageing and illness can no longer be glossed over, kept hidden, ignored. Ageing announces itself loudly, through such things as tiredness and loss of resilience. This is a time when losses are more likely to occur, when life feels less secure, increasingly vulnerable, when there is fragility about continuing working. We are thrown into a changed world by such things as the sudden announcement or appearance of ageing or illness, into a world that may be very different from the one we were previously immersed in.

Participants' age, or apparent age, produces comments from others, revealing that they were viewed in a certain way because of the physical changes of ageing affecting appearance or a decline in emotional strength. While appearance throws some light on older health professionals ageing, it connects to something outer, on the surface, that is easily seen; a mere semblance of the experience of aging. For the experience of bodily ageing is frequently obscured, hidden from the casual observer, concealed, at times misinterpreted as something other than it is, as simply a mood rather than physical or emotional weariness. Bodily ageing will play a significant part in older health professionals' ability to continue in work roles. For many of the older health professionals, in this study, their ageing has become

apparent. They have come face to face with who they now are in terms of their body; they will need to alter their work roles. It will be how that occurs that will challenge them, the managers they work with, as well as the rules and regulations that apply in health care services to employment, as well as the accommodations they are willing to make for ageing clinicians. While not all the older clinicians in this study spoke of bodily weariness, many did. Ageing points to a progression from 'what was' to something different in the future. The future is unknown and while planning and hoping can reduce concern and anxiety much remains uncertain.

Hope for the Future

For some of the participants in the study, when they reflect on changes in their future role, there is also a sense of impending loss in their hoping. Here hoping announces concern for their future, for aging means moving towards retirement and an inevitable change of role. The character of the phenomenon of hope is described by Heidegger as relating to the future as well as the present, showing the way that in hoping we are also confronted with our own fears:

> What is decisive for the structure of hope as a phenomenon is not so much the futural character of that to which it relates itself but rather the existential meaning of hoping itself. Even here its character as a mood lies primarily in hoping as hoping for something for oneself. He who hopes takes himself with him into his hope, as it were, and brings himself up against what he hopes for. For this presupposes that he has somehow arrived at himself. To say that hope brings alleviation from depressing misgivings means merely that even hope, as a state-of-mind, is still related to our burdens, and related as Being-as having been. (Heidegger, 1927/1962, p. 396)

Here Heidegger describes how hope lies not just in the desire to possess something or have something positive happen in the future but more significantly the way in which the mood of hoping for something for oneself, reveals a glimpse of what always lies beneath hoping, the opposite of that which is desired, the possibility of the undesired happening in the future.

The Paradox in Hoping

Paradoxically hope is linked to dread as shown in stories from older practitioners, Elizabeth and Alice. When Elizabeth, an occupational therapist, looks ahead hopefully to what she might be doing in her future retirement she also considers the worst that could happen; *my next door neighbour died unexpectedly last Saturday night…so you know it could be anything really. Mortality really is the biggest thing*

and health. If those stay fine then the potential is unlimited. So many options when your health is 'good' but the dread behind such words rises to the surface revealing that anything could happen in this world, including death. The power that dread has is to bring all other things being considered into insignificance. The range of options following retirement fall away with the dread of being thrown unstoppable into the world (King, 1964). Yet paradoxically many of the older health professionals look hopefully into the future.

Alice, a midwife, considers the way her past invades her work world and reflects on her feelings concerning her work role and her future:

> *Because I've practiced for so long I'm starting to look after the babies of the babies, or the siblings of the babies, and friends whose children I've watched grow up. I've started to look after them when they have their babies. And that feels like such trust that, 20, 30 years later the mothers and fathers are sending their precious daughters back to me to look after. I feel really honoured.*
>
> *I think of working less in the practical field and I have such regret about even looking at that because I still enjoy it so much. I really love working with students and I enjoy teaching so I'm quite drawn towards that. But the idea of never being at a birth, and watching that family's journey, it just feels too awful to contemplate at the moment. In five years time I would still like to be doing some births. Just how active it will be I don't know but I can't imagine not being involved in midwifery in some way. I know that there's still a magic there for me.*

Alice's past practice is with her in her current work. It comes back to her from past generations, from people who believe in her as a practitioner, into her future work. Rather than being a role or identity that she can choose to put on or put aside, her immersion in practice, in being with others as they grow, still holds her in its grasp. While she contemplates alternatives that, to varying degrees, involve her in roles within the midwifery profession, she also considers the loss of never being present at another birth, of never following a family's journey toward parenthood.

Looking into the future, Alice holds hope for her future practice, and hope for herself as a midwife, and it is this hoping that brings her up against what she hopes for, (Heidegger, 1927/1962) that is, her continuance within midwifery practice. For she cannot turn away from the 'spell' midwifery has cast on her, a spell that holds her captive. Yet hope also brings her up against the unthinkable, revealing that which she most wants to not think, of no longer being there immersed in her practice world, as well as the finiteness of her working life.

Alongside hope, lies the mood of fear. While fear will be attached to something real and specific that is a part of the world, such as an older clinician fearing not being able to manage financially following retirement, and is something that "we may not be totally helpless before" (King, 1964, p. 130), dread relates to something bigger. Heidegger (1927/1962) says that "dread is the basic mood which lies at the ground of man's being" (p. 128) that it connects to something that is not part of this world with the threat coming from within oneself. Revealed behind these words from Alice's story *... the idea of never being at a birth and watching that family's journey, it just feels too awful to contemplate...* lies dread. The dread relates to the unavoidable sense of impending loss and emptiness for Alice when her work as a midwife is done.

Hope is futural in structure (Heidegger, 1927/1962), in that hope lies in the future; yet in hoping, we hope for something for ourselves. It seems that we draw on the mood of hope to light the path forward, but against the brightness of the hoped for possibilities lies the alternatives, that which we hold at bay, the black possibilities of the un-hoped for, the mystery of what awaits us in the future along with our inability to control it. For we may find ourselves thrown into an unknown, unforeseen future, with little opportunity to change what occurs for we are already there.

Heidegger (1927/1962) tells us that "…to say that hope *brings alleviation* from depressing misgivings means merely that even hope, as a state-of-mind, is still related to our burdens…" (p. 396). Alongside this, van Manen (1990) says that "...to hope is to believe in possibilities. Therefore hope strengthens and builds" (p. 123). In hoping for the best of future possibilities older health professionals, in holding back the burden of the unknown and the finiteness of all things, may strengthen and build on their chance of retaining work related to a still loved profession.

Alice's hopes are also for her fellow midwives and she offers thoughts on some of the ways that services might alter to accommodate older clinicians:

> *I think there are probably new ways of practicing that haven't yet evolved. And there is a great need for that because I know how demanding the work is. There is a real need for midwives to have a locum who doesn't have a caseload who says "right, you go and have a month off and I'll run your*

practice and I'll look after your women for you and do your births". Because sometimes you can't always plan for time off or for having two women labouring and your midwife partners are busy, and there is mentoring too for new grads. Every area has got its own particular difficulties, but it would be great to find ways of using expertise that has come through years of experience and not losing it if the practitioner is still willing to continue practicing. Part of that willingness probably comes from how supported or how valued practitioners feel because if they feel supported and valued then they'll want to keep going. But if they feel devalued, they don't want to keep putting themselves in a situation, so it's like a two way process.

Midwifery work is demanding and Alice hopes for some relief in the future for herself and her colleagues, suggesting ways of practicing that are not yet occurring. While acknowledging that this help will be different for each clinical area there is still the core understanding that it will be the willingness of individual clinicians, their enthusiasm and eagerness to persevere in their work roles affected by the valuing and care shown to them that may make a difference to their continuing at work.

The paradox of hope confronts some older health professionals, ageing and contemplating leaving their work role and retiring. It is a time of uncertainty, of misgivings, and of hopefulness; the possible end to their experience of working in clinical roles.

Grasping the Future

At times older practitioners in the study reach out to grasp future possibilities. Some participants talk in positive terms about their future and also hope to fulfil alternative lives they have not had time to fully explore. There is an appearance of tentative acceptance of 'what is to come' and 'hoping for the best' outcome, yet alongside this are the possibilities that still lie in the future with a postponement of facing the unwanted. There are also stories from participants of eager planning. For Laura this was a priority:

I didn't do a detailed budget but I was working towards it. I was saving and pretty careful. So it's financial, how you feel everything coming together. And what I wanted to do was work as hard as. Now that the freedom is amazing! If I don't get something done today I can do it tomorrow or the next day or the next day. And if it rains on the weekend I can still enjoy the sun during the week. You can almost do anything anytime! So that's great.

Getting ready to finish in her work role was a long term plan for Laura and brings a sense of rightness when it happens and a wonderful sense of liberation from work and the daily need to support herself as she aged until she was financially secure enough to retire. While stopping work can be liberating, the means of getting there can be restricting; a time of concentrated hard work, of pacing, of always focusing on the goal. It is not surprising then that with the end of work comes a sense of euphoria and personal freedom. A paradox here lies in the personal restrictions that will allow for the flowering of freedom. Jessie too contemplates leaving her work world behind her:

> *You never do leave that work behind, you never do, it is like osmosis though you gravitate to different things. I have this idea, I've bought paints and pastels, I've got an easel in my bedroom there but you know you've got to transform it, you've got to do something with it.*

The easel sits in the bedroom waiting the moment its new life will begin. Like Jessie's life it will be transformed, from what it was in the past, by a new beginning that takes it forward into the future, acknowledging where it has come from, taking aspects of the past with it. This is the tension then of leaving, the coming transformation alongside the retention of what has been good, the experience we all carry with us from the past that makes us who we are in the present and future.

Summary

Those older health professionals taking part in this study are ageing and their ageing announces itself whether or not they recognize and accept it. Frequently they are taking work for granted when others in their world observe the transformations that are occurring that suddenly announce the signs of ageing. At times change is subtle and creeps up on older practitioners. Outer change may be mistaken for something it is not, while the bodily experience of ageing lies partially hidden. For some of the older health professional participants there is an overwhelming feeling of bodily weariness that they may or may not link to ageing.

While it begins to loom up ahead of them, for many of the participants 'retirement' lies ahead in the future, and in the future, amongst the possibilities, there is hope that there will be continuation, or link to their professional work. Paradoxically hope also reveals something hidden; a sense of dread for what cannot be changed. Alongside this is a dawning clarity about the significance to them of their working life as an aspect of the whole of their life.

Chapter Eight: Being-with Others in the World of Work

> Heidegger points out that in the everyday environment, I always experience things in relation to other people… Heidegger's name for this communal dimension of my own Being-in-the-world is *Being-with*. (Polt, 2006, p. 60)

> Thus as Being-with, Dasein 'is' essentially for the sake of others. This must be understood as an existential statement as to its essence… (Heidegger, 1927/1962, p. 160)

We are always with others in-the-world; they are a part of our context. Heidegger's philosophy (1927/1962) shows us how in being-in-the-world, we interconnect with people, and in being with them we cannot ignore them. Rather, we are for-the-sake-of-others. Alongside this, the era in which we find ourselves thrown, shapes who we are; as "Being essentially conceals itself beneath tradition" (Inwood, 2005, pp. 87-88). For the older health professionals in this study their immediate work world is a particular world, in a specific time, different from others, for the world is always local, always already there (Diekelmann, 2005). While being in this world is influenced by the mores and beliefs of our times, the values and understandings that older health professionals hold onto come, in part, from their past clinical education and their history of living and working. It seems that the things that have shaped who they are, set them apart from others they encounter in the world of health care provision.

Older health professionals are in turn shaped by the people with whom they are in relationship. Many of the people they work with will be from other generations, have different values, and have been educated in more recent decades. The impact of such difference is visible in participants' stories. They describe the ways that their experience has moulded them and stories from both the health professional and manager participants show their interaction influencing each others' way of practicing. The phenomenon of being an older health professional, shows in their stories of relating to others, in managers' description of the interaction between them, and in seeing themselves involved in their relationships anew, through others' eyes.

Being Me with Others

The older participants in this study tell of how their working with others has influenced what they do in the present. At times they describe the courage they have towards what now confronts them. Experience carried with them from the past enables them to be unafraid. There is a sense that they now know themselves. All older clinicians participating in the study are 50 years old, and more, and many have worked for more than 20 years in the world of healthcare. Hence, being-in-the-world of healthcare provision is ingrained in them, a part of their being. At times this seems to give them strength and credibility in their own eyes and in the eyes of others. Showing in participants' stories is how these older health professionals see themselves when being-with others in their work-world, revealing aspects of their relationships. The way that clinicians, who are ageing, approach interaction with others can be unlike that of the distant past.

Being Authentic with Others

It seems that ageing can bring a heightened authenticity to relationships with others. Elizabeth's handling of a difficult situation when in her 60s shows an altered way of being-in-the-world of health care. She describes her mode of being-with a recently appointed manager, whom she believes needs to understand the team she is interacting with:

> *After she had trodden on three or four toes, people were getting really up in arms. I thought, I'm old enough and brave enough to take this young manager aside and tell her that she needs to pull her head in, not just make decisions, but to stand alongside people, to listen to what they have to say. If she does that she might actually be alright. So I said, "as I'm old and grey, I'm going to tell you some home truths, I really don't care if you don't like me at the end of it, that's not my problem". So I said "things have gotten off to a bad start, if you want to make friends with this team you have to sit alongside. We always make decisions as a team; we do things from a lot of thinking, a lot of planning. We don't take kindly to people telling us how to do things". I said, "I've heard you talking to people on occasions, and it's not ok". And she was very gracious, said "thank you very much", and she went off and from then on she very rarely had anything to say. But everybody said "Only you could have got away with it". I couldn't have done that if I was 28, I wouldn't be able to do that at 28, I'd look really trumped up. I could only do that because I had been around a long time and had absolutely nothing to lose. There is no cost, why would they get rid of me? They'd lose a lot of experience. She's my best buddy now, she'll bend over backwards to do anything I want. I think it's because we had that encounter at the beginning. And I had the confidence to do it.*

Elizabeth observes the new manager. She sees *that people were getting really up in arms* with continuing damage being done. She opens up a way for change when others hold back. Revealed in her story is an authentic, confident, assertive Elizabeth who not only knows what she wants and believes, but has the strength to 'leap-in' to change things with a new manager when she deems it necessary. In this story her mode of care towards the manager she works with is a positive one that takes over and in her concern, relieves care from the other to direct the way forward (Heidegger, 1927/1962; Inwood, 2005).

Elizabeth draws on her years of experience, on her sense of invulnerability, and on wisdom acquired through years of working with others. While her authenticity enables her to be resolute in her being-with the new manager, there will always be a risk when we choose to stand out amongst our peers. Authenticity shows in ways of being, such as being open to possibilities, of being one's own self, and having a sense of belonging in the world. Yet, Heidegger (1927/1962) tells us that "Dasein has first of all always already fallen away [abgefallen] from itself as authentic ability-to-be-itself and fallen [verfallen] into the world" (p. 175). The world of health care in this story is one where the team, everyone that is except Elizabeth, holds back and lets one of their own speak up on behalf of all of them. One reason for people avoiding confronting those in positions of seniority can be because they are caught up in a world where approval matters and they fear the possible disapproval of 'the They' (Heidegger, 1927/1962), those who influence our decision making. This story shows that there can be powerfulness in growing older as a clinician while moving towards retirement. At times they guide and mentor people in positions senior to themselves.

Being Resolute with Others

For some older clinicians it is as though their relationships with others at work have undergone a metamorphosis as they have aged and gained experience. Now that she is older and has been in her role for some years, Grace, a theatre nurse, finds she manages demands at work differently. Here she talks about her present and previous experiences with surgeons in theatre:

> *Since I've been over 50, I probably don't buy in to the surgeon's stress as much as I used to. In the past I probably would have gotten really upset if they had yelled about something or if they had told me off if something had gone wrong. Now I tend to stand back a bit more and I think 'well, what was the*

problem, and what have I done to cause it', or 'what could I do to make it better?' I'm much better at standing up for myself and saying "no, I'm sorry I didn't do that, however, we can do this to fix it". Or I find it much easier normally to pre-empt a tirade from the surgeon and say "okay, well we haven't got this today because of this reason and so I'm now warning you that it's not there". So in other words don't go nuts at me half way through because you can't find it.

When she was younger Grace found it hard to stand back and apart from surgeons' emotional outbursts, to not take it personally. Now she brings a calming influence to potentially fiery interactions in the theatre. Such defusing discloses a state of understanding. It is understanding for the for-sake-of-which that is revealed in Grace's story. Heidegger (1927/1962) tells us that "a state-of-mind always has its understanding, even if it merely keeps it suppressed," and that "understanding always has its mood" (p. 182). Bringing a state-of-mind that leads to understanding what is occurring, and a mood of cooperation in working with others, will come from recognizing the situation and having the skill to bring about change. One mode of our being certain shows itself in conviction (Heidegger, 1927/1962) where 'the truth' of a situation is plain to see. At such times being resolute in our mode of interacting with others assists in our "holding something for true" (p. 300). It seems that in being resolute we are at an 'intersection' between the past and the future, where we detach ourselves from the immediate present in order to be decisive about our future (Inwood, 2005).

Being Concerned with Others

Since they have become older, both Elizabeth, and Grace have changed in the way they interact with others in their everyday-work-world. Alice, an independent midwife, working in a different environment from the past, also tells about having the confidence to do what she sees needs to be done. Despite her newness in her role of working in a hospital setting, and possible vulnerability in speaking out, she shows the way forward:

It was soon after I started working at the hospital, when I was the new kid on the block finding out what worked. I started to see the areas that were difficult, mostly around difficult obstetricians and trying to liaise with them in a supportive way for the women. I knew that a lot of independent midwives were really struggling trying to work in with management or secondary services. And I think you have to address those sorts of things and, perhaps that's where being an older practitioner, you're more able to do that. Everyone was moaning about it, so I thought what's the point of moaning and doing nothing? So I wrote them a letter about the difficulties and very carefully put

my name in the middle and got everyone to sign around it. We sent it off jointly to management who rang me and said 'oh we got your letter', so much for hiding my signature, someone blabbed. Then we went along to a discussion they set up and it was a catalyst to being open with management about what the problem was. Finally they got a mediator and a facilitator and they rostered everybody off that could be off. And it was made mandatory attendance; if staff didn't attend they wouldn't get their contract renewed. We went off site and got it thrashed out and it made a major difference. Everyone started to see everyone else's perspective and it also gave a stern message to people of cultures where women are not highly rated at the best of times, let alone standing up in front of you and being professionally equal with you. That kind of behaviour was not going to be tolerated. So it was a very positive outcome.

Just as Alice sees what works, she also sees what does not. While being a *new kid on the block* could work against her, paradoxically it works for her. Despite her newness to the hospital setting, she is the one who is aware, the one who steps forward when it is clear that a difficult issue needs addressing. While grumbling, finding fault, and objecting may provide short term relief from deeply damaging staff relations and exchanges, it is the meaning in the action that opens the possibility for change to take place. For the people Alice comes to work alongside, there is an absorption into their everyday world where they have the character of "being lost in the 'publicness' of the They" (Inwood, 2006, p. 65), where people tend to follow what most others do, that leaves them unable to be their authentic selves; failing to take a stand unless led by another. This absorption in the world shows in relation to their busyness with what is present-at-hand in the everyday work-world. Being courageous and leaving fear behind brings with it a throwing aside of concern with what colleagues and management might think, and pulling oneself out of a mode of avoidance by speaking of the unspeakable. While turning aside frequently leads to inaction, and fear can paralyse, others recognise the call for action. As King (1964) proposes:

> Fear, as the fear of... always discovers some definite threat approaching from a definite direction in an already disclosed neighbourhood. The whereof of fear, the fearsome, has the character of some handy thing, or real thing or another man approaching from the world ... No matter how fearsome a thing is, we may not be totally helpless before it; we can at least try to run away or try to do something, as we say, to help. (pp. 128 & 130)

The fear that makes health professionals voiceless, at a time when speaking out matters, is always directed towards something. It is likely that their fear is related to

what others think, to how both 'Others' and the 'They' may react; to self concern on the speaker's part. As shows in the previous story, what we are afraid of is not something we are necessarily helpless before. However, both wisdom and courage are called for when choosing the right time to speak up for there is a time for such things. An aspect of being authentic lies in knowing the right time or in being prepared to take the risk that the time may or may not be right.

Being authentic, and therefore resolute in their being-with-others, is not necessarily something that older health professional participants Elizabeth, Grace and Alice claim for themselves; rather, we catch glimpses of their strength and courage in the stories they tell. Yet, in being courageous and resolute there is a being-for-the-sake-of-others bound up in their speaking out. Sometimes, for Elizabeth and Alice for instance, this is for-the-sake-of the team, whereas for Grace, it is for-the-sake-of a harmonious working relationship with another in the theatre. These positive modes of concern are linked to being authentic and the resoluteness that follows. While in being resolute they give strength to others they co-exist with, it will be from their being-through-others (Luijpens & Koren, 1969) in the past, that such older health professionals gain and develop strength and wisdom. Others might perceive these relationships from a different viewpoint.

Perceptions of Others

Manager participants told stories that show differing aspects of their being in relationship with older clinicians. Their stories reveal both the ways in which they work well together and the struggles that at times exist between them. Although older health professionals tended not to focus on the notion of 'respect', though there may have been a hidden expectation of being worthy of respect, for the people who managed them, this was an important hallmark. A number of stories from manager participants point to the issue of older health professionals seeming to expect respect automatically from them as managers because of a range of factors; particularly those of advancing age and length of service in health care roles. Alongside this, managers tell of their regard for the contribution older clinicians make to their service, showing that respect is not a given. Respect still needs to be won, and that can only happen when both manager and older health professional share common values.

As Earning Respect

At times older health professionals are highly regarded for what they bring to the service for which they work. The following story shows that while a manager already respected some of the older nurses, it was possible to build on that respect. Joy, who manages a team of nursing staff at a private hospital, shows why she holds many of the older nurses she works with in high regard:

> *We give all our patients a feedback form and so many of our older nurses are mentioned by name 'and our thanks go to …', 'please convey our thanks to…' It's these older ones that keep getting their names mentioned. And they wouldn't mention them if they didn't mean it. Some of those older ones like Deidre, Sally, Jenny and Clare, they are the ones that get a lot. They are well over 55. And then others get the occasional one, but the older ones, they're the ones. They're always getting them out as they have a copy to put in their profile. I have respect for a lot of these nurses. They're just great staff and because you know that the patients love them, as a manager I've built up a level of respect for their clinical skills. I know that they are making money for the business as basically if the patients have had a good experience, they'll go and tell others.*

The older ones *they are the ones;* loved by patients, providing care that is commented on and appreciated, making a significant contribution towards giving the clinic a good name, and thus gaining the respect of their manager. They prove to be an asset for what they contribute. Joy knows their value to her service, and they know the value of their work to their work place; it sits visibly before them for they have it in writing. Being thanked by others is an acknowledgement not only of clinical expertise but for the manner of being-with-others in the world of work. Joy tells us *I have respect for a lot of these nurses.* In respecting she holds regard for them which the online etymology dictionary (Harper, 2001), says "implies in an act of looking back at one" and an evaluating and considering. As part of her relationship with them Joy looks back through time at the older nurses she works with, nurses she works alongside, accompanying them into the present. It is through her positive mode of care, her way of respecting and regarding them that she builds on the work they engage in, adding to their self respect. Other manager participants, however, have relationships with older health professionals that do not build on respect.

As Not Respected

Sometimes managers struggle to respect an older clinician. Here Jack, a younger manager, talks about his sense of what was going wrong for a health professional working in the team he manages.

> *One particular older clinician wasn't doing as much as she could have. She was just going through the motions of turning up to work and doing what she was happy doing. She could have been doing a lot more. Her age made it harder for me to handle because she's only slightly younger than my mother. So that's always hard. I think she was more than able to do it, she just never really pushed herself, never really pushed the boundaries. As people get older I think that they, especially her, believe she should have respect from other people around her. When that respect wasn't there she took it quite personally. She saw a lot of young guns coming in with these new ideas on how to change things, and she seemed to feel quite threatened by that. Yet as far as I know she never made any attempt to keep up to date and she continued to use techniques that she should have changed. There was the tension that she should have respect because she's very experienced and on the other side that you have to earn that respect. If your actions don't engender feelings of respect then there's always going to be a tension there.*

Jack sees an older health professional going through the motion of working, just turning up, doing what needs to be done, staying within her 'known' field. She appears to not be fully engaged with the world of health care provision, out of context, no longer fitting with expectations of the current health care service focus of goals and competencies. Her mode of working seems to be stuck, a part of the past. Once, being a qualified health professional may have ensured she was highly valued; her length of experience adding in this regard, but valuing a qualification and length of time in a role is no longer enough. Despite being surrounded by others who could show her a way forward in her practice, she resists. The threat of what others know can be menacing, holding the potential exposure of ignorance. At times older health professionals may no longer feel at-home in today's world of health care, becoming closed to the possibilities that are always there, possibilities that could open up the future. Their engagement with work and fellow workers shows a negative mode of care of turning aside and letting be. At times older health professionals find themselves thrown into a changed world and are unable to change with it.

The age disparity between a younger manager and older staff member can present a difficulty. The clinician in this story could be Jack's mother and he struggles with

how best to manage her. For many people their mother is someone they esteem, someone who has a special place in their life. Yet this positive mode does not show here. This is Jack's dilemma. He feels torn between what she stands for and his lack of regard for her, for through her inaction she has failed to earn his respect. Alongside this, the natural order in life is to look up to our elders, to those who came before us into the world, people who we can learn valuable lessons from and who can show us a way forward. To break with that natural order is to be filled with the tension of being-with in a challenging form.

Being willing and able to move from the past into the present and future is signified in practice, in the doing. Being stuck, and unable to adapt through habit and custom, resides in the doing and in the being. Respect, has both a positive mode and a negative mode and it is always in the context of the 'with relationship'. When a pre-judgment forms in having little respect for another, it can then flavour how a person is seen, closing down opportunities for the other person to develop self respect.

As Losing Respect

For Lubi, a manager in his 30s, there is a struggle with getting through an obstacle to understanding an older staff member of his team. It is as though there is a language barrier resulting in a lack of recognition between them:

> *When I go to meetings and say "How's it going Annette?" she'll say "Bloody awful". I'll say to her "why what's the matter?" She answers, "I'm overworked, you guys are working a 66 year old like a dog, and I'm going to collapse". So I tell her, "Your workload should not increase because we're not expecting you to pick up that load. Just do the same clinics as you would do if we were fully staffed. We will manage the shortage by not booking for those clinics". She says, "There are patients out there that need to be seen" and I'm saying, "Yes, but we have a shortage. Now I'm happy if you want to see them, that is great, but you can't see them and then be a martyr about it". She'll say, "I'm not being a martyr." But she's very, very bitter about the fact that her service is short staffed. She's very bitter thinking I'm sitting doing nothing and I can't get the message to her that there is a shortage. And I'm sure she's not stupid, she knows there's a shortage but she does bang on.*

> *With Annette the conflict is about her not fully understanding the recruitment process. She just feels that there's a vacancy, she's busy and what are we doing to fix it. It's worked to some advantage, she's gone off and found somebody, a dietician that she knows, who wants the role, and I received her CV yesterday, so it's good that she's proactive. The bad news is that I'll hear more about it, that I did nothing, and she had to get off her own butt and go and find someone.*

Lubi and Annette's way of being-with is one of not understanding, of holding differing expectations, of speaking a different language. They talk past each other for Annette comes from a work-world where patient needs come above all things, where they must be seen at any cost, including to herself. Her work values relate to a time when seeing all the patients referred to a service, no matter how large the resulting load, was expected of clinicians, even demanded. Altruism, once considered the most important of values in clinical areas, such as nursing is now shown to have diminished in importance (Rassin, 2008). Here we see Annette bringing her past mode of working forward with her into her present and future way of being in her work world. In contrast, Lubi has a pragmatic approach to staff shortages. As a younger manager he brings his modern management values, his understanding of rationing of health care dollars (Feek, 1999). Though he does his best to fill vacancies, he accepts that with staff shortages the work cannot be done in the previous volume; some patients will not be seen. Annette does not accept this. Inevitably, their values clash with the consequence that they are unable to see the horizon of the other. For we all have an historical horizon (Gadamer, 1975/2004) and it is from this horizon that we each gain our viewpoint, and bring to an encounter our own interpretation of what is occurring and what is needed. It is in this way that we can come to a shared meaning.

While Annette continues to work in a manner that she expects respect for, Lubi's approach fails to earn her respect. On Annette's part there is likely to be a belief that she is being treated indifferently, without care and concern; whereas Lubi sees Annette as someone who does not understand recruitment processes, and interprets her as being a martyr. From Heidegger's (1927/1962) perspective "in every case this interpretation is grounded in something we have in advance - in a *fore-having*" (p. 191). We also bring our *fore-sight*, what we see in advance and in our *fore-conception*, that which we grasp in advance. These projected ways of understanding can bring with them distance and misunderstanding between people. For example, Annette holds dearly to the premise that all patients need to be seen as soon as possible, while Lubi prioritises a manageable workload. The tension that has arisen in this difference lingers between them. Respect will be hard to win back, as prejudices such as negativity that build up in a relationship will always come in

front of the next encounter, as 'the past always goes ahead' (Heidegger, 1927/1962), impacting on the mode of being together into the future.

As Not Respectful of Others

While respect is sometimes missing, or lost, as in Jack and Lubi's stories, for others respect seems to sit alongside fear. Reflecting on his work world, Jack, considers here the sometimes devastating impact that an older charge nurse manager has on members of his team when they come to work on 'her ward':

> *The charge nurse was in her early 60s, possibly a bit older, but as a charge nurse she was absolutely terrifying. She would go out of her way to make new people on the ward feel welcome until the time she bawled them out, which seemed to be a rite of passage, and after that everything went smoothly. Every time a new member of staff from my team went on to that ward they'd come to me in tears saying that she'd picked them up or bawled them out in a MDT meeting. She wound people up as she wasn't afraid of telling them where they went wrong. She was very confrontational but had an absolute heart of gold. Every time I went and saw her and told her how she'd upset a member of my team, she'd be distraught, grief stricken but then it would happen again the next time a new person came along. There was one particular new graduate therapist who did come bawling to me very upset, and the previous day the charge nurse had told me how she was a meek little lamb. When the therapist came, I said "well you just need to stand up to her" and she did the next week. The charge nurse tried bawling her out in the MDT and the therapist said "no, this is the way that it is". She listed the reasons why the patient couldn't go home and the charge nurse really appreciated that and said to me the following day "I can see she's got guts" and from that point on they never looked back. I'm not sure whether she only bawled out the people she could get away with it with, or when she felt people had made mistakes. I don't think they all had to go through the same rite of passage, I think they just had to stand up to her.*

Though initially the older charge nurse makes new staff welcome to the ward, soon there comes a time when they are not welcomed, when they are subjected to challenging encounters where they are bawled out, for 'crimes' they do not understand. For a new graduate therapist on Jack's team it is very frightening. Meeting the challenge of the older health professional can be compared to facing an initiation rite-of-passage, where standing your ground in the confrontation gains you respect. It is almost as though the ward and multidisciplinary team meeting constitute a battle field, a place where a lead nurse seeks to retain control and authority over others, and withholds respect for them until they show her that it has been earned.

Being over the age of 60 indicates that this Charge Nurse Manager's education and early years of work occurred in a distant time when such things as models of partnership between clinician and patient were unheard of, when multidisciplinary and interdisciplinary teams did not exist in anything like their present forms. And in the past, as Charge Nurse, she may have held a sense of ownership over the ward on which she worked.

Much has been written about the strict discipline of early nursing training and its concept of a total institution, "a place where the usual social boundaries between public and private life collapse" (Andrist, Nicholas & Wolf, 2006, p. 9). Nursing is described as having its origins in the Nightingale plan, which began in the nursing carried out in Military hospitals (cited in Andrist et al., 2006) and was based on a single pervasive authority, with total subordination to that authority. "Hospitals were thus able to create a culture of nurse training that produced a docile, loyal, dedicated, submissive and cheap workforce. Students had no advocates in a hierarchical system" (Andrist et al., 2006, p. 9). While much of this system of training nurses to be loyal and obedient above all things, lies in the past, remnants of nursing training and values are likely to linger long after their relevance has diminished.

The culture in nursing and other health care professions has evolved and changed with a marked diminution of hierarchical structures. Consequently where once 'bawling junior people out' may have been a relatively normal practice for those 'in charge' it is unlikely to be seen as acceptable in the health care services of today. It seems that the older charge nurse manager in this story does not understand this or is unable to change her past practices. While it is possible the charge nurse manager may view herself as acting in an authentically honest manner, it is likely that those in her work world perceive her behaviour differently.

Much of Jack's story, of a charge nurse manager, reveals an adherence to a past 'culture.' However the future is not 'fixed' in place. Predicting 'workplace culture' and behaviours in the present and future, based on past experience, is not a certainty; but rather the past is inherent in the present and future as Grosz describes:

> Life is a becoming beyond what it is because the past, not fixed in itself, never fixes or determines the present and future but underlies them, inheres in them, makes them rich in resources, and forces them to differ from themselves. (cited in Dall'Alba, 2009, p. 39)

While it could be expected that older health professionals will learn and grow from new experiences, at the same time, they will remain 'who they are', retaining within them their past and present as they move into the future. In her doctoral research Webster-Wright (cited in Dall'Alba, 2009) contends that, "This process of change with continuity continues throughout our professional lives; it is integral to both being professionals and continuing to learn as professionals" (p. 39).

For Cathy, a younger manager, it is the way that older practitioners in the team she works with relate to her that is disconcerting:

> *The older ones on the team give me a lot of advice, they'll constantly make comments about my physical appearance, "gee you lost weight girl" and you know I often had one of the dieticians trying to fatten me up. She would be an older health professional. The younger ones make no comments whatsoever about my physical appearance.*

It is not the younger ones who remark on Cathy's appearance, it is the older ones who feel free to constantly comment and give unsought advice. They look past her role to her physical appearance, possibly assuming a right to be protective of her because of her apparent youth. Assumptions of wisdom and caring can be made by people as they age, taking on a 'parenting role' for instance, for "Dasein essentially interprets itself, as say a soldier [or carer], and such self interpretation makes Dasein what it is" (cited in Inwood, 2005, p. 87). While in this story, the older practitioners offering the comments bring caring of a positive mode, it is in the nature of intrusive leaping-in (Heidegger, 1927/1962) active care towards a person who they assume needs help (Inwood, 2005). There is a sense in Cathy's story that less solicitude from others would be more respectful.

As Respect for 'Professionalism'

Respect also relates to the manner in which older health professionals display who they are to others 'as being professional'. Lubi, a manager, reflects on the unchanging sense of pride in their qualification and experience that many older nurses on his team have. He considers the way older health professionals differ from those who are younger in the team:

All of these old practices are going. In my services there is a clinical director who you honestly wouldn't know was a clinical director. He wears jeans and doesn't wear a tie and he's pretty scruffy. But the others are old school, older generation, and it's the same with the older generation of nurses. They wear their badges from way back when they qualified as a nurse. They don't wear uniforms but still wear their qualification badge. There is a difference in how they present themselves, in how they work, in what they do and their work ethic. They still wear their badges and they're still very proud to be a nurse with four stars that say 'I'm a level four nurse'. With the younger nurses, some of them turn up and you wouldn't realise that they're nurses, they're either power dressing or in very casual smart clothes. But again you wouldn't know their profession, they've got their ID badge on but they haven't got their nursing badge on.

All these old practices are going, a part of their past context, they have been carried forward into current times where they at times have a place, and at other times are out of place. The nurses that Lubi brings to our attention stand in contrast to their younger colleagues. They present themselves 'professionally', proud of the badge that represents their clinical qualification and experience in their field, displaying it for the world to see. The clinicians surrounding them, from differing generations, appear more complacent, indifferent even, to showing a health-care identity. The older nurses are part of the *old school*, a way of doing and being that is consistent with the past, for we are all swayed by the unwritten rules and influences that surround us. This is the manner in which 'the They' (Heidegger, 1927/1962) would have expected these older nurses to conduct themselves in their earlier lives as clinicians. For "in everydayness one is not himself"; rather, we are influenced by the 'publicness' that both controls and levels our behaviour (Inwood, 2006, p. 212).

While 'falling' (Heidegger, 1927/1962) in with their specific way of going about their everyday role, older health professionals are thrown into a group of others, people who are at variance with them. Being thrown into the world with others indicates that we are there not in any planned way; rather, we find ourselves already there, in a place that may feel foreign (Inwood, 2006). While it is likely that older practitioners expect to feel a part of their current work-world of health care provision, their pride in their role, manner of dressing, a previously taken-for-granted way of being at work, may cause them to stand out as different, seemingly left behind, a fragment of the past world of practice.

The gap between old and young opens a chasm, a gap possible to fall through, out of the safety net that catches, away from the known, into the unknown and uncertainty. All the while we hold close to us others who are like us, for they provide the opportunity to be in-step, synchronised in terms of our thinking and doing in our everyday work-world.

Reciprocity and Responsiveness in the Relationship

Stories from manager participants show that in their relationship with older health professionals they can bring out the best and the worst in each other. In working together there is the opportunity to develop trust, and overcome the possible barrier of age disparity that lies between them. At times, stories show the way working with another can improve practice. On the other hand, the age disparity can be central to anger or annoyance. Inevitably there will be boundaries around such relationships, yet in the play of their being together (Gadamer, 1975/2004), in the push and the pull, the relating can take off in any direction.

As Needing to Move Forward

A number of managers talked about the effort required to move older clinicians forward in their practice. Inevitably, some older clinicians became caught between acceptable standards from the past and current expectations. Joy, a manager, tells how she went about getting the older members of 'her team' to catch up with her beliefs about standards, and how they responded:

> *At first it was really tough, especially for these older ones, really, really tough. Oh they grumbled!! Rah, rah rah 'we don't have to do them', and I said, "Nursing Council is going to make it mandatory any day, you are going to do it". I did use quite a bit of bribery, put carrots out, and I was just able to persuade them. I introduced objectives. They'd never had real objectives, and so I asked the Board could we reward people who could meet their objectives. So they have this goal at the end of the year, every Christmas, we give them a monetary award, like a Christmas bonus, but first they have to meet their objectives. Yes, there was a bit of bribery and carrots dangled but now it's just so different... It's been exciting, because they were a crowd that were quite stuck in their ways; that's not their fault, not their fault at all. They hadn't had any encouragement and if you don't have any encouragement, you know what happens. But we were able to change that.*

> *I'm now quite proud of my older nurses here with their PDRP's [Professional Development and Recognition Program]. When I came here they said, "Joy, I am not doing a CV", as I am never going to work anywhere else, and me telling them, "if you're going to be here, you are going to have a CV, you are going to have a profile, you are going to be an up to date nurse, and you're*

going to prove to me you're an up to date nurse". "But I am" they would tell me and I would say "well how can you prove it". In-services and things weren't encouraged, in the old hospital. They worked hard and they didn't get any extras. I came along and we had… in-services, up-skilling, the whole time, to make them more aware because the case mix had changed a lot and they have just all flown, all flown. It's just wonderful.

Older nurses in this team had been left behind, no longer current in their nursing practice. Initially they resisted change, they grumbled and groaned, dug in their toes, and held back. However much they resisted, they inched forward as, *carrots are dangled, bribery used and goals put in place.* In her positive mode of care for the older nurses she works with, Joy 'leaps-in' (Heidegger, 1927/1962), pulling them from the past, where they are stuck as a group. She draws them into a future way of practicing and at last they have responded, taken off and flown. The older nurses have made this change with support. Their manager's belief and at-oneness with them, and the building up of trust, has been the catalyst for change.

As Challenging

Pressure on other managers comes from working with older health professionals who know almost too much. For Cathy the tension between her and an older practitioner relates, in part, to having had a different past relationship. As a younger manager, she finds herself working with an older health professional, someone who was formerly a colleague, that she had previously enjoyed working with. However their newer relationship challenges Cathy:

> *One older person in our team is really sassy and funky and because her energy is really young and vibrant I never think of her as an older health professional. Before I went into the managerial role I loved working with her because she's so open and vibrant. Now I'm in a managerial role I find her hard to manage because of that energy and confidence. She has an ability to apply pressure that a lot of the other team members don't. And she'll lobby for stuff and because she's really good at it, making it her business to find out stuff, then bringing that knowledge to building a case, I find that quite hard to manage. Some of it has to do with my inexperience as a manager and not knowing how to deal with her level of confidence and the information she's gathered. It highlights my lack of knowledge or lack of experience. So it pushes my buttons. She might have found out something that I don't even know about the organization. I then have to somehow contain her expectation, which I found hard to do because of the age disparity, and the change in my role. Those are hard conversations to have and I don't know if it gets easier but I'm hoping it does.*

It was easy for Cathy to work with this sassy older clinician when she worked alongside her as a peer. *Then* her energy, confidence, and institutional knowledge

could be seen as the asset it was. Whereas *now* her same confidence makes her manager feel doubtful of her own abilities, as she struggles to come up with answers. Cathy is early in her career as a manager whereas this older health professional has had many years working in her career as a clinician. The older clinician has not changed, she knows her role, and she brings with her a depth of understanding of the service, qualities that are an asset to any service. She continues as before, pressing for what she sees is needed, and in doing so unintentionally challenges Cathy's way of knowing. Cathy is vulnerable, relatively new to her position, still learning and at times uncertain of how to proceed. Their being-with one another was once a happy relationship, with the difference in years concealed. That generational difference has now been brought into prominence, for the older clinician's maturity and experience seems to highlight the manager's tentativeness and lack of confidence. The younger manager is uncertain how to respond to her pressure and expectations. It is as though this confident, energetic staff member expects too much from her. While the manager's respect for the older clinician's abilities show in the story, her mode of responding is still on the way to fully developing.

As Fluid

Like Cathy, Jack, a younger manager, finds himself managing an older clinician who he has worked alongside in a previous role. He talks about how over a number of years their relationship expanded and changed. Jack describes how his early impression of his colleague altered:

> *This older clinician was on the team the first day I arrived years ago and she was very, very scary at that time. It seemed when you first met her that she had a very fierce personality. Later we gradually became accustomed to each other and our relationship stayed as it was for the next eight or nine years. Time after time over those years I witnessed people having the same initial reaction. But now in her mid to late 60s and still one of the most committed members in the whole team, she's an absolute gem, wonderful, really inspiring. She's absolutely fantastic. She would take on new projects completely whole heartedly and act as a resource and as a leader. Even when she went to part time hours she'd still give it 110%. She's great, really great. She benefited from leadership that recognised her talents and let her act within those boundaries, giving her free reign and recognised that. It would be a very collaborative process because that's what she responded to best. So I would go with a genesis of an idea and she would expand on it. We'd brainstorm together and we'd come up with an action plan solely around clinical work and I could rely on her to go away and do it. She was very flexible and really committed to anything to do with clients and had absolute*

integrity. Even though she was very experienced and had worked in almost every area of her profession, she was always ready to learn.

Once at a surface level the clinician initially came across as *very, very scary*. Jack judged her to have a very fierce personality. But *now* he finds that what lay beneath his early impression is a committed *really inspiring* clinician. Formerly this older clinician was Jack's peer, now in this story he finds as her manager that she responds to being-with a leader who recognises her abilities, and who allows her the freedom to work in areas where she has strengths. The giving of space in the relationship provides leeway along with freedom for each to move as and when is needed. The 'allowing' generated between them comes not so much from a superimposed rule but comes spontaneously from the mood that is there in their being together (Inwood, 2005). Alongside this Jack, in his positive mode of care, one of leaping-ahead (Heidegger, 1927/1962) and showing a way forward, opening up the pathway and enabling the older clinician to gain in strength in the areas that she loves to work. In part this comes about through their attunement to each other and from the reciprocity between them, leading to a trusting relationship. But it is also brought about in the setting aside of the manager's earlier prejudgment of her personal qualities.

In contrast to the stories that begin this chapter, stories which reveal older clinicians seeing themselves being strong in the face of tension and adversity in their everyday work-world, the following stories reveal how such self-understanding 'comes'.

Seeing Myself through the Perception of Others

When we see ourselves through the perception of others there is a coming back to ourselves, a revisiting of our beliefs, and a questioning of who we are at the centre of our Being. It can be a time when we see ourselves anew. For some older practitioners, seeing who they are, reflected back through others' eyes, can be a time for affirmation; a time when confidence and strength are built on. However, for some, this can also be a challenging time when what is reflected back to them, from others they work with, undermines their self belief.

Being Seen as Mattering

When Jessie, a community mental health nurse, reflects on her work experience she reveals a picture of her, and her practice, being affirmed by others:

I've only got one client who is on an indefinite order, and I then act as a key worker. I would want to do that for my client, to do the best for her, to have the best outcome for her, because it's in her best interest. While I'm here I'll always be keen about that process. It's interesting that in judicial reviews, 2 judges refused to continue unless I was there, because I was the key person for two of those clients. One judge who refused to continue said that he wanted me there. I was on leave at the time, and he said, "Well, it will be when she's back from leave and meetings will be renegotiated".

Being a key worker indicates that your presence is of key importance for your client at significant times. Jessie understands this and it is likely her client also recognises the importance of Jessie's presence or absence. Yet, what Jessie finds *interesting*, is the judge's attitude in the midst of a client's hearing. Meetings are called to a halt, reviews stopped. It is in her absence, when attention is called to her, that she is made visible (Heidegger, 1927/1962), highlighting the need for her presence. The judge will not continue without her being present; he depends on her, it is in her he trusts. All else comes to a standstill awaiting Jessie's return to work. In doing so the judge acknowledges Jessie's significance, for she is key to these client reviews. Affirmation such as this, from those they work with, builds on layers of experience that anchors older health professionals in their practice as they gain in confidence and courage.

Being Seen as Experienced

While Alice, an independent midwife, has a preference for homebirths, the GPs she works with have other ideas about the area in which they would like her to be working. Their preference shows in the referrals they send her:

I get doctors referring the very complicated women to me, because I've been around for a long time. That's quite difficult because it starts to flavour your practice. My heart lies with home birth, simple uncluttered birth. But at the same time I think these women need nurturing and good care too, and I also feel this is not a woman who should be cared for by the midwife or the intern, so I tend to take the tougher ones on myself and hand over one of my nice lovely ones to them. That's going right back to feeling that I should be protecting the younger generation of midwives because I have that experience.

The GPs' *very complicated women* come to Alice. They are the tough, complex ones that need her experience and skill. Some of her *nice lovely ones* go back, for they can be safely cared for by less experienced, less assured midwives. While Alice's heart lies elsewhere, and she would prefer that the core of her practice focused on home births, others she works with have a bigger vision for her. The GPs who know her see her skill and abilities differently from how she pictures herself.

Their perception is that they can hand over their complex women, surrendering them to someone who has the ability to care for them. With this trusting and regard reflected back to her, Alice comes to see herself as able and willing, to do this work. Through experiencing the belief and conviction of others we can be made powerful by rising to a challenging claim.

Being Seen as Unknowing

Just as belief from others, and their regard and esteem in a relationship can build confidence and ability in a clinician, having someone stepping into what you consider is your work has the potential to undermine confidence and destroy self esteem. Hilary, a therapist, tells what it is like to have someone who could be her son, overlooking her work:

> *I was used to being absolutely independent, making all my own decisions, speaking for myself. But when I was in that room I found that this person spoke for me all the time and when I was asked a question this person jumped in and answered it for me. And it was really quite extraordinary, had an extraordinary effect on me. I had been working for so many years for goodness sake, I did know what I was doing and I didn't need someone to jump in and know everything and answer all my questions, or direct me. I felt very much as if I was being directed the whole time. I seemed to be under scrutiny all the time and couldn't be relied on to give my own answers or to know anything.*
>
> *Then I began to lose confidence without perhaps realising what was happening, thinking I didn't know the answer because someone always knew a better answer. Especially because he was never at a loss for words and so articulate, so much more articulate than me, and I began to get less and less articulate, that was the funny thing. So it happened slowly and it went on for some months before I reached the stage of thinking, 'oh I can't cope with this'. I guess it was the age of the other person as well, that was really hard, the same age as my son. That was very, very hard. And it was awkward to deal with, and even more so because I thought to myself, 'he knows everything, he does know more than I do'. It doesn't sound like a big issue, that's why I just let it go for so long, but it was just extraordinary. It was awful. I lost my autonomy, and lost my sense of knowing what I was doing. I nearly reached the stage where I thought I didn't know anything and I almost left, it affected me so much.*

Hilary was confident that she knew what she was doing. After all she had been in her role for many years. But then a new stage of her working life began. A person, young enough to be her son, begins to oversee her work, taking responsibility for her role and for her communication. No longer is she able to speak with her own voice, no longer able to respond with her own ideas, her own reply. Hilary's co-

worker jumps-in wresting all responses, all decisions, away from her. Heidegger (1927/1965) points out how positive care can involve leaping-in, an inauthentic mode of care that dominates and relieves the other person of their ability to act. Alongside this there is another positive way of being-with care, an authentic mode that leaps-ahead which does not take away from the other person but shows a way forward. In Hilary's work-world one person loses their voice while another gains theirs. When our voice is taken from us we can come to see ourselves as not deserving a voice. Here we see the contrast of a person gaining in energy and confidence and future possibilities while another is being drained of theirs. And as in a parasitic relationship, one person loses her life force while the other thrives. Just as the taking away of decision making can expose the possibility to a clinician that they are not considered capable of fulfilling their role, another's perception of being worthy, with affirmation coming from the look of the other, will enable a person to grow and gain in confidence. Van den Berg (1952) tells us:

> It is in the eye of the other that justifies my body, that makes my words sincere and my actions transparent. The somewhere where the movement takes place lies in *this look…* It has come into being through the instrumentality of the loving or friendly glance of the other… The accepting look of the other gives me the almost exceptional right to be myself as a moving body. (p. 181)

Thus, belief in oneself can come from the relationship with another person who looks at me with conviction and acceptance, just as self belief can be lost when that look is turned away from me, when that person becomes my voice.

Being Seen as a Worker

For some older practitioners there came a time when they sensed that they were insignificant in their workplace. Here Hilary talks about her difficulty with attitudes from those more senior to her in her everyday world of work:

> *I had the feeling when a manager talked about workers at the coal face that sometimes things management say indicate that they look down on us and feel superior. I don't mean that about everybody, just that they've moved up and act superior. I still come under restrictions put on by people much younger than me. I think probably if I was younger I wouldn't find it so offensive; I found it incredibly offensive. The person who I talked about it with didn't, she was younger, but it just offended me so much. I thought 'Yeah, that doesn't surprise me'. I think it's about the 'worker ant' really. The worker ant just blindly does what it's told and the others make the decision, or they spend a hell of a lot of time working out systems, and sometimes the decisions aren't necessarily sensible. So much time that goes into working out how we, the worker ants should be doing things.*

It is not so much what is said directly; rather, it is what sits underneath the language used that offends Hilary. She understands the implications barely concealed by language that show the reality of people's attitudes and beliefs. Diekleman (2005) says that "the meaning of being lies in what is spoken" (p. 41). Hilary finds it *incredibly offensive* to be viewed, not as an individual, rather as one of the many, seen almost as an object. A certain look can bring the sense of another's subjectivity to us, in that their gaze can be used as a means to their end, rather than our own. For "under his stare I am just a thing in his world, I experience the death of my own subjectivity" (Luijpens & Koren, 1969, p. 161). In this way Hilary came to see herself as insignificant, a thing in the manager's world.

When we have cause to be alienated by the language used by others, the words stick in our mind, colouring how we are with those we work with, at times causing resentment with a hardening of attitudes between people who need to co-exist in the same work-world. Writing about co-existing, Luijpens and Koren (1969) point out that "to exist is to co-exist" (p. 145), for there is no escape from one another. They describe Marx's philosophy as calling attention to:

> The fact that every generation begins with the tools of work produced by the preceding generations means that every man is tied to the past and dependant on it… [for] … no man is alone in his actions: he always bases himself on meanings established by others. (Luijpens & Koren, p. 148)

In terms of stories, such as Hilary's, it seems inevitable that in this turning away, in forgetting that our present and future are built on work past and understanding of others, we alienate or reject those who came before us. For "in my appreciation of values I am a child of the twentieth century, but it was the children of the nineteenth century who made me this" (Luijpen & Koren, 1969, p. 148).

Being Seen as Out-of-Step

Like Hilary, Laura also finds that what others in her workplace say concerns her, when it is at variance with her own values. At such times, when older health professionals find themselves at a distance from the reasoning and decisions of others in the everyday world of work, then their sense of being out-of-step comes to show itself. Sometimes they struggle with a sense of not being 'in sync' with principles to which others work. Certain stories show older health professionals standing alone and at risk of isolation. The values that are an integral part of their

being, values that may have served health professionals well in earlier times, can become a barrier between themselves and others. Encounters within the work-world then become a constantly moving ground of uncertainty, questioning and challenge.

For Laura, being out-of-step with others is uncomfortable and results in her being labelled:

> *I started doing home modification before ACC came in and what we saw as adequate then is seen differently now...For years and years, a wheelchair user went down the hall to the bathroom that was modified to suit both them and the family. Only if there are a large number of people in the family going to school and work would you expect them to be provided with a second toilet. Nowadays, every wheelchair user expects to have their own ensuite and maybe a new bedroom built on to the house. Younger therapists are automatically recommending that, even if there's a simpler solution. Compared to the system people with medical conditions are under, that's beyond reasonable. The changing level of what is thought of as normal goes up and up and up over the years. I've adjusted my expectations up to a certain extent but there's a point where you say "no! That's outrageous". My supervisor of a similar age understood and thought it outrageous too.*

> *It didn't get to argument stage with the younger staff, but it was more them saying "well I think this" and I'd say "really?!" It was that sort of thing. It came up with case managers under ACC and I was accused of being a socialist because I tried to give everybody about the same, whereas case managers vary like people do, and some were very generous and some were less so. But quite a few of them would, for the sake of peace, give the clients exactly what they wanted and, people with more expect more. I didn't think that was fair and I would try to recommend about the same for everybody. And therefore I was saying no sometimes! So I was called a socialist! I was totally out of step with the thinking on clients' entitlements. Whereas now it seems the sky's just about the limit, we used to recommend a whole lot less. Being out of step was an age thing. I felt several times as though I was in a time warp.*

For years and years Laura has done things a certain way, acting towards others in a mode of fairness and equity, in a manner that reflects her values, and in the way she would also hope to be treated. Her views speak of a time past when 'her generation of people' reflected a range of values that fitted their era, of being fair to all, even-handed with money and not extravagant, during a time when government subsidies related primarily to what was essential for people in need, and no more. Yet these values have come into conflict with the divergent views and values held by others who come from differing eras. Although Laura has *adjusted her expectations up* it seems that the adjustment is not enough. We are never without a mood (Polt, 2003) and the lack of attunement brings with it a mood of frustration and outrage at what

others say or do. In saying that she felt several times as though she is in a time warp, we are being offered a glimpse of Laura's displacement in her everyday world where others reflect back a view of her that has her feeling she belongs elsewhere. Time present has come to feel distorted, pulled out of shape, and unfamiliar. Consequently Laura no longer feels at-home (Baldursson, 2002) in her work-world, for she is no longer in tune with a world that has changed, and the secure world she felt at-home in is absent.

When the work-world becomes an unfamiliar place, then the things and people encountered in everdayness raise doubt and uncertainty about how to engage within it (Heidegger, 1927/1962). An aspect of at-homeness is feeling able to be ourselves (Baldursson, 2002). Whereas for some older clinicians, their lack of at-homeness, the sense that they can no longer be themselves as well as their inability to feel secure or comfortable in their work-world, comes to them in what others show them about themselves. It announces to them the meaning of being an older health professional.

It may well be part of human nature to want to keep our everyday world familiar and smoothly flowing in order to maintain our sense of being-at-home; yet, being in the world of everyday is not a stable place. Rather, as Nancy (cited in Diekelmann, 2005, p. 49) says, everydayness is a place of "constantly renewed rupture, its intimate discord… its relief and variety". Thus, the everyday workplace brings together evolving aspects of being at work, where who we are and what we stand for are challenged by the ideas and values of others, and by the constant change around us; change that it is impossible to stop. For some older health professionals, the possibilities of change and disruption amidst swirling certainty leaves them out-of-step with others. Being-in-step implies a synchronicity with the movement of the other or with a service; being out-of-step does not. Much like partners in a dance, lack of attunement and synchronicity is likely to diminish the synergy or flow that develops when people are together, in-step and in harmony with others (Polatajko, 1996).

When people from differing eras seek to understand each other's viewpoint, a fusion of horizons can occur (Gadamer, 1982). By reaching their interpretation of the other's meaning, they come not only to understand and interpret the other and their

ideas, but to understand themselves (Abbey, 2000). In the encounter alone there is the opportunity to recognise something more clearly about ourselves (Abbey, 2000). This matters, as we do not stand alone in the world, it is a with-world and we are always in relationship with others.

For some older practitioners respect comes reflected from without and also from within. When Tom, who works in mental health, considers his experience it is twofold:

> *With my number of years I'd like to think that I have more respect for my own experience and I've gained the respect of others. People in the workplace do see me as an experienced person and ask me questions about how I would manage things in certain situations so, in that way, it's affirmed for me. I think it just comes through in the interpersonal skills. The times when your experience counts, outnumber the other more difficult times. You're falling back almost constantly on your experience, it's something that's there and it carries you through lots of different situations, with both staff and patients.*

Respect for Tom's experience surrounds him in his workplace. He encounters respect in the questions people turn to him with; he sees it coming from his response to both staff and patients. While it is his experience that builds confidence in others, it is their respect that builds and adds to his confidence in his own experience. We gain our sense of who we are through others we work alongside. The idea that we know what we are doing, that we are good at what we do, frequently comes to us reflected through the eyes of others.

Summary

This chapter shows that for older health professionals the complexity of being-in-relationship comes full circle for it portrays the hermeneutic circle of understanding self. While the chapter starts with stories of confident, mature older health professionals it moves on to show how their self builds from their sense of being valued and respected by others. Encouragement and respect can assist them to blossom into strong clinicians, and leaders within their practice field. Alternatively, feeling disrespected and undervalued leads to disillusionment, and the emotions that come with diminishing self esteem, feeds into further loss of respect. Opening up possibilities for growth and change lies in interconnectedness with others. For self is not experienced in isolation; 'self' is experienced through the feedback of others. This chapter reveals that the being-with relationship is crucial in maintaining the morale and expertise, or otherwise, of older health practitioners.

Chapter Nine: Into the Heart of Practice

What distinguishes practice from theory is not that practice applies thought or concepts technically to some real thing in the world upon which it acts. Rather, the phenomenology of practice involves a different way of knowing the world. Whereas theory "thinks" the world, practice "grasps" the world – it grasps the world pathically. (van Manen, 1997; 1999, cited in van Manen, 2007, p. 20)

Introduction

At the heart of health professionals' work is their clinical practice. Central to participants' stories is experience, an integral aspect of what older health professionals bring to their practice world. It is not so much how they think about their practice or bring theory to the client encounter; rather, they demonstrate their pathic knowing (van Manen, 2007) of how to be with clients, how to act, how to talk with them, and how to hear and understand. This shows in the way they intuitively grasp and relate to what matters within their shared world. It seems that their years of experience help shape their response to clients, bringing with it increasing confidence to their practice. Along with the layers of their clinical experience, older practitioners have accumulated years of lived-experience from being in the world with all its complexity. While some stories reveal these health professionals as frequently assured in the way they comport themselves in the to-and-fro of being-with clients, other stories show a clear tension for older clinicians between embodied ways of knowing and, finding themselves situated in a context where technology and imposed systems, have created a vastly different work world from what they are familiar with and from that experienced in their past.

How Experience Reveals itself to Others

Experience, while frequently mentioned as a phenomenon in participants' stories, remains something glimpsed, not fully showing itself. Experience, rather than theory, shows as a significant key to unlocking the meaning of being an older health professional; hence, exploring its significance will assist in bringing forth what matters about older practitioners working in the world of health care. The Online Etymology Dictionary describes the word *experience* (Harper, 2001) as coming from the Latin word *experientia*, which means 'knowledge gained by repeated

trials'. So it seems that the experience of older health professionals has a repetitive quality of doing and redoing, of trying different ways of doing leading to becoming skilled in a way that assists in laying down a solid foundation. It is the German meanings of the word *erfahren,* which has an external quality meaning "to go, travel through" and "to learn, find out, hear of, but also to receive, undergo" (Inwood, 2005, p. 62) that reminds us that their clinical experience has not come easily to older practitioners. These meanings seem to most closely link to aspects of the participants' stories that follow.

To a large extent, being health professionals has taken over much of their lives, as a great deal of their living has happened while on this very journey. They bring with them a layering of personal and clinical experience from their travelling through the world of health care and life. The word *erfahrung*, signifying an "external or objective event, and the lessons one learns from such events" (Inwood, 2005, p. 62), shows itself in these stories, in the way that the older practitioners have learned and strengthened their practice. This comes through their ability, for instance, to hear and recognize what is happening in situations, as a consequence of their life-world experience. Alongside this the word *erlebnisse,* lived experience, is a notion that describes "inner states, activities and processes that we are aware of or live through but do not usually make objects of introspection" (Inwood, 2005, p. 62). The meanings of such words ring with significance in terms of participants' stories, for it is their living through events in their lives and what they have witnessed and learnt from that living that comes towards us. Yet, opening up the meaning of experience is no easy process. Others see its meaning as shifting for "in experience understandings dance together as unthinking being and responding" (Smythe, MacCullock, & Charmley, 2009, p. 18). This interplay is seen in participants' stories.

The German word *erleben,* "to live", has an internal dimension relating to an effect on one's inner being, as in living through something such as "fear by feeling or witnessing it" (Inwood, 2005, p. 62). This notion of experience as witnessing something can be seen in the effect on managers when observing the work of older clinicians. Throughout the narratives from managers come stories, paragraphs, sentences that point to the way in which they regard, and value, aspects of the

clinical practice of older practitioners. In describing the attributes that older clinicians bring to their work, the words used were frequently emotive, evocative and sweeping. Included from the four manager participants, Jack, Lubi, Cathy and Joy, are stories that bring into the light different ways of valuing.

The Price of Experience

Life experience is what Jack, a younger manager, talks about when considering what it is that older clinicians bring to their practice. For him it is all about the depth and complexity of their lives and he tells us why:

> *The way the older clinicians could interact with older clients, with an 80 year old with dementia, was just on a completely different level to a 22 year old new grad. You just couldn't put a price on their experience. The fact that all of them were mothers, they all had children in their twenties and thirties and what that allowed them to bring to the job was immense. I don't think it is work experience, I think it's entirely life experience. All of them had had significant times in hospital, major operations, and cancer. So they had all lived through these things and it's just something you couldn't put a price on. All that made them fantastic health professionals, even if they were inflexible, didn't want to be involved, they were still the absolute bedrock of the whole team.*

Older clinicians in Jack's team are steeped in experience, in being and in doing, which comes from their accumulated years of living, being mothers, past illness and being themselves recipients of healthcare. Their 'lived experience' (Inwood, 2005, p. 62) means that they have lived through many significant events that are still with them, from which they draw. In Jack's eyes, the value of their life experience is immeasurable. Despite their inflexibility at times, they have a 'practical wisdom' that goes beyond skills and knowledge. Goodfellow (2003) states such wisdom "is orientated to the experiential aspect of thoughtful action in practical situations" (p. 49), in their being-with clients, in knowing just how to act in the moment. This is not a description of bringing theory to practice; rather, it is an embodied way of being-with clients. It is as though all the events in their lives are still with them, connecting to the present and brought into actions and decisions in what confronts them in the moment of the clinical encounter. The depth of their practice gives them a knowing how to be with clients that comes from deep within, "representing the tacitness of our thoughts and actions" (Goodfellow, 2003, p. 49). At the core of the service being offered, and an asset to it, is what Jack calls the *priceless experience* older clinicians bring to their practice, providing a stable and solid foundation on which they and others can build.

You Can't Hire Experience

When Lubi talks about the experience of practitioners in the team he manages it is a particular nurse specialist he is drawn to think of. He weighs up her value and contemplates its loss:

> *The clinical nurse specialist who has been in the service here for 25 years at 63 is coming up for retirement. She brings her life experience and the experience that she has seen in the health environment over time. Nurse specialists and younger nurses rely heavily on her for her knowledge and her clinical expertise but she's talking about retiring in the next 18 months. That's going to be a big hole to fill in terms of what she does in our team because you can't hire that experience. Even now she still has the ability to adapt and change. She's not as stiff as doctors are about change, the megalomaniac side of things and goes with the flow. She doesn't think she knows everything so she keeps herself current in her practice and she still has an enthusiasm for her role… She puts her patients first and goes the extra mile the whole time.*

You can't hire that experience, for the clinical nurse specialist's experience is not a commodity, something you can put a price tag on, easily purchased or replaced. Rather, experience just is, it just happens, it takes time to accumulate, and in this instance it takes being-there immersed in her work-world. Heidegger (1927/1962) tells us that 'is', the verb *ist,* describes something that exists, something that is constantly at hand, that "we can ask not only what something is and whether it is, we can also ask how (*wei*) it is, what is its How-being (*wei-sein*), its type, manner or mode of being" (Inwood, 2005, p. 27). This older practitioner's 'How-being' is one of being open and available, dependable yet, able to change and move *with the flow.* We come to consider the gaining of experience and how it might be assumed to have come with age alone; however, for older clinicians it relates frequently to some integral aspect of how they approach their work, to their sensing of the world and their openness to learning. Though experience as a phenomenon exists, its meaning is not always clear. For some, such as the manager Jack in the previous story, experience means someone being the bedrock, the foundation of the team. Similarly in Lubi's story, as he contemplates trying to hire someone experienced to fill *the big hole* in the service created by the clinical nurse specialist's coming absence, experience seems to feel like no one else can step in to replace all that is offered by having 'been there' for 25 years.

Trusting in Experience

While both managers, Jack and Lubi, talk about the experience of older health professionals in terms of adding value to the team, Cathy's story tells of a more

personal time when she needed help and called on an older clinician's presence at a meeting:

> *I had a workplace issue with another staff member and an older health professional who has lots of fiery energy and passion took the role of mediator… There wouldn't have been a lot of other people that I would have trusted to be able to facilitate it well because it was very complex issues. It was a very emotional session, in fact the other staff member was crying through most of it which was unusual. The older practitioner had years of experience in her chosen profession. And she was really good at being able to hear, to tease out what was happening for both of us, to feedback, to offer suggestions but not in an imposing way, and help us come to some resolution. She was just able to facilitate it really well. That was due to her experience as a health professional. I was able to trust her.*

Cathy's older colleague's experience sits in the room with them. Her experience assists her in knowing what is needed and when. In saying that her colleague *had years of experience* Cathy is pointing to the reason she sees for the session going so well. She builds on this by describing the 'How-being' of her older colleague's experience. Her experience shows in her attentive mode of being there; it is in the *hearing*, in the *teasing out* of detail and issues, and in the *giving of feedback* yet not imposing her own ideas. For the facilitator has a felt understanding, a pathic knowing of what is happening and what is needed with her two colleagues. Van Manen (2007) describes pathic knowledge as being present in situations we find ourselves in and "in the confidence with which we do things" (p. 21). That "knowledge inheres in the world already, in such a way, that it enables our embodied practices" (p. 22). While Cathy's older colleague has a sense of awareness and understanding of what is needed in this situation from her past experience and sense of knowing, Cathy too understands, at a pathic level, that her colleague is someone she can trust in this situation. As "to trust you is to go beyond what I know and hold on to that real individual that is you" (Lingis, 2004, p. viii), Cathy goes beyond what she already knows of the person who is her older colleague, trusting that she will bring what is needed through her presence at the meeting.

Experience that Just Knows

Joy is another manger who talks of the experience of a particular older health practitioner, a nurse she manages, working in an ear, nose and throat clinic:

> *Deidre has got such a passion for children, she works with them, and gets down at their level. She'll take crying babies off their mothers, settle them down, and really supports mothers to look after their children. It makes your heart glad because it takes years and experience to learn some of those little ways.*

It is in '*those little ways*' that Deidre's experience and love of working with children shows itself. It is in her mode of being with children, in the 'How-being', it is in her touch, in the soothing, in her lifting and carrying babies, it can be seen in her attuned mode of care for their mothers. And experience reveals itself in the way she brings her body and mind to the person before her; in the way she turns her attention to them, away from the background demands of the clinic. Who she is shows in how she acts and as part of her sense of being herself, in her practice. Revealed in Deidre's manner, in her relation with others, is a confidence of just 'knowing' what is needed in her response to encounters. Yet, such embodied practice may frequently be invisible to others (van Manen, 2007). It can be such a routine, everyday aspect of older clinicians' way of being-in-the-world that it may be overlooked by managers and colleagues, or not understood and valued for the contribution to practice that practical wisdom brings.

Just as it is not easy to show how experience comes into being, as experience 'just is' present, van Manen (2007) talks about practice having a "kind of corporeal in-being: a pre-ontological understanding of being that is hard to make explicit" (p. 18). When thinking about how we learn, he refers to Pierre Bourdieu (cited in van Manen, 1997, p. 94) as saying "the child imitates not models but other people's actions… a style of speech… subjective experience" (p. 94). In addition Bourdieu states that "the essential part of the modus operandi which defines practical mastery is transmitted in practice, in its practical state, without attaining the level of discourse" (cited in Dreyfus, 1991, p. 17). We learn the how of practice primarily from subjective experience; that is, observing, imitating and in the throw of acting and doing rather than through being told something. Because knowledge shows in everyday actions van Manen (2007) contends that "we may discover what we know in how we act, in what we do" (p. 22). Mastery and understanding for older health

professionals will come from the specific being-with clients and other clinicians, observing, and absorbing an understanding of what excellence looks and feels like, for "it is in the meaningful context or the sense of our world" (van Manen, 2007, p. 17) that things come to our attention. In this way, for practitioners, 'embodied knowing' comes along with just being there, witnessing and experiencing the events and actions that make up their practice world; actions that become so familiar that they grow to be a part of them. Alongside their practice world, experience also comes from older practitioners' wider lived-experience of being-in-the-world. For being-in-the-world gives us our sense of what matters.

Recognizing their Own Experience

Just as managers' stories show them valuing the experience older health professionals bring to their work-world, older practitioners too consider the value of that experience. At times they applaud the understanding that their years of practicing has brought to their experience. On other occasions, a more complex picture emerges where despite their increased ability to interpret and understand what is happening in their practice world, they are still learning to see the practice picture more fully. Older practitioners, Jessie, Grace, and Coral reveal in phrases and words, taken from their narratives, how they hear, find out, undergo and receive (Inwood, 2005), from all that surrounds them, the pieces that together give them a view of what is occurring around them. It is from our everyday actions and the things in our world that meaning comes (Heidegger, 1927/1962).

Grasping the World of Practice

When Jessie considers her work with clients she returns to something fundamental to her interactions. She says: *every day I think that my experience matters*. Jessie's experience enables her to find a way forward in what can be precarious situations with clients: *It was about conflict resolution really and I was able to facilitate the whole process easier... It was fluid.* Jessie turns to what is in front of her, differentiating between what matters and what does not by her focused attention (van Manen, 2007). Through her turning to, and understanding what is significant, an encounter flows smoothly when it might not have done. For on a daily basis, whenever Jessie comes face to face with the possibilities that confront her, she is

able to draw on her 'reading' of situations, grasping what is needed, helping the interaction to flow, making it work.

Yet, this grasp of the practice world is balanced by the need for older practitioners to avoid being constrained by the familiar habits and routines that might exclude other ways of practicing (Dall'Alba, 2009). Dall'Alba (2009) argues that "our own pasts that we carry forward also places limits on the possibilities open to us" (p. 40). Past experience then, while having a semblance of wise practice, may introduce barriers to the breadth of possibilities open to older practitioners who remain stuck in habits and ways of being brought forward from their past. Visible in managers' stories are older practitioners who remain committed to past practices along with their experiencing difficulty in being open to new ways of thinking.

Lived Throughness

A call comes to Grace for 'showing how' to be. When needing to focus on a complex situation in theatre she brings her practical wisdom to dealing with an emergency situation:

> *I said to the younger girls 'Just think logically about what you can do next'. So, telling them not to panic, to take time, now that things are under control. It was a really major thing to show them, and myself, not to panic.*

It has been a learning time for both Grace and the nurses in theatre, learning to stay calm, learning to bring calm, to move along with what needs to be done. Grace understands theatre nursing for she has had many years experience in this field. She brings her experience and understanding to this particular place, in this particular time (Harman, 2007). Yet she says: *I think that's a gradual thing for me, learning to think on my feet.* Thinking on her feet involves Grace being in a mode of embodied knowing, of just sensing what to do next, for this is not the time or place for thinking. Grace has lived-through this before, been there already: *We have that all the time, it happens a lot.* At such times "the past becomes a resource for the present" (Dall'Alba, 2009, p. 39). Consequently, without thinking, what is needed comes forth. Immersed in practice, being caught up in the play of it (Gadamer, 1975/2004), practitioners have a sense of knowing what is needed, of what comes next.

Being Perceptive

Much as Jessie and Grace call on their experience, Coral's current practice draws on her past experience of working with clients. This provides her with acuteness of perception and 'acumen' about her work focus. "Acumen means keenness and depth of perception especially in practical matters" (Stamp, Burridge, & Thomas, 2007, p. 480) and it is to such practical matters that Coral turns, saying:

> *Learning only comes from working with different clients. I have clients that are here for six months. I don't expect things to happen straight away and I often structure my exercise program with a lot slower progression than the others do.*

Coral's way of being with clients is influenced by understanding their needs; in not being hurried she gives the time her clients require. In this context other staff members are less perceptive. They confuse the slower pace of treatment with pointlessness: *It's usually at lunch time that they say things like 'I'd have murdered her if I'd had to do that' or 'Why would you bother', though Most of them feel I've got incredible patience.* On the one hand Coral's work with clients may seem pointless to others; on the other, her persistence and fortitude comes to their attention. Coral gains strength from following her chosen pathway. The path itself reveals the way forward, for it is in our acting that we come to see what is needed. She focuses on her clients' need and away from her colleagues' criticism saying: *As you grow older, you develop a sense that time is relative. Having a program that is much slower gets the same results in the end. That really comes with experience.* Coral reveals her perceptiveness, her acumen, in her grasp of what matters in her practice world.

We see in their descriptions the way experience underpins older practitioners' work, along with recognition that their experience strengthens the confidence they bring to their practice focus. Yet, no matter how experienced they are, older clinicians describe looking back, recognizing, and understanding the meaning and existence of risk in their practice. It seems that experience does not safeguard from risk. Rather, experience helps in identifying the risk and learning how to work with it; for risk and uncertainty is always with us (Stamp et al., 2007). Stamp et al., (2007) describe *sunesis,* a word meaning "perceptiveness, understanding why a situation is as it is" as "an important element in reaching out to discern risk" (p. 480). *Phronesis,* which means "the reasoning used to deliberate about good actions" (Polkinghorne, 2004,

p. 114); then follows *sunesis* (Stamp et al.). *Sunesis* then is the understanding of the action before the act while *phronesis* is the understanding of good action.

Despite their practice confidence, Laura, Elizabeth, and Genevieve tell of times when their experience could not 'pin down' what would occur in client encounters. Rather it was being open with clients that brought them to a greater depth of understanding. For we "reach out, to see, to look in unexpected places… events or influences, in order to discern where risk may lie or later emerge" (Stamp et al., 2007, p. 479). It will be in the reaching out and discerning of risk that practice is strengthened.

Being open to the possibilities, the surprises and uncertainty, that may open up before them requires a clinician to be confident, despite the risk of what they will find. In the following excerpts there is a pointing to their learning from risks encountered. It seems that their experience could aid them in recognizing uncertain, even risky moments in practice, bringing understanding that is always on the way rather than fully arrived at.

Being Uncertain

Despite her years of clinical experience, the years of client encounters she has 'lived through,' Elizabeth finds that she is still 'on the way' to understanding, saying:

> *I can leave work at work except for those two patients with personality disorders. I could have totally overstepped the mark. It threw my clinical confidence out the window. It was very scary and I'd question myself all the time.*

At the end of her working day Elizabeth is unable to leave these two clients behind. They stay with her. Elizabeth continues:

> *It's very seductive getting hooked into that you can do it when others couldn't, to just be aware of the seduction of 'I can make it alright'. It certainly taught me to make that boundary very clear for people that I train.*

Elizabeth trusts herself to know the boundaries; yet, in part because of her positive mode of care (Heidegger, 1927/1962) for clients, she is seduced by feeling needed, by her sense of knowing that she can mend what is wrong. Initially Elizabeth does not discern the uncertainty or risk; rather, it is in hindsight that all the pieces come together revealing a pattern. Being able to join the pieces together is the *sunesis* of

practice, something that comes before the actions involved in *phronesis,* that implies practical wisdom in action (Stamp et al., 2007). It is from their experience that older health practitioners come to see and comprehend the meaning of changing and moving patterns in their practice. This allows for the possibility of future resolution of ambiguous and complex interactions.

Understanding Risk

Genevieve's practice, like Elizabeth's, is steeped in experience but she too finds she is still growing, always 'on the way' to becoming rather than simply 'knowing' something (Dall'Alba, 2009). She is also coming to understand, recognizing "that irreducible uncertainty which is the nature of life" (Stamp et al., 2007, p. 480). She tells how:

> *People often come to me because they change midwives and I'd think 'Yes, I won't stuff it up' but of course you do. It used to make me feel a bit important. I work in such a non black and white world and I've learned now, not to put myself in those unsafe situations so much.*

When Genevieve says *I won't stuff it up* she is depending on her perceptiveness about people and situations to keep her safe within a context she knows well. But she is still 'on the way with learning', building on her experience, coming to see hazardous patterns that are a part of the thrownness of being-in-the-world (Heidegger, 1927/1962), where we all encounter situations not of our making. For like understanding, "self understanding is always on the way; it is a path whose completion is a near impossibility" (Gadamer, 2007, p. 239). We are reminded by van Manen (2007) of how understanding comes:

> From Heidegger's perspective one cannot account for the context since we already live it, before we make sense of it in an interpretive manner. We live out that context by constantly actualizing and realizing our understanding that already inheres in our practices and that cannot necessarily be explicated. (p. 17)

It is through context and through her accumulated experience that Genevieve makes meaning of her world. Despite difficulty in explaining why she does 'stuff it up' in these situations, she understands something of why it does not work in the course of living through the experience. The understanding then inheres in her mode of practicing, becoming a part of her approach to encounters. It is their accumulated living-through that enables experienced practitioners to know when to persist and when to move on.

These stories reveal the way experienced health practitioners have the confidence to reach out in situations of ambiguity, to take the risk to explore further, coming to glimpse what lies before them. They understand the uncertainty that confronts them in their practice world just as uncertainty confronts us all in life. Harman (2007), in writing of Heidegger's philosophy, says that "human beings always take a stand within the world, occupied by it, fascinated by it, overjoyed or horrified by it"; that "we do not primarily look at the world like neutral observers, but care about what happens in it" (p. 29). These stories reveal how older health professionals care about their practice, take a stand and both grasp and are grasped by their world of practice.

Though frequently being self-assured in their interaction with others, experienced older health professional participants tell stories of tensions with new and changing aspects of practice. Alongside their developing practice wisdom, some struggle to make sense of "the dominance of technological and calculative thought" (van Manen, 2007, p. 19) within their field of professional practice.

Techne's Impact on the Practice of Older Practitioners

Participants' stories reveal the way technology, and the systems that accompany it, have invaded and impinged on their world of practice. Van Manen (2007) refers to this pervasive change occurring in professional fields such as nursing. This is the techne of practice. Polkinghorne (2004) says that "in modern technology humans make use of sophisticated scientific instruments and tools as the means of achieving results" (p. 39), with technology having both positive and negative effects. Techne is the practical reasoning required to make things, in "using, applying and above all tools – what we call instrumental action and that is about the human propensity to gain control over nature" (Polkinghorne, 2004, p. 9). For the present we will focus on and explore the impact on older practitioner participants of the increasing technification of health care practice.

At both a personal and professional level, techne's sweeping influence on older health professionals' world of work is unavoidable for the participants in this study. Alteration to their practice world may not always be sudden; rather, participants tell of their awareness, and frequent discomfort, in the incrementally different world surrounding them. In contrast to such gradual change, there can be a sudden transformation, with little consultation in how health care is provided, when older

health practitioners find themselves in a work-world where new technology and the consequent expectations of them, is prominent and dominating rather than residing in the background.

Questioning the Value of Change

When Hilary is faced with a new system designed to make sense of clients' aims of care she finds that what she must follow seems nonsensical when she is with clients:

> *The blinking Care Aims, I've found it so difficult to get my head around the words they use. You have to get the persons goals, but you can't just say "what would you like to be able to do"? Because then they'd say "I want to be able to get off the toilet" that for me is a sensible goal and I can put an objective. But that's not the goal. You have to ask deeper and deeper questions. And these Care Aims are supposed to be for the sake of the client. Quite frankly I can't see any benefit for the client at all and just a hell of a lot of work for us. I find it difficult to get the words right, because invariably, though I ask people in all different ways, they never answer the right question. I asked this young girl who's in a power chair, "What do you want to do with your life?" and she said, "For goodness sake, I'm 21. I don't know what I'm going to do tomorrow!" I thought it was such a beautiful answer. And you get caught up with people saying, "I want to die", and then you have to write an objective about how to help them achieve their goal. It drives me nuts, absolutely drives me nuts. They are very hard work and I don't know how valuable it is. When we first had to get onto the computers and do our stats and then the Care Aims came on top of that, it just about drove me mad.*

A new system has arrived in Hilary's work place that she feels compelled to comply with. While the intention revolves around ensuring the care aims for a client are considered and met, Hilary finds in the process of using the system, that for her it is unusable. The deeper questions and responses expected of her do not seem to relate to the clients before her and their needs. Though, in her being there with the client, she attempts to make it work, to follow 'correct procedure', she seems to get nowhere. For paradoxically in trying to elicit the 'right response' the 'wrong answer' comes forward. Her adherence to *the blinking care aims* seems to hinder her mode of being-with clients, affecting the 'normal' flow and embodied knowing brought to encounters as these occasions preclude her being able to intuitively grasp what is needed. And beyond that, the system creates additional work. The tension from the expectation that she will use a system that does not seem to work for either the clients she works with or for herself is likely to add to Hilary's questioning: Who are the care aims for? Why are they needed and who benefits from them? While setting goals can be seen as mattering in terms of outcomes for the client, for Hilary, it is just one more imposed system adding to others. For other older

practitioners there is also concern around the value of such systems and the way they crowd out their practice wisdom, and practitioners' situated judgements about what is applicable.

While practitioners need to attend to new ideas and aspects of practice, their attention also needs to focus on the situation and person before them and the links one aspect has to another. For they need to see the 'whole picture' and its context as "every human being is unique" (Polkinghorne, 2004, p. 109). It is this uniqueness, of both client and practitioner and their situatedness, that a system such as care aims appears to not take account of, seeming to treat all contexts as alike. While general rules, such as a mode of assessment, can be useful as a guide, it is when they come to take over practice that we can see older health professionals struggling.

Being a Face-to-Face Person

What happens for clinicians who came from an era when much of health practitioners' work was primarily face-to-face, when systems were minimal, when there was time to turn to the client to find out what was required? Faced with a work-world where technology instead of people contact, systems instead of professional wisdom, appears to dominate and direct their work, they may become hesitant. In the following excerpts from Jessie, Alice and Tom's stories, we are drawn to thinking about how their time is spent. Jessie considers the tension arising from the different demands on her time:

> *We have a new system, which will come in soon. You have to use all different programmes, you've got risk assessment, you've got early warning signs, you've got hazard forms, you've got a whole host of things like depressive rating scales, GP referral, hospital referrals, clinical data base. We've got this software now where you just click in so you don't have to write so much. Some people enjoy the computer, but I'm a face-to-face person. I like people, I like being out there talking to people, and doing. I do miss it terribly; that's the whole thing, nursing has changed.*

While Jessie recognises the gains in the new system, the speed and convenience, she also acknowledges the loss, the reduction in time for just being-with clients. For she is a nurse who came through in the 'old system', a system where time was made for clients, where nurses frequently relied on their embodied knowing of what was required of them rather than the filling out of forms. She wonders about the changes to nursing. Once *you had to be really aware of people's mental state and mental disabilities, and how very grievous it can be if people are not being observed or*

nurtured adequately. As she considers the changes and conflicting values Jessie feels her personal loss, she admits missing terribly that mode of being-with clients.

When Techne takes Over

The difference in now and how it used to be is also noted by Alice:

> *Now there is that sense of protective documentation, so that you've demonstrated that you're aware of what's going on and made appropriate decisions around it. The more complicated the situation, the more you're at the bench writing notes. My care plans document the exact advice I give women... You're protecting the person in care but a lot of the time you're also protecting yourself. So in the middle of your friendly care you are jumping ahead to protect yourself if there is a hostile overview anywhere along the line. If it isn't written down it hasn't happened... Unfortunately that's part of the model of care.*

Where once Alice would have spent time in *friendly care*, that of being involved with women while birthing, now her time is used up *writing notes*. The more complex the situation, the more the woman needs her attention, the more time is taken in protecting herself and the woman from potential criticism, for *if it isn't written down it hasn't happened.* Alice's enforced mode of leaping-in (Heidegger, 1927/1962) is not a mode of care where she reacts to a situation in concern for her client to take care of the way ahead for them. Rather, it comes as a necessity of a system, a model of care that requires this of her. What is absent in this description is the notion of the relationship between the woman and Alice being in-play (Gadamer, 1975/2004). For the techne of practice has the potential to close down trust and the human connection in encounters with others, with the care transferred to a system that supposedly protects them all.

Tom also finds that following an increase of techne in his practice world, the look of practice is changing, with techne at times covering up what is actually occurring:

> *The amount of my time on the computer in the last five years is increasing. It can be abused in that it can be used by some people to avoid client contact. As a nurse, in the past, you may have hidden in the sluice room for some down time, the modern nurse hides behind the computer screen. It's like a parallel virtual reality, so everything can look just wonderful on the computer and then it's ticked off and it's got nothing to do with the real world, so you manage two realities, if you like, in the work place.*

As a consequence of the widespread use of computers in the workplace, Tom points to the veneer of everything looking good, while beneath the surface everything may

be falling apart. He sees that in the techne of practice there can be just a semblance (Heidegger, 1927/1962) of everything working well; giving the appearance only, when in reality it is not. Significantly, the system, while failing to detect what matters in health professionals' practice, picks up instead on adherence to a system with all the 'boxes ticked' satisfactorily, the focus being on 'instrumental' care (Polkinghorne, 2004).

Being 'On Board' with Techne

Tom wonders also about the value of technological advances and he considers what it is like for the people he works with:

> *There's no problem with getting older workers on board with the new changes providing they're convinced there is some value in those changes, and they want to do it, then they can do it. Just that I have to be conscious myself of what it takes to keep up to date and not look for resistance saying "Oh well, I'm only going to be working for another five years so I'm not going to be bothered doing this sort of stuff". That's what I call practicing retirement.*

In a work world where he is surrounded by ongoing changes to systems and practice, Tom is concerned with not falling into the everyday inauthentic way of being (Heidegger, 1927/1962); that of continuing along unquestioningly, of not bothering or forgetting, and just awaiting the future (Polt, 2003). He sees this as a choice older clinicians make, to press forward into their chosen work (Dall'Alba, 2009) being fully there, still learning as health professionals and adding to their professional identity while engaging with the increasing technological aspects of practice. At the beginning of becoming health practitioners, older health professionals will have gone through a transformation of self in taking on their professional identity (Dall'Alba, 2009). For some clinicians, as they age and become distanced from that transformation, the ability to engage with new ways of being becomes lost to them. Yet others chose to engage with new aspects of practice that surround them.

'High Tech' Impacting on Being

When Alice comes to work in a different midwifery environment she finds that much has altered within that work space:

> *There have been major changes in midwifery and it's been a huge learning curve. I hadn't used CTG, that's continuous tracing, on babies in labour. I had no idea what plugged in where and was really ignorant about running post natal drips or epidurals… there are so many opportunities to make great big mistakes when you're using that technology. With my sticking to my guns*

previously about just doing normal births I wonder if that was a way of not going there, not stepping into the more high tech side of technology.

In stepping out of the low tech, hands-on, world of home births, Alice steps into the increasingly high tech world of hospital births. There she is confronted with a space full of objects and tools that feel foreign to her, a space full of things that need to be plugged in and women who need monitoring, where the techne of practice has taken over, filling up the space once occupied by the practitioner-client interface. These differences in practice have challenged Alice's everyday sense of knowing what she is doing. Now she must read and understand the language of techne, rather than depending on her own judgment–based way of being; a way of being, as Alice reveals in her earlier stories, that trusts in the language and interplay between herself and women in labour. For Alice brings from the past an embodied history and tradition that inhere in her as part of "learning professional ways of being" (Dall'Alba, 2009, p. 37). Now she, and other older practitioners, must take up a different way of being, that of "a technologically guided approach for determining their practice" (Polkinghorne, 2004, p. 1) that has crept into the world of health care, a shift that demands adherence to new systems. Hannah Arendt (2002) points out the difference in tools of the past and the machinery and technology that have followed:

> The much discussed question of whether man should be 'adjusted' to the machine or the machines to the nature of man never arose with respect of mere tools or instruments. And the reason is that all tools of workmanship remain the servant of the hand, whereas machines indeed demand that the labourer should serve them, adjust the natural rhythm of his body to their mechanical movement. (Arendt, 2002, p. 369)

Just as Arendt describes people becoming the servant of the machine, we see the way that through the 'high tech' side of midwifery, Alice has had to learn to adapt. In this setting her practice appears to have become less one of her using her tools of practice, and rather, one of bending to the movement of the machine. Alice's reluctance to 'go there' her concern for how the change could affect her practice appears to have been borne out in what shows in her story of her everyday experience in her changed role. For many older health professionals the difficulty of technology is as Heidegger (1993) reminds us that "we can't 'opt for' technology or 'opt out' of it" as it is just there, "fundamental to our time" (p. 309).

While Grace, unlike Alice, remains within the same workplace, the daily work within the theatre has altered. It too has become crowded with 'high tech' equipment. To maintain her role in theatre she must adapt:

> *We get a lot more complicated surgery and a lot more complicated instrumentation than we used to… There's a huge amount of stuff now that you've got to know, a lot of different technical things. Now, instead of there being one way of doing a hip joint with laparoscopic surgery, there's about 50 ways of doing it. Every surgeon does it a different way so it all involves different equipment, different instruments. We've got to know how to work towers, and cameras, and take photos of their surgery while they're inside. And we've got to learn to navigate round knees with lasers and things like that and I think 'Heck I didn't sign on to do this'! But it is stuff I've had to learn as I'm going along. So it's hugely more technical than it used to be.*

Grace *didn't sign on* as a theatre nurse to do the work now demanded of her. Techne, the skills of practice, and its complex tools have taken over her role. Previously, in past stories, we have seen how Grace in times of crises led the nurses in theatre. Her embodied knowing, her understanding of how to bring calm to the theatre, shows them the way. Now, in this story, we see her swept up, almost overwhelmed by the layer upon layer of imposed technological advances that remove the time for anything else, as a technologically guided approach comes to determine her practice (Polkinghorne, 2004).

Seeing the Good in Techne

Alongside participants' stories of the techne impinging on the space for practice wisdom, Laura highlights the positive benefits to her practice that increasing techne has brought:

> *I've found it amazing and wonderful in terms of equipment that's now available, because, for instance, the old reclining wheelchairs, the manual ones, when somebody reclines you had to elevate their legs, and you elevated the leg rests by one person holding the leg up while the other person used a spanner and adjusted. And then you did the other leg… Whereas nowadays you just press the button, I think that's wonderful for the clients and their care, and for caregivers. I don't see it as a problem, well not all of it.*

Just pressing a button now makes things happen that previously happened manually, with the therapist's hands, not so much concerned with the care of practice, but rather the use of tools that extend what they can offer. Now with advances in technology Laura finds that the past 'hands on' labour is gone, enhancing the ease of providing care rather than the focus being the adjustment to equipment. In contrast to earlier stories of the worth of 'old fashioned care' this story of Laura's

reminds us of the value of technological change that eases the way for both clients and those who care for them in their engagement with the world.

Professional know-how and skills are essential to the role of being a health professional. As their professional education program falls further into the past, older health practitioners who chose to remain in practice will have opportunities to nurture their professional skills. For we are always in the process of learning and becoming, of "taking up some of those possibilities and not others" (Dall'Alba, 2009, p. 36). Yet how and why those learning choices are made is likely to determine, in part, whether the learning inheres in us. Heidegger reminds us that "being human means having possibilities, or possible ways to be" (Heidegger, 1927/1962, p. 40). We now turn to some of those possibilities.

Taking up Possible Ways to Be

Showing in participants' stories, are views of the value, or otherwise, that older practitioners placed on the opportunities for ongoing training and education. But excerpts from Genevieve, Coral and Kate's stories reveal how restricted the possibilities can be. For Genevieve:

> *Working in midwifery has got more and more and more directive, with these technical skills that you have to have. Every year you have to do CPR, every three years you have to up-skill yourself or demonstrate that you are skilled to deal with emergency breaches, whereas before this you're just doing more normal things.*

The things that take her away from practice do not feel like normal things to Genevieve. Normal things are likely to involve her in the care of women and babies, where she could call on her situated knowing of how to be in the encounter. Now the possibilities before her are *directive,* and skills focused, so that as an older midwife she has little choice, for she must meet the current expectations of her profession and her workplace. For Coral, keeping up with the demands and monitoring, in order to demonstrate competence, does not sit well with the importance she places on the differing possibilities before her:

> *Now we have to complete a log which covers professional activities, extra learning that you've done. I got audited the year after I'd been back in work… just to ensure that you're in a safe practice mode. I thought a lot of what went in to that log was really overkill. They've almost gone the other way, now they want you to do huge number of extra curricular activities, to justify why you're a safe practitioner. As a physio you're required to complete all those hours of education whether you work part time or not. Yet they clocked my*

hours of study at university and I got a very polite letter back saying that I could only record a percentage of those hours, as that was all that the log entitled you to do. It felt to me like they were really saying "Well, why did you bother doing it all because it was of no use". But, it was a lot of use to me.

What matters to Coral did not matter to the Physiotherapy Board. She sees them as expecting of her *huge number of extra curricular activities* of their choosing; to write up a log that Coral sees little value in. Rather than what the Board directs her towards, it is the opportunity to take time out of practice to deepen Coral's knowledge that helps her in becoming and being the sort of health professional she wants to be. Coral talks of the demand for older health professionals to comply with these expectations:

People suddenly say to you "You need to go on courses, you need to do this and this", the constant feeding in of new information, yes I think there is a point to it. But I also think it has to be tempered with an understanding that after a while when you've acquired a huge body of knowledge, you apply that knowledge and you move forward with it.

Coral wonders about *the constant feeding in of new information* and questions the value of enforced attendance at courses where the focus of education is likely to relate to what the organization or professional board directs you towards. Choosing between this possibility, or that, is part of being human and shapes who you become. Being directed clearly diminishes such opportunities. In the previous story, we see how Coral took a stand against the techne of practice, in the form of organizational expectations of courses focused on skills alone. Instead, Coral engaged in, what was for her, 'real education' (Dall'Alba, 2009), something she chose and wanted for herself, and something that she sees as invaluable to her practice.

Kate also looks at the possibilities in front of her. She personally funds her study in order to be engaged with the education of her choice:

Study has given a massive boost to my self confidence and made me feel as though I'm on the path alongside the new graduates whereas before I always felt a step behind because I wasn't quite up with them… I look back at some of the other podiatrists that haven't done any study and I think it's going to be extremely difficult for them because it's all changed, accreditation has come in, getting our license is much more involved… I had the time and the money when I didn't have it before. I saw it coming long ago and I'm so pleased I did.

Kate's course of study in ensuring that she speaks the language of more recent graduates has impacted positively on her confidence, as she is no longer *a step behind*. Keeping up helps both in Kate's practice and in terms of accreditation. This is a course of Kate's choosing rather than one she is directed towards. Both Kate and Coral's stories point to the important role further education can play in capturing what it is that matters in staying abreast of practice changes. Heidegger (cited in Dall'Alba, 2009, p. 37) says that "real education lays hold of the soul and transforms it in its entirety"; thus allowing us to become who we are "by turning us back to this world in a more reflexive way" (p. 37). In contrast to 'real education', stories from Coral and Genevieve bring to our attention how an 'instrumental view of education', one where the learning is a means to an end, frequently links to the techne of practice.

Techne that takes away from Being

A major aspect of Being lies in the way choices and possibilities open up before us; thereby shaping who we are, our lives and our work. Yet the focus on techne can take away this characteristic of Being. Elizabeth questions a new system that alters the service where she works:

> *The systems don't seem to take cognizance of the needs of a small service. Management moved all the clinics to this sort of hotel concept, where you check in at the 'check in' desk for many different clinics. Previously, our clinic coordinator was the important person who made the appointments, who knew the patients, who could reassure people and gave that sense of continuity. Now we have the call centre people who don't understand the way it all fits together, so they constantly tell patients "Oh don't worry about that, but follow this bit". We have people not turning up for half their appointments, because they were told "Oh you don't have to do that." The idea was to get more efficiency, as you'd have more cover by centralizing it into packed components; in reality you get a lot of inefficiency. With the call centre, they say "Sorry no, I don't know who doctor so and so is". Whereas being able to reassure the patient means they know the doctor, that he's nice, Understanding the whole story means that the people coming into the service know what is going on, rather than being fed wrong info about what is required of them by someone who doesn't understand. It has also taken the humanity out of the job, it's taken the networking away from people, and it has taken away the team focus.*

A new model has come to Elizabeth's place of health care. Like other older health professionals she knows a different model from the one now introduced to her workplace. She remembers how it used to be, looking back at a time when the focus did not have the distancing remoteness of a hotel concept, but was more about

understanding the whole story, of placing the client at the centre of care. Rather than the past model of a personalized service, she uses the metaphor of a centralized hotel concept for the new service. At the hotel 'check-in desk' people anonymously come and go. There is likely to be little concern from the receptionist for their welfare because, as hotel guests, it will be assumed that they know their way around the system and can look after themselves. 'Guests' would need little explanation to comprehend check in and check out times. The 'guest' becomes part of what is a comparatively featureless service, one that can set aside caring and humanity for supposed efficiency. This is a changed service 'story', where the client, administrative staff and health professionals are treated as part of a depersonalized concept, a mechanism, devised to ensure that each cog in the wheel combines to work in a synchronized way that keeps the machinery of health service provision moving forward. Within this model there is no room for individual difference and no space for the time needed in supporting and caring. Rather than services revolving around the client it seems that clients revolve around services. Yet the model devised for efficiency results in inefficiency when clients miss appointments and become confused through not understanding.

Polkinghorne (2004) comments on techne's impact, saying that "all that remains is a fund of resources and raw materials that can be controlled and manipulated by humans to serve their own interests" (p. 41). Heidegger (1927/1962) used the word *Enframing* to describe this notion of the enslavement of people and resources for a purpose. In writing about Heidegger's notion Polkinghorne relates that "enframing identifies aspects of things that can be stored as stock for later use and consumption, but covers over and conceals any other aspects" (p. 41). Thus people and resources, as part of technification, become *standing reserve,* for systems that threaten to drive out alternative possibilities and ways of being (Polkinghorne, 2004). In explaining aspects of Heidegger's philosophy Harman (2007) writes:

> We have entered a world of sheer presence that reduces things to objects of calculation. Everything in our world turns into nothing but a stockpile of standing reserve. Everything is reduced to its utility. (Harman, 2007, p. 135)

In Elizabeth's story we see how the clients, the administrative staff and clinicians become standing reserve for a new model of accessing health services; there to be

used, as and when needed, in the service of the system. This story shows the removal of ways of being, in relating to clients as individuals in all their complexity and situatedness, and its replacement with a model that treats health care clients and staff as serving a system. In this way we see how techne can diminish and make the client invisible. Heidegger concerns himself with the threat of modern technology (Polkinghorne, 2004, p. 41) in that a model of care that attends to clients in a personal way can be set aside, replaced by a system that removes practices of care that align with clients needs.

There can be no doubting the essential nature of techne to health care practice; yet, the transformation of care into one dominated by technology and systems crowds out opportunity for the essential human contact that is central to effective health care practice. Visible in a number of older practitioners' stories is their frustration when they are pulled away from interaction with clients by the demands of systems, with the consequence that the human to human encounter is lost or diminished. We catch glimpses of the central core of practice in older practitioners' stories, in the quality of their engagement with clients in the human to human encounter.

The Phronesis at the Heart of Practice

Unlike techne, skills and know-how, the phronesis of practice is difficult to measure. Phronesis has been described as "the reasoning used to deliberate about good actions" (Polkinghorne, 2004, p. 114). Such reasoning can be embodied in older clinicians' practice; yet, not all older practitioners will have it. What they do have is a greater possibility of having developed phronesis over their years of practice. For the phronesis of practice comes together over time, it lies in being-with and shows in confidence and the smooth way of engaging with others. Phronesis is present in the way older practitioners lose themselves 'in the play' (Gadamer, 1975/2004), in the to and fro between clinician and client, while immersed in their practice. Phronesis of care is also visible through 'in-seeing' (van Manen, 2007), in making sense of what is before us.

> We draw on *phronesis* when the journey starts as predicted, but gradually, the near horizon, gives way to a different picture: a cliff edge beyond which is the abyss of the unknown. (Stamp et al., 2007, p. 482)

Seen from an ontological perspective, what lies at the heart of health care practice is the way health practitioners pathically grasp what matters in their practice world, in

their everyday encounters with clients. For it is while we are in our everyday being-in-the-world that we become caught up in it, immersed and intertwined with it, always involved with the things of the world (Heidegger, 1927/1962). Human life becomes visible in its context, because life is "marked by what Heidegger calls facticity" (Harman, 2007, p. 25), meaning that life is not theoretical but relates to a specific situation. So it is that in certain stories, in certain situations, we catch a glimpse of the embodied way of practicing of a number of older experienced health practitioners in this study.

Seeing In

Hilary does not fully understand how things have gone between her and a client. It takes the student to show her this:

> *I took a student with me to see a client who is quite disabled and dependant on her husband. She'd told me in the first interview that he won't let her do this, won't let her do that, and one of their children is not even allowed to come and see her. Then I found that he was knocking her around. So I contacted 'Age Concern' and the person I spoke to, who has a title like 'Elder Abuse,' fortunately told me that when she visits, she often says that she's an advocate. On the second visit with the student, I knew that I had to go in and somehow get the okay from her without her husband knowing. And it was one of those tricky, tricky things. I really didn't think it out because it wasn't a thing you could think out. I pretended I needed something from the car, and I went outside to check where the husband was to see if he was listening. Then I just quietly talked to her about a person who was an advocate, how they could visit her and keep an eye on things. "Would she like it if that person rang her"? I put it across a bit subtly; there were just these little things, little messages. And then she said "yes." I was really pleased, and thought "it did go well".*
>
> *Later the student said "you handled that so well, it was just amazing", she was quite blown away. If the student hadn't been there, I would have just thought, "yippee she's agreed". I asked "do you think she understood what I was getting at" and she said "of course she understood and if the husband had been listening he wouldn't have cottoned on". I wonder if it's because I've been around so long. Often you think anyone could do this, anybody could say that, or anyone could handle it and forget that you've actually learnt a lot along the way. You just accept that this is your job and this is what you need to do.*

Hilary's interaction with clients is an integral aspect of the fabric of her working life. When she needs additional information she seeks it out. Her familiarity with family settings, and being able to go with what evolves, helps her move into the unknown. She knows it will be tricky and delicate, yet does not plan out how she will do it; her sense of it is held in the little things rather than a grand plan. While

she rejoices in the success for the client, she does not recognize her own success. It is the student, with much less experience, who draws the therapist's attention to what she has witnessed. For the health professional, the meaning of her own actions lay hidden in the every-day-ness of her work, invisible beneath the surface matter-of-factness, of simply doing what she does.

Hand in hand with learnt practice skills, her know–how, the older health professional brings an intuitive grasping of how to respond in the moment, bringing her practice wisdom, phronesis (Polkinghorne, 2004), to this client interaction. Through past experience and the insight that follows she knows how to be with her client at this tricky moment in time; she trusts herself. This subtlety of action comes from responding to what is occurring in the giving of little messages, rather than in using practice skills in the execution of a carefully planned process. How the encounter played out came from trusting in her understanding and experience.

Van Manen (2007) calls seeing meaning in the moment, *in-seeing*. He likens in-seeing to Heidegger's "'in-being' or our everyday being-involved-with the things of our world" (p. 12). From their accumulated experience of engaging with the world of practice, the being-competent that older experienced practitioners bring to encounters lies in their in-seeing and in a particular way of knowing the world; of seeing what is needed, of grasping it (van Manen, 2007). Van Manen adds that "the competence of professional practitioners is itself largely tied into pathic knowledge" where practitioners draw on "aspects of knowledge that are in part pre-reflective, pre-theoretical, pre-linguistic (p. 20). It is this pathic knowing that we see in older experienced practitioners' stories.

Bringing Calm

For some experienced practitioners it is not so much their actions but rather the impact of their presence on staff and clients. Tom reflects on what happens in his workplace:

> *With my work in the acute mental health setting some of the younger staff comment that when I'm on duty they look to have a fairly settled shift. They see me as someone who can diffuse situations. They say quite encouraging things like "It's going to be a quiet shift; we won't have any problems, Tom is here". At my age I bring a maturity into situations when some of the testosterone driven moments crop up. They do crop up when you're working in acute mental health areas.*

Sometimes there are physical demands put upon me. I feel that I can cope with them but I'm conscious of my years. When you get patients with heightened irritability there can be threatening behaviour towards staff and I feel more at personal risk than when I was 10 or 15 years younger. That can be a little bit disconcerting. A fortnight ago, working on the weekend in the acute setting, there was a lot of volatility, a patient just being in my face, in a very threatening way, and for me that sense of feeling a bit unsafe, more unsafe in that situation than say three years earlier. While I can maintain an outward calmness of coping with the situation, I'm feeling quite a lot of internalized angst, with general apprehension and my anxiety's raised. It's my work experience I'm relying on and my skills to get me through the episode and keep myself safe. Having got through it I can relax a bit more within myself. Sometimes I'm left with a feeling of, 'how much longer can I cope with these sorts of situations'; am I at the end of my ability working in that setting.

Tom's presence is reassuring to younger staff in the acute mental health setting. They see him as bringing a sense of calmness with his maturity and years of immersion in the world of acute inpatient psychiatry. With Tom present they expect a settled hassle free time. However in this workplace, incidents occur at times where not only skill, but physical strength, may be needed in response to threatening 'in your face' aggression from patients. Tom is confident in the skills and knowledge he needs in order to deal with this but the necessity to do so unsettles him. While many health care professionals go to work place settings feeling secure about their physical safety, the world of acute psychiatry is an environment where personal space can be violated, and having a sense of physical strength may seem necessary. Paradoxically, while the age and experience of this older health professional means younger staff feel more confident and less at risk through his presence, his advancing age causes him to feel more vulnerable and anxious. In addition his depth of experience is likely to signal to him when trouble is looming, increasing his sense of exposure. Here lies some of the complexity of being an older experienced health professional. Van Manen (2007) says it can be argued that pathic knowing:

> Not only inhere in the body but also in the things of our world, the situation(s) in which we find ourselves, and in the very relations that we maintain with others and things around us. For example, pathic "knowledge" also expresses itself in the confidence with which we do things, the way we "feel" the atmosphere of a place, the manner in which we "read" someone's face and so forth. (p. 22)

On the one hand the practitioner, through his sensed understanding of a situation, brings a mode of outer calm, while on the other has feelings of internal disquiet that

remain hidden from view. For those they work with, the outer mode of confidence and calm bringing peacefulness to the work situation can be enough.

Older practitioners' stories reveal the way their specialist knowledge of a practice area can link with their practical wisdom and outer calm in producing a successful outcome. Alice combines both modes of being:

> *I had a woman who had planned to birth at home but had complications. She left it a little late to come in to the hospital and arrived at the hospital car park having the baby in the back of the car. There were two charge midwives doing a cross over of duties and I was just amazed at the state of panic they were in. Their contribution was to hold sheets up around the car so no one could see while this woman was giving birth. Because I'd just dashed out, I had very little equipment and I very calmly delivered the baby. I was just super calm; it was no big deal to me. Once we had our baby born the charge midwife said "I was so impressed with how calm and unfazed you were". I said "but that is what I do" and I am so impressed by how calm you are when you are dealing with really fraught situations because they were new experiences for me at that time.*

When Alice says she was *just super calm* she reveals her at-homeness (Baldursson, 2002) in the situation she finds herself 'thrown' into (Heidegger, 1927/1962). That it was *no big deal* for Alice to deliver a baby in a car relates to a number of things. This is her specialist area and she has experience of already having 'been there' previously. Also delivering babies with little 'high tech' equipment has been part of her everyday world. She brings a sense of stillness, staying focused on the care of mother and baby for she is at home in this world, whereas the charge midwives, panicking, are not at home. Practical wisdom comes frequently from a depth of experience. Whereas the process of making decisions might be thought to be slow, Alice's story reveals how in phronetic deliberation when there is a "rightness with regard to the expedient" then "the decision making process is immediate and fast" (Polkinghorne, 2004, p. 119). Such understanding is not something that can be taught as, unlike the skills of practice, the actions of phronesis in practice just come. Practitioners reveal their practical wisdom by engaging in a to-ing and fro-ing (Gadamer, 1975/2004); of acting and reacting to the situation they find themselves in, of being at-home.

Being in the Moment of Practicing

Like Alice, in the previous story, Kate describes working in a specialist area in which she is at home. The confidence that she works well in her role is embodied in her listening and receptivity:

> *I get quite a lot of patients where I'm the last health professional in a long line of health professionals they come to for pain relief generally for their feet. You can do just one simple thing and it makes a huge difference. There's one that does stick in my mind when I picked up on heel pain. He had heart problems and also tired easily. Because he kept saying "I've got this pain his doctor had him on depression pills for about two years" and the doctor said "It's in your head". Then he'd really gone into depression. I listened to him and I believed in him and just ignored the rest of them. I suppose you learn that with age, and I think maybe just living life and developing compassion over time. The 'know how' is actually my professional work.*

Sometimes Kate is the last one they come to see. Being there, being open to what presents itself, having a sense of what does and does not matter in what is said, along with her skills of practice, guide Kate in her work with the client before her. It all happens in the moment of practice. By setting aside *the rest of it,* ignoring it, Kate turns to what matters. What matters is what the client says, how he says it, and in the way he holds himself. It seems that although our actions are embedded in habits and routines they are also aligned to what is in front of us in our world (van Manen, 2007). Although it may be part of Kate's practice to listen well, she also remains open to all eventualities. She brings her phronetic deliberation to the encounter (Polkinghorne, 2004) for the phronesis of practice happens in the moment of practicing; it comes as part of bringing the best that you can bring to your situation. Through the combining of many different background considerations Polkinghorne says phronetic deliberation "produces knowledge about practical choices" (p. 116). Practical wisdom comes with practitioners to their practice encounters. Because it calls on 'integrating background understandings', the possibility of older clinicians having a more ready access to deeper and wider background understandings becomes visible.

Trusting in the Moment

Laura acknowledges her past experience as being there in her being-with clients, showing her the way to be fully open with them in encounters. Laura says:

Because of my past experience at the specialist unit where the patient load is largely made up of very assertive people, angry young men, I found that it was useful to just listen and hear people out. If you don't you won't get anywhere. It affirmed that I understood, to a degree. My experience helped me.

Laura draws from the past, from all that she has learnt from being-with clients, bringing an embodied sense of knowing what is called for in the present. Though she cannot know what will come when she chooses to be open to stopping, listening, and heeding the person before her, she lets the possibilities come forward. Confidence opens up the to-and-fro in being-with clients, keeping the encounter in-play, for Gadamer (1975/2004) tells us that "play clearly represents an order in which the to-and-fro motion of play follows of itself... it happens, as it were, by itself" (p. 105). An encounter being in-play is not forced. For older practitioners like Laura, their practice being in-play just happens as part of being absorbed in what they do.

Being in the Play

For Coral there is also an integrating of past understandings in her more recent practice. She reflects on this difference between the past and now:

My life experience has changed my understanding; having had a family helped this. It makes me somewhat sceptical about some programs. When I was a young PT at Princess Mary, we'd give mothers home programs, I didn't understand that there was no way they could fit it into their day with a disabled child.

And later:

We had new computers arrive at a school I worked at. I looked at all those big empty boxes. We built a tower and tunnels and tents. We used some that were very strong standing a child in one and others pushed them along. It helps to be inventive, to have the children help you make and develop things. When you have limited money for resources you have to decide how you are going to use it.

Earlier, when she was younger, Coral gave mothers home programs for their children in the expectation that they would follow them. Now that she is older, and has more life and work experience, she is different. For now Coral sees the unreasonableness of her earlier beliefs. Her experience has changed her practice and Coral has learnt to 'go with' what is before her. Hence when computers arrive, Coral does not immediately focus on them, for another possibility presents itself. In the to and fro of practice Coral feels free to play with ideas and encounters. In the

spirit of playfulness the original focus of the computers is replaced by Coral with a new idea. Gadamer (1975/2004) tells us that:

> Play clearly represents an order in which the to-and-fro motion of play follows of itself. It is a part of play that the movement is not only without goal or purpose but also without effort. It happens, as it were, by itself. (p. 105)

So it is that older practitioners with many years of practice experience come to play and be in play with their clients, rather than remaining focused on their original plan that they may find needs to be put aside (Polkinghorne, 2004).

Summary

The phronesis that "lies at the heart of practice" (Smythe, MacCullock, & Charmley, 2009, p. 3) comes together in this chapter, along with the techne of practice, for the two are inevitably intertwined. Yet we see that central to health professional/client interaction is the human to human encounter that calls for older practitioners to understand what is occurring for the client, how to be in tune with them and how to respond. Much of what happens and the 'rightness' of it, lies in practitioners ability to move beyond a set of practice steps to trusting that in their attunement to clients, that in the play of practice, they will find a path forward that fits the way a given situation unfolds. This practice wisdom is not something that can be taught as practice skills, for it is frequently acquired through the layering of practice experience that creates the possibility for wisdom to come. Though not all older practitioners will be wise, the possibility of wisdom coming through in practice is greater as experience becomes embodied, inhering in the being of older practitioners. Yet older health professionals increasingly practice in a world of health care that has at its core, systems and the necessity to prove they are competent to practice. From this arises a tension in what can be easily shown, learnt and measured, techne, and that which is frequently less visible even to the wise practitioner, the phronesis of practice.

Chapter Ten: Discussion - In the Clearing

> The way is long. We dare take only a few steps. If all goes well they will
> take us to the foothills of thought. But they will take us to places that we
> must explore to reach the point where only the leap will help further.
> (Heidegger, 1993. p. 377)

Introduction

The lengthy process of doing this research has carried me along the wood paths, through the highways and byways, sometimes uncertain, at times striding out purposefully, moving towards "the foothills of thought" (Heidegger, 1993, p. 377). Now is the time when I find myself in the clearing away from the sheltering trees. Heidegger refers to the 'clearing' when considering "the occasional treeless spaces found on the dark forest paths" (Harman, 2007, p. 3); spaces where thinking may bring the appearance of something.

> The quiet heart of the clearing is the place of stillness from which alone
> the possibility of belonging together of Being and thinking, that is
> presence and apprehending, can arise at all. (Heidegger, 1993, p. 445)

This is the place where a leap into thinking can bring unconcealment, *aletheia*, to what lies waiting to be revealed (Heidegger, 1993). Taking the leap means to come, not to "deal with shapeless lumps" (Harman, 2007, p. 91) but to the place where what I seek resides. This chapter provides that open space where I seek to highlight the findings of the preceding chapters, to show meaning in such a way as to make the sense of it clearer, visible in a way not seen when previously taken-for-granted. Some things will remain obscured, for the interplay between what comes into the light and stays in the shadows is unavoidable (Harman, 2007). This study set out to explore the meaning of being an older experienced health professional. Inevitably such meaning will not be straight forward. Because of the question asked, what the research shows will not be contained in a theory, in a list of results, or in a single answer. Rather the meaning of being an older experienced practitioner is complex, multi-faceted and convoluted.

To encapsulate the significant findings from the thesis, to show in a new way what matters in this exploration of being an older experienced health professional, Heidegger's view of the world has been drawn from, as it is within their world that the experience of being an older practitioner is revealed. Heidegger (1927/1962)

saw the three differing modes of being-in-the-world as part of human existence, modes that encompass the phenomenon of experienced older health practitioners' being-in-the-world. These modes are "the world of the self… the with-world… [and] the surrounding world" (McGrath, 2008, p. 40).

The World of the Self: The World within Us

Within the world of self lies the psychological, emotional and historical phenomenon of 'inner' life (McGrath, 2008, p. 40). An aspect of inner life is mood, showing outwardly in the way we are attuned to things (Heidegger, (1927/1962). As everyone's life is different, the world within is 'always about me'. For the older health professional being me feels different, for now just being older is different from how I once was.

Older practitioners described that years of working in a particular profession had shaped who they had become and how they saw themselves. 'I am a nurse', 'I am a midwife', or "I am an occupational therapist' was a statement about much more than the name of their profession. 'I am' had come to mean that 'being a nurse' was central to who 'I am'. Thus to contemplate retirement has within it the fear of losing an understanding of who I am. Further, it is to lose the identity one offers to others. Growing older, they find that who they are links closely to their professional role; in part, it gives them their identity. As Hilary said, *I see myself joining the grey haired population… If people talk down to me now… it doesn't affect me… because I know who I am.* Older practitioners feared losing their professional identity as they moved into what can feel like the anonymity of old age.

While a work role may offer protection in terms of providing an identity, it offered no protection from the experience of living with an ageing body. For many older practitioners there was an adjustment, a learning to live with their changed body, a body that was now felt and becoming a burden. Some sensed their bodies becoming stiff and unwieldy, no longer fluid, tiring more quickly. For some the adjustment to change from within proved too hard. For others there was a desire to maintain the idea of youthfulness; that as their body aged at least their mind remained youthful. Yet others may see only grey hair and wrinkles. From an external viewpoint Jack described the potential for ageing clinicians to cross the line to become patients within services to rehabilitate the elderly. There was a diminishing gap between

carer and cared-for. Either way, adjustment to bodily change in the context of work is a deciding factor in whether older health professionals feel able to continue in their professional role. The alternative is to leave; to find less arduous work or to retire.

The word within includes adaptations to bodily ageing. Older health professionals in the study described how they adapted to this by renewing their energy outside work, giving up aspects of their former lives to conserve energy for their professional role. They did this, for instance, by separating themselves physically from work, by sleeping and resting more, by retreating to a place of calm where they recharged their source of energy, and by zealously guarding their time away from work. A loss of equilibrium in their lives was one consequence of these strategies. Hilary told how: *You've used all your energy up at work and there's none left when you get home.* For others it was the glossy picture carried in their minds of their future retirement that kept them motivated while still working.

But for some there was little adapting. It just got harder and harder. Alongside the older practitioners who found ways to replenish their energy, there were stories of older practitioners not adapting to ageing in their roles. Jack said: *She was pretty switched off at work… I asked her to be involved in projects but her heart wasn't really in it.* The study findings show that some older practitioners lose the ability, or will, to adjust to changes within themselves and changes outside themselves. For others, adapting to change may always have been difficult. This study reveals that the ability to adapt is key to the wellbeing of older practitioners and the respect they earn from others.

From their years of experience, older health professionals bring from within themselves an attunement, a way of listening and hearing, a way of reacting that comes from having been there before with clients. Many older practitioners brought a vast store of lived experience to their practice, encompassing both work and home. That store encompasses a physiotherapist's belief in *the laying on of the hands* and their sense of at-homeness in their practice role, an intrinsic felt knowing of just what is called for in the moment of practice, an ability to be in the to-and-fro of practice, responding in a way that shows their understanding.

Grasping what matters, they knew when to just *listen and hear people out* and brought an understanding born of life experience to practice. Coral said: *My life experience has changed my understanding; having a family helped this... It helps to be inventive, to have children helps you make and develop things*. In this way older practitioners have adapted, building on their practice understandings over many years, culminating in what can be described as practice wisdom. At times knowing what to do lay in action not language: *It was one of those tricky, tricky things. I really didn't think it out because it wasn't a thing you could think out.* The embodied knowing of what is required in the moment just happens. This is the practice of experience that just knows what is called for, that grasps and responds to whatever is in front of the practitioner. Understandably not all older practitioners will have achieved practice wisdom.

It was the whole breadth of their experience that signified older practitioners' worth to others, for alongside practice experience was what their many years of living in the world contributed to their practice. Some managers viewed it as invaluable; others understood the value of older practitioners to the organisation. A student noticed the expert practice that an older practitioner took for granted, saying: *You handled that so well, it was just amazing.* In this way the expertise of older health professionals is, at times, identified and acknowledged by others and prized by those they work with: *I was so impressed with how calm and unfazed you were*. At times older practitioners' expertise was witnessed by others, sometimes it is out of sight. Additionally, practice expertise may be invisible to some heath care managers as outside of hospital settings much of clinical practice takes place out of sight in the one-to-one context of client-practitioner care.

Professional development mattered for many of the older practitioners. Some needed little encouragement to participate in ongoing education, seeking out the courses they saw as necessary to advance their expertise. This gave the potential of bringing them in to line with the new ways of looking at healthcare, enabling them to feel confident in their practice and when interacting with others. Yet some needed to motivate themselves to commit to professional development. Tom said: *I have to be conscious myself of what it takes to keep up to date and not look for resistance*. The importance of keeping practice current, kept older health

professionals 'switched on' to updating work skills. Many older practitioners in this study felt strongly about professional development, whereas others struggled and resisted the demand to show competence that is now required of them as part of practice. Joy told how: *At first it was really tough, especially for these older ones, really, really tough. Oh they grumbled!! Rah, rah rah 'we don't have to do them'.* However they did respond to encouragement, to rewards, and obtained their objectives. Through adapting to the new demands on their practice, through being able to respond to changes within nursing, these older nurses were able to maintain their professional skills and work positions. Such a willingness to keep growing and learning was another hallmark of success.

Frequently in their professional roles the older practitioners related calling on an inner strength to move ahead in times of great difficulty. Beyond the notion of adapting was something even stronger; they drew on their authentic selves in facing the possibilities before them. At times this involved challenging someone senior to them. Elizabeth grew the courage to speak saying: *I've heard you talking to people on occasions, and it's not ok.* Revealing the authentic aspect of themselves other older practitioners spoke up in moments of crises, made their views known in letters of complaint in situations where their being vocal could have worked against them. Despite the risks to themselves and their position, older experienced practitioners at times chose to speak when others remained silent, revealing their inner resolve in the actions they undertook. This quality may not always endear experienced older practitioners to managers. However there will be occasions when a strong voice is needed to bring the concerns of practice or practitioners to management. This study shows that this may well be a role taken on by older practitioners.

The With-World: The World between Us
The with-world, that is the world between people, refers to family, culture and society (McGrath, 2008). Unlike the inner world of self which is focused on me, the with-world according to Heidegger (1927/1962) is a place where as part of the everyday environment I am always with others, and am essentially for the sake of others. In the world between us I understand myself in terms of others and am influenced by others and 'the They'. While older health professionals have always been in relationship with others in their work world, now is different.

Evident in a number of participants' stories were issues around respect. Respect will always be in the context of relationship. While at times older practitioners complained of not feeling respected, managers talked of older practitioners needing to earn respect rather than assuming it as an age-given right. Experienced older practitioners earned managers' respect by their professionalism, by their ability to talk to clients, their pride in wearing their badges, their love of their work, through the way she'd still give it 110%. Conversely, there were times when older practitioners did not earn their managers respect*: She never made any attempt to keep up to date… if your actions don't engender feelings of respect then there's always going to be a tension there*. In addition being seen simply as a worker, one of many, felt incredibly offensive for older practitioners, who felt disrespected. For some of these managers and practitioners there were adjustments to be made, in order for them to continue to work together, as the need to adjust to new circumstances is an ongoing aspect of being a health professional and a manager.

Gaining the respect of others, through the work they did, and reciprocity in their relationships, allowed for this growth to occur when older practitioners felt as though they mattered. Those older practitioners who received mentoring and coaching, who were at the receiving end of reward systems, who were talked to by managers as though they mattered, found their self perception enhanced. Feeling needed, and valued by others, fuelled the desire to continue working: Jessie, an older practitioner tells of being wanted: One judge who refused to continue, said he wanted me there…. *it will be when she's back from leave and meetings will be renegotiated*. The self takes meaning from the way one is respected by others. The possibilities for growth, change and adjustment lie in how one perceives oneself amongst others. Again the double nature of work for older practitioners is revealed, while at times they are valued and trusted; at times they are not.

Once they were younger, *now* they are older. It is as though they have changed sides. Sometimes they have adapted to this, sometimes it proved difficult. Generational differences became highlighted for the older practitioner and manager, affecting their ability to have a truly professional relationship. The impact of those differences was; that older practitioners and younger managers in this study did not always see or hear each other clearly, were not open to the person who stood in

front of them, seeing them as other, categorizing and bringing a personalised perception of the person that interfered in their working relationships. The once assumed order of an age based hierarchy, where oldest lead and younger follow, has been turned on its head in participants' stories. Aging practitioners in this study were uncomfortable being answerable to younger managers, at times feeling resentful or experiencing differences of opinion with them. There was a tension when the manager could have been their son or daughter. Conversely, younger managers struggled when older experienced practitioners gave unsolicited personal advice, at times taking on a parental role that potentially undermined their status. Some were unnerved by older practitioners superior knowledge of the organisation and opinions about how to achieve things and knowing what matters, feeling that someone older telling them what to do showed up their inexperience. Again we see the double sided nature of working between generations. In relationships between older practitioners and younger managers, the inability to move beyond generational difference reveals incapacity in adapting to changing dynamics in the healthcare environment.

Despite their struggles with conforming, this study has shown that older practitioners found that working with others helped make them who they became, revealed through the way they are spoken to and treated. A GPs' referring his *very complicated women* to Alice, confirmed her expertise. Others seem to have the power to bring the best or the worst out of the older practitioner. An older practitioner said; *I'm overworked, you guys are working a 66 year old like a dog,* making evident her belief that her manager could have improved her work load but elected not to.

The Surrounding World – the World around Us

It is in the surrounding world of older health professionals that the context, locality and events can be found (McGarth, 2008), constituting experience. As part of the journey of ageing, the whole world has altered, pressing in on practitioners' lives. Heidegger (1927/1962) refers to the being of entities that are encountered within the environment as part of the worldhood in general and that it is through such entities that the worldly character of the world announces itself.

Older experienced health professionals found themselves in a place far removed from that encountered when they were first introduced to the world of healthcare. Because life is 'thisly' (Harman, 2007), this life, in this situation, they now find themselves grappling with a changed environment, different systems and equipment. Space and tools that once may have seemed simple, straightforward and able to be grasped, have become highly complex. Now they are confronted on a daily basis with ever changing technologies. Health professionals may now become secondary to the tools in this environment, almost a slave to the systems that dominate practice. Remember Grace, the theatre nurse who said: *There's a huge amount of stuff now that you've got to know… how to work towers, and cameras, and take photos of their surgery while they're inside… I think 'Heck I didn't sign on to do this!'* Although, the degree of modern technology that Grace worked with daily was extreme, almost all participants talked of their experience of facing up to the demands of complex technology that they were not experienced in using. Thus through awareness, and thinking, there is a choice. Many older practitioners' stories show how they managed the use of computers and similar tools that aided them in their work, adapting to such advances. Some adapt their practice, driven primarily by their care of their clients. Remember Laura who found that the use of advanced equipment was advantageous for her clients, and Alice who decided to master the technology associated with hospitals births, so that she could provide continuity of care for women requiring care beyond the homebirth environment. It seemed that some older practitioners, in facing the danger of what can be an all consuming technology, made their decisions to choose to work with advanced technology when the outcome was improved care.

Older practitioners were less welcoming of a business model that changed the face of how staff interact with clients, seeming to some older practitioners to depersonalise care. The values of preserving the client-practitioner relationship were undermined by a system beyond their control. This distancing from interaction with the client is commented on by Alice who said: *Now there is that sense of protective documentation…The more complicated the situation, the more you're at the bench writing notes.* Older health professionals in this study found the element of systems that remove and distance them from clients to be onerous. It seemed to negate the reason that they were there. No longer the human touch; instead the

transformative power of technologically imposed systems. Paradoxically the very systems of advanced technology that aid in healthcare provision, streamlining work for health practitioners, also made the work of older practitioners more challenging.

Factors impinging on the day-to-day work of older practitioners sometimes came from within health, yet while the period of the health reforms was seldom talked of, the spin off from closely monitored systems and cost cutting revealed their impact. It was the business model introduced into health during the reforms that brought changes to their work environment, introducing new ideologies such as client centred care, and a privacy code upholding the rights of clients. An older practitioner, Hilary, told of attempting to comply with the care-aims, a system that she could not get her head around; one that took away her professionalism. While for younger managers and practitioners these changes may not have seemed dramatic, for older practitioners with many years experience in vastly different systems they were huge.

For older practitioners the breadth of change is much wider than health, for the world has also changed. It is how we approach everything, for society has been transformed, bringing with it a consumer focus to health. As a consequence people have been empowered to make informed choices and to demand what they need from services. Consumers of services, including healthcare, make complaints about their care, and access the latest research and information from the internet (Carden, 2007). At times this placed older practitioners on the back foot in their interactions with clients when once they could have expected to lead. In the midst of change within health care and the wider world older health professionals are changing, ageing, growing tired. This is the double jeopardy of change; it is occurring in relation to both self and the world.

In exploring the world of self, the with-world and the surrounding world, the threads that make up the meaning of older experienced health professionals were teased apart to show their world more clearly. For the meaning of being an older experienced health professional lies within practitioners' worlds, part of the fabric of their internal and external lives, their interactions with others, and things, and with their surroundings. Now, in drawing those threads together a deeper

understanding emerges, much as in the hermeneutic circle as an ongoing interweaving of the parts with the whole, we come back to the circle of understanding to look at the whole.

Returning to the Circle of Understanding

As a much younger person, the call to be a health professional seemed to come from nowhere, "the call comes *from* me and yet from *beyond* me" (Heidegger, 1927/1962, p. 320). This thesis shows that the call is not in the past, or of the moment, for the call is there in the beginning of every healthcare encounter even into older age. Working in acute mental health, Tom felt the call to be there when younger clinicians welcomed his calming presence at work. Kate felt it when her client required her thoughtful care, when others had failed him. For Alice it was the ongoing call of the women she worked with that meant she could not yet leave midwifery behind. The call helped older practitioners be resolute, providing authentic care 'that knows' when to leap-in and when to leap-ahead (Heidegger, 1927/1962). The call was there for many older experienced health professionals, for they remained practicing in order to be there with their clients. The call to care is what builds the phronesis of practice of older practitioners, as without the call, the care might be expert but also routine, a set of steps to be followed.

What has this research revealed about the phronesis of practice of older practitioners? Their phronesis became visible in the play of practice, in the ease of the to-and-fro of encounters (Gadamer, 1975/2004), visible too in the quality of the listening and hearing, in listening that stays open to the meaning of the other. Phronesis is in the dwelling with, bringing calm at times of crisis. It is there in adapting and keeping variables in balance; it shows with in-seeing (van Manen, 2007), in "everyday being-involved-with-the things in our world" (p. 13). Phronesis shows in grasping what lies before you. Practice wisdom reveals and is phronesis in practice.

This study reveals the diversity amongst older experienced health professionals. While many practitioners had the hallmark of practice wisdom, some did not. Other practitioners may simply not have expressed practice wisdom in their stories, while other older health professionals may never attain phronesis. What undermines the development of phronesis of practice? At times, the lack of connection between

practitioners and managers means that practitioners felt their work was undervalued; the lack of trust or positive feedback then inhibiting the development of insightful care. Having to adhere to systems that interfere with time with clients and the use of advanced technology impacted on older practitioners' sense of being a professional with choices. Developing self worth, and the possibility of phronesis of practice, is unlikely to occur when older practitioners feel irrelevant. Feeling undervalued is likely to undermine the call to care; perhaps it is when the call to care has weakened that older practitioners feel able to leave. Or their ageing body overwhelms them, in systems that lack flexibility to allow the renewal they need? Perhaps it is at the end of a career of deep fulfilment that the older practitioner steps forward to embrace the era of retirement. Yet the sense of who I am; **I** am a nurse, **I** am a midwife, **I** am an occupational therapist remains.

Integrating Findings with the Literature: Showing what is New

In the process of carrying out the literature review I became more deeply aware of the limited research on the meaning of being an older experienced health professional. Despite this I found that there was some literature to draw on coming from the field of nursing and the vast amounts of literature relating to older workers generally. Whereas the nature of ageing at work (Davey & Cornwall, 2003; Letvac, 2003a, 2003b; McCrindle & Pleffer, 2008; McGregor & Grey, 2003; Trinkoff, Brady, & Nielsen, 2003) and the embeddedness of ageism in organisations (Letvac, 2002a; Loretto, Duncan, & White, 2000; McGregor & Grey, 2002; Trew & Wyatt Sargent, 2000), show in research across industries, I have found few studies that link closely to the findings of my study that explores the nature of experience from a phenomenological perspective.

Linking this Study to the Literature

The purpose in looking at the existing literature, alongside this study, is to draw together writing that highlights areas where the findings of this research connect with prior understandings. These areas are drawn from my discussion of 'the world of self', 'the with-world' and 'the surrounding world'.

The Call to Care Links to Professional Identity

This study shows the way being a health professional provides older practitioners with an identity (Squires, 2008), it tells the world who they are. 'I am' a nurse or a

podiatrist, identifies that call to care. The call, a notion of Heidegger's (1927/1962), is not planned for and comes regardless of whether it is wanted or not. The call relates to caring about doing that enables a choice to be made between one thing and another; "the call is obscure… a call of conscience or of interest or attention, that is connected with a person's Being" (Reed, 2008, p. 78). The call to care has also been described, in a study that draws on Levinas, as responding to the face of the other (Water, 2008). Primarily the call to care connects to who we are in our Being (Smythe & Spence, 2008). At times older practitioners can be seen in this study to not only be called to be a health professional but to be called to continue to care in the manner they learned when they entered their profession. Congruent with the findings of Smythe and Spence's study, this study shows the sense of an authentic professional identity that comes from responding to the call.

Older Practitioners Working across Generations
Older experienced health professionals in this study inevitably found themselves working across generations. While the focus of this study was not that of intergenerational relationships, stories from participants revealed a number of generational tensions for older health professionals working with younger managers and vice versa. The issue that arose was in not being able to move beyond personalising the way they saw each other, potentially 'as their son' or 'as their mother' indicating that in their being in relationships they had even bigger issues to overcome than simply that of generational difference. Relationships between managers and older practitioners becoming personalised, did not come through in the literature. Rather, a range of papers highlight generational characteristics of nurses and the tensions that can result with differing generations working together (Letvac, 2003b; Santos, 2003; Sherman, 2006; Weston, 2006) along with leading diverse cohorts (Sherman). A number of tensions discussed were those related to work ethics, the use of technology and those resulting from changes to hierarchical systems. This thesis adds something new to the research that I have read by showing the personalising of intergenerational relationships between older health professionals and health care managers.

The Expertise of the Older Practitioner
Expertise develops over time. Evident in this study is the way the experience of older practitioners built layers of expertise that is revealed in their practice.

Although the majority of the available studies focused on older nurses (Hatcher et al., 2006; Letvac, 2003b; Moseley & Paterson, 2008; Santos et al., 2003; Squires, 2009) their pointing to expertise as one of the hallmarks of being older experienced practitioners is congruent with the findings of this study. In Hatcher et al. 'older seasoned nurses' were found to be intuitive and accomplished in demanding situations and calm in emergencies, whereas Squires' (2008) New Zealand research into the experience of older nurses found that they enhanced patient care. As a consequence they are frequently mentioned in the literature as having the potential to be mentors and role models (Hatcher et al.; Letvac, 2003b; Moseley & Paterson; Santos et al.). Along with the existing studies this research points to the potential for practitioners with expertise to be called on as mentors to others within their field. Additionally, in this study a number of older practitioners could be seen offering their expertise to enable other practitioners to strengthen their practice. This study differs in its application to a wider range of clinical professions rather than being focused primarily on the disciple of nursing.

Professional Development and the Older Practitioner
The findings of this research reveal that it is not enough for older practitioners to be involved in professional development; in order to keep them engaged at work, their professional development needs to look at individual professional need rather than simply what is required to be competent to practice. At times older heath professionals ask to have input into what they need and what would be useful to them in developing expertise. A number of other studies have discussed the need for ongoing professional development programmes for older nurses (Letvac, 2003a; Moseley & Paterson, 2003; Palumbo et al., 2009), as continuing professional development was seen as adding to the quality of their work (Squires, 2009). Older nurses also desired continuing education (Letvac, 2002a). The literature that focused primarily on older workers in general discussed the difficulty older workers had accessing training and development that kept them up-to-date with current work practice (Davey & Cornwall, 2003; McGregor & Grey, 2002), because of clearly ageist attitudes and beliefs (McGregor & Grey, 2002; Stoney & Roberts, 2002). With the current emphasis on competency requirements for all health practitioners in New Zealand, this study found that it was not the ability to access professional development that was problematic rather for some older practitioners it was whether the professional development that individuals chose and undertook,

that was important to them, was recognised and acknowledged by the service they worked within.

Loss of Autonomy and the Rise of Technology

This study found that modern technology's impact on older health professionals is a broader issue than mastery of new tools. The findings of this study linked the domination of modern technology over practitioners to Heidegger's (1977) view that people have become enslaved by technology. Visible in the findings was the loss that older practitioners experienced when their work was tied to a technological approach rather than to clinical work that required situated practice decisions. While this study recognised the necessity for high levels of technological competence in some areas, such as the operating room, the study also revealed the way techne takes over from the autonomy of older practitioners, pushing aside the phronesis of practice. In this way older practitioners experience a loss of autonomy and of their authentic selves to the systems that are part of their everyday workplace environment.

Literature focused on older nurses discussed mastery of new technology in the health care environment, how it enhanced their work (Squires, 2008), and how the pace of technological change influenced nurses' capacity to cope with their job (Moseley & Patterson, 2008). As in this study, the necessity for both techne and phronesis in the practice of caring was also acknowledged (Benner, 2000; Loscin, 2006). Nurses being technically competent as well as understanding the vulnerability of people when called to care for them was said to demonstrate nurses' authenticity with technological competence being seen as integral to caring in nursing (Locsin). While the findings of this study showed that technology was unavoidable in older practitioners' practice, in few of the older practitioners roles did it reach the level of technology dependency discussed by Sandelowski (1993). Technological dependency, where an "absolute need" (p. 37) for the technology exists, with the nurse reliant on assistive devices has been an important issue in nursing literature (Sandelowski, 1993). Sandelowski described advanced technology as sometimes being a practitioner's preference. In a work world where older practitioners are surrounded by complex technology, this thesis calls attention to older practitioners' struggle with the encroachment of technology on their work roles and the negative impact it can have on the phronesis of practice.

Strengths of the Study

By including a range of health professionals as well as managers this study has a multidisciplinary approach that differs from other studies. Consequently the findings show the depth and breadth of older practitioners' experience. Having two participant groups, including a smaller group of managers, gave an additional view to that of older health professionals adding depth to the research. The use of hermeneutic phenomenology as the philosophy underpinning the research allowed a focus on meaning that differs from many of the studies that looked primarily at retention of older nurses. The connection between older practitioners' internal change of ageing, to change in the external world, reveals the double jeopardy for older practitioners as they face major transformations to their daily lives and this link has no been made apparent in other studies. While the focus of the research is older experienced health professionals, I have been aware throughout the project that many aspects of the findings resonate with the experience of being older as a worker, not only for health professionals. Other stories resonate too with what it is to be human and grow older. This offers the potential for future resonance with further audiences.

Recommendations from the Research

A considerable number of recommendations come out of the research for those involved in health care management. Alongside these are recommendations for older experienced health professionals.

For Managers and Professional Leaders of Healthcare Services

The World of the Self

Promoting an atmosphere where different generational values and expectations are respected and acknowledged emerged as important with specific focus on older practitioners. A major work tension for a number of participants such as Hilary, and Annette in Lubi's story, and John and Cathy's stories arose through generational differences. Being older may demand a different response and mode of being-with from managers. There is a call to anticipate and respond to tensions of generational difference in a manner which values expertise rather than personalising the age difference. It is to see beyond situations of "she could have been my mother" to appreciate the person as an experienced health professional. Committing to an

organisational culture that values age and experience would assist in retaining older practitioners.

There is a need to recognise and utilise the advanced competency and practice wisdom that is the phronesis of each older experienced practitioner. Some older practitioners will be able to pick up additional organisational roles in keeping with their clinical status, such as mentoring, facilitating in conflict situations and taking on extra project work, while others will not. Older practitioners in this study, such as Alice, Coral, Elizabeth and Grace offered their expertise to help build other practitioners' practice. In order to retain older practitioners along with their expertise, changed roles, such as part time work, or mentoring roles, for those who wish to continue at work, who have a lot to offer the service but who cannot physically cope with a full clinical load may be advantageous to all. A number of weary older practitioners in the study, on the cusp of retirement are likely to have welcomed such options.

The With-World

When older health professionals are perceived as not current in their practice the call to care may have lessened, they may not feel respected by their manager or colleagues, or are too tired to respond in the way they may have in the past. At times older practitioners could be waiting for someone to tell them it is time to finish work, as Jessie and Nancy, in Joy's story were. Manager participants made it clear how difficult it is to work with older practitioners whose work no longer meets practice expectations, yet did not always address this early on. Managers may be blocked in their thinking by perceptions arising from generational differences. The findings of this study offer insights for managers to address issues of poor performance in a manner that seeks to reveal what lies behind. It may be exhaustion, physical strain, or a sense that it is time to retire but a lack of courage to take the final step. Addressing such issues early will assist in retaining

Older practitioners will frequently prefer to have some input into the type of ongoing education that they attend. At times professional education needs to go beyond what is necessary for older practitioners to be competent for their work role. Study participants Coral and Kate believed their practice benefitted considerably from courses that they undertook that were not specifically recognised by managers

as adding value in their workplace. Managers can motivate older workers to keep up to date and satisfied with their work by using a reward system that encourages and acknowledges expertise, such as letters of commendation and appreciation.

The Surrounding World

Managers need to consider the impact of frequently changing systems on practitioners who may have already been though similar changes previously in the same service. For some older practitioners in this study, grappling with new systems detracted from the quality of the time they spent with clients. There is a need to consider the consequences of such changes, and how the organisation can ensure that staff, including older practitioners, are 'in tune' with the need for the change.

It is wise to enable older practitioners working in high stress areas to have input into their conditions of work. This is particularly necessary where midwives such as Genevieve and Alice, and theatre nurse Grace were working shifts, were on call, or worked in particularly physically or mentally demanding roles as was evident in the study. Physical exhaustion and at times mental tiredness were visible in stories that showed older practitioners just managing to cope in strenuous work roles and in environments where they were unable to change their work conditions. Yet their exhaustion was primarily evident in their lives outside work, therefore not necessarily obvious to managers. There is a tendency for work conditions to be standard across all employees. The findings of this research argue that valuable older practitioners may be retained longer and function better if their work conditions are able to be tailored to meet the energy of their ageing body and if they are consulted about decisions that will impact on them.

The preretirement phase of employment needs to be managed to assist older practitioners in planning their transition. A number of older practitioners' stories showed them weighing up their options long before retirement. Properly managed, with opportunities to have extended leave or work flexible hours, some older practitioners may elect to stay at work longer as part of a phased retirement. Older nurses on Joy's team benefitted from such consideration, for example reducing hours. This phase is just as important to the older health professional as retirement planning.

For Older Health Professionals

The World of the Self
Older health professionals themselves need to recognise the importance of adapting to an ageing body. Their bodily change became evident in this study through their mood, their weariness and their need for additional sleep. Awareness of bodily change and accommodating that change, by not putting increasingly excessive energy into 'keeping up' at work, could assist in bringing some equilibrium back into a life that has become unbalanced. In order to reduce bodily stress, work options such as reduced hours or a changed practice role should be considered.

With the wisdom of age, the older experienced health professional may be more skilled at recognising and dealing with tensions arising through generational difference than their younger colleagues. These can be reduced by, for instance, talking one-to-one or looking for positive ways of working together.

The With-World
Younger managers and colleagues expect older experienced health professionals to earn the respect of colleagues and managers by being up-to-date and by maintaining their professionalism. One way of doing this is for the older practitioner to seek opportunities to attend courses that assist with practice roles.

During years of practice, through ongoing experience valuable ways of being with clients have developed. The older health professional can be proactive about opportunities to mentor, educate and share experience and wisdom, while recognising the expertise and contribution of others.

The Surrounding World
It can be difficult to be the expert practitioner on one hand, and yet feel completely at a loss with new systems and technology. The older health professional needs to seek assistance, as needed, to best work with such change. The ability to be flexible and adjust in the midst of advancing technology will assist in fitting into the evolving world of healthcare.

Performance appraisals can be an opportunity to receive the honest feedback that allows the older health professional to maintain competence and respect. They can provide an opening to get the support needed for strengthening practice and

interpersonal skills. Rather than feel threatened by being judged by younger colleagues, the older health professional needs to see appraisal as a proactive strategy to holdings one's place as a valued employee. Further, encouragement and positive feedback allows their expertise to be acknowledged.

Limitations of the Research and Possible Future Research

In the process of doing the study I have become increasingly aware of the ways in which both the approach and chance occurrences along the way have influenced how it evolved. This is the way of all research projects; boundaries set at the beginning and the philosophy underpinning the research inevitably place limits on where it can go. There are aspects to the research that were restricted by its scale, by the inclusion criteria and by the process by which participants were selected. Thus the study became uniquely 'this' study (Harman, 2007).

I brought with me a number of pre-suppositions which will have coloured the study, for instance in the questions that I asked and in my interpretation of findings. Those pre-suppositions were that: experienced older health professionals were not valued, they created barriers to change, they held differing values than younger colleagues, they struggled with new technology, and issues of ongoing education and competency impacted on them disproportionately. At the completion of the research, I now find that while they are still relevant I am seeing them with more clarity. No longer black and white, I see these issues as having become various hues of grey. Each participant brought their own strengths and challenges. There was no one size fits all.

Although I intended to include male participants in similar numbers to women, I found that with the older health professional workforce being primarily women, it was largely women who came forward as possible participants, with only one male health professional participant being included. In contrast, of the four manager participants, two were men. I acknowledge that the findings of this study may well have been different if there had been a larger proportion of older health professionals who were men, or in a study that focused on men alone.

Two study participants identified themselves as being of Māori/European descent. There are no Pacific people or Asian participants. As the inclusion criteria required

participants needing to be 50 plus years of age, I was drawing on a pool of older New Zealand health professionals who were largely Pākehā of European descent. A study that included other voices would inevitably have brought different experiences to the fore.

In the process of carrying out the research I recognised that the inclusion criteria of the selected age range of 50 years up was very wide. As a consequence of the criteria, the participants taking part in the study were 50 years to 66. Having a narrower age range in the study would have likely produced different findings as both bodily ageing and planning for retirement, for instance, may bring different experiences than those of the 'younger' older practitioners. I recommend that further work is carried out with more specific age ranges.

Older doctors were not included as participants in this study. My presumption was that their working conditions differed substantially from the older health professionals who were included, in terms of status within the healthcare hierarchy, allocation of time and funding for professional development, and work conditions. Therefore a study that looked at the experience of older doctors would be useful and build on this research.

The health professionals taking part in this study represent the clinical areas of nursing, midwifery, occupational therapy, physiotherapy and podiatry. They worked in a range of diverse settings, both public and private, in hospital and community settings. Towards the end of recruitment I looked for people in roles that would be more likely to highlight the difficulty of working in that role at an older age; frequently they were nurses and midwives because of the nature of night work or theatre nursing. Despite the diversity of participants a number of health professions came not to be included. This occurred because over the period of recruitment no participants from other professions happened to come forward or met the inclusion criteria. While there was no intention to try and involve someone from each health care profession, the study could be seen as more inclusive if it had done so.

There were no co-workers bringing their voice to the meaning of being an experienced older health professional. This would be valuable for ongoing research as it is likely that co-workers 'see' what the older workers themselves may not recognise as being important. These insights began to emerge from the data of the younger managers interviewed in this study.

The study has raised questions about whether there are initiatives that focus on the training and culture shift within healthcare organisations needed to get the most from older health professionals. A study that included managers of New Zealand DHBs that set out to explore this possibility would be very useful.

Soon after I started this study I recognised that there was no opportunity for clients of older health professionals to add their voice to the focus of this study. As the research was already of a size that precluded any further change it was not possible to include the client perspective. At a time when having input from the receivers of a health service really matters, this would have been an important aspect of the study. It is possible that younger and older clients would have different perspectives on older health practitioners. Future research into the client perspective, of both younger and older clients, would build on the findings from this research.

A study that explored the reasons why older experienced practitioners leave the health workforce prematurely, that pointed towards the initiatives that could assist in retaining older practitioners in their professions longer, would build on the focus of this study. Such a study would further address the issues surrounding the identified shortages of clinical staff.

There is one further limitation to the study to address; that in taking a phenomenological perspective this research was not looking specifically at issues of power or economics which would have been much more prominent if a philosophical approach such as critical ethnography or a discourse analysis had been used. In using this approach, I have no expectation that the results of this study will be generalized to all health professionals, or other older workers. Despite this the findings of this study are likely to 'ring true' and to provoke thinking relevant to

the context of the reader, offering insights in particular to both healthcare managers and older practitioners.

Conclusion

Do all those years of lived experience matter, or are they just empty containers? Are those years truly the stuff of which people's lives are made (Andrews, 1999)? Some of the answers to these questions sit within this research. This study has shown that those years of experience are a vessel that contains the meaning of being an older experienced health professional. Held within those years are health professional roles that are significant to the world of health care provision.

This world has shaped an identity that older health professionals will find hard to relinquish. Being, for example, a 'midwife' becomes who they are. Their lives have been full of the experience of caring and of working with others, of developing expertise, of being caught up in the play of practice, and in the forming of an authentic professional identity. For many, their years of experience contain a wealth of understanding and expertise that has grown, and changed against the backdrop of major trends in the world of health and in the world at large. They are precious, if sometimes invisible, jewels within the world of healthcare.

Some, however, increasingly feel their age as they face ongoing changes. A point of tension arises when older health professionals become exhausted and disengaged but do not encompass the prospect of retiring. At such times, managers can become dissatisfied with their performance and withdraw their respect. Recognition by management of the need to tailor work conditions to suit older practitioners' changing sense of wellbeing was not always present. The findings of this thesis suggest that attention to shaping work conditions to allow the older practitioner to function effectively at work while they prepare for future retirement is in the interest of everyone.

Those older health professionals who have embraced the ongoing changes that are part of today's world, who have found it worth their while to acclimatize to the new world, see the healthcare context differently. Their ability to evolve means that they are likely to look forward to a future of new possibilities. The satisfaction older

practitioners get from working in their professional role and the way they and their experience are acknowledged by others will be a factor in whether they stay or go. As they offer considerable value to health services, opportunities to mentor others as they plan towards retirement can mean that, while they will one day leave, their practice wisdom remains.

Throughout the lifecycle, change and continuity weave an intricate web.
As we meet the new challenges, both physical and psychological,
with which our lives confront us, so then are we changed,
even as we remain the same.
(Andrews, 1999, p. 309)

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Appendices

Appendix A – Ethics Approval

Appendix B – Ethics Approval Amendment

Appendix C – Participant Information Sheet (Older Health Professionals)

Appendix D – Participant Information Sheet (Managers)

Appendix E – Consent Form

Appendix F – Interview Prompts (Older Health Professionals)

Appendix G – Interview Prompts (Managers)

Appendix H – Confidentiality Agreement

Appendix A: Ethics Approval

AUT UNIVERSITY
TE WĀNANGA ARONUI O TAMAKI MAKAU RAU

MEMORANDUM

To:	Liz Smythe
From:	**Charles Grinter** Ethics Coordinator
Date:	21 August 2006
Subject:	Ethics Application Number 06/154 **The meaning of being an older experienced health professional: a hermeneutic phenomenological study.**

Dear Liz

I am pleased to advise that the Auckland University of Technology Ethics Committee (AUTEC) approved your ethics application at their meeting on 14 August 2006, subject to the following conditions:

1. Clarification of the inconsistency between the response to section E.11 of the application and the information about travel reimbursement in the Information Sheet and consideration of the use of vouchers rather than money;
2. Justification of the non-standard storage duration given in the responses to sections F.3 and F.6 of the application;
3. Removal of the methodological clause in the working title in the participant documentation;
4. Amendment of the Information Sheets as follows:
    a. Removal of the fourth sentence in the last paragraph of the section titled 'How was I chosen…';
    b. Alteration of end of the last sentence in the section titled 'Opportunity to receive…' to read '…findings will be made available on request'.

I request that you provide me with written evidence that you have satisfied the points raised in these conditions at your earliest opportunity. Once this evidence has been received and confirmed as satisfying the Committee's points, you will be notified of the full approval of your ethics application.

You may not of course commence research until full approval has been confirmed. You need to be aware that when approval has been given subject to conditions, full approval is not effective until *all* the concerns expressed in the conditions have been met to the satisfaction of the Committee.

To enable us to provide you with efficient service, we ask that you use the application number and study title in all written and verbal correspondence with us. Should you have any further enquiries regarding this matter, you are welcome to contact me by email at charles.grinter@aut.ac.nz or by telephone on 921 9999 at extension 8860.

Yours sincerely

Charles Grinter

Ethics Coordinator

On behalf of Madeline Banda, **Executive Secretary, AUTEC**

Cc: Ann Paddy annpaddy@ihug.co.nz

Appendix B: Ethics Approval Amendment

M E M O R A N D U M
Auckland University of Technology Ethics Committee (AUTEC)

To:	Liz Smythe
From:	**Madeline Banda** Executive Secretary, AUTEC
Date:	2 October 2007
Subject:	Ethics Application Number 06/154 **The meaning of being an older experienced health professional: a hermeneutic phenomenological study.**

Dear Liz

I am pleased to advise that on 2 October 2007 as the Executive Secretary of the Auckland University of Technology Ethics Committee (AUTEC) I have approved the amendment to your ethics application. This delegated approval is made in accordance with section 5.3.2 of AUTEC's *Applying for Ethics Approval: Guidelines and Procedures* and is subject to endorsement at AUTEC's meeting on 12 November 2007.

Your ethics application is approved for a period of three years until 28 August 2009.

I remind you that as part of the ethics approval process, you are required to submit to AUTEC the following:

- A brief annual progress report indicating compliance with the ethical approval given using form EA2, which is available online through *http://www.aut.ac.nz/about/ethics*, including when necessary a request for extension of the approval one month prior to its expiry on 28 August 2009;

- A brief report on the status of the project using form EA3, which is available online through *http://www.aut.ac.nz/about/ethics*. This report is to be submitted either when the approval expires on 28 August 2009 or on completion of the project, whichever comes sooner;

It is also a condition of approval that AUTEC is notified of any adverse events or if the research does not commence and that AUTEC approval is sought for any alteration to the research, including any alteration of or addition to the participant documents involved.

You are also reminded that, as applicant, you are responsible for ensuring that any research undertaken under this approval is carried out within the parameters approved for your application. Any change to the research outside the parameters of this approval must be submitted to AUTEC for approval before that change is implemented.

Please note that AUTEC grants ethical approval only. If you require management approval from an institution or organisation for your research, then you will need to make the arrangements necessary to obtain this. Also, should your research be undertaken within a jurisdiction outside New Zealand, you will need to make the arrangements necessary to meet the legal and ethical requirements that apply within that jurisdiction.

To enable us to provide you with efficient service, we ask that you use the application number and study title in all written and verbal correspondence with us. Should you have any further enquiries regarding this matter, you are welcome to contact Charles Grinter, Ethics Coordinator, by email at charles.grinter@aut.ac.nz or by telephone on 921 9999 at extension 8860.

On behalf of the Committee and myself, I wish you success with your research and look forward to reading about it in your reports.

Yours sincerely

Madeline Banda
Executive Secretary
Auckland University of Technology Ethics Committee
Cc: Ann Paddy annpaddy@ihug.co.nz

Participant Information Sheet

AUT
UNIVERSITY
TE WĀNANGA ARONUI O TAMAKI MAKAU RAU

For older health professionals

Date Information Sheet Produced: 28 July 2006

Project Title: The meaning of being an older experienced health professional. (This is the working title and may be changed prior to the final research report).

An Invitation
You are invited to take part in a study that explores the experience of older health professionals who come from a range of disciplines, working within a variety of health care settings, within the North Island of New Zealand.

Who am I?
My name is Ann Paddy and I'm an occupational therapist. My areas of practice have been as a clinician and in senior roles working in the community and as an occupational therapy professional advisor. I will be undertaking this research as a full time student as part of my Doctor of Health Science qualification at AUT. My current research interest is to develop a greater understanding of the experience of being an older experienced health professional.

What is the purpose of this study?
The study sets out to explore and show the experiences of older experienced health professional within their world of work. In order to do this as fully as possible both older health professionals and managers who work with older health professionals will be participants in this study. I expect that this study will increase awareness of the things that are important to older clinicians in their work context. I see the implications from the research relating to the retention of older health professionals as active workers in healthcare settings.
The final research report will be available as a doctoral thesis in the Auckland University of Technology library. Articles relating to the research will be published in relevant journals and could contribute to a number of publications such as a chapter in a book. The research findings are also expected to be presented at seminars. The implications for practice from this study may be used in the development of information for managers and health professionals in health service settings.

How was I chosen for this invitation?
There will be 2 participant groups in the study and you will fit into one of those groups:
Older health professionals of 50 plus years, actively working primarily in clinical roles with 10 years recent experience and who gained their professional qualification 20 or more years ago in New Zealand. This group of health professionals includes clinicians from a variety of disciplines excluding medicine.
Managers, who work with older health professionals, whose primary role is management.

I want to talk with up to 13 older health professionals and up to 5 healthcare managers. Many of you will be approached by other health professionals who know me, or who are participants in the study. Others will hear about the study from me and my colleagues at AUT. When you have read this sheet and you have decided to participate, I would like you to contact me directly, or if you prefer I can contact you.

What will happen in this research?
We will arrange an interview, which will be approximately 1 to 1 ½ hours, at a time convenient to you. It is possible that I may wish to interview some of you a second time or have a telephone discussion with you to gather further information. The interviews will be at a place that is private, and agreed on by both of us, away from work place settings, in order to maintain confidentiality. You will be asked to tell me stories of your experience that relate to the research topic. For instance I will be asking for you to tell me about a time when your experience as a health professional mattered.

The interviews will be audio-taped and then transcribed. Once the interviews are completed and stories have been drawn from the narratives you will be sent a copy of these. You will be invited to comment on them or delete aspects that you do not want included in the study. Your participation in the study is entirely voluntary and you can withdraw from it at any time until data analysis is completed.

What are the discomforts and risks?
I don't anticipate any risks to you from participating in this study. However there can be occasions when interviews such as the ones that you will be involved in raise past experiences that might be upsetting. If you find that this occurs as a consequence of participating in the research, a free counselling session can be arranged for you. The Health and Counselling Service at AUT is available providing they are made aware that the session is necessary as a consequence of research being carried out through AUT.

What are the benefits?
As a health professional there will be no direct benefits to you from participating in this study. However I have found that some people participating in research of this nature have found it personally helpful and empowering to have their story heard as part of a research project. Also through the research I hope to enlighten health professionals and their managers about the range of experiences that are aspects of being an older health professional. Therefore as research participants you will be part of a project that adds to the knowledge and understanding in a little researched area.

How will my privacy be protected?
Interviews will be in a place of your choice away from your workplace as interviews there could compromise confidentiality. The tapes and transcripts will be confidential to me and the typist who will sign a confidentiality agreement. A pseudonym, used on all material such as the tapes and transcripts, will protect your identity. Audiotapes of interviews and the typed transcripts will be kept in a locked cabinet which only the researcher and supervisor will be able to access. They will be destroyed 6 years after the study's completion. Every attempt will be made to avoid identification of any person or place in reports prepared from this study.

What are the costs of participating in this research?
The cost for you will primarily be in terms of your time. This amounts to approximately 1 to ½ hrs for the first interview and could be up to another hour if there is a second interview, making a range of a minimum of 1 hr to a maximum of 2 ½ hrs. If interviews are held away from your place of residence, for instance at an office at AUT, this will add time needed for travel.

Opportunity to consider this invitation
I appreciate you taking the time to read this information sheet and for considering being a participant in my study. If you would like to participate it would be really good to hear from you. Please contact me within 1 month of receiving the participant information sheet.

How do I agree to participate in this research?
If you have any questions concerning participating in this study you are welcome to contact me by phone or email. If you leave a message giving your contact details I can ring you back. You may elect not to go ahead, or I may find that you do not meet inclusion criteria. Once you have agreed to participate a meeting time and place will be arranged that suits both of us. At that first meeting we will go through the Consent Form which will be signed prior to the interview.
Opportunity to receive feedback?

If you would like feedback on aspects of the research, or the results, then we can discuss how this will occur at our initial meeting. At completion of the study a summary of the research findings will be made available on request.

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, see below.
Concerns regarding the conduct of the research should be notified to the Executive Secretary, AUTEC, Madeline Banda, madeline.banda@aut.ac.nz, 921 9999 ext 8044.

Researcher Contact Details: Ann Paddy
Auckland University of Technology
Doctoral candidate (AUT)
Mobile ph 021 1191 984
Email: annpaddy@ihug.co.nz

Project Supervisor Contact Details: Dr Liz Smythe
Associate Professor
AUT, Akoranga Campus
Private Bag 92006,
Auckland
Ph (09) 9219999 ext. 7196

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Approved by the Auckland University of Technology Ethics Committee on 11 September 2006, AUTEC Reference number 06/154.

Participant Information Sheet

AUT
UNIVERSITY
TE WĀNANGA ARONUI O TAMAKI MAKAU RAU

For managers working with older health professionals

Date Information Sheet Produced: 28 July 2006

Project Title: The meaning of being an older experienced health professional. (This is the working title and may be changed prior to the final research report).

An Invitation
You are invited to take part in a study that explores the experience of older health professionals who come from a range of disciplines, working within a variety of health care settings, within the North Island of New Zealand.

Who am I?
My name is Ann Paddy and I'm an occupational therapist. My areas of practice have been as a clinician and in senior roles working in the community and as an occupational therapy professional advisor. I will be undertaking this research as a full time student as part of my Doctor of Health Science qualification at AUT. My current research interest is to develop a greater understanding of the experience of being an older experienced health professional.

What is the purpose of this study?
The study sets out to explore and show the experiences of older experienced health professionals within their world of work. In order to do this as fully as possible both older health professionals and managers who work with older health professionals will be participants in this study. I expect that this study will increase awareness of the things that matter to older clinicians in their work context. I see the implications from the research relating to the retention of older health professionals as active workers in healthcare settings.
The final research report will be available as a doctoral thesis in the Auckland University of Technology library. Articles relating to the research will be published in relevant journals and could contribute to a number of publications such as a chapter in a book. The research findings are also expected to be presented at seminars. The implications for practice from this study may be used in the development of information for managers and health professionals in health service settings.

How was I chosen for this invitation?
There will be 2 participant groups in the study and you will fit into one of those groups:
Older health professionals of 50 plus years, actively working primarily in clinical roles with 10 years recent experience and who gained their professional qualification in New Zealand. This group of health professionals includes clinicians from a variety of disciplines excluding medicine.

Managers, who work with older health professionals, whose primary role is management.
I want to talk with up to 13 older health professionals and up to 5 healthcare managers. Many of you will be approached by other managers who know me, or who are participants in the study. Others will hear about the study from me and my colleagues at AUT. When

you have read this sheet and you have decided to participate, I would like you to contact me directly, or if you prefer I can contact you.

What will happen in this research?
We will arrange an interview, which will be approximately 1 to 1 ½ hours, at a time convenient to you. It is possible that I may wish to interview some of you a second time or have a telephone discussion with you to gather further information. The interviews will be at a place that is private, and agreed on by both of us, away from work place settings, in order to maintain confidentiality. You will be asked to tell me stories of your experience that relate to the research topic. For instance I will be asking for you to tell me about a time when your experience of working with an older health professional mattered.
The interviews will be audio-taped and then transcribed. Once the interviews are completed and stories have been drawn from the narratives you will be sent a copy of these. You will be invited to comment on them or delete aspects that you do not want included in the study. Your participation in the study is entirely voluntary and you can withdraw from it at any time until data analysis is completed.

What are the discomforts and risks?
I don't anticipate any risks to you from participating in this study. However there can be occasions when interviews, such as the ones that you will be involved in, raise past experiences that might be upsetting. If you find that this occurs as a consequence of participating in the research, a free counselling session can be arranged for you. The Health and Counselling Service at AUT would needs to know that it is necessary as a consequence of research being carried out through AUT.

What are the benefits?
As a health care manager there will be no direct benefits to you from participating in this study. However I have found that some people participating in research of this nature have found it personally helpful and empowering to have their story heard as part of a research project. Also through the research I hope to enlighten both health professionals and their managers about the range of experiences that are aspects of being an older health professional. Therefore as a research participant you will be part of a project that adds to the knowledge and understanding in a little researched area.

How will my privacy be protected?
Interviews will be in a place of your choice away from your workplace as interviews there could compromise confidentiality. The tapes and transcripts will be confidential to me and the typist who will sign a confidentiality agreement. A pseudonym, used on all material such as the tapes and transcripts, will protect your identity. Audiotapes of interviews and the typed transcripts will be kept in a locked cabinet which only the researcher and research supervisors will be able to access. They will be destroyed 6 years after the study's completion. Every attempt will be made to avoid identification of any person or place in reports prepared from this study.

What are the costs of participating in this research?
The cost for you will primarily be in terms of your time. This amounts to approximately 1 to ½ hrs for the first interview and could be up to another hour if there is a second interview, making a range of a minimum of 1 hr to a maximum of 2 ½ hrs. If interviews are held away from your place of residence, for instance at an office at AUT, this will add time needed for travel.

Opportunity to consider this invitation
I appreciate you taking the time to read this information sheet and for considering being a participant in my study. If you would like to participate it would be really good to hear from you. Please contact me within 1 month of receiving the participant information sheet.

How do I agree to participate in this research?
If you have any questions concerning participating in this study you are welcome to contact me by phone or email. If you leave a message giving your contact details on the mobile number I can ring you back. You may elect not to go ahead, or I may find you do not meet the inclusion criteria. Once you have agreed to participate a meeting time and place will be

arranged that suits both of us. At that first meeting we will go through the Consent Form which will be signed prior to the interview.

Opportunity to receive feedback?
If you would like feedback on aspects of the research, or the results, then we can discuss how this will occur at our initial meeting. At completion of the study a summary of the research findings will be made available on request.

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, see below.
Concerns regarding the conduct of the research should be notified to the Executive Secretary, AUTEC, Madeline Banda, madeline.banda@aut.ac.nz, 921 9999 ext 8044.

Researcher Contact Details: Ann Paddy
Auckland University of Technology (AUT)
Doctoral candidate
Mobile ph 021 1191 984
Email: annpaddy@ihug.co.nz

Project Supervisor Contact Details: Dr Liz Smythe
Associate Professor,
AUT, Akoranga Campus,
Private Bag 92006, Auckland.

Ph (09) 921 9999 ext 7196

Consent Form

Project title: The meaning of being an older experienced health professional

Project Supervisor: Liz Smythe

Researcher: Ann Paddy

○   I have read and understood the information provided about this research project (Information Sheet dated 28 July 2006).

○   I have had an opportunity to ask questions and to have them answered.

○   I understand that the interviews will be audio-taped and then typed word for word.

○   I understand that I may withdraw myself or any information that I have provided for this project up to a month following receipt of the typed stories from the interview transcript, without being disadvantaged in any way.

○   If I withdraw, I understand that all relevant information including tapes and transcripts, or parts thereof, will be destroyed.

○   I agree to take part in this research.

○   I wish to receive a summary of the report from the research (please tick one): Yes○   No○

Participants signature:
        ....…………………………………………………
……………
Participants name:
        ....…………………………………………………
……………
Participants Contact Details (if appropriate):
……………………………………………………………………………………..
……………………………………………………………………………………..
……………………………………………………………………………………..
Date:
Approved by the Auckland University of Technology Ethics Committee on 11th September, 2006, AUTEC Reference number 06/154
Note: The Participant should retain a copy of this form.

Appendix F: Interview Schedule (Older Health Practitioners)

Interview prompts for older practitioners

Interview openers
Can you tell me about being at your stage of your working life, do you see yourself as an older health professional and how does that feel?

Regarding your peers, do you find that you are amongst a few or are you the last one of your age in your team and what does that feel like?

Can you tell me about your most difficult experience as a health professional since you reached 50 years?

Can you think of a recent time when you felt that your experience as a health professional really mattered or conversely when it was overlooked in terms of your work?

Can you talk about a specific instance when your age came up for you in relation to your work?

Can you tell me about a time when you seemed to be out of step with someone you worked with or someone who managed you?

Can you tell me what drew you to becoming a health professional?

Can you tell me about how it seemed that the values/beliefs of your clinical education were carried with you into your way of working?

In terms of on-going training and education can you tell me about a time related to that, which stands out for you?

What would you describe as your hopes or fears?

Closing -
What might you be doing in 5 years or 10 years time?

Be mindful of -
Aging body
Time - thinking about possibility of retiring – what related to?
Relation to others
Technology
Prompts -
How did that feel?
Can you tell me more about that?
What did that mean for you?

Appendix G: Interview Schedule (Managers)

Interview approach for manager working with older health professionals

Regarding the interview:

- Need to put aside inhibitions about talking about good aspects or problems with working with others and the sense that you need to be fair to *them*. Need to focus on how it was for you.

Keeping the data safe:

- You will see the stories drawn from the transcript. There will be opportunities then, on both our parts, to ensure that confidentiality is well protected as well as the anonymity of both yourself and those you have worked with. This can be done by altering details eg. Altering the gender of an older staff member and leaving out some details altogether. The demographic details you give me about yourself will not be attached to your pseudonym but will sit in general information regarding the participant groups as a whole.

The interview:

- Focus on being a manager.

- Who were the older health professionals you worked with?

- Picture their faces in your mind, and then decide who you are going to talk about.

- Tell me about a good time…tell me about a bad time…tell me about a frustrating time…

- Decide who you are going to talk about next.

- Tell me about a good time…tell me about a bad time…tell me about a frustrating time…

Appendix H: Confidentiality Agreement

Confidentiality Agreement

Project title: *The meaning of being an older experienced health professional*

Project Supervisor: *Liz Smythe*

Researcher: *Ann Paddy*

○   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 while the work is in progress.

Transcriber's signature:
....……………………………………………
…
Transcriber's name:
....……………………………………………
…
Transcriber's Contact Details (if appropriate):
…………………………………………………………………………………………..
…………………………………………………………………………………………..
…………………………………………………………………………………………..
…………………………………………………………………………………………..
Date:

Project Supervisor's Contact Details (if appropriate):
Liz Smythe……email: Liz.Smythe@aut.ac.nz
Wk Ph 9219999 ext 7169…………………………………………………………..
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Approved by the Auckland University of Technology Ethics Committee on 11th September 2006, AUTEC Reference number 06/154