

# PREVENTING AGEISM IN NURSING STUDENTS: AN ACTION THEORY APPROACH

*Mary Beth de la Rue, RN, DipAppSci (NAdmin), BAppSci (Nsg), GradDipEd (Tert), MN, PhD, former Lecturer, Department of Nursing, University of Southern Queensland, Toowoomba, Australia*

*Accepted for publication October 2002*

## ACKNOWLEDGEMENTS

Funding was received from the Queensland Nursing Council to support this research project. The author is appreciative of the support and assistance provided by Roslyn Reilly, HOD, Nursing, Faculty of Science, USQ, in the undertaking of this study. I would also like to acknowledge the nine USQ undergraduate students who voluntarily participated in this research project and their generous contribution.

**Key words:** ageism, nursing students, participatory action research

## ABSTRACT

Australia has an ageing population and increased longevity has resulted in a larger proportion of the older population surviving to be 75 years and older. As a result of demographic trends, nurses are more likely to come into contact with older people. Ageism exists in Australian society and can unfortunately be found in some practicing nurses. 'Ageism' is a term used to describe a process of systematic stereotyping and discrimination against older people because they are very old, in a similar vein as racism and sexism accomplish this with skin colour and gender.

The aim of this study was to explore final year Bachelor of Nursing (BN) students' attitudes toward ageism and emancipate them to come to terms with these issues to prevent replication of ageism in their future practice as registered nurses (RNs).

Critical social theory (Fay 1987) combined with Stringer's (1996) model of Participatory Action Research (PAR) provided the theoretical directions for this study. Nine final year BN students at the University of Southern Queensland (USQ) volunteered to participate. Data were collected by focus group meetings and clinical diaries over a duration of six months.

Findings of this study revealed an acute self-awareness of what ageism was and a personal fear of the ageing process itself. Identified issues are discussed and re-framed in the form of recommendations so they can offer potential for renewed critical conscious raising to prevent ageism.

## INTRODUCTION AND LITERATURE REVIEW

Populations across the world are ageing, a trend that is expected to continue for at least the next few decades. For example, if an older population is defined as people aged 65 years and over, projections indicate a growth in the proportion of this age group to 11.9% of Australia's population by 2001, 16.38% by 2021, and to 20.08% by 2031. Furthermore, by 2036 it is estimated there will be 5.2 million Australians aged over 65 (Commonwealth Department of Health and Family Services 1998).

An older population will comprise a greater number of people seeking health care. Given that RNs comprise the greater number of health care professionals, it is likely the older person will be cared for by RNs more than by any other health care professional. For example, according to the Australian Institute of Health and Welfare (AIHW 1996), there are at least 184,761 people working as RNs in Australia of whom 14.6% or 22,663 work directly in aged care.

The term 'ageism' refers to attitudes and stereotypes and is a generalisation made about people who fall into a similar age bracket. The potentially damaging implication it has is that ageism can be negative in regard to older people (Picton 1991). Hoyer (1997) and Smith (1997) have argued that ageism is reflected in the view that older people are a burden, and that the process of growing older is widely viewed as being associated with the loss of independence, loss of self-control, social isolation and disengagement from life.

Prevailing attitudes in Western countries are argued to influence the quality of services offered and the treatment to older individuals (Koenig 1995), and to affect the behaviour of policy makers, health and community care agencies and service providers (Sherman 1993). Reports in the literature have focused upon aspects of ageism among health professionals, such as medical practitioners, psychologists and nurses (Gething et al 2001; Gatz and

Pearson 1988; Gattuso and Saw 1998; Minichiello et al 1998; Le Couteur et al 1997; Haug 1994; Gething 1994). Some studies indicate that attitudes toward ageism both commence and already exist, in health professionals, during their preparation for a career in health and human services (Gattuso and Saw 1998; Le Couteur et al 1997; Braithwaite et al 1993).

However, the fact that no attempt has been made to eradicate these ageist attitudes during the preparation of health professionals before their graduation raises issues for concern for their future aged care practices. The literature has drawn attention to attitudes among nurses and questions whether such attitudes could have a detrimental effect on the care provided to older people. The discussion has not been directed to nursing practice in aged care contexts alone, but is extended to all areas of nursing practice. For example, Donahue and Allgood (1995) argue that nurses are in a pre-eminent position to address the health care needs of the 'greying' society, but that negative attitudes toward older people are often incorporated into the beliefs of health care providers and influence behaviour toward and care given to older people. Gibb and O'Brien's (1990) and Gibb's (1990a, 1990b) studies found that an ageist attitude held by some nurses could be related to the managerial hierarchical position they held in an aged care agency and the role they had to fulfill. These studies showed that RNs, who were the most senior professionals in the nursing home, were often quite distant and cold to the older person, often because of time pressures and because they had to deal with issues directly concerned with, for example, medication. In contrast, people in a lower hierarchical position, for example, the enrolled nurses, had a much kinder approach. This could be attributed to the fact that they interacted with older people much more than the RNs by attending to their personal care such as taking them to the shower.

Hence, there was much more opportunity for social interactions which reflected equality in the relationship, as opposed to the RNs who tended to quickly wash someone in their bed, because of time pressures to administer the more complex nursing care. The author also concluded that if there is a dominant philosophy that does not respect and value older people coming from management then all nurses will adopt the same attitudes.

Stevens and Herbert (1997) strongly attest that ageism has many expressions in the health care industry in Australia where its effects are systemic. For example, they argue that the priorities of the health care industry are predicted on the value of obtaining a 'cure' and on the high status of working with 'high tech' equipment. Similar findings have emerged in the United States, Canada and United Kingdom (McMinn 1996; Lookinland and Anson 1995). In this same vein, studies by Stevens and Crouch (1997; 1995) show, despite the best intentions of many institutions that prepare nursing students for practice as RNs and promote aged care as a dynamic professional domain for nurses, students tend to devalue aged care

from a time somewhere between the start and completion of their course. Hence, a profile seems to emerge that technical nursing, such as in intensive care units, is perceived as high-status, whilst the more basic areas such as mental health and aged care, are regarded as having low status (Stevens and Crouch 1997; Lawler 1991). According to these studies, this perception is most likely to be held by students and new graduates. This raises an area for concern, as this particular cohort is either just beginning or preparing for a career in the health care industry, and if they already possess ageist beliefs and behaviours, the negative implications can be perpetuated as they further their practice. In addition, the ageist attitudes and behaviour can affect the way older people view themselves. For example, negative messages in relation to ageism received from others can create a 'self-fulfilling' prophecy that the older individual comes to believe and acts accordingly. The results reflect limited horizons or opportunities, lowered self-esteem, and limited freedom of choice (Gething 1999).

In summary, while the findings of the above studies have determined that an ageist attitude does exist within nursing and other health care professions, and that it has a negative impact on practice, none of the studies utilised a research methodology to facilitate the goal of a deeper understanding of the context in which ageism practices take place, based on open communication, critique, reflection and co-researching between the participants and the researcher. Such a methodological research approach could have the potential to help nurses and other health professionals to lose their 'false consciousness' and gain a state of questioning and confronting their previous beliefs and behaviour in relation to ageist practices (Lather 1986).

Therefore, there was a need to conduct a study which had the potential to emancipate, or free, student nurses and new graduates from their previously held ageist practices (Grbich 1999). Such an approach would have the potential to transform nursing students' and new graduates' attitudes towards ageism before they enter the health care industry, from a base of awareness-raising through the rejection of false consciousness and the pursuit of alternative ways of thinking and strategies to accomplish change (Owens et al 1999). The need for such a study to be conducted is further supported by the emphasis of the then Commonwealth Department of Health and Family Services (1998) which emphasised how a positive attitude toward older people can influence the process of successful ageing. Such was the platform from which this study was conducted.

### Research aims

The aim of this study was to explore final year pre-registration nursing students':

- 1 attitudes towards ageism;
- 2 perceptions of the issues arising out of practising ageism; and to,
- 3 critically raise the consciousness levels to develop an

understanding of the issues and to make choices in relation to the prevention of ageism in their future practice as an RN.

## THE STUDY

### Participatory Action Research Method

Participatory Action Research (PAR) combined with Fay's (1987) version of critical social theory provided the theoretical direction for this study. The rationale for choosing this combination was that, firstly, the Fay approach (1987) fits very well with the emancipatory action research ideology and processes, because he sees that critical social theory encompasses knowing human abilities and attitudes, a theory of value, and, an account of social change through education and politics. He sees the relationship between conditions and ideas not as unilinear, going from point to point as in a straight line, but as a dialectal relationship that undergoes review on a continuing cylindrical basis (Fay 1987, p.22). Hence, this dialectal relationship also facilitates the PAR approach, in that PAR provides a process of inquiry, intervention and evaluation, and is most appropriate when improved practices and problem solving are core concerns. The PAR position involved those at the lower levels of the hierarchy, (eg the participants in this study), who defined the issues to be addressed and assessed action for change in a co-researched manner (Grbich 1999; Lather 1986). The processes that enable the dynamic outcomes of PAR to be achieved are those of collaboration, critical reflection and confidence to the point that PAR participants are emancipated to participate in bringing about social action and change through their awareness raising through the rejection of ageism (Owens et al

1999), and therefore are set free from previous controls such as ageist behaviour and beliefs (Grbich 1999, p.209).

The specific approach to PAR, for this study, was Stringer's (1996) model. Stringer (1996) proposed that PAR was community-based action research providing a process or a context through which people can collectively clarify their problems and formulate new ways of envisioning their situations. The steps of this model of PAR are: setting the stage; looking; and, thinking and acting. By 'look' Stringer (1996) means that participants should define and describe the problem to be investigated and its context; by 'think', he means participants should analyse and interpret the situation in order to develop their understanding of the problem; by 'act', he means that participants should formalise solutions to the problem. The PAR model aligned with Fay's (1987) critical social theory guided the data collection and simultaneous data analysis process in this study to achieve its purpose and aims, as shown in Table 1.

### PARTICIPANT RECRUITMENT PROCESSES

After full ethical approval was granted by the USQ Ethics Committee for Research Involving Human Subjects, a verbal invitation was offered to participate, on a voluntary basis, to 110 USQ final year BN pre-registration students. While numerous students expressed interest, many stated that they felt time commitments in relation to finishing their degree and pursuing prospective employment opportunities prevented their participation. A total of nine final year BN pre-registration students returned signed consent forms and agreed to participate in the project. Although this was a numerically small

**Table 1: The integration of the Stringer (1996) PAR model with aims and data collection strategies**

Step of PAR model	Project aims	Data collection strategy
Setting the stage	Explore participant's attitudes towards ageism	[a] Focus Group Meeting 1 - To tap into the participants' attitudes to the older person; attitudes towards ageing process; awareness to ageism
Looking	Explore the issues arising out of practising ageism	[a] Focus Group Meeting 2 - Group and co-researched analysis of case studies from participants' previous clinical experiences and identification of the issues [b] Group and co-researched preparation for clinical and guidelines for maintaining the clinical reflective journal whilst on the forthcoming clinical
Thinking	As above	[a] Clinical reflective journals [b] Focus Group Meeting 3 post-clinical - Group and co-researched analysis and identification of the issues arising out of clinical reflective journals
Acting	Critically raise the consciousness levels of the participants themselves to come to terms with the issues and make choices in relation to preventing replication of ageism in their future practice as an RN	[a] Focus Group Meeting 4 - Group and co-researched solutions to all the issues arising out of this project [b] Individual de-briefing

sample, it was considered adequate as the primary goal was to understand in-depth the phenomenon of ageism (Llewlyn et al 1999). In addition, the sample was justified as Morse suggests that a good participant is 'one who has the knowledge and the experience the researcher requires, has the ability to reflect, is articulate, has the time to be interviewed, and is willing to participate in the study' (1994, p.228). For example, when applying the above criteria to the sampling strategies utilised in this study, the nine participants' age range was 20-25 years, three were currently working in aged care settings as assistants in nursing, all had one semester to complete both theoretical and a remaining 40 clinical hours to satisfy the Queensland Nursing Council's requirements to be eligible to register as an RN.

## DATA COLLECTION AND ANALYSIS

Data collection and analysis for this study was an ongoing process of monitoring action by the same techniques used in any other qualitative research that places an emphasis on transcripts of audio-taped focus group meetings and reflective diaries. However, instead of analysing the data inductively through content analysis (Bowling 1997, pp.353-4) to allow emergent themes as in thematic analysis, the data were shared with the study participants in a collective, self-reflective inquiry to allow the inquiry, action and evaluation cycle of action research, controlled by the researcher, to become group planning, acting, observing and reflecting. For example, in Stringer's (1996) PAR model, data analysis occurs simultaneously with data collection throughout the research process, but the final outcomes of the analysis of data are proposed as agreed solutions to the problem and are planned by the researcher and the participants involved. These agreed solutions can be used for foundations for an ongoing relationship as areas for action, and in this current study are proposed as recommendations. Springer's (1996) approach to data analysis is a marked comparison to Morgan's (1983) approach, which also proposes a collaborative approach, but as collaborative theorising which results in theories that possess 'evocative power' (p.298). Therefore, in relation to this current study, Stringer's (1996) approach to data analysis, within a broad framework of PAR, is the most appropriate to achieve the research aims.

## METHODOLOGICAL TRUSTWORTHINESS

To ensure validation of findings, on completion of each stage and prior to the next subsequent data collection strategy, issues identified were reviewed and agreed upon in a co-researched manner with both the participants and researcher. In this study, this was integrated and directed by the utilisation of Stringer's (1996) PAR model of: setting the stage, looking, thinking and acting. This process allowed the outcomes of the analysis of this study to have an emphasis on emancipation of the participants through praxis (Grbich 1999, p.209).

## FINDINGS

The findings are presented in accordance with Stringer's (1996) PAR model as explained above.

### Setting the stage

This was in two stages: firstly, a preliminary survey to allow the participants to become aware of their own attitudes towards ageism; and secondly, by utilising a focus group strategy, to allow the participants to confront the issues emerging from the analysis of the survey.

#### (a) Preliminary survey

The participants both consented to and completed a preliminary survey questionnaire prior to the first focus group meeting. The purpose of this questionnaire was to identify self-awareness of any present attitudes of ageism in the targeted population. The three-part instrument was adapted from Braithwaite et al's (1993) ageism scale and had an equal number of positively and negatively worded items. All items were rated on a seven point scale from *strongly agree* (1) to *not sure* (the mid-point) (4) to *strongly disagree* (7). Part I comprised of eight randomly ordered statements tapping the attitudes towards older people. Part II comprised of 16 randomly ordered statements tapping the attitudes towards the ageing process. Part III comprised of 10 randomly ordered statements tapping awareness of ageism. The results of this preliminary survey are presented in Table 2.

Table 2 reports the analysis of the preliminary survey. The positive and negative nature of responses to old age, as well as the variability across individuals, can be appreciated through analysing the frequency distribution on the three scales. Given the balance of positive and negative items, the midpoint of each scale can be

Table 2: Results of preliminary survey

Scale	Number of scale items	Mean (n=9)	% at midpoint	% below midpoint	% above midpoint
Attitude to older people	8.0	3.5	0.0	44.4	55.5
Attitude to ageing process	16.0	4.3	0.0	0.0	100.0
Awareness of ageism	10.0	4.08	22.2	33.3	44.4

interpreted as indicating a neutral attitude or unwillingness to generalise about older people in a positive or negative way. High scores on the scales consistently mean a positive view or endorsement of the concept being measured. With reference to attitudes towards older people, 44.4% scored below the neutral point, while 55.5% scored above the neutral point, showing that most of the respondents were somewhat favorably disposed towards older people. With reference to attitudes towards the ageing process, 100% scored above the neutral point, showing a positive attitude towards the ageing process. However, the overall mean was 4.3, which indicated a tendency to be neutral or unsure of the ageing process as applied to self. With reference to awareness of ageism, the results were somewhat inconclusive. For example, 22.2% were neutral in their awareness of ageism, 33.3% were unsure or not aware of their awareness of ageism, while 44.4% were unaware of their awareness of ageism. In addition, the overall mean was 4.08%, which indicated a tendency to be neutral or unsure of awareness of ageism. The results formed the basis for self-analysis of awareness of ageism in the Focus Group Meeting 1.

#### b) Focus Group Meeting 1

The first Focus Group Meeting allowed the participants to probe deeper into the influencing factors and to confront the underlying causes of attitudes towards the older person. Based on the results of the preliminary survey as discussed above, these attitudes were found to contribute toward those already in situ, because of both positive and negative experiences with older relatives, upbringing, and personal culture, as exemplified by the participants:

*I found when I was doing the questionnaire, because I live with my father who fits into this category, I had to consciously step away because I have some negative problems with him.*

*The upbringing and cultural environment that you live in can really affect you... the way you view them [the older person].*

A fear of the ageing process was also identified:

*At the moment, I'm watching my parents get old... they're watching their friends pass on... I'm actually terrified of getting old, because I'm going to be in that same situation where my friends are going to be getting sick and passing on... that is scary... not for me... for the more emotional side of it and being alone...*

An interesting finding, in this study, was a personal fear of how the ageing process might affect the individual participant when they become an older person, and also concurs with Braithwaite et al's study (1993). The personal fear was influenced by factors such as: being in the same situation as some older people observed while on clinical and a potential to be disadvantaged because of lack of nursing care resources affected by time and staff shortages, which also concurred in Gibb's (1990a, 1990b) studies:

*...when you're there with an old patient, there should be more time given to that patient... and, just given the lack of time, resources and nursing staff... it's very sad... you can't give them the emotional support as well as the physical care... we're all getting older, and you don't know when you're going to end up in hospital, and if things don't change, you could be that person in that bed... it's the real life situation... that fear of laying in that bed... that situation...*

This self-identification of personal fear of becoming older had a confronting impact on the participants in that it made them want to explore their attitudes further.

#### Looking

The participants agreed to explore further the self-identified issues that arose out of Focus Group Meeting 1. They saw this discussion as important for their own self-awareness towards ageism which had the potential to affect their own professional practice when caring for the older person, thus it raised their consciousness levels. As a group in collaboration with the facilitator, they decided they should explore past real life case studies arising out of their clinical practice and life experiences, in the next focus group meeting. The participants self-identified the purpose of this strategy to both prepare them to identify appropriate outcomes and actions to be taken in clinical practice, and to prepare them for maintaining a reflective journal whilst on their forthcoming clinical placement.

At Focus Group Meeting 2, the participants recounted case studies from their past clinical practice. The emerging issues that were both confronted and explored were: inappropriate communication with the older person; negative ageist attitudes of the health care professionals who deliver care for the older person; the influence that ageism has on other health care professionals also delivering care; potential for harm because of inadequate and inappropriate assessment; rehabilitation and discharge planning; and, disempowerment of the older person caused by: paternalism, insensitivity of cultural needs, lack of resources, cost-saving health economics, denial of choices and/or decision-making, lack of privacy and/or respect, and being a victim of institutional routines. These emerging issues concurred with findings of previous studies (Gibb and O'Brien 1990; Gething 1999; Donahue and Alligood 1995; Koenig 1995).

#### Thinking

The next step was to analyse the discourse arising out of the participant's reflective clinical journals, with the aim of understanding the complexity of the issue in order to develop negotiated change.

Prior to commencement of the clinical during which a reflective journal was to be maintained, each participant was given a set of guidelines upon which to base their reflections, together with an attached stamped and self-addressed envelope to the facilitator, for their return. Within these guidelines there was an assurance that the

clinical journals would be stored in a locked file in the facilitator's home away from her workplace; only the facilitator would have access to them; and that the participant's anonymity and confidentiality would be assured in a summary of the contents. A summary of all clinical journals was forwarded to each participant prior to Focus Group Meeting 3 for further group discussion and exploration.

The clinical journals allowed critical reflection to take place by the participants of the actual practice of ageism, both within themselves and others. For example, as the participants themselves attested:

*Once you are aware of the bias you hold, you can more consciously control them... I have learnt a valuable lesson on how the individual elderly folk are... what it is like for them... it has been valuable to me, from a nursing and civilian viewpoint.*

The group decided to identify the focus of ageism they had observed whilst on clinical practice, and to identify what they themselves could do to prevent replication in their own future practice as RNs. The group agreed that in the clinical practice of health care professionals, there were not only negative factors that could reinforce ageism, but also positive factors that have the potential to prevent ageist practice from occurring. For example: health care professionals who are in control of a ward or aged care facility, and whose actions demonstrate respect and non-ageism towards the older person, can model non-ageism practice.

The group also identified that in indigenous aged care settings there was cultural respect by the health care professional for the indigenous older person, which appeared to have the potential to negate ageism. In addition, the group identified that there was a decrease in the practising of ageism in health care agencies such as respite centres and community centres, in which the older person has resident status, as compared to the 'routine' care as demanded by public hospitals in which the older person has patient status.

### Acting: Solutions to the stated concerns

Based on the findings of this study, the following solutions were proposed as recommendations by the participants in this study. The group proposed that these recommendations could be implemented in the curricula of pre-registration BN programs, for the purpose of minimising any possibility of ageism in future practice as an RN:

- a clinical experience, within an aged care setting, should be encouraged for the final clinical experience before completion;
- inclusion of an assignment of which are criterion is to collect the life history story of the 'healthy older person'; and,
- assessment of students competency in aged care in the final year of the BN program.

## CONCLUSIONS

The outcomes of this study provide further confirmation for earlier authors who have argued the need for inclusion of education that focuses upon reducing misconceptions and stereotypes about ageing and older people (Stevens and Herbert 1997). The study also demonstrates the usefulness of employing critical consciousness raising strategies to use in education. The strategies may also be used to guide the design of courses to address inappropriate attitudes and beliefs and to base further action and recommendations aimed at preventing ageist practices.

Results suggest that all educational programs for all health care professionals, regardless of their context, specialty and setting, must incorporate material and experiences that challenge stereotypes and promote cultural awareness within the older population. For example, this study has shown that in indigenous aged care settings there was cultural respect by both the health care professional and members of the indigenous community, and this could have the potential to negate ageism. Education addressing cultural awareness to negate ageism should be incorporated into all aspects of education, not just gerontological courses. Furthermore, Prevost et al (1992), have argued that optimising service provision for older people concerns all segments of the health care sector, not just aged care specialists.

Because of the small sample size of participants in this study, the results cannot be generalised. Further research should be conducted within a larger population to investigate whether the identified attitudes and beliefs, as found in this study, exist in other groups of final year BN students. However, this study, through its research design of PAR (Stringer 1996), facilitated the raising of the participant's critical consciousness to confront the issues and make choices to prevent the replication of ageism in their future practice as an RN. Similar strategies designed to address ageism must be implemented for all health care professionals that have direct dealings with older clients, regardless of setting, context and speciality. Many universities and educational institutions are taking steps to include content within their curricula to combat ageism.

Although this article focused upon final year BN students, the research reported confirms that these strategies are of utmost importance if implemented before any professional embarks upon their career in the health care industry.

## REFERENCES

- Australian Institute of Health and Welfare (AIHW). 1996. *Nursing Labour Force 1993-1994*. Canberra: Australian Government Printing Service.
- Bowling, A. 1997. *Research methods in health: Investigating health and health services*. Philadelphia: Open University Press.

- Braithwaite, V., Lynd-Stevenson, R. and Pigram, D. 1993. An empirical study of ageism: From polemics to scientific utility. *Australian Psychologist*. 28(1):9-15.
- Commonwealth Department of Health and Family Services. 1998. *International year of older persons - overview*. Canberra: Australian Government Printing Service.
- Conference for Older Australians. 1998. *Conference for older Australians: Interim Report*. Canberra: Commonwealth Department of Health and Family Services.
- Donahue, L. and Alligood, M.R. 1995. A description of the elderly from self-selected attributes. *Visions: the Journal of Rogerian Nursing Science*. 3:9-12.
- Fay, B. 1987. *Critical social science: Liberation and its limits*. Ithaca, NY: Cornell University Press.
- Gattuso, S. and Saw, C. 1998. Reactions to ageing among Australian students: A rural-urban comparison. *Australian Journal on Ageing*. 17(1):38-39.
- Gatz, M. and Pearson, C.G. 1988. Ageism revised and the provision of psychologist services. *American Psychologist*. 4:143-8.
- Gething, L. 1994. Health professionals' attitudes towards ageing and older people: Preliminary report to ageing questionnaire. *Australian Journal on Ageing*. 13:77-81.
- Gething, L. 1999. Ageism and health care: The challenge for the future. *Australasian Journal on Ageing*. 18:2-3.
- Gething, L., Fethney, J., McKee, K., Goff, M., Churchward, M. and Matthews, S. 2001. Knowledge, stereotyping and attitudes towards self ageing. *Australasian Journal on Ageing*. 21(2):74-9.
- Gibb, H. and O'Brien, B. 1990. Jokes and reassurance are not enough: Ways of nurses' relating through conversation with elderly residents. *Journal of Advanced Nursing*. 15:1389-1401.
- Gibb, H. 1990a. *Representation of old age: Notes towards an examination of ageist practices in nursing*. DINR Monograph Series.
- Gibb, H. 1990b. *This is what we have to do - are you OK? Nurses' speech with elderly nursing home residents*. DINR Monograph Series.
- Grbich, C. 1999. *Qualitative research in health: An introduction*. Allen & Unwin: St Leonards.
- Haug, M.R. 1994. Elderly patients, care givers and physicians: Theory and research on healthcare triads. *Journal of Health and Social Behaviour*. 35:1-12.
- Hoyer, W.J. 1997. Positive contributions of the elderly to society. World Congress on Gerontology. Symposium on positive contributions of the elderly to society Adelaide: Supplement. *Australian Journal on Ageing*. 17:39-41.
- Koenig, G. 1995. *Aged and dementia care issues for people with an intellectual disability*. Brighton, South Australia: Minda.
- Lather, P. 1986. Research as praxis. *Harvard Educational Review*. 56:257-77.
- Lawler, J. 1991. *Behind the Screens*. Melbourne: Churchill Livingstone.
- Le Couteur, D., Bansal, A. and Price, D. 1997. The attitudes of medical students towards careers in geriatric medicine. *Australian Journal on Ageing*. 16(4):225-228.
- Llewellyn, G., Sullivan, G. and Minichiello, V. 1999. Sampling in qualitative research. In Minichiello, V., Sullivan, G., Greenwood, K. and Axford, R. (eds). *Handbook for research methods in health sciences*. Sydney: Addison Wesley.
- Lookinand, S. and Anson, K. 1995. Perpetuation of ageist attitudes among present and future health care personnel: Implications for elder care. *Journal of Advanced Nursing*. 21:47-56.
- McMinn, B. 1996. Ageism: The challenge for nursing. *Australian Nursing Journal*. 3(10):18-19.
- Minichiello, V., Browne, J. and Kendig, H. 1998. Perceptions and consequences of ageism: Views of older men and women. Paper presented at the Australian Association of Gerontology National Conference. Understanding ageing: Through experience, practice and research. Melbourne.
- Morgan, W. 1983. *Beyond method: Strategies for social research*. Beverly Hills: Sage.
- Morse, J.M. 1989. *Qualitative nursing research: A contemporary dialogue*. Rockville: Aspen Publishers.
- Owens, J., Stein, I. and Chenoweth, L. 1999. Action Research. In Minichiello, V., Sullivan, G., Greenwood, K. and Axford, R. (eds). *Handbook for research methods in health sciences*. Sydney: Addison-Wesley.
- Picton, C. 1991. The social context of ageing. In M. Shaw (ed). *The challenge of ageing*. 2nd edn. Melbourne: Churchill Livingstone.
- Prevost, S., Wilson, E. and Gerber, D. 1992. Acute care nurses' knowledge and attitudes related to ageing. *Heart & Lung: Journal of Critical Care*. 20:302.
- Sherman, B. 1993. *Dementia with dignity: Handbook for carers*. Sydney: McGraw Hill.
- Smith, J. Profiles of the young-old: Different strategies of positive well-being in late life. International Association of Gerontology. XVth Congress of the International Association of Gerontology. 1997. Adelaide.
- Stevens, J.A. and Herbert, J. 1997. *Ageism and nursing practice in Australia*. Discussion Paper No 3, Royal College of Nursing, Australia.
- Stevens, J.A. and Crouch, M. 1995. Who cares about care in nursing education? *The International Journal of Nursing Studies*. 32(3):232-242.