THE EXPERIENCES OF OLDER

WOMEN PARTICIPATING IN THE

WORKFORCE

A qualitative study of ten registered nurses over the age of 60 working in the Waikato's health sector.

A thesis presented in partial fulfilment of the requirements for the degree of Master of Social Sciences (Anthropology) at Waikato University, Hamilton, New Zealand.

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ABSTRACT

The purpose of this study was to explore the experiences of older working nurses and the reason they were still in the workforce while the majority of their cohort had exited from active nursing. New Zealand's legislative changes in the Human Rights Act, 1993 and the Employment Relations Act, 2000 makes it unlawful to discriminate on the grounds of age. In effect, this means the abolishment of mandatory retirement as the individual is now able to exit from the workforce by choice. For nurses the choice for exiting the workforce occurs noticeably in the 50-54 age group with further declines in subsequent years. This research study revealed a group of older nurses who valued autonomy in their nursing practice and valued the contribution they made as experienced practitioners in a variety of health sectors in the Waikato. As the demographic shift in New Zealand's population is towards older age groups and likely to require future nursing care, it becomes essential to retain experienced nurses in the workforce. This small scale qualitative study interviewed ten registered nurses over the age of 60 to discover how social life was constructed as they aged.

HOW OLD IS 'OLD'?

Most non-western people think of folks as being young or at least middle-aged if they continue to carry out the responsibilities and activities required of them, and they think of people as being old when they can no longer perform their required duties. In other words, definitions of old age are functional (have to do with performance) rather than chronological (having to do with age) (Holmes 1980:277).

ACKNOWLEDGEMENTS

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To my family thank you for accommodating the endless reading, note taking and library visits required for this project, distracting from family time. I want to say a special thank you to Michael for developing his culinary skills and keeping our home orderly and clean. This has been especially important for me when so much has converged this year in the form of work, study and family loss of a younger brother.

I have also appreciated collegial support at our thesis meetings and during informal conversation from Sandy, Andrea, Helen and Katrina who were also working through Masters programmes at Victoria University.

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INTRODUCTION AND BACKGROUND

An anthropological perspective

This study explores the experiences and meanings of a group of older

nurses who are participating in the paid workforce within various health

facilities in the Waikato. My interest in this topic reflects my own

experiences of being an older woman in the nursing workforce. Paid

employment for a significant number of older women is a recent

phenomenon and little is known about the meanings, understandings and

shared ideas of this group within our contemporary society.

My approach is influenced by anthropology. Anthropology is concerned

with culture, that is, the way people live. The integrated totality of that way

of life includes people's behaviour, the things they make and their "ideas"

(Rosman & Rubel 1995:5). The culture of a group consists of shared,

socially learned knowledge and patterns of behaviour (Peoples & Bailey

2006: 22). In this study of older nurses in paid employment, I intend to

explore their shared understandings and socially constructed meanings of

being older nurses in current New Zealand society. In the past,

anthropologists studied small-scale traditional societies in exotic locations.

Increasingly the anthropological gaze has turned to studying the complex

social fabric of western culture. This study has taken several avenues of anthropological enquiry to gain an understanding of ageing and workforce participation. I became my own participant observer during fieldwork for a day to search for an understanding of an older Public Health Nurse in paid employment. My own autobiography of ageing and participation in the nursing workforce would suggest some useful observations of how the ageing body negotiates a path through working and social life. This observation follows later in this chapter. If this observation was with a community of older nurses showing the organisation of social life my subsequent recordings and analysis would be formulated in an ethnography. Instead, for this study I have chosen to have conversations, in the form of in-depth interviews, with a small number of respondents to elicit their experiences and meanings of ageing and participation in paid nursing employment.

Older workers

The Human Rights Act, 1993 prohibits discrimination on the grounds of age, supporting the employment of older workers. However negative socially constructed perceptions of older workers persist and pose difficulties for an older age group, especially men, in finding meaningful paid employment. Compared with the male rate, older women's participation in the workforce has grown at a faster rate in the period from 1991-2005 across the age bands 50-64 (Dept. Labour 2007:3,4). Labour market participation for those in the 50-64 age group rose by 70% in the period from 1991-2005. The proportion of New Zealander's older labour force in work now ranks among the highest in the OECD (Dept. Labour

2007:5).This growth needs to be viewed against a structurally ageing demography in New Zealand. There is also, I would suggest, a certain nervousness amongst older working people with regard to a further rise in the age of eligibility for New Zealand superannuation as the current 65 years may not be sustainable in the future.

An ageing body and work

An ageing body can impose some limitations on paid workforce participation. In particular sensory changes to vision and hearing and the ageing effects to the musculoskeletal system may pose limitations on employment requiring physical stamina. Muscle mass and strength decrease after age 40 especially in the knee and hip joints. This means that around "50% of older nurses are unable to lift any weight from certain postural vantage points" (Robert Wood Johnson Foundation, White Paper: 22). Nurses are also exposed to needle-stick injury, back injury, repetitive strain injuries body fluids and assault. This White Paper noted that the physical limitations of older nurses are far outweighed by their expertise, accumulated knowledge and strong interpersonal skills.

Nursing and Midwifery female workforce data

From the 50-54 age band nursing workforce participation decreases, a trend also seen in the United States of America, Canada and Great Britain. The 2006 data illustrates this point.

Age band	% of workforce
44-49	17.8%
50-54	13.2%
55-59	9.9%
60+	7%

Table 1. Age of female registered nurses and midwives in the active workforce (NZ Health Information Service personal communication 10/4/08).

The nursing workforce has issues around the recruitment and retention of staff; many western countries have the same issues. Of concern is the exiting of experienced staff from the age of fifty. As New Zealand's population ages there will be demand for more nurses and especially those with experience. Although we are living longer and in better health than our predecessors, nursing workforce participation is lessening at a time of rapid growth in employment of women in other work sectors for this age group.

The researcher's interest in this study

My decision to undertake this study was based on my own experience of ageing while working in the nursing workforce and along the journey assisting with the care of elderly family members. I re-entered the nursing workforce fulltime when my eldest son was aged ten and his younger brother seven, after the completion of an intensive child health course. Some years later I completed a midwifery course with an Advanced Nursing Diploma. After school care is of concern for working parents.

This concern was resolved, for me, with the children attending a school that had after school activities integral to its daily programme. During school holidays peripatetic care was provided by their farming father. I have continued nursing in various roles in the community, the last 17 years as a Public Health Nurse. In the past four years I have elected to work four days a week to give time for academic study.

My interest in this study is also reflected in my concern that there be societal recognition of the competence and wisdom of older workers and due acknowledgement given for intergenerational support. Although New Zealand has anti-age discrimination law in the Human Rights Act, 1963 and banned compulsory retirement in 1999 socially constructed ageism myths still persist.

For this thesis I have explored the experiences of older female nurses participating in the workforce. The definition of an older worker varies between international and New Zealand jurisdictions. For those countries with mandatory retirement policies an older worker is deemed as nearing retirement age. The State Services Commission Report (2004) defined an older worker at 55 years or older. For the purpose of this Masters thesis, an older female nurse is defined as over the age of sixty. The ten research participants in this study are all European New Zealanders which may be an effect of the snowball process for recruitment into the study as well as a demographic reflection. The respondents worked in various community roles within the Waikato. This included District Nursing, Public Health Nursing, regional palliative care, and nursing in a small community rest home for the aged and a hospital in a small town. None of the

respondents worked in a large hospital facility. (See Table 1 for research participants' socio-demographic characteristics). Nine of the research participants had taken time out of the workforce to have children and initially returned to work part time dependent on partners for child care.

Name of Respondent	Nursing practice area	Marital status	Age band: 60-64 65+	Length of time in position	Working: Full time (F) Part time (P)	Income: Main (M)or Supplementary (S)	University Diploma/Degree
Dot	District Nurse	Divorced	60-64	20 years	F	M	
Missy	District Nurse	Married	60-64	20 years	P	S	
Margaret	District Nurse	Married	60+	17 years	P	S	Degree
Joan	District Nurse	Married	60-64	17 years	P	S	
Bette	District Nurse	Married	60-64	20 years	F	M	
Judy	Palliative care	Divorced	60-64	17 years	F	M	Diploma
Pat	Long term care for elderly	De Facto	60+	10 years	P	S	
Kerry	Community Hospital	Married	60-64	15 years	P	S	Degree
Ros	Community Hospital	Married	60-64	30 years	P	S	
Kath	Public Health Nurse	Married	60-64	5 years	F	S	Diploma

Table 2 . Socio-demographic characteristics of the research participants

Embodiment

Initially I thought that the ageing body would be of central concern to active nurses. However this was not a major concern and may be due to the cohort of nurses in this study being physically fit. Those who found nursing too physically demanding may have already left the workplace. Nonetheless, I was interested in the idea of embodiment because of the sheer physicality of the day-to-day work of nursing practice and the impact on the ageing body.

The idea of embodiment, that is being in the body, has historical antecedents. Western philosophical thought from the time of the Enlightenment had been influenced by a Cartesian duality of the body and the soul. The soul was the domain of priests and religion and associated with superstition, primitivism and irrationality. Science, especially biomedical science, from the positivist paradigm, claimed the body (Scheper-Hughes 1987:6). This separation of the body and soul signified the replacement of theological concepts of body sanctity and dignity and the intimate connections between the body and soul with a rational scientific investigation. This separation of the visible entity of the body from the person became manifested in the public dissection of corpses around the 1630's and the associated anatomical drawings increased the notion of separateness. Descartes' legacy was of a divided body and soul; the soul contained the human essence and was therefore sacred. The body was viewed as profane with the less desirable aspects reflected upon the soul. Cartesian thought maintained that the soul became equated with the mind and this mind/soul resided in the body. The mind

was viewed as the basis of individual identity but a separated entity from the body. Using this rationale the body then is

> defined as unruly, disruptive, in need of direction and judgement; merely incidental to the defining characteristics of mind, reason, or personal identity through its opposition to consciousness, to the psyche and other privileged terms within philosophical thought (Grosz 1994:3).

The study of embodiment discards this notion of human duality and instead asserts the unitary nature of the physical body and mind/spirit thereby privileging the understandings of the subjective lived experience. Embodiment encompasses physical and emotional feelings, intuition, tacit knowing, is the "human face to technology" (Csordas 1999:143) and the knowledge of roles played out in a social context. Embodiment is experienced and located within the historical and cultural milieux of society.

I want to explore this concept of embodiment in a social context relating it to my recent professional role as a Public Health Nurse working in a poorer multi-cultural school community. First, my early understandings of cultural difference were gained through my observant child eyes in the migrant community I grew up in. I can remember, as if it was yesterday, the extended families of Dalmatians that surrounded our family home. I was intrigued in the differences in the Dalmatian family diets and what they grew in their gardens in comparison with what we ate and what my mother grew in an extensive garden. In the Dalmatian family kitchens were huge tins of olive oil for cooking and splashing over food and their productive gardens grew rows of various tomatoes, different beans and

large fig trees. Wine was drunk at mealtimes. In my home the occasional

beer quenched a thirst on a hot afternoon; wine was confined to a

celebratory champagne.

I now return to the present. Public Health Nursing is multi-faceted but the

central core of activity is about health education in the form of disease

prevention and a knowledge of treatment modalities. To accomplish this I

have to be cognisant of the "authority" of the position and the

contextualised social lives of families in this community. My embodied

knowledge has been gained through the subjective lived experience as an

older nurse working in this community.

I have attempted to be my own participant observer in following the

activities and movements possible in my day as a Public Health Nurse. In

this community of intersecting cultural values how does a nurse

interweave both the nursing tradition, with its embeddedness in the

biomedical paradigm, and my embodied experience. This begins with the

way I look or the way I present my body as well as the way I live in it. The

essentials of a dress code are dictated by the community of interest:

practicality, comfort and discretion define this code. The frequent bending

to get in and out of a car requires clothing that is non-restrictive and can

cope with sitting on a classroom floor with children or on the floor or

furniture when visiting a home. In a community where women wearing the

djellaba are frequently encountered the dictates of a discreet dress code

assists with social acceptance. There is no place for shrink-wrapped

clothing stretching over my middle-aged contours. I wear trousers, in their

various guises, throughout the year as these cover the skin and modern

fabrics allow for active movement and easy laundering. A cotton shirt and jacket completes the dress. There are no vertiginous high heeled shoes worn in this nursing job; a comfortable low-heeled shoe is worn for ease of slipping off at doorways when visiting. On this particular day by 9am I am entering a classroom, shoes slipped off at the door. The kaiawhina greets me with a light touch on the arm and we move quietly to low chairs waiting for the classroom teacher to complete her session. After several minutes we are beckoned over to the group of children sitting on the floor. The kaiawhina introduces me as Whaea Marjorie and explains that as the class are shortly going on a marae stay there will be a korero about the importance of hand-washing when helping to prepare kai. The children greet me with a Maori greeting. On the completion of this health education session the kaiawhina follows me out of the classroom to discuss a health issue with one of the children. I agree with her concern and it is suggested we visit the parent together the following day. As the kaiawhina has social status as an elder in her community I accept her invitation to visit the family. I am now back in the car checking the diary for the address of a Tongan family, where English is a second language. The visit today is to arrange the details of an orthopaedic clinic visit for the eight year old son. Driving along I reflect on a previous visit to this family. The parents were shopping at the time of this visit and the eight year old was caring for four younger children, including a six month old infant. Tongan children, like Maori and Samoan children, "are expected to become independent and autonomous as quickly as possible, able to look after and look out for not only themselves but younger siblings as well" (Metge & Kinloch 1978:39). My thoughts were of a liminal space, where

the traditions and mores of a Tongan village had not yet adapted to the social and legislated life of their adopted country. I later visited and explained to the parents that young children needed to be in the care of a person over the age of fourteen years. A cousin down the street was "keeping watch" from her home. I suggested that the children physically go to the cousin's home for the safety of the children. Several neighbourhood homes had recently been extensively fire-damaged in situations where an adult was not currently in the house and I related the child safety aspect to these fires. At this visit, following a door knock, I am invited inside. I leave my shoes with a medley of family footwear at the doorway. Traditionally footwear is removed so that detritus is not carried into clean living areas of the home. I am provided with a cold orange drink and settle into an armchair. Pela sits on the floor while we work through the transport details of getting to the hospital clinic visit; Pela does not drive or own a car. Sitting at a lower level is showing respectful behaviour towards me, acknowledging my role. Eye contact is not made, Pela focuses her gaze elsewhere and I accept this is part of cultural difference as it would be considered impolite to look directly at me when talking. On returning to the car I find that late February's sun and heat has made the car interior sauna-like and my body feels enervated enwrapped in moisture. My last visit of the day is to a home with a large brown dog of indeterminate breed and tetchy temperament. Although he is usually tethered to a hunky piece of chain I can't help but stiffen, giving him a wide berth as I try to avoid his mean eyes. I knock on the door with sweaty hands hoping that someone will respond and quell the maniacal barking. By late afternoon I am looking forward to the relief of walking over

undulating farmland, away from burning hot city pavements, with the cool

breeze of early evening having a restorative and relaxing affect on the

body. I have described a typical working day in my role as a Public health

Nurse and the embodied social knowledge that has been acquired over

the years.

Structure of the thesis

The research is presented in six chapters:

Chapter 1 Introduction and background

Chapter 2 Ageing

Chapter 3 Older people and workforce participation

Chapter 4 The research process

Chapter 5 Findings

Chapter 6 Discussion

Chapter 2

AGEING

As this thesis is concerned with the experience of ageing for a cohort of Registered Nurses participating in the workforce this study begins with an exploration of issues relevant to an ageing population. This includes the demographic trends occurring within New Zealand's population, theories of ageing, and women within the context of growing older. Individuals inevitably age and the aged are featured in all cultures. Within a culture ageing has its own socially constructed rituals, emblems and structures. Anthropologists describe age grades in all cultures showing the individual's progression through each part of the life cycle. Societies must resolve the question of how to structure age differences. Within a culture the question of family and kin structures, connection across the generations with the transfer of wealth, power and knowledge, wider social participation and societal contribution that older members make require resolution (Gulliver, Linton cited in Fry 1980:6). In the past, anthropology has been concerned with the aged as informants from disappearing cultures rather than in the contemporary roles, status and experiences of being old. It is only in more recent time that the anthropological gaze has turned to advanced industrial societies with ageing members.

Ageing in traditional society

In traditional societies men and women were usually engaged in home-based agriculture and handicrafts. The domestic economy depended on women's work to sustain their families. Women might be expected to carry water, collect firewood, tend gardens and animals as well as rearing children. In traditional societies most men and women did not live to see an old age. Press and McCool (in Fry 1980) studied the prestige of older adults in a Central American peasant community, less affected by modernisation. These authors located four roles and statuses generated by elders. These four basic prestige-generating components were advisory, contributory, control and residual. In the advisory role older people are a source of information and wisdom for younger community members. Prestige was generated by older community members in this study by their participation and contribution to social activities. The third prestige-generating component related to the control of resources and "supernatural sanctions". The elderly also retained a residual prestige-generating component from previously held statuses and expertise.

Ageing in contemporary society

The impact of industrial modernisation has effected major social transformation among the elderly. Cowgill and Holmes (in Fry 1980: 4) assert

> [t]hat modernisation and the associated features are inversely related to the status and treatment of the elderly. Although depressed prestige of older people is associated with industrialising societies, mature industrial systems appear to support higher prestige for the elderly, especially as cohorts having better education, health, and finances reach old age.

Modernity was associated with the big ideas of the welfare state and retirement with an institutional construction of the later life course. The 1970's saw the decline in full employment and the prospect of unemployment and early retirement. Both the social construction of a retirement wage and the accord across generations underpinning the welfare state was being questioned. More recent critiques have suggested that the compartmentalising of the life course were "neither socially nor spiritually adequate and the social meanings of life's stages are in great flux" (Phillipson 1998:44).

Giddens (1991:83,84) in describing contemporary modern society, states that this period of late modernity has loosened the traditional bounded order of society resulting in a much more diverse and segmented social life. Increasingly, globalisation of the media, especially television, exposes the individual to a range of social possibilities and diversity. The emancipation from traditional oppressive social roles has given individuals and groups the possibility of diverse life choices. For women, emancipation has provided for more social independence with opportunities for tertiary education and employment in non-traditional settings. Increasingly older members of society are making lifestyle choices not bounded by homogenous cultural traditions. Globalisation has given their children opportunities of employment in other parts of the world resulting in cross country visiting or residency for their parents. Late modernity is also marked by mass production being displaced by more

flexible forms of work organisation for the production of goods and services.

Demographic Trends

Following the trends of other developed countries New Zealand is experiencing a demographic shift within its population. This is due both to lower fertility rates and the decline in rates of death (mortality) increasing the chances both of surviving into old age and of living longer once old age is reached. Changes in fertility have played their part, particularly through the post war baby boom and the subsequent rapid decline in fertility. Fertility change has been a major factor in shaping the course of structural ageing in New Zealand. Improved living standards reflected in improved nutrition, advances in medical science and access to medical services, and effective control of infectious diseases are now the main reasons for living longer with accidents and degenerative diseases now the main causes of death (Zodgekar 2005: 20). Women now also survive childbirth. The high childbirth mortality rates seen until the mid 1900's has disappeared in industrialised countries with improvements in poverty, water supplies, sanitation, widespread infectious diseases and improved nutrition. Diseases and the science of sepsis were better understood and the use of sulpha drugs in the 1930's and penicillin in the 1940's greatly reduced the chance of succumbing to puerperal infection. Victor (2005:112) comments on the current imbalance in the numbers of men and women surviving into old age:

> Thus any discussion of old age and ageing within the developed
> world context is very largely concerned with women rather than
> men. Far from this being a demonstration of the biological

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superiority of females, it seems to be a reflection of the differences between the sexes in terms of smoking patterns and the resultant health effects in combination to greater exposure to social and environmental risks and occupational exposures. This example illustrates rather neatly the need to link biological, social and psychological perspectives when investigating old age.

Chronological age defines both demographics and statistics. The eligibility for National Superannuation defines older people at 65 years. The age band 65-74 is defined as young old; 75-84 years is defined as medium old and the old old are 84 years and older (Statistics New Zealand, 1998; Heenan 1992: 31). From 1970-2005 the number of people aged 65 and over has doubled, and now stands at half a million. Future scenario projections suggest an increase in this age group to 1.33 million by 2051. Eighty seven per cent of the growth in the total population between 2005 and 2051 is projected to be in the over 65 age group. Within this ageing population, 7% will be 80 and older, constituting 23% of the elderly population with the greater number being women (Zodgekar 2005: 74).

Although all cultures have ageing members, it is only in recent times that the elderly have constituted a significant proportion of society. Roebuck (1983:255) has posited that our social perceptions and social institutions are not prepared for the increased number of elderly. The demographic shift to an ageing population, a characteristic of our own and other western societies, is often constructed in negative terms of "economic and political instability, disease or environmental threats" (Boston & Davey 2006:1). The negative stereotypes ascribed to the elderly individual are also attributed to populations of older people. Typically the descriptors are "lack of energy, enthusiasm, motivation, artistic and intellectual

achievement" (Victor 2005:79). Coupled with a socially constructed

perception of traditions unresponsive to change, the burgeoning

population of older adults is seen as impacting negatively on health and

social services in what has been described as an "apocalyptic demograph"

(Victor 2005: 79). An older population is a heterogeneous group of people

where the social concomitants of health will be determined by their control

of life circumstances. Poorer health and wellbeing will be linked to their

past social and economic backgrounds (Raeburn 1994:336,337). One

does need to be mindful that although demographic data informs health

policy it does so without regard to distinctive cultural, regional and

community characteristics, that is, without a sense of real people. As well

demographic data, while important in understanding "the social impact of

mortality decline" in a society that provides for retirement funding and

medical benefits does not describe the actual experience of any particular

population (Zodgekar 2005:71). Impacting on groups within a population

are the effects of life cycle exposure to wars, loss of family, displacement,

refugee status, migration, malnutrition, colonisation, racism, urbanisation,

poverty and the major impact of world economic events including financial

depressions and share marker failures. Fry (1980:45) summarises these

concerns

> [Neugarten and Datan] have distinguished three dimensions of
> time; life time, social time and historical time (1973:56-58). Life
> time is a series of orderly changes that occur in the life cycle, of
> which chronological age, despite its problems, is the index. Social
> time is the age-graded system of status and norms which underlie
> the major periods of life distinguished in a particular ethnographic
> setting. Historical time refers to the social, political and economic
> events which occur through time and have impact upon the lives of
> people within that system. The cohort-historical approach is most
> directly concerned with the interplay between life-time and social
> time.

<u>Mortality and morbidity perspectives</u>

Mortality refers to death and can be expressed, epidemiologically, as mortality rates (from accident or disease) per 10,000 or 100,000. Morbidity refers to sickness or disability. The death rates in the very young, youth and midlife have decreased transferring mortality to an older cohort. "The consequences of this compression of mortality into the later phases of life are contested within two major perspectives; the compression of morbidity and expansion of morbidity" (Victor 1994: 126). The compression of morbidity perspective optimistically argues that as mortality has been constricted into later life, morbidity will demonstrate similar trends. Fries (cited in Victor 1994Z: 127) based his theoretical position on the advances made in medicine and improved living standards. This hypothesis would see the mean age of onset for chronic disability pushed back from, for example, 55 years to 65 years. Fries argues that there are more people surviving into old age and that those who survive will be fitter because the factors that have delayed mortality will also have delayed morbidity. Hence those people surviving to old age will be fitter for longer with significant levels of morbidity being limited to a short period at the very end of life. This theory has obvious policy implications. If the compression of morbidity thesis is correct the expenditure on health care could, in theory at least, be reduced (or perhaps contained) and the ageing of the population does not imply any great challenge to the provision of health and social welfare. Conversely the stance taken within an expansion of morbidity perspective is less optimistic maintaining "that the result of the compression of mortality will be an increased morbidity"

with more frail elderly in poor health and chronic disabling disease. Greunberg made the observation that there were "lower fatality rates from disease rather than improvements in population health status" (in Victor 2005:128).

Ethnicity data

Although the contemporary elderly population is predominately of United Kingdom and Irish extraction older populations will become more diverse with an increasing proportion of Maori, Pacific and Asian peoples reaching and passing 65, both as a result of increasing life expectancy and larger birth cohorts reaching old age (Zodgekar 2005: 69).

Composition of households

Most of the over 65 age group either live in a family home with a partner, or in a one person household . "Eighty percent of the growth in one-person households is projected to occur among those aged 55 and over. Of people living alone, 64% are projected to be 55 and over in 2021, compared with 57% in 2001" (Boston & Davey, 2006: 37). In 2005, for every male over 65 there were 1.25 females, largely reflecting the lower female mortality rates for all ages. Although the gap between female and male life expectancy will narrow and women will be "partnered at increasingly older ages in the future the number of women aged 65 and over living in a one-person household is projected to increase from 100,000 in 2001 to 150,000 in 2021" (Boston & Davey 2006: 37). Divorce rates in New Zealand have increased from 5.1 divorces per 1,000

marriages in 1971 to 12.2 in 2001, leading to the likelihood of women living alone.

New Zealand's fertility patterns and declining mortality have been accompanied by social and demographic changes within the family. Women are having children later in life with the "median age of women giving birth is now 30 years, and the median age of women giving birth to their first child 28 years" (Ministry of Women's Affairs 2004: 7). Demographic changes within the family also includes the gradual change of the number of living generations in families; in essence grandparents, parents and children are more likely to be living at the same time. In effect, this means that the age group 60-64 will have parents still living at the same time (Zodgekar 2005: 69) These demographic changes mean that those in mid-life may well find themselves at the centre of supporting both ageing parents and adult children. This support is channelled more towards the adult child mainly in the form of financial assistance. Older parents are assisted with daily tasks (Hillcoat-Nalletamby & Dharmalingam 2002: 3).

Theories of ageing

There are several theoretical perspectives in ageing some of which will be examined here.

Biological ageing

Biological ageing is universal to all life forms. Both intrinsic and extrinsic factors contribute to ageing. Intrinsic ageing includes decreases in lung

capacity, loss of brain cells and hardened arteries (Sullivan, cited in Novak 1996:96 103). Cell changes "lead to changes in the body's system causing decline of lost reserve capacity, changes to the musculoskeletal system, the endocrine system and sensory changes and their functioning demonstrates the link between physical change and an older person's ability to function in social life" (Novak 1996:103). Extrinsic factors related to ageing body changes include sunlight, smoking, noise, environmental or occupational contaminants. Physical functioning declines with age. However the experience of ageing is not a homogeneous one and by presenting it as such, overlooks possible ameliorating effects and the particular needs of women. Rowe and Kahn (1987) assert that

> [r]esearch on ageing has emphasised losses. In the absence of identifiable pathology, gerontologists and geriatricians have tended to interpret age-associated cognitive and physiological deficits as age determined. We believe that the role of ageing per se in those losses have been overstated and that, a major component of many age-associated declines can be explained in terms of life style, habits, diet, and an array of psychosocial factors extrinsic to the ageing process (p.143).

These authors also comment on cross-cultural differences suggesting that factors of diet, exercise, and nutrition have been underestimated or ignored as potential moderators of the ageing process.

Sociological approaches to ageing

Functionalist perspective. The analogy of the body and its related and interrelated parts best describes the functionalist perspective when analysing society's development and maintenance. Functionalism emphasis social order, the maintenance of equilibrium rather than change

and conflict. The functionalist perspective influenced the development of other theoretical perspectives in gerontology including disengagement, activity, continuity and social roles. Some of these theories view ageing negatively while others are more positive.

Disengagement theory, as a sociological theoretical position, posited a gradual decline and withdrawal from society by the old, with the transfer of power to the young, while the elderly prepared themselves for death. Disengagement, in the form of mandatory retirement, could be seen as society's mechanism for the transference of jobs to a younger generation allowing for a balance of employment in society. It is argued by Victor (1994: 22,23) that disengagement theory has been influential in the development of government policy for the aged resulting in policies based on age segregation, separating out older people from other forms of welfare development and

> [t]his theory has further enabled the erection of barriers between older people and other social groups and the professionals dealing with them, with the inevitable consequence of poor quality services and inadequate education and training for the staff working with them (Biggs cited in Victor 1944: 23).

The resulting indifferent services, stipendiary pensions and poor standards are justified on the basis that disengaged older people do not require the same level of services expected by others in the community.

Activity theory was a response to the disengagement perspective and is concerned with an equilibrium being maintained in society. The hypothesis within activity theory is that activities and roles surrendered with age are

substituted with other activities to compensate for prior loss (Victor 1994:24). For example, on retirement an older person substitutes the paid working role with volunteerism, caring for grandchildren or developing previously side-lined skills. Activity theory argues for a meaningful integration of older members in society.

Continuity theory suggests that individuals, as they grow older, will endeavour to maintain lifetime habits and preferences. Health and income may dictate what can be maintained in older age and individuals may need to adapt with increasing frailty and age. For example an older person may seek out accommodation that is easier to manage, replace an active sport with a more sedate activity or forego a driver's licence because of failing visual acuity.

Conflict theory
The sociological perspective the neo-Marxists hold is that discord and conflict are generated within society over class struggles for the control of resources. Within this macro-level view of society's economic inequities and the control of power by an influential elite, is the perspective of structural dependency or political economy approach. This perspective emphasises that early life inequalities persist into later life and coupled with society's socially constructed perceptions of age and health, creates a position of dependency for older people and the problems they experience. The conflict perspective has been critical of the type and quality of services available and the need for better integration of older people into society.   These macro-level approaches to ageing are unable

to describe the experience of ageing at an individual level. An interpretive

perspective provides information on ageing from the individual's point of

view.

Interpretist theory and ageing.

To understand ageing, within the social interpretive tradition, researchers

are required to view the world by interacting with the individuals

experiencing social life, social action and social processes. Meanings are

socially defined but the social actor defines the social world as well as

being defined by it (Victor 1994:34). The interpretive tradition within

anthropology is either by participant observation or in-depth interviewing to

gain insight into the social meanings of research participants.

Women and ageing

Some of the previously discussed theoretical perspectives on ageing are

more applicable to men and associated with power and status.

Emancipatory politics have re-defined a wider social role for women over

the last century, overcoming (for the most part) exploitative, unequal and

oppressive social relations (Giddens, 1991: 213). Generally the

adaptation to age is seemingly better for women than men; women remain

more active and involved with family friends and community (Roebuck

1983: 255) despite a lack of available material resources. Life patterns

have changed for women in the nineteenth and twentieth centuries.

Widowhood, and increasingly separation and divorce, leave many women

without male partners. Women are living to older ages and as a

consequence there are changes to the family composition in the twentieth

century. In contemporary society women have become even more important in inter-generational support systems than in pre-industrial or traditional societies. At the beginning of the twentieth century the life of a grandmother overlapped the life of a grandchild by about 12 years (Roebuck, 1983, p.256). The "grandmother revolution" as some writers have called it, continues this new trend into the present with grandmothers actively raising grandchildren or being a significant presence in the lives of her grandchildren. Demographic changes within the family include the gradual change of the number of living generations in families. Employed women are more likely than their male co-workers to provide care for elderly parents, taking annual leave, time-in-lieu, sick or domestic leave to attend to elder care (Employment Agreement, July 2006).

There are various perspectives on ageing which can have implications for the modern workforce. Older people and workforce participation is examined in the next chapter.

Chapter 3

OLDER PEOPLE AND WORKFORCE PARTICIPATION

In this section older people's workforce participation will be discussed using contemporary New Zealand data. This will be followed by examining the case for older worker retention, the meaning of work for older workers and a discussion on ageism in the workplace. In the New Zealand context (Davey 2006: 212) there is little information about what influences choices about labour force participation and retirement. Labour force participation is influenced by a number of factors including a legislative framework making age discrimination unlawful and the abolition of compulsory retirement at 65 years. The effects of divorce on women and the cost of care for children may be influential in older women's participation in the workforce. The ongoing financial support of young adult children may mean longer working lives for parents (Hillcoat-Nalletamby & Dharmalingam 2002:3)

.

Throughout the latter part of the twentieth century, few elderly New Zealanders participated in the workforce unless they were self-employed. Over half the older male population worked in the earlier part of the century but mandatory retirement at a given chronological age and government funded superannuation saw many withdrawing from the workforce. Consequently life for the

elderly became associated with state dependency and low incomes (Heenan 1992:51). The relinquishment of jobs meant more positions available to younger cohorts of work seekers in a constrained job market. Mid twentieth century discourses still persist into the twenty first century as a group of older workers are attempting to forge new identities in a post industrial society. As technology and machinery have improved there are fewer jobs that require strenuous physical activity in the workplace. As we are in better health and live longer than our predecessors there is the option of working longer or combining work with other lifestyle choices.

The definition of an older worker varies between international and New Zealand jurisdictions. For those countries with mandatory retirement policies an older worker is deemed as nearing retirement age. In the absence of an agreed definition, in the report on "Facing an Ageing Workforce: Information for Public Service HR Managers" (State Services Commission, 2004: 3) an older worker was defined as an employee 55 years and older. For the purposes of this Masters thesis, an older female worker is defined as over the age of 60 years.

The research participants for this thesis are in the vanguard of older women who continue participating in the paid workforce: they represent both an aging demographic and lead, what is anticipated to be, increasing participation in the workforce. The largest

workforce participation rate increase over the past 15 years has

occurred in the 60 - 64 years age band.

The growth in the workforce is:

> [n]ot simply due to the baby boom population bulge reaching higher age groups - strong increases have also occurred in the proportion of older peopled engaged in the labour market. Different attitudes towards paid work and careers among the baby boom generation (particularly women) may also be a factor (Dept. Labour 2007:3,4).

Other reasons behind this growth in workforce participation include:

> raising the age of eligibility for New Zealand superannuation from 60 – 65; reduction in surcharge on extra income earned in 1997 (for the 65 plus age group only); the Human Rights Act 1993 which has made age-based discrimination illegal; better health, and the recognition among older people (especially aging baby boomers) of the benefits around keeping active, technological change reducing the manual intensity of some work and the on-going skill shortages increasing older workers bargaining power (Dept. Labour 2007:4).

Older workers are assumed to prefer part-time work rather than full-

time employment, however, this was not reflected in Statistics New

Zealand Household Labour Survey 2007:

> [t]he employment growth has been largely in full-time work (over 30 hours per week). The proportion of older persons working part-time has actually decreased slightly from 22% in 1991 to 19% in 2005. While there has been steady growth in females working part-time, the growth in female full-time work has almost trebled over this period. By 2005 67% of older females were working full-time, up from 60% in 1991. The proportion of older males working full-time has increased slightly (cited in Dept. Labour 2007:12).

Crossnan (2006:2) commented on the social transformations

women had made earlier in their lives and how the second half of

their lives is being rethought: "the notion of retirement which

permanently divides work from leisure, is simply no longer

universally practised". Women, in particular, seek flexibility in paid employment, including part time work, additional leave (paid and unpaid), having more input into rostered shifts and the hours worked.

While female workforce participation has grown overall the New Zealand Health Workforce Statistics (New Zealand Health Information Service, 2006) show diminishing numbers of nurses and midwives remaining in the workforce from the age of 50. This decline in an experienced nursing workforce is occurring at a time when the Ministry of Health (2004:2) is concerned with the growing health requirements of an ageing population. To meet these projected needs the Ministry has identified an increased need for psycho-geriatricians, geriatricians, nurse specialists and geriatric training for all health professionals. An increasing demand for surgery, laboratory services and care for the chronically ill are also projected.

The case for older workers

Against a background of increasing numbers of "baby boomers" eligible for retirement and the potential loss of institutional memory and experience, this section will discuss the reasons for retaining older workers in the paid workforce. The Hudson Report warns

> [f]or many organisations this will mean a chronic shortage of talent in key areas, which points to the need to extend the tenure of older workers in a way that meets their lifestyle requirements while also retaining their skills and services (2004:3).

The employers identified in the Hudson Report as the most aware of the impact of an ageing workforce with looming retirement and insufficient numbers of adequately skilled younger people for replacement are largely government departments.

McGregor (2006) in the Introductory Paper for the Employment of Older Workers Summit, commented on New Zealanders effectively retiring at 64 and the participation rates in the labour force starting to decline from the age of 55. To have the same proportion of the population in employment in the future, more older people will need to be employed. Increasing older workers' workforce participation would assist in reducing labour shortages, provide for on-going economic growth and the increased tax revenue would support the costs of New Zealand superannuation. McGregor argued that the retention of mature workers in paid employment has social and economic benefits in the workplace. These benefits included the positive impact on social cohesion, intergenerational dynamics, knowledge transfer, workplace socialisation and a sense of identity and self esteem for the individual.

To meet the increased health services of an ageing population the current recruitment and retention of staff in the nursing workforce requires in-depth consideration. Acknowledging the "severe and looming" nursing shortage in the American context, the Robert White

Foundation (2006) argues that there is a high monetary cost in losing experienced staff, recruiting new staff and negative effects on patient outcomes in the absence of registered nurses. The White Paper produced by this foundation acknowledged that workers nearing retirement are

> [r]e-evaluating their retirement plans and their future lifestyles. Their changing views are the result of several converging factors. One important factor is the change in stereotypical image of retiree, from a feeble and reticent old person to a more useful and active senior. The baby boomers are more adventurous, healthier, more optimistic and better educated than their forebears. The boomers **expect** [emphasis in the original] to live longer. Improved health and technology advances make it possible to extend work life beyond 65. Boomers are reframing the discussion of technology needs from a focus on injury, diseases and disability to a focus on extending independence, productivity and quality of life (p 4).

The meaning of work for older workers

Work is a part of who we are and work provides us with a sense of social worth. Victor argues (2005: 321) that paid work provides a wage, regulation of time, social status and social relationships for individual workers. These are socially constructed meanings, specific to our contemporary culture and may not be experienced by all members of society. Over a period of time these meanings may well change. The significance of paid employment and its meaning for older members of society, I would suggest, rests on the adequacy or indeed the continuance of state superannuation at age 65. The increase in divorce rates and "increasing numbers of un-partnered people in mid-life mean many people may have to work longer to provide for their retirement" (Statistics NZ cited in Boston

& Davey 2006: 199). Work regulates other activities in people's lives, including leisure time, family commitments and social life. The structure of the day is regulated by start and completion times of work and holidays are frequently defined by work commitments. Professional workers often continue workforce participation because of the social standing their occupations have in our society and a commitment to pass on their knowledge to a younger professional cohort.

. Older workers may not have social networks developed outside of the workplace; retiring from work means the loss of these social relationships. Dendinger et al (2005: 21) suggest that personal reasons, including self-esteem, self efficacy, personal satisfaction and sense of pride give meaning to work. These authors also propose generative reasons for continuing workforce participation and cite Mor-Barak's (1995) adoption of Erikson's developmental theory in which "in the later stages of life, humans have an inherent need to teach and pass their knowledge

Ageism in the workplace

Workforce participation for older workers does, however, present challenges, especially in the stereotypical social thinking leading to ageism. Although legislation in the form of the Human Rights Act ended mandatory workplace retirement, covert socially constructed ageist notions still exist. Herzfeld (2002: 294) asserts that the media has a role in the construction of contemporary images,

identities and power relations as well as the most localised of cultural productions. Taking the notion of cultural production I explored how stereotypical perceptions were used in job advertisements. Phrases such as "energy and flexibility" or "a high degree of fitness" discourage older workers from applying for positions (Hart 2007). A reading of the 12 page job vacancy section of the New Zealand Herald, 15 December 2007, was scanned for the use of ageist language. Overall an impression was gained that employers were requiring "experience", "proven track record", "ability to work in a team environment" or to be a "team player". From a selection of individual advertisements the following language was noted: a printing company advertising for "an experienced professional"; a plastics company wanting "a friendly motivated person", "a manager experienced in change management, leading teams and building relationships" required for a social service agency; and an "experienced" trade certificated builder for a property repair and restoration company. The language used in these advertisements would suggest the employer would be interested in interviewing a mature, skilful worker. Conversely the language used in the following advertisements would discourage applications from older workers. These included: "dynamic textile lover with a high level of personal presentation"; "professionalism, team spirit, energy and passion" for a clothing retail manager; "high level of enthusiasm and self motivation wanted by a progressive electrical company"; "a young and dynamic engineering company offering employment to a civil

designer"; and a fashion apparel company requiring an e-marketing specialist (the advertisement featured young women wearing fashionable shoes and clothes). Where a job description seems likely for an older person, and an application made for the position, they are often eliminated in the job selection process by recruitment agencies when age becomes apparent (Hart 2007: E1).

McGregor and Gray (2002) comment on the variety of discriminatory stereotypes that label older workers in particular. In their research for the Employment of the Older Worker Study, in which two large surveys were undertaken of older workers (all union members) and New Zealand employers, a set of common questions were asked to test the respondents' views of older workers and to explore stereotypes. The study also included questions specific to workers and employers. Both surveys had a healthy response rate by international standards, with a response rate of 55% from the worker's survey, and a response rate of 49% from the employer's survey. The average age of those replying to the workers' survey was 59 years. The survey results of the older workers showed that the highest five responses related to reliability, commitment to the job, productivity and setting an example to others. Forty nine percent of these workers believed that older workers resisted change; 48% believed that older workers had more problems with technology. The highest responses from employers related to reliability, loyalty, job commitment, willingness to stay longer in a job and resistance to change. Both surveys, of the older workers and

employers, included questions asking "respondents to identify

certain characteristics with particular age groups from 15 years to

75 years". A majority of both employers and older workers held

negative stereotype thinking about adaptability factors such as

computer technology and resistance to change and positive

stereotypes about dependability factors such as reliability, loyalty

and commitment.

> The general similarity of perceptions about older workers
> found in the two New Zealand surveys reported here has a
> number of implications. First, the "dependability" findings
> indicate that employers have a sense of worth about the
> reliability of older workers. Second, the findings confirm
> important policy implications in relation to workforce training.
> To maximise productivity it is clear that older workers need to
> remain comfortable with and equipped to cope with new
> technology in general and computer technology in particular.
> Both workers and employers acknowledge the stereotype of
> technophobic older people in the workplace and the
> challenge for policy making is to address attitudinal change
> and relevant training for older workers (McGregor & Gray
> 2002: 163).

Addressing attitudinal change and relevant training for older

workers becomes more pertinent as the pool of younger workers

reduces due to a low birth rate and immigration. The employment

of skilled older workers with good industry contacts and

experiences becomes a reality as the labour market becomes

tighter (Hart 2007:E1).

Although New Zealand has anti-age discrimination law in the

Human Rights Act, 1993 and banned compulsory retirement in

1999, successive governments have not committed to "providing

support to employers or look to a consciousness-raising campaign

about the contribution of older workers to combat ageism'

(McGregor 2005: 18). Despite the difficulties there are a group of

older workers who continue to enjoy their working lives. What work

means for a group of older nurses in this study will be discussed in

the next chapters.

Chapter 4

THE RESEARCH PROCESS

> As extensive and sustained female labour market
> participation is a fairly recent phenomenon, the likely pattern
> of older women's participation in the labour market remains
> the subject of speculation (Victor 2005: 235).

The objective of this study is to discover the meaning of ageing for ten registered New Zealand nurses over the age of 60 in contemporary society. Although the numbers are small this is consistent with qualitative methodology where in-depth interviews were conducted with a small group of respondents. The interviews, held in settings that suited the respondents; either in homes or work meeting rooms or office, explored the lived experiences and their meanings of these older nurses. Qualitative research is used where the study is exploratory. As the phenomenon of prolonged workforce participation is recent, little has been written about the topic. As the researcher I listened to the respondents express their lived experiences, situations and ideas to build an understanding of their socially constructed lives. The assumption in qualitative research is reality is in the minds of people and constructed through the interactions with others (Crotty 1998:142) Reality is subjectively known. The researcher searches for the meanings that human actors use to make sense of their world. Knowledge is gained not only through the senses but rather through the meanings and interpretations given by the researcher during the analysis of the data.

Social constructionism

From a social constructionism perspective knowledge gained through the interaction between people and their world is transmitted within a social context. In this study of older female nurses' experience of working I wanted to explore with the respondents the social production of their own identities as they aged. Through these conversations I wanted to discover how they actively constructed their social world; what explanatory concepts, models and schemes they used to make sense of their experiences and how possibly these may be modified in the light of new knowledge. It is only in recent history that older women have participated in the paid workforce. Historically women didn't have long lives and in more recent times where women are living longer, both paid and unpaid work has remained invisible.

Ageing as a phenomenon has been institutionally socially constructed as dependent on services provided by health, welfare and housing. As a consequence older people are considered an economic burden to society. New Zealand has a legislative framework making age-based discrimination unlawful but covertly ageing is socially constructed in terms of failing health and decrement. The widespread use of a descriptive metaphoric language in our culture gives meaning to how we construct ageing. This language is bounded by our own cultural assumptions and

viewpoints preventing us from seeing alternative constructions. For

example the metaphoric language to describe age is often linked to the

climatic seasons of the year. Autumn (the autumn of life metaphor) is full

of vulnerability with fading fragile leaves falling to the ground to decay in

the winter senescence. Time as a metaphor is variously expressed; sands

of time running through the hour-glass being indicative of life's ending with

a sense of unattained achievement. The biological clock metaphor relates

to the timing of growth and decline and the possibilities and limitations at a

cellular level. In a future history older people may well be socially

constructed as productive and contributing members of society. Gannon

(1999: 30) suggests alternative constructions with the observation that

cultural changes and technological advances have necessitated a

redefinition of "normal" timing. Marriage, parenthood and retirement no

longer occur at precise ages but have been accepted options of persons

within the expanding age range of working lives. I want the voices of the

respondents in this study to provide a rich array of interpretations and

perspectives of their long working lives. This will construct meaning

against a backdrop of shared understandings, practices and language.

Finding research respondents for this study

Participants for this study were obtained through a snowball process. I

wanted to interview ten registered nurses working in a variety of Waikato

health settings who were over the age of 60, working either full-time or

part-time. The research began with four participants known to me who

asked others of their interest in participating. I did have some

apprehensions on electing a 60 plus age group as they are only 7% of the

active nursing workforce and I had no idea how many of this age group would be working in the Waikato. By the time that the fourth interview was completed I had expressions of interest from more nurses than was required for this study.

Ethics and research in the social sciences

As in-depth interviewing has the potential to intrude into the lives of individuals research ethics requires careful consideration. To protect human participants in the social sciences the following core ethical principles were observed. This included doing no harm to the research respondents who had the opportunity to withdraw consent (Consent form Appendix three) or to retract comment from the transcript. Voluntary participation was sought from the participants and no payments or inducements were made. A written explanation in the form of an information sheet (Appendix two) was given to each participant a week prior to the interview. I was available to clarify and respond to questions prior to the interview. The ten registered nurses each chose a pseudonym to preserve anonymity. The written transcripts were returned to the respondents prior to analysis to check for errors and clarify comments. All but four of the respondents made changes to clarify meanings and remove redundant words. Transcribed interviews and audio-tapes were kept in a locked file in my study so that confidential information was secure and accessible only to myself and my university supervisor.

The respondents were interviewed in a range of settings; several in their homes on a Saturday morning and others in workplace meeting rooms or

offices. Biographical details were collected prior to proceeding with in-depth interviewing. I used an interview guide (Appendix four) to assist participants expand on themes considered important to them, to explain their views and what they considered critical factors in growing older and engaged in paid employment. The interview guide was not a prescriptive formula for in-depth interviewing; there was variation in questioning to engage the respondents on what was important for them. A list of suitable prompts accompanied the interview guide to assist in effective probing for further information. I carried out an evaluation after the first two interviews to confirm with my academic supervisor that there were concepts and themes that could be explored. Field notes recorded the settings and impressions not captured by audio-taping. Although I was of a similar age and experiential background as the study's respondents one doesn't usually engage with in-depth conversations with colleagues. This has meant some unexpected revelations from the respondents on their experiences of ageing.

Data analysis

The principal means of analysing qualitative data is through a process of analytic induction. As the data was collected from the in-depth interviews and following several readings of the transcriptions I identified ten themes These later became subsumed into five major themes with a cluster of sub-themes. In establishing these themes I chose manually to highlight transcript passages in coloured pen and included additional descriptive coding rather than use a computer programme. The major themes identified were: the changing nature of work, the meaning of work, work

and the ageing body, the social roles of women in an era of emancipatory

politics and the ethic of care in nursing. These themes are discussed in

the following chapter.

Chapter 5

FINDINGS

The data emerging from the in-depth interviews was analysed using an inductive approach. This process identified the main themes and sub themes. These are detailed in Table 3.

1 The changing nature of work Re-aligning and expanding the roles of nurses in the community Use of biomedical technology in community settings Specialisation of nursing roles
2 The meaning of work The socially constructed meaning of work and retirement How older nurses perceive themselves and the perceptions of their peers and patients/clients
3 Social roles of women in an era of emancipatory politics Thoughts on re-entering the workforce and paid employment Traditional roles of care-giving and workforce participation Intergenerational connectedness
4 Work and the ageing body Health and health maintenance Work/life/leisure balance
5 The caring ethic in nursing

Table 3: Themes and sub-themes emerging from the data.

I acknowledge that others looking at the rich data may have identified other themes and followed a different line of enquiry. Also my interpretations of the data may be different from the interpretations of others.

1 The changing nature of work

This theme identified the changes in nursing over the course of long working lives and how the role of nurses has expanded in community settings. The closely associated sub-themes are the use of biomedical technology and the specialisation of nursing roles. The ten registered nurses participating in this research had initially trained in nursing schools attached to larger hospitals throughout New Zealand. From the mid 1980's the training of nurses became the responsibility of polytechnics and hospital-based training was phased out. Within some of the nursing hierarchy, 40 – 45 years ago, there was active discouragement for newly married staff to continue in the workforce. To staff hospitals nurses had to be available for rostered duties over the 24 hour period. Staffing hospitals in that era was made easier with hospital-employed nursing students – that endless supply of low-paid, compliant willing workers. For married nurses with young children rostered duties were problematic unless on a part-time basis and then this was dependent on partner support. Nine of the research participants had nursing career breaks, ranging from 4 to 17 years to care for children or other family members. On their return to nursing part-time work was chosen, usually night duty or week-end duties, leaving children in the care of supportive partners. The research participants commented on the learning required on returning to the

nursing workforce. This included becoming familiar with metric

measurements and a totally new drug nomenclature as well as the more

general rapid changes in health care. The newer technologies and

medication regimes allowed earlier discharge from expensive hospital

beds. However, this required a competent workforce in the community to

manage the continuing requirements of patients dependent on biomedical

technologies. The expansion of the nursing workforce in the community

and the changing nursing role enabling the care of medically compromised

patients required organisational commitment to professional development

programmes.

Joan described District Nursing's move towards the management of more

complex bio-medically dependent patients in the community leaving the

once familiar nursing duties of bathing and ambulating patients to a non-

regulated workforce. A professional development programme and on-site

training was initiated in supporting the technical aspects in the expanded

community nursing role. Joan has been employed for 17 years as a

District Nurse and reflects on these changes:

> (p.1) Those were the days when you used to bath or shower
> patients – and that has moved onto employing staff to do that
> specifically and has freed up District Nurses to develop their skills
> and expertise in other areas. This has given more time to do those
> things.

Joan explains the development of new skills required of the changed

nursing role:

> (p.2) Staff are required to have certification in a lot of areas – for
> example intravenous therapy is now a big part in the community
> and therefore you have been required to gain a certificate within a
> basic or generic area which means assessing intravenous therapy
> just through a peripheral leur. Our portacath [a semi permanent

device placed under the skin to access veins for chemotherapy] is a separate issue again. Earlier on 2 or 3 staff would be certificated and able to do this work but now pretty well everybody is, which is a **huge** learning curve for a lot of staff and meant a lot of encouragement and practice to become competent on their own and confident. We get a lot of patients with cellulitis and they require intravenous antibiotics for 2 – 3 days. However that is gradually moving further now that some of the GPs are doing this work. The other thing is male catheterisation – we now have to do a workbook and have an assessor come out to supervise doing one catheterisation. Whereas before you used to catheterise people – sometimes we might send the males to their GPs – but sometimes we would have done it ourselves – now we have to have a certificate for that.

An expanding role for nurses was also experienced in other sectors of the workforce where health dollars are contested and awarded on a contractual basis. This has allowed a small community's Trust Hospital to better meet the needs of its surrounding community, with unwell or frail people able to stay within familiar surroundings and where friends and family have easy visiting access. Ros provides an insight into her experience of working in a community trust hospital where the nursing role has expanded:

> (p.2) Well, we have got a 25 bed hospital and we've got long-term care, palliative care and primary health care.. When I first started , there was a long term facility and we had 10 beds. And then we started to get a few respite care ones and when the Trust took over, we got the contracts for all these things like palliative care and the continuation of respite and the primary care ones. And of course the big difference in nursing, I mean when it was long term care it was the basics – they used to sit in old geriatric chairs with a tray in front of them and there was no life really for them at all. The hospital has all been extended, they've got this huge lounge and they've got a good quality of life. But we had to learn because what I did when it was long term, we had to teach ourselves. I got the District Nurse to come and show me how to do a Grazeby pump when they first came out, I got a doctor to show me how to do male in-dwelling catheters. And in those days we didn't really need certification to say you could do these sort of things…you just got on and did them.

Other changes in the nature of work were dependent on the ideological assumptions permeating and influencing the health sector. For example the Health Department at one stage employed Public Health Nurses as occupational health nurses. These positions were discontinued and became the responsibility of private sector industry. Kath speaks of her journey from an occupational health nurse within the Health Department to that of a Public Health Nurse working in school communities.

> (p. 6) the Public Health Nursing I did was attached to one Health Department clinic which was for workplace accidents, and that was a long time ago, in Penrose. I don't know that it exists any more, so, even at that time, industry was starting to employ their own occupational health nurses. That whole field grew with special training, and now there is certification and all sorts of things around that area. (p.7) So that was a "y" in the road, and I was a rarity as an occupational heath nurse and working for the government in those very young days. But I carry what I have learned with me forward and then when I got the job as a Public Health Nurse of course I already had all that prior knowledge around working with people, and for organisations as a entity in its own, as a community in its own and so I had, I was able to look at, transfer that and look at the same sort of things as working with the community and working with people within the community and their children and their families. Yes, what changed in fact was a decision locally by the Health Department that they would exit out of occupational health.

The structural ageing of the population, longevity and improvements in health care have meant an older cohort entering rest homes. When older people finally make a decision to enter a rest home they are more dependent on nursing care which is changing the nature of work for nurses employed in this sector. Pat explains:

> (p.2) Well, probably the people that have come in are perhaps different than they used to be. They're probably, on the whole, more dependent and they require more care, but I think the way they are looked after is actually a lot better. They have diversional

therapy and they make sure that other people are involved in doing things and the idea is that they can maintain their independence. (p.13) One thing we do find with the population ageing is that the majority of our residents would be hitting over 90. We've got one at 102 years, one of 100. One old lady is going on for 103- she's walking, lives by herself and her daughter keeps an eye on her [the daughter was going on holiday for 2 weeks and used the rest home for respite care]. But the lady we've got who is 102 is still up walking and she walks everywhere; she's a bit deaf but she manages really well and she has lived at home, we have only had her in the rest home for probably 2 years. You are nowhere near old at 70 years. You are not old until you hit 90!

Nursing within communities doesn't happen in a vacuum; cognisance of changes taking place within the wider community affects nursing practice and safety. Dot reflects on these changes:

(p.5).I think that even though they often say that older people don't accept changes – I think we move with the times, because it is a job [District Nursing] that lends itself to move with the times too. Being older I think I probably accept the drug problems out there better. I don't feel any safer, but I think that it has probably made me understand, or to be able to, talk to friends better that have got children with problems. Just for what we see out in the community, because everyone doesn't live like we do. We think they should but they don't and you would know that.

Use of biomedical technology in community settings

One of the rapidly changing areas in the health sector is the use of bio-medical technology in treatment modalities. Once the preserve of hospital wards and acute care, greater numbers of patients are dependent on bio-medical equipment in their homes. As stated earlier this has required considerable time in up-grading skills. Joan provides a descriptive account of the technological apparatus used in her District Nursing role:

(p.2) The person might have abdominal surgery and following surgery a few days later, especially if they are unwell or have a huge medical condition, the wound will break down or split open causing a dehiscing. There will be a lot of exudate coming out and can't be contained with gamgee for example, or some of the other

dressing products. The surgeon might say we will put in a vac dressing on this. The vac dressing – all sterile stuff- has a piece of black foam just like the foam in the chair, and you cut to fit the wound. There is a wee hole there – and in the hole you put in a pipe [for drainage}. The tubing goes into a bottle which is controlled by a machine and you put Tegaderm all over the vac dressing. And you turn on the machine and it goes "shpp". So it's like the meat in the supermarket it is vacuum-packed – that is what happens to the wound the dressing gets all sucked in and sealed tightly and the patient is attached to this machine and so every few minutes the machine will turn itself off because the pressure will have been reached. And then the machine will turn on when the rate drops off – so that the patient is not forever vacuum packed. It's done on airflow – you know like an air mattress – the patient is on a mattress and the different cells are pumped up – and the air moves from one to another to prevent pressure areas. Well, the vacuum dressing is similar – it's autonomic – comes on and off but the pressure is maintained.

The management of pain is an important aspect in softening the affects of disease processes. This aspect of palliative care for home-based patients is a component of District Nurses'work. Dot discusses pain management and the accompanying technology:

> (p.2)…sub pumps are always managed by us, but then you see now instead of the elixir we've got the tablets that you can take easily which means that liquids don't have to be measured out like the elixir had to be measured out. That type of thing has changed a lot I think. Also probably in the last 3 years we have de-accessed ports. Portacaths with chemotherapy, which we never used to do; they used to have to go back to oncology and get that done. If portacaths are not in use for treatment and not yet removed we access these monthly and flush them with heparin saline to maintain potency. Advanced IV certification is required for this.

Specialisation of nursing roles

Alongside re-training, on-site training and self-directed learning packages and an organisation's commitment to on-going training and continuing education for staff there has developed a pool of expertise within nursing. These specialised roles have developed in District Nursing so that there is

expert assistance in each team for the management of complex surgical

and medical conditions. Joan discusses specialisation in District Nursing:

> (p.4) District Nurses often choose an area they would like to specialise or become an expert in. You get some nurses who will be interested in ostomy and so they will trot off to training days pertaining to that. And they will be advisors for us in the community in that particular field – like when a patient comes home with a new colostomy and how you care for that and how to look after that stoma. Then you have other nurses who are interested in continence – and so different pads and things you can use and help with catheterisation. So these are different areas that District Nurses have moved into. Some of us are assessors for Disability Support Link.

Bette explains some of her specialised roles within District nursing

> (p.2) I'm a Doppler assessor, which I have to train for and I have to re-certificate every year and that enables me to diagnose and prescribe treatment. It's a big assessment that we do, because you are looking at the leg for ulcers and the medical history. A leg ulcer is anything that's had a skin break of longer than 6 weeks. So here, if we, actually get the referrals early enough, and the nurses know their jobs, and they look at an ulcer the sooner they get them referred for a Doppler assessment the better for healing. When the Doppler is done we need to put the leg into compression bandaging if it is a venous problem. It's so much better because we can get ulcers healed really quickly. Expensive to put a patient's leg in compression bandaging but in the longer run, cheaper.

Wound management resource nurse is another of Bette's specialised roles

and a large part of District Nursing work:

> (p.6) Nettie and I are both wound resource nurses here and we get out to do a lot of things, do in-services [staff education] and I went away 2 years ago and did an advanced wound care course. I am going to Aussie at the end of next month to learn to become a VAC [vacuum assisted closure of the wound] educator.

Parts of the health sector employ non-regulated employees, that is, staff

with no formalised education and registration with a nationally legislated

and recognised body. Non-regulated staff, care assistants or health

assistants, are employed in the care of the elderly. Education and training

for this sector of workers is available through various training

establishments. Kerry, a participant in this study and a university graduate

is concerned about the care of the elderly from the non-regulated

workforce and uses her skills in teaching health assistants in a community

trust hospital

> (p.10) [aged care education] is run by the Health Education Trust,
> down in Christchurch, It came out, probably 10 years ago before
> NZQA qualifications. They had to add a few things that had been
> missed. So they do topics and then they've got some units that are
> catch-up. But it is a programme that the staff can do, the Care
> Assistants, and Health Assistants can do. And we can apply it to
> our situation. It's got a curriculum and work book and we can say
> we're doing a case study looking at the behaviour of dementia and
> apply the learning.

Margaret , a registered nurse and university graduate, has a specialist role

in nursing research and has used these skills in a nation-wide leg ulcer

study:

> (p.3,4) I was the [research nurse] for this District Health Board in a
> multi-centre randomised trial. We were the largest leg ulcer study
> in the world and the results haven't been published yet. I did some
> training for that, we did 2 days training up in Auckland. I had to do
> a lot of computer enhancement learning as well as take
> photographs and put them through the computer. …but the people
> seeing the photos, the photos I took then and the photos that I took
> at 3 months, had to go through the computer. The people reading
> those photos didn't know which ones, they were blind. They
> wouldn't know which ones had honey treatment or not. The other
> thing that will come out of it which is absolutely mind-boggling is
> that everything was costed. The honey dressings were costed.
> There were 4 study areas, one is very keen on silver dressings so
> the cost of that and the healing rates of as well as the honey – so
> there will be a total comparative on costings. And the quality of life
> surveys that went with that as well. This was a big job, you had to
> do quality of life surveys as well initially and at 3 months, again at 6
> months.

2 The meaning of work

This theme, the meaning of work, is supported by sub themes: the socially

constructed meaning of work and retirement and how older nurses

perceive themselves and the perceptions of their peers and patients/clients. When the majority of their colleagues have deserted the nursing workforce one would question whether nursing offered meaningful quality work after the age of 60. The consensus from the research participants was overwhelmingly positive. The responses were related to autonomy, enjoyment, being able to contribute, intellectual stimulation, generativity, and diversity. The sub themes identified were the socially constructed notions on retirement, and perceptions of the nurses themselves, their peers and patients/clients on older nurses participating in the workforce.

Pat describes the meaning of work for her in terms of social contacts and an income:

> (p.7) I would find it very hard if I didn't work. What on earth I was going to do? For a start, its company. And it gets you out of the house and financial things, it's good that you have a bit of spare money. The company is probably a lot of it.. It gives you something to get up for in the morning. Even if its only the few days a week, you really look forward to it. A lot of it is social interaction, and its sort of nice that you **can** do the job.

Margaret describes the meaning of work and the intellectual stimulation that this provides:

> (p.4) Well I know when I was out of the workforce I missed it, I really missed it. And I felt the brain turned into a cabbage. So there was the intellectual, the nursing, nursing is wonderful because it enables you to do things for people. So you've got the altruistic feeling, the buzz you get from that, and then its got the intellectual stimulation because there is so much to learn. The physical part of doing it that actually gives the body a workout, your brain gets a workout and you are giving you all, everything gets a workout.

Judy comments on the interest, variety and the on-going changes within

medicine that supports people in the last stages of their lives:

> (p.10) Well, I enjoy what I am doing. I don't think at this stage I am
> ready to give up. I like being with people. It's one where you get
> plenty of exercise and meeting different people in different
> environments like the hospital, home and rest homes if necessary.
> So it's a variety. The other thing that is probably a motivator is,
> probably palliative care, like any other area of medicine is
> constantly changing. People are not going to get well. When we
> first meet them they may have symptoms with a lot of pain and it is
> very satisfying to actually see them change and those symptoms
> relieved so they can actually enjoy part of their life, or enjoy as
> much as they can, with the time they have left.

Dot likes the variety and autonomy in District Nursing:

> (p.6) I just love what I do. I enjoy the different people and
> everyone's different, everyone's their own self, they don't put on
> airs and graces in the home. I find it rewarding to work
> autonomously. And another thing that keeps me here is that I have
> got super with the DHB – that's another thing that you have to
> actually got to think of as you get older – savings for when you
> retire.

Missy finds that District Nursing offers her the opportunity to assist unwell

patients to become as independent as possible:

> (p.8) Because I still feel I contribute quite a bit and enjoy my job
> caring for sick people, and I don't mean that as sick people,
> because a lot of them aren't sick they have just got a problem like
> an ulcer or multiple sclerosis. I enjoy the education side of it in our
> job as well in keeping people independent and healthy. I enjoy that,
> I find that stimulating and I enjoy coming to work.

Joan likes to manage her own working day and has an interest in teaching

nursing students:

> (p.13) I like being involved in other people's lives and like to be to
> assist, and I like to make a difference and help their wellbeing. For
> example, with wound care you talk about diet, exercise, rest – you
> look after them holistically. I think District nursing one of the lovely

jobs in that it is 8 – 4:30pm. You don't do shift work. You have a list of people to see so you make priorities for your own day – and you have a fair bit of autonomy within that, provided that you get your work completed. I also enjoy students coming out with us on a fairly regular basis and I love to be involved teaching them. And when you drive around from patient to patient you do a lot of talking in the car. They are very good for you as an older nurse because they keep you young. They say – "tell me what do you see the difference between this and this" or "how would you do this"? And they always make you constantly think, they are very tiring students as they are always in your face. But they keep you on your mark as you can't have sloppy practice because they are watching and you are teaching them. Then they have to do it [nursing technique] and you supervise them. So they are very good for the older nurses – brilliant!

Kerry expresses her satisfaction with teaching health assistants:

(p.13) I would like to think I can work until at least 65. I think satisfaction – knowing that they're getting good care [elderly patients]. And teaching the ACE [Aged care Education] programme to non-registered staff.

Bette defines the meaning of work in terms of variety, diversity and learning:

(p.18) I think because nursing is something that you give of yourself and you get a lot back from you patients; you are mixing with all types of people, all ages and you learn from one another. It [work] keeps you young, it keeps you going. You see things in a different light at times. I just don't think you get the diversity we get as a nurse, particularly in District Nursing, out and about in the community.

Ros considers that work has always been a part of her life and this is what

keeps her interest:

(p.14) Well, I actually think it keeps you younger if you keep on working too, because it gives you a reason to get up and face the day. Because I have worked so long it has become part of my life. And once you have worked for that long it becomes very hard to give up.

Kath describes nursing as part of her being and the wider role of Public

Health Nursing within the tradition of serving those in more unfortunate

situations:

> (p.20) [Nursing] was part of who I was. It was never a job, it was
> part of who I am - that caring. It's really hard to put into words. I
> belonged to being a nurse – or however you want to put it – and the
> other thing was that I was the only person in our family that actually
> studied and became anything, out of five siblings. I was really
> proud of that, not that it is derogatory to my siblings. They also
> used to talk to me as the nurse, ask me questions and things as the
> "nurse'. I was really quite proud to have achieved something that
> my parents didn't achieve, except that my mother was a politician,
> almost, but she was involved in politics for many years. She was a
> staunch member of one of the political parties, major political
> parties, was one of the first rural women to stand for parliament. So
> I suppose that was part of her that was already in me. And yes that
> striving to do things and be there and look at the big picture and,
> yes, that's probably why I am a community person because her
> interest was in improving things for her community and for her
> nation. Well, you talk to any Public Health Nurse I have worked
> with in New Zealand – a New Zealand born Public Health Nurse I
> am talking about here, they all have that same sort of ethos. Carry
> the banner for our people and our country and people's rights to
> have things that are necessary for life.

Comments on retirement

Comments on retirement were elicited by asking what advice the

respondents would give to a 50 year old nursing colleague considering

retirement. In the 55 -59 age band there is a dramatic decrease in nurses

actively participating in the workforce. Now that mandatory retirement at a

given chronological age has been abolished the older nurses participating

in this research contemplate the complexities of retiring from the nursing

workforce. Most of the responses were framed in a personal context –

that is what each research participant personally thought about retirement.

Missy provides some thoughts on retirement at age 50, with the belief that

women are still very active at this age and what would substitute if

retirement from nursing is considered:

> (p.15) I think it is too early to retire, it depends if she loved the job, it depends why she is retiring. Why has she come to this decision in her life at this stage? To me life is out there to be lived and if you are young you can contribute and I still feel I am young at 61. I think this is how things have evolved and changed. Could be that she had reached that decision in her life at 50 – it could be because they had a property and they were getting more involved, she was having more hands-on with a property such as market gardening of farming.

Kath provides ideas on early retirement and some cautionary advice on

keeping mentally active:

> (p.14) I looked at this question with great interest, and I thought depending on the nursing colleague, someone that's been involved in their job for a long period of time I would say take a year or two out, go and do things you want to do and then look at coming back. Have a gap year, because it renews your interest and whether you spend that time travelling or you just have time at home and do all those other things, because as nurses, I would think that you need to have your brains occupied. We are people, especially in community health, we have got to think of lots of different ways of doing things for people, your brain doesn't enjoy not being occupied, and you don't feel challenged. So it's about having that time out and then coming back and getting back into it, keeping yourself interested and active, keeping up with the play of new things that are happening. The occasional grumbles about, gosh, we have done this before and it didn't work. It is that circle of nursing life that happens. There actually isn't a barrier to continuing work, when you are keen, interested, monitor yourself, look after your health. OK you might decide that if you are not going to work five days a week you might decide you want to work three and if that works with your employer you are a valuable asset.

Ros provides examples from her own experience on the notion of early

retirement:

> (p.13) I would say "no" to retirement because I have learnt more in the last ten years probably than what I ever learnt before, because our Principal Nurse keeps us all up to date and she makes sure we

are all aware of everything as well. I mean, 10 years ago before the Trust took over, we would never have done IV antibiotics or anything like that…it certainly is a lot more interesting….we are learning all the time. I'm not looking forward to retirement at all. And once you have worked for that long, it's going to be very, very hard to give up. It would have to be a gradual reduction [in work time] and if I did leave I would have to give 6 months notice….to find time to find someone else.

Kerry is reflective on nursing choices at age 50 based on her own

unrealised ambitions:

> (p.15,16)I think if there is something you wanted to do, like I wished at 50 I went into palliative care, I'd say really think about what area of nursing you would like to continue in and sort of focus on that. Mind you in a small community, you'd be limited like we are here whether you would get a job. I'd say just look at what you are happy with, what area of nursing you'd be happy with and get the education. I will always regret, I wished I would have done palliative care or oncology nursing.

Margaret ponders the retirement question at age 50 and the choices

available to nurses at this age:

> (p.18) How important is nursing to them? Have they got other things they want to do, you've only got one life. If you leave, don't close the door completely, because you might decide to come back because good nurses are wanted. We have a lot to offer, you're not past it at 50. It's not too late to get another speciality in nursing if you want to. There are so many opportunities out there now than there were. I went into a bit of a shock for a while and it's taken me a couple of months to sort of get over it [65th birthday]. I'd like to stay and get my four weeks long service leave because I reckon I've done 28 years any way. If I had to, if my husband was sick, I would leave smartly. But family-wise my daughter will want to go back to work and will probably want me to look after the kids, but we'll see. I would like to do another two or three years if I can. I don't intend to be here when I am 70.

Pat considers the physical, social and financial aspects of retiring at 50:

> (p.12) Well I would say that they would think very carefully before they did it because if they retire at 50 and then really find they want to go back, they would find it very hard if you haven't done [nursing]

on a continuous basis. Because things change and it's hard to catch up and probably your body would find it harder too. Socially what are you going to do and financially. Well if you don't need the money that is ok, but it is a long time to live without an income if you retire at 50.

Judy lives by herself which influences her thoughts on retirement at 50:

(p.9,10) I would probably want to know what they were planning to do –what family, what support they've got, financial and all that sort of thing because I know that I can't retire because I won't get paid anything. You have to be responsible for your own home and yourself- yes, everything, you just can't give up work. And I think the other thing is having a major project that you can get yourself into and retain your interest.

Dot's advice to a colleague considering retirement is framed around superannuation and continuous learning in nursing. However Dot does appreciate that there are stresses in the job:

(p.8) I would tell them to think of their super, and hang in there because it actually is really, really good. I am sure that no other job would give anybody such job satisfaction. You are always learning something, so it is keeping your brain active too. But today with staff shortages there is a lot of "burn-out" and a person must do what is best for them and what they feel comfortable with.

The third sub theme identified within the major theme the meaning of work related to how the research participants, colleagues and clients/patients socially constructed the nursing roles of older nurses. One respondent reflected on the general ageing of the nursing workforce and how fit and energetic, at 60, she felt. and believed she didn't stand out as "old" (many people would of thought her age nearer to 40). There was a perception that as many patients cared for in the community are older, they shared, trusted and related their concerns to a nurse who had life experience. The nurse in return appreciates the needs of elderly patients. The experience

of older nurses was frequently sought by younger staff wanting an opinion

on an issue or problem. Dot reflects on the daily sharing that her District

nursing patients make with her and her mentoring type role with younger

staff members:

> (p.5) [patients] probably share more with an older person – trust, I
> think. Maybe they just feel that you are a bit on the same level. –
> because they tell us funny little things in a way, and I don't think
> they would say to a younger person. Well, I don't know that a
> younger person is even interested. Because I think as you get
> older you actually appreciate older people more, because then you
> have got some of life's experiences. I think at work the young ones
> appreciate an older person [on the staff] and often tend to ask my
> opinion on some problem. I am often used as a "sounding board",
> sometimes they come in and share things, and just check that
> they've done things the right way or might ask your opinion before
> they go to somebody [patient] that they're not so sure. I think that
> even though they often say that the older people don't accept
> changes, I think we move with the times, because it is a job that
> lends itself to move with the times.

Margaret was concerned about the professional dress standards and

social perceptions of a nurse. As a farmer's wife Margaret thought that

nursing dress standards should not include an oilskin coat:

> (p.10) I wouldn't go District Nursing in a swan-dri. An oilskin cape
> was, for a while was a part of uniform issue. I looked at that and it
> was actually a beautiful coat and I thought, well, I can't go and visit
> people in an oilskin and gumboots even on a foul day because I'll
> look like I've just come off the farm. And you wouldn't have much
> confidence – so for me, it's about what people think too. You've got
> to be confident in that you look professional. To me, you don't look
> professional in an oilskin.

Kath reflects on her experienced maturity and what this offers in her role

as a Public health Nurse:

> (p.9) I would say that my peers see me as an experienced and
> mature person, with a lot of knowledge in the area of Public Health

and my previous experience prior to this job. When we employed three new beginning Public Health Nurses they would come a lot and ask me about various scenarios, how would I do this, on a very regular basis, until they got themselves up on their feet. So not as a preceptor but as a working colleague, I was there for encouragement. And have you got any information about this one, what do I do, and the situation. So, yes I was regarded as a mature and knowledgeable person and someone who had respect of members of the staff. Also in my job a part of my work I have got two schools that have registered nurses employed by these schools and I've developed relationships with them, and they respect me in the fact that I support them in their role and encourage them with whatever processes they might be doing within the schools and really value that, because they don't get peer support other than from their school nurses group. So having someone outside that group who is also community focused is a real benefit to them, and who understands schools as well.

As an older nurse working with families, Kath makes this response :

(p.10) Within the area I work in, which is a low socio-economic area, mainly, I'm well regarded, I think, in that I have no difficulty entering people's homes . I have no difficulty sitting and talking with people because I think I have a very easy manner and I'm not dictatorial and also a lot of the Maori families I have established links through areas that I have lived in, where I have been brought up. So it creates family links because I might know somebody that is part of their whanau. That creates rapport and they feel relaxed with me.

3 Social roles of women in an era of emancipatory politics

The social roles of women in an era of emancipation was the third theme identified from the data. The sub-themes identified in this section are re-entering the workforce and paid employment with young children; the traditional roles of care-giving and workforce participation and intergenerational connectedness. Continued participation in the nursing workforce after marriage was determined by nursing hierarchy attitudes, as explained earlier. This predicament is discussed by Margaret:

(p.6,7) [The hospital] definitely discouraged [working] when you got engaged. The sub Matron said "that's disgusting, why did you want to go and do that for?' I was currently an acting Sister, I wasn't even a Ward Sister. So that was as far as your career went in the

hospital. All the people in authority were unmarried and childless. Yes, you left when you got married. And I got married and was offered a job as District Nurse starting off at Ngaruawahia. You had to find your own car seven days a week. We actually didn't have a car, he only had a Landrover that sometimes had brakes. So, I didn't work; I said "No". Yeah, 17 years because I lived in the country I never thought I would be able to come back. It was actually because my mother-in-law and father-in-law were both ill at the same time and I had to go out every day and help look after them and travel into hospital day after day. I thought if I can do that I can probably go back to work if I am out all day. So yes, that was the catalyst, really.

The return to the nursing workforce was very much part time for eight of

the research participants and had to be fitted around partner's work and

child care. Ros describes her return to nursing, balancing her nursing job

with her partner's availability for child minding:

> (p.5) I didn't start work again, until after I had the children and W. was six and J.was four and I started off on night shift and I did three nights a week. So, I've never had to leave the children with anyone else. And when they went to College I went to afternoon shifts and then morning shifts. It's actually been very good.

This experience was a familiar one for nurses wanting to return to work.

Kerry discusses her return to the nursing workforce:

> (p.,3) I worked at night and an afternoon a week when the kids were young and of course it was just long term care then (local hospital) that's all it was. It was a Friday night and a Saturday afternoon I worked at [church owned rest home] and was there about 10, 11 years. [The career break for children] it wasn't all that long, probably, let's see about four years.

Returning to the workforce was not without some stereotypical sexist

thinking, as Joan explains:

> (p.8,9) I had a 14 year gap from when I married, had kids and went back to work. I had to have acceptable childcare - family responsibilities come first. When I went back to work I did two nights a week at the hospital and slept during the day. When the children come home from school I got up. I did that for many years until I came District Nursing. They [children] were older then, at high school by then. So it didn't really affect me having little kids - I didn't work when they were little. I worked the job around the

family. I wanted to get back into nursing and night duty seemed to be the best way. I have to say that it caused <u>huge</u> havoc in our home - my husband was most displeased. And he said that - in fact - he is not like that now, but in those days he saw his role as being the breadwinner as men did in those days. I am over 60 and I think that generation provided for their wives. They didn't call them partners - they called them wives. And they provided for them big time. I badly wanted to go back nursing. And he said if you wanted to be a nurse you should never have got married. You should have stayed nursing. To which I think is a sexist thing - however I have got over that now

There were various motivations in returning to the nursing workforce. Pat

discusses her expectations on continued workforce participation as a

young woman and the catalyst for re-entering paid employment:

(p4) [As a young woman] actually I think when I got married I thought I would probably finish for the rest of my life to be honest. We lived on a farm, but then suddenly I got this kind of thing that I really wanted to go back. I know, it was because I always liked horses (Pat was a horse trainer) and my husband at the time had a dairy farm and he said, well, one horse eats as much as 12 cows or something so virtually if you want a horse, well you pay for it. So I said all right, I'll get a job. So, I went in [to the local hospital] and I could start the next day. So that's that really – I didn't think I was going to finish back nursing but I did. And I'm still there.

A large family didn't prevent participation in part-time work. Missy explains

how she managed a large family and paid employment:

(p.3) Twenty years next year I came into district nursing and I started in Otorohanga for two years. I started there as a 'casual'. I had a two year old little boy, and just prior to that had done Plunket training and had been a Plunket Nurse in Te Kuiti on a job share basis with another girl. Then she got pregnant and left and they wanted me to take the area over full time doing three days a week. I was a five day week job so I said 'no' it wasn't fair to the community to do that. It would have been too much pressure, we covered a huge area, and so I enjoyed my time doing that - I loved it. I was very involved in the committee [Plunket] as well…. Great time and then I resigned from Plunket and the following week saw the job for District Nursing at the time, and went for the casual position in Otorohanga, and then went on to one day a week as well as casual so I used to work two to three days a week. Then I transferred up here, after about 18 months because my husband moved up here. That was quite different because in those days they only had casual district nurses, no part-time district nurses.

That changed around 14 years ago, when part-time district nurses were employed.

Missy had a career break when her children were small:

> I have got a big family, I've got six children and since 1963 when I started my training at Palmerston North Hospital and I had seven years where I have not worked in full time or part time as a nurse. It was a juggle but I was very fortunate really in my career because I would be in places where I could see a need. And I would say I was available, would you like me to move into that area.? I got good hours because of that I was able to mainly work for a few years between 9 and 3pm. I had five school aged children at that time and I would be able to drop them and pick them up - so I was there [for them]. I have been very fortunate.

Intergenerational connectedness and how this was achieved is a sub-theme of the social roles of working women. The care of older parents was a dominant theme as was the continuing parental role throughout the research participant's working lives.

Missy has concerns about her elderly frail mother and explains her continuing role in caring for her parent:

> (p.4,5) My mum is 91. I have her quite a bit of the time. [Her care] has changed in the last 12 months, like you have to be there when she showers, she is 91. She is independently mobile, but she does have CORD [Chronic Obstructive Pulmonary Disease] and her immune system is totally depleted and so you have only to go have someone sneeze around her and she'll get pneumonia. It is quite a big undertaking, so when she's with me I have to get someone to be with her when I go to work. She has her own little unit [in Palmerston North] and we have had the same boarder in there for eight years. So she has somebody in there with her at night….it is just this year that's been a bit of a struggle for her, and she's usually with me. But I had major surgery in January so she didn't quite get here before she got her first bout of pneumonia. We can't get her up here, she is just too frail so I haven't quite worked out what we are going to do yet. I want her to come up here because I have got everything organised here.

Missy's large family are geographically widespread, living in both New Zealand and overseas, and social contact with her adult children is important:

Well we have got our eldest son Michael in Kuwait with his lovely wife and their son of eight years. I have a daughter who was in England and now in South Africa for four years and she has two daughters and one son. I have another daughter who was in England who has moved back here with her English husband so I have got one here in Hamilton. I am just hoping they'll stay close because our kids are all over the place - a daughter in Wellington with four little boys and she is a twin and she has got twin boys. A daughter in Tauranga, with three lovely boys - so I have a busy life. I tend to arrange my duties so I get time with my New Zealand grandchildren. (p.12) I do take regular breaks from work. I think that as you get older that it's important to regulate the holidays and with a big family our holidays are basically travelling to see the kids.

The care of an elderly mother-in-law while working also featured in Kath's

life:

(p.6) My mother-in-law lived at home until three days before she died. She lived in her own home with three times a day caregivers until she was just on 89, and I shared the burden with my sister-in-law who lived just round the road from my mother-in-law.   She did a major part of the care-giving, and funny how the roles work out when you have got an intense situation like that - I was the one that my mother-in-law talked to about the way things were in her life, about any grumbles that she had; I received the grumbles. Any decisions about her ongoing care when she started thinking about will I stay here she talked to me about. Because it developed into a situation with her daughter where it was quite a fracas, as often it is between a parent and child. And so I had a different role. I did quite a bit of transporting to the doctor; going over in the middle of the night when she had a fall. St Johns would ring us up and say we can't get hold of your sister-in-law, mother's obviously on the floor. It was us that picked her up when she fractured her neck of femur in the kitchen. Yes, and when she got to the extremes she'd dirty her bed and that was the worse thing for her. She would sometimes ring us up and say Kath can you come and help me. So we would get those phone calls in the middle of the night and clean her up and put her back to bed. But she was staunch about not going into care. So we, despite the fact that we had spoken about it, that was her wish, so we abided by that wish until it got to the point that she knew that she couldn't be by herself any more and then she chose, because she was dying, she chose to go into a rest home, and her last 3 days were in care.

Ros and her daughter provided care for an elderly parent who had been injured in a road accident. This hands-on assistance was worked around part-time employment:

> (p.5) I haven't had to have any [work] breaks for [elderly parent] even when my mother was hit on a pedestrian crossing. So when she came out of hospital, I went over there and looked after her and then my daughter looked after her until then she got care [coming] to her home. I did the showering [of her mother] and the cooking. I did this on my days off and then my daughter took over.

Bette provided care and support for four parents:

> (p.7, 8) I cared for four parents. I handled this on my own - particularly any in-laws who were here I Hamilton. My father-in-law died of cancer - his death was quick, in only about 8 months. And then my mother-in-law had a stroke. Nine years before, she had cancer. She stayed in her own home; a nightmare but she was lovely. It was like, that, she was so determined, she did your heart good. [She] struggled on because she had dressing apraxia and I would go round and check on her and get her clothes on properly; she had them on all back to front. And so she did really, well, we were really involved with her, very involved. We took her home to live with us, oh, for about a week, but she kept getting lost. Then she'd fall down the stairs and things.

Bette's own parents were in Nelson:

> I have a brother down there and I spent a lot of time down there with my Dad. He died of cancer two - three years ago; my Mum just died last October. She was a hard case little Irish lady - she lived with my sister for years, so I was back and forward on my overseas trips [across Cook Strait!] - stayed six weeks at one stage.

Bette's own adult children are healthy and independent. Grandchildren are important to Bette:

> (p.10) We probably do quite a bit with them. Sometimes, I'd like to see them more but that's because I'm working full time, I can't. And when they lived in Hamilton, it was great - they were only out five minutes - not very far - Whatawhata.

Pat's father lived some distance away in Marton.

> (p.4,5)…. and if he had an appointment at Wanganui [Hospital] he did expect you to go down there and take him. If you could possibly do it you did, because he didn't actually ask for much. Pretty independent, so if he actually asked you if you could do it, you really felt that he needed you.

Terry assisted with the care of an elderly parent-in-law:

> (p.4)….we looked after Richard's mother, until she went into K…… She had Alzheimer's. So between her daughter and I we looked after her for about three years.

Terry cares for her grandchild part-time when her daughter returned to

teaching:

> I look after my part grandson part-time now that my daughter has gone back to work. I have him a couple of days a week.

Margaret assisted with the care of elderly parent and a son prior to

returning to work: The experience of assisting her elderly parents-in-law

were the catalyst for returning to work:

> (p7) yes, elderly parents, and then my mother and I have a son who had ME for six to seven years. He was sick when I went back [to nursing] so that actually was an experience of looking after chronic ill health. ….. He's got a PhD now - He's not physically as well as he would like to be. But, yeah, he's got a PhD and a good job.

Margaret comments on her social role as a grandparent

> (p8) Grandchildren come when I'm not working. I'm called nana, work nana. Beach nana and work nana. Says it all doesn't it. It has it's down side. ….. the other one [grandmother] is beach nana. Yes, she doesn't work, she's beach nana because when she comes over they go to the beach.

4 Work and the ageing body

The experience of work and the ageing body was the third major theme

identified from data generated from the in-depth interviews. The sub

themes identified in this section are health and health maintenance and the work/life/leisure balance. The affects of ageing and paid employment is discussed in this section by the research participants. The research respondents described a medley of conditions affecting their ageing bodies. With appropriate medical care, supportive technology and a belief in remaining physically active, they didn't see that their existing health issues were disabling or cause for an unwanted exit from the nursing workforce. Sensory changes, especially in visual acuity, were the most commonly noted effect of body ageing. These changes were corrected with prescribed glasses, but depending on ambient lighting had to be used in conjunction with a hand-held magnifying glass to see tiny suturing. Judy (p9) made the observation that with the ageing of the contemporary workforce little recognition is given to problems with visual acuity for older nurses. This point was illustrated by stating that the New Zealand nursing magazine had more recently been printed on glossy paper with smaller print, making it harder to read. New patient chart stickers are now printed in a smaller font and the labelling on ampoules is too small for accurate reading.

Part-time work was chosen by some of the research respondents so that they could effectively cope with both an ageing body and work. Missy explains how she copes with working five days a fortnight:

(p10) I feel that I have got it pretty sweet really doing five days a fortnight. I'll do more if its required but I am quite happy with what I do. When I do 5 days, like I am just onto my fourth now, and sometimes I still do five or six days together, I am really ready for a break by the time I reach day six. Yes, I could push it to seven which we often do. The full timers do seven days straight sometimes. If they do a week-end they start on a Saturday and they finish the following Friday. And I think I could do that, but I do find I am a bit tired the next day. But it is like everything you have to pace yourself. When I am working I definitely go to bed earlier at night.

Musculoskeletal injury has been common in the nursing workforce. In ameliorating these effects on back and shoulder injuries, patient hoists and devices like "slippery sams" are used for turning patients in their beds. The use of these devices is accompanied by regular on-site training. The weight of District nursing bags is restricted to 15kg to prevent musculoskeletal strain to the neck and shoulders. Body positioning when tending to patients was commented on by respondents in preventing back strain and injury. Margaret explains how to limit damage to an ageing body in environments where there are not ideal working conditions:

(p14) I haven't got any damage to knees or hips or anything. I can get up and down, I do most of my work on my knees. Your back would never survive if you didn't. Going to people's homes where they are sitting in a chair or lying on a sofa – that's low. If you are going to lean over, you may as well give up nursing because your back just won't take it, and yeah, your hands go like this as you get older [shakey if the body is not well stabilised]. So you're stable on your feet, stable on your knees. And patients quite like it, right, because you stand in a position of, sort of, they being in control [the nurse is at a lower level than the patient]. At the rooms [Community Services office] we've got a high bed, a high plinth and you can do work standing up. But I think if you don't kneel, you're in trouble. And if you are bandaging people's legs –you've got to do half a dozen of those a day [that would be a strain on the back].

An elevated blood pressure is often an accompaniment to an ageing body.

Four of the research respondents managed their elevated blood pressures

with regular medical monitoring and medication. Margaret talked about

controlling her blood pressure (through biofeedback principles):

> (p13) I became aware earlier on in life that I can control my blood
> pressure by the way I react to different things. I could feel it coming
> up…so I learnt that when something happens, things come at you,
> to actually think about what's happening, don't react to it. You can
> act later when it's past. So I actually have a very calm way of
> looking at facts, no matter what's happening; it's calm while I am
> looking at it, but I panic later…but by then its too late. – so that's
> actually helped with the stressors.

Health maintenance or wellbeing were significant factors in the lives of

these older nurses. Long working lives and experience in the managing of

stress feature in their comments. Kath explains her history and current

modes of coping:

> (p11)Well managing stress is a good one to talk about because
> having a period of three or four years, maybe longer, it was
> extremely stressful to the point of causing me to have a breakdown.
> I've learnt now that if I am feeling pushed I take time out and that is
> how it is because there is no way that I ever want to go back being
> that gibbering wreck. So now I look after me and so I take time out.
> I read, in fact my husband and I are having a four day weekend
> fairly shortly in Turangi. And just relax in the hot pools and maybe
> have lunch up at the Chateau and just literally chill out because it
> will be winter.

Margaret works on her health and wellbeing by taking care of her weight

and getting plenty of exercise:

> I watch my weight. The weight is a big issue…I find that getting the
> exercise into every day is difficult. With exercise the brain is clear
> and good. I have a huge hill behind my house. And I have to keep
> fit enough to climb up that hill at 8 o'clock on a Saturday morning, if
> I have been on-call through the night, to turn the phone over to the
> nurse who is on for the weekend [there is no mobile phone
> reception from the house]. So you have to keep fit to walk up that
> hill. Unless you are practising, you can't get up that hill. Otherwise

you have got to get in the car and traipse back to work and take the phone back and turn it over. So that actually keeps me quite fit and I do this several times up and down the hill on the day off or the weekend. The country garden provides exercise as well as collecting the mail. Walking to the letterbox is good exercise because there is a steep hill on the way back. And I mow the lawn. It's a killer of a lawn. [It takes] about an hour [to mow] but it's very steep.

Wellbeing was also maintained by the research respondents with regular walking, floor exercises, riding motorbikes, training for sheepdog trials, jogging, playing tennis and squash, cycling to work and yoga. Aspects of preventative health were commented on including regular mammography screening, 'flu vaccination and cervical smears. Tiredness and its impact was frequently commented on as posing limitations on an ageing body. This was offset by working part-time, retiring to bed earlier and having a balance of activities in life. Kath comments on having this balance in her life;

(p11,12) My favourite recreations are first of all gardening, and because we now have a new house, garden planning and all that sort of thing in the process. And its balancing the finances and the next stage of the project. That occupies quite a lot of time with magazines and gardening books, planning, seeing something else, changing plans. I find that really quite pleasurable. I have an older sister who is very knowledgeable around plants, gardening and all things horticultural. Another of my pleasures is going to visit my three sisters who all live in the same township [Ruakaka]…going up there and visiting with them and having dinner is a real pleasure. I fish from a boat, my husband doesn't enjoy it much, he'd much rather look after the boat while everybody else fishes. I do want to fly fish, I have inherited my brother-in-laws rods and some beautiful flies, probably very expensive …I even inherited the waders.

Joan posits that psychological wellbeing is also maintained not only through physical exercise but with a balance of work and leisure activities:

(p13) I have a big garden and I like recreational activities. I enjoy my garden and it is very important to keep up with my friends and touch base with them and love going out for coffee. You have to

have a balance in your life to cope. You talk about stress and recreation – I am quite involved in our church and I play the organ there. And I go to Toastmasters once a week – a morning meeting 7:30 – 8:30 and I do that on my day off.

5. Ethics of care in nursing

The fifth major theme to emerge from the analysis of the in-depth

interviews was the ethic of care in nursing. A relational ethic of care has

an ethos in empathy, connectedness, reciprocity and emotional feelings.

This contrasts with the rational, objective and detailed tradition of

biomedical ethics with its Cartesian inheritance of the separated mind and

body. This was something of a surprise finding as I was concerned with

the more pragmatic notions of the embodied experiences of older women

participating in the work-force. This theme, the caring ethic in nursing, is

explored with data generated from the in-depth interviews. Margaret

struggles with a business case model and the nursing ethic of care:

> (p.9) If you see the needs of the patient. I tend to see the needs of the patient. The needs of the patient and how they are going to fit with the current mode of delivery of care rather than saying that one doesn't fit any more [as defined in a service delivery business model of care].

Kerry reflects on her journey towards understanding and moral comportment:

> (p.9) [I] listen to what they want more, pain control is better, and I think, you know, I can always go back to the very incident when I was in Canada, a young woman was dying. She had two children and she said 'Nobody wants to talk about what I want to talk about". The nurses come in and they just talk about the weather or what they are doing. I want to talk about my children and what's going to happen to them and, she says, nobody wants to face the issue that I am dying and talk to me about it. And it really hit me then and I've sort of turned around then and thought we really need to talk about it [dying] (p.2). There wasn't all that much out there, of course there was Dr Kubler Ross, you know, but there wasn't all that much out there until the last ten years really. Until the hospice came in and their palliative care programmes and they have got the training for

nurses in that. There wasn't all that much out there. You did your own thing, you tried to listen to them [patient].

Pat discusses a vulnerable older group of patients and how her engaged

knowledge relates to their everyday concerns:

> (p.2) Well probably the people that come in [rest home] are perhaps different than they used to be. They're probably on the whole more dependent…. And they probably require more care but I think they are looked after a lot better. That they have diversional therapy and they make sure that other people are involved in doing things - this idea is that they [patients] can maintain their independence.
>
> (p.6)… I think they appreciate that you do often have more understanding of what their needs are [as an older nurse]. Little small problems as they get older. You can sort of relate to them and they relate to you.
>
> (p.13)…one thing I do enjoy is the interaction with some patients, you do actually find out what wonderful lives some of them have lived. One lady was a Fulbright Scholar….she got married but it didn't work out and then she had this one son and she carted him all around America, went places where women never wore slacks until she got there and, yes, in her time it must have been quite innovative.

Judy acknowledges the exigencies of vulnerability and deprivation of well-

being for her clients at the end stages of life

:
> (p.7)….palliative care is an area of work where, the patients that we get do not have a cure for the condition they have and they come to us when there's no further treatment or surgery or other treatment that will cure their disease and so we look after them and the main thing is from the medical point of view that we treat the symptoms that occur as a result of the disease. We don't treat the disease, and our aim is to ensure that they are kept comfortable and that quality of life is maintained for as long as possible. Knowing the disease is still there and unaltered by any treatment and to ensure that the patients have the care and support in, wherever they are going to be cared for….
>
> (p. 7)….and it's very satisfying to me, perhaps, I know that we're not going, people are not going to get well….when we first see them they may have problems with a lot of pain and it is very satisfying to actually see them change and those symptoms relieved so they can

actually enjoy part of their life… or enjoy life as much as they can… with the time that they have left.

Joan expresses empathy and connectedness with patients in her role as a

District Nurse:

> (p.13,14) I like being involved in other people's lives and like to be able to assist and I like to make a difference and help them and assist wellbeing by offering health education. For example, with wound care you talk about diet, exercise, rest - you look at them [patients] holistically.

Bette proffers a sense of reciprocity and skilled know-how developed

through her District nursing role:

> (p.18) I think because nursing is sort of something that you give of yourself and you get a lot back, from your patients, you're mixing with all types of people, all ages and you learn from one another.

Ros describes empathetic understanding in alleviating the vulnerability of

older rest-home residents:

> (p.3)….Of course the big difference in nursing, means when it was long term case it was the basics, they [patients] used to sit in old geriatric chairs with a tray in front of them and there was no life really for them at all. But since it has changed, it's wonderful for them. The hospital has all been extended, they've got this huge lounge and they've got a better quality of life.

> (p.6) I just enjoy being with the elderly. They have got so much to offer, they are so interesting and I just do my best to keep them as happy and comfortable and brightened because I've got a weird sense of humour which they really appreciate. They actually feel safe - and that's why even people when people come in, they said it's just like coming into a home with people you know, and they know everybody and they just keep coming back. And they all stipulate when they do come in 'do not send us anywhere else'.

The next chapter will discuss these findings generated from the in-depth

interviews.

Chapter 6

DISCUSSION

In the previous chapter the findings from the research on the experiences of older women's participation in the workforce were discussed. The purpose of this research was to explore the socially constructed meaning of work with this group of ten registered nurses. The analysis revealed five main themes, supported by sub-themes. These themes are now discussed in relationship to the literature reviewed for this thesis.

The changing nature of work

This discussion of the findings begins with the theme of the changing nature of work and the sub-themes of re-aligning and expanding the work of nurses; the use of biomedical technology in community settings and the specialisation of nurses' roles. Aged care facilities are experiencing the admission of an older, frailer populace requiring more biomedical support. The registered nurses participating in the study spoke of the unsettling and challenging nature of the changes in their places. District Nursing, which previously had a simpler task of delivering nursing care in people's homes now had to focus of aspects of biomedical technology that were previously the domain of hospital wards. The learning in this new work environment was described as "huge". With an in-service education programme, encouragement and practice the initial apprehensions gave way to confidence and competence. This skill acquisition described by the study

participants parallels the Dreyfus model (Dreyfus, cited in Benner 1984:

13) who posits, that in

> The acquisition and development of a skill, a student passes through five levels of proficiency: novice, advanced beginner, competent, proficient and expert. These different levels reflect changes in three general aspects of skilled performance. One is a movement from reliance on abstract principles to the use of past concrete experience as paradigm. The second is a change in the learner's perception of the demand situation, in which the situation is seen less as a compilation of equally relevant bits, and more as a complete whole in which only certain parts are relevant. The third is a passage from detached observer to involved performer. The performer no longer stands outside the situation but is now engaged in the situation.

The infrequent exposure to biomedical technology, using the Dreyfus model, means that the acquisition of skills is more problematic and the nurse likely to remain a novice. These nurses had well developed insights into the well-being of their clients. Their use of experiential knowledge enabled these nurses to provide words "of comfort and activity through the care of the body, moving back the walls of isolation and suffering" (Benner 1989: 11). This knowledge also enables the recognition of irregularities in signs and patterns of illness, behaviour [and biomedical equipment] (Benner1989: 394). The development of specialised nursing roles, a sub-theme, identified by the research participants is best understood using the Dreyfus model of the expert nurse who is coach, mentor and educator for nurses with developing levels of skill and competence.

The meaning of work

The meaning of work is the second major theme revealed in the general inductive analysis of the data. The research participants verbalised the meaning of work in terms of providing structure in their daily lives. For

example "I would find it hard if I didn't work – what on earth am I going to do?". Victor asserts that the four functions of work are: "the provision of a wage, the regulation of time, the provision of social status and the provision of social relationships" (1994:231). The nurses in this study who lived alone stated that the income was important in providing for their households and superannuation contributions. This finding endorses Boston and Davey's (2006: 199) contention that with "increasing numbers of un-partnered people in mid-life mean many people may have to work longer to provide for their retirement". A sense of identity (Victor: 232) is attributed to continuing workforce participation. This identity was defined by research participants, not in the sense of social status, but rather in a socially constructed notion of the value their nursing contribution makes to society. A frequent comment of the nurses interviewed for this study related to the intellectual challenge of their workforce experience. This challenge included keeping pace with evolving biomedical treatment changes; new areas of research and having to extend their skill base and competency in a changing world. Phillipson (1998) comments on the need for continuing education and learning for older ages , adding to the quality of life in retirement. These registered nurses have not yet retired, unlike most of their fellow colleagues, but the point here is that on-going education in their employment has added to the quality of their work experience as well as a competency requirement for registration with the New Zealand Nursing Council.

The social contacts that working provided was a frequent response to ongoing workforce participation, and this is endorsed within the literature

(Victor, 2005: 231). I would suggest that the social contacts developed within the workplace are often extended into work organised social clubs, meals and other activities. Dendinger et al (2005: 21) comments on the generative reasons for continuing workforce participation and cite Mor-Barak's 1995 adoption of Erikson's developmental theory in which "in the later stages of life, humans have an inherent need to teach and pass on their knowledge about what they have mastered and accomplished throughout their lifetime, to younger generations". The passing on of technical know-how was commented on by research participants, especially to nursing students, health assistants and younger staff members. Self efficacy (Dendinger, 2005: 21) was given as a meaning for work by several research participants. One participant described her nursing work as something she could do.

The Robert Wood Johnson Foundation White Paper, "Wisdom at Work: the Importance of the Older and Experienced Nurse in the Workforce" in commenting on the key characteristics of Magnet Hospitals [health facilities that attract workers and retain nurses in an exemplary environment] stated that professional practice of nursing should include the promotion of professional autonomy and responsibility and emphasise teaching responsibilities of the staff. From the data generated by the in-depth interviews the ability to practice autonomously in community settings was commented on by the research respondents as well as the responsibility to manage and plan a daily work-load. The teaching aspect was integral to District Nursing and an enjoyed aspect of this work.

Ideas about retirement were elicited with the researcher asking what advice the respondents would give to a colleague considering retirement at age 50. Fifty years was chosen by the researcher as there is a noticeable increase in nurses and midwives exiting the workforce in the 50 – 54 age group. Most of the respondents chose to apply this question to their own situation. The reasons for staying in the workforce, that is, social, economic and structure for the day, influence the decision to retire. There was, indeed, an ambivalence about retirement which reflects Phillipson's suggestion that

> [a]gain, in relation to retirement as a whole, the scope of decision-making has been drastically widened. Increasingly, people are being called upon to build retirement around their own individual planning both in relation to finances and the timing and manner in which they leave the workforce. These questions indicate that old age has simultaneously become a major source of "risk" but also a potential source of "liberation" (1998:125).

Victor (2005: 230) makes the observation that previous academic work on retirement has presumed a male-oriented model of working and further comments that

> [g]iven the changing role of women within the labour market, this is clearly going to change in the future and can contribute to the development of a whole new female-based exploration of the meaning and experience of retirement.

Following this vein of thought where there is a dearth of literature, how did the research participants in this study socially construct retirement at 50? The responses were novel and practical, for example: "take a gap year, because it renews your interest and whether you spend that time travelling or just have time at home and do all those other things that you have

wanted to do. You may decide that you are not going to work five days a week, you may decide you want to work three. And if that works with your employer that's really good, because you are a valuable asset", "think of what area of nursing you would like to continue in and focus on that" (this respondent regretted not following her earlier dream into palliative care or oncology nursing)" And in a similar vein – "It's not too late to get another speciality in your nursing if you want to. You know you are not past it at 50!". "If you leave, don't close the door completely, because you might decide to come back. You can always change your mind – because good nurses are wanted".

The last sub-theme in the section on the meaning of work is concerned with the socially constructed meaning that the nurses have of themselves, their peer and patients/clients perceptions of an older nurse participating in the workforce. Comments from the respondents were around "experience", "maturity", "lot of knowledge". "I still feel that I contribute and enjoy my job caring for sick people"; "Being older, older patients appreciate that you have more understanding of what their needs actually are"; " I think as an older nurse that you are more experienced and more mature and more tolerant and when you have been doing it for a long time you get very experienced about summing up people". It is these very characteristics of knowledge and wisdom that older nurses contribute that forms the basis of the "Wisdom at Work" White Paper (Robert Wood Johnson Foundation, P.1). This White Paper discusses the vexed question of an "increasingly daunting crises resulting from the shortage of

nurses" in the American context. One promising strategy is the retention

of experienced nurses (p.1).

Work and the Ageing body

The third theme generated from the data analysis is that of work and the

ageing body. The sub-themes are health and health maintenance;

work/life/leisure balance. Biologically ageing is a normal process for all

living things affecting cells leading to changes in the musculoskeletal

system, blood pressure and sensory changes amongst other body

changes (Novak 1999:96). Sensory changes to vision, requiring

correction with glasses was the most common of these bodily changes for

this group of research participants. The twinges of arthritis in fingers and

shoulders were commented on.

Rowe and Khan argue on the emphasis of loss with ageing and further

comments:

> We believe that the role of ageing, per se in those losses have
> been overstated and that, a major component of many age-
> associated declines can be explained in terms of life style, habits,
> diet and an array of psychological factors extrinsic to the ageing
> process (1987:144).

This group of registered nurses participating in this study were physically

very active. For example one respondent biked to work, another had a

large, steep country garden, walking was a common activity, yoga was a

regular activity of another and Scottish country dancing the interest of

another. Comment was made on the regular mammogram screening and

another took care of her weight. As Rowe and Kahn suggest the

ameliorating effects of activity, diet and the psychosocial factors of working in an occupation that offered challenge, stimulation and variety are factors extrinsic to the slowing of the ageing process. Although elevated blood pressures were commented on by several research participants this was managed with medication and regular medical checks. Overall the expectation was that these nurses would continue to participate in the workforce because of "improved health and technological advances make it possible to extend work life beyond 65 (Robert Wood Johnson Foundation). Six of the respondents in this study worked part-time in their nursing roles which provided a balance between life/leisure and work. Leisure time was spent with family, community activities, recreation or travel. Crossnan comments (at the Managing the Ageing Workforce Conference, 2006):

> But from the age of 60, there is a much greater balance between work, family and leisure. As people reach their 60's (or earlier if they can afford) they are exercising more choice over their work patterns and their leisure. They start thinking about how to change their balance from work/life to work/leisure. The whole concept of retiring is changing.

The fourth theme identified in the data generated from the in-depth interviews relates to the social roles of women in an era of emancipatory politics. The sub-themes are how the participants re-entered the workforce and paid employment when children were young; the traditional roles of care-giving and workforce participation and intergenerational connectedness. The research participants experienced the second wave of feminism in the 1960's and 70's where exploitation and the traditional roles of women were deeply questioned. Giddens (1993: 213) gives a detached perspective on emancipatory politics:

> Emancipation means that collective life is organised in such a way that the individual is capable – in some sense or another – of free and independent action in the environments of her social life. Freedom and responsibility here stand in some kind of balance. The individual is liberated from constraints placed on her behaviour as a result of exploitative, unequal or oppressive conditions; but she is not thereby rendered free in any absolute sense. Freedom presumes acting responsibly in relation to others and recognising that collective obligations are involved.

Returning to the nursing workforce for the research respondents was a gradual process. There were limited group child care facilities outside of the family. Fathers provided the care for children on the weekends or evenings when their partners worked. Having the freedom to work outside of the home meant a collective responsibility for the care of children. Returning to work appeared to be mutually acceptable to both partners with one exception where working outside of the family home was considered irresponsible initially.

The sub-theme of intergenerational connectedness is, I would assert, an important one. Older women workers have been identified as providing social, emotional support and assistance with shopping, transport, laundry, gardening or household maintenance to their elderly parents (Hillcoat-Nalletamby & Dharmalingam, 2002: 3). What this research highlighted was the nursing care provided by the research participants to some of the elderly parents and parent-in-laws; this is beyond the notion of emotional support.

Ethic of care

The fifth major theme identified from the data was the ethic of care

demonstrated by the research participants. In a relational ethic of care

nurses acknowledge both the mind and physical body within the

experience of illness and disease. An ethic of care has an ethos in

empathy, connectedness, reciprocity and emotional feelings. Defining a

theory on the ethic of care has proved elusive but some of the elements of

a care ethic are defined as:

> The alleviation of vulnerability; the promotion of growth and health;
> the facilitation of comfort, dignity, or a good and peaceful death,
> mutual realisation; and the preservation and extension of human
> possibilities in a person, a community, a family, a tradition (Benner
> 1991:2).

Benner goes on to maintainsthat nurses build on their moral comportment

through experiential practice and through this develops "an embodied,

skilled know-how of relating to others in ways that are respectful and

support their concerns". Central to an ethic of care is the knowledge of a

patient, family or community and the exigencies of vulnerability and

deprivation. In this study an ethic of care was central to the participants'

nursing practice. This was demonstrated by sitting and listening to elderly

patients' stories and concerns; the struggle to find better ways of

connecting with a young dying women; and connecting emotionally when

a pain management regime has improved the quality of life for a patient.

In summary, this section has described the main themes and sub-themes

emerging from the data generated from the in-depth interviews and made

links to a body of literature. In the next section of this chapter the limitations of the study will be presented followed by recommendations emanating from the findings and some fruitful future areas of research.

Limitations of this study

This study was confined to experienced registered nurses working within the Waikato in a range of health care facilities. A limitation of the study was the small geographic area covered; what would be the embodied experiences of older nurses working in isolated rural communities and probably within a more generic nursing role? None of the research participants worked within a ward situation in a large tertiary hospital. The research participants were all of one ethnicity, that is, European New Zealanders . This may be a limitation of a snowball process used in this study to engage participants and/or a reflection of demographic characteristics.

Recommendations

Because New Zealand will be facing a nursing shortage and retention of nurses is problematic it is recommended:

- that the contribution of older workers be made more visible generally and in particular the contribution of experience and wisdom be more widely acknowledged by health care managers;
- that options be explored that would support the employment of older workers who are also caring for elderly relatives. This may be in the form of laundry assistance, in-home care or assistance during working hours.

Areas for future research

The questions for future research are:

Why do registered nurses leave the nursing workforce in increasing

numbers in their 50's and in subsequent age groups?

With the knowledge of increasing workforce participation of older women

in other work places, what would encourage experienced nurses to stay in

the health sector?

How widespread is intergenerational nursing care by working nurses?

The findings could support policy development as has been done with

maternity leave, but in this instance would be for elder care. Elder care by

and within families is likely to become more common as the demography

is structured towards an older populace.

Concluding statement

Growing older for these nurses did not mean seeking less onerous nursing

work. Instead they enjoyed the challenge of roles where increased

technical knowledge was required. Nurses working in the community had

a sense of autonomy and independence in their practice. They were able

to plan their work day and deliver care for their patients free of hospital

ward nursing and medical hierarchies. Expressed relationships with the

medical fraternity were more collegial and supportive of community based

nurses. The experienced mature nurse in a sense is re-writing the roles of

older nurses in the workforce albeit outside the confines of hospital wards.

This research has given me an opportunity to discuss with similar aged

nursing colleagues their socially constructed meanings and

understandings of workforce participation as they have become older. To

retain this knowledge, wisdom and expertise of older nurses in the

workplace is the challenge for future workforce planning when staff

retention in an older age group is problematic.

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Appendices

Appendix 1

THE UNIVERSITY OF
WAIKATO
Te Whare Wānanga o Waikato

Marjorie Squire
Dr Judith Macdonald

23 April 2007

Dear Marjorie

Application for Ethical Approval: ANTH593, **Embodied Experience of Older Women in the Workforce**

Thank you for submitting your revised Consent Form. As it complies with the requirements set out in my letter of 18 April, I am now able to confirm formal ethical approval for your research.

With best wishes,

John Paterson
Chair
FASS Human Research Ethics Committee

Appendix 2

Information Sheet

Faculty of Arts and Social Sciences
University of Waikato
Private Bag 3105, Hamiton.

A qualitative study of "The Embodied experience of older women participating in the workforce"

Researcher	Marjorie Squire		
Contact phone	Day	(07) 838 3565 Ext. 2113	
	Evening	(07) 889 5070	
Supervisor	Dr. Judith Macdonald		
	Phone	(07) 856 2889, Ext 8282	

Date…

Dear……,

Thank you for considering participating in an in-depth interview which forms part of the academic requirements for a Masters of Social Sciences thesis in which I am currently enrolled at the University of Waikato.

The aim of this interview is to collect information from you on the experience of being an older Registered Nurse participating in the workforce.
This topic of workforce participation will explore the experiences, motivation and perceptions that you have as an older nurse currently working, either part-time or full-time, in a Waikato healthcare setting. The research will involve an in-depth interview of about an hour at a time and place that is suitable to you.

A copy of the questions I would like to cover will be given to you prior to the interview so that you have the opportunity to think about them beforehand.
This in-depth interview will be tape recorded and later transcribed by me. The interview tape and transcription will be kept in confidence and accessed only by myself (as the researcher) and my University supervisor.

Your anonymity will be protected by using a pseudonym instead of your name. You are free to refuse to answer any questions or to withdraw from this interview at any time. I will offer you the tape recording and interview transcript after the thesis has been assessed or you may prefer that I destroy these six months later. The findings of this in-depth interview will be used for a Masters of Social Science thesis.

This interview has been given ethical approval by the human Research Ethics Committee, University of Waikato.

A consent form needs to be signed agreeing to your participation in this in-depth interview. I will discuss what is required and ensure you understand what your involvement means prior to signing the consent form. If you have any queries or require further clarification regarding any aspect of this research, please contact me on (07) 889 5070 in the evenings.

Yours sincerely,

Marjorie Squire,
Masters of Social Science candidate,
University of Waikato.

Appendix 3

Department of Societies and Cultures
Faculty of Arts and Social Sciences
University of Waikato
Private Bag 3105, Hamiton.

A qualitative study of "The Embodied Experience of Older Women Participating in the Workforce".

Masters of Social Science student	Marjorie Squire
Contact Phone	Day: (07) 838 3565, Evening: (07) 889 5070
University of Waikato Supervisor	Dr. Judith Macdonald
Contact Phone	(07) 856 2889, Ext. 8282

CONSENT FORM

1. I am undertaking an in-depth interview as part of the academic requirements for Anth 593-07C, a Masters of Social Science thesis, at the University of Waikato. The aim of this research is to gain an understanding of your experiences as an older New Zealand Registered nurse participating in the Waikato health care workforce, either full-time or part-time.

2. I would like to interview you about your experiences of workforce participation as an older New Zealand Registered Nurse.

3. I would like to tape record the interview for later transcription. I will produce a verbatim (word for word) transcript of the interview, which I will show you. You may add to the transcript or remove parts from this if you wish. My University supervisor will have access to the edited transcript, but no one else will be able to see it.

4. When I am not using the tape recording and transcript they will be kept in a locked file in my study at home. You may choose to have your tape recording and transcript returned to you after the thesis is completed and assessed. Otherwise I will destroy them six months later.

5. During this in-depth interview, you have the following rights:

a) To refuse to answer any particular question and to terminate the interview at any time.

b) To ask any further questions about the interview or thesis that occurs to you, either during the interview or at any other time.
c) To provide information on the understanding that it is confidential to the interviewer and University supervisor.
d) To remain anonymous – anything that might identify you will not be included in the research thesis.
e) To read and add to the transcript of the interview and to indicate any part of it that you do not wish to be used. You may withdraw your consent and be given all material relating to you, at any time until you have approved your transcript.
f) To discuss further the conditions of your consent at any stage.
g) To receive a copy of the thesis.
h) To make any complaints you have about the interview or the research for this Masters of Social Science thesis to Dr. Judith Macdonald, (07) 856 2889, Ext. 8282 and to the Human Research Ethics Committee of the Faculty of Arts and Social Sciences, University of Waikato, Private bag 3105, Hamilton 3240.

This interview has been given ethical approval from the Human Research Ethics Committee, University of Waikato.

I wish to have my tape recording and transcript returned to me at the completion and assessment of the researcher's Masters of Social Science thesis.

The researcher seeks your permission to publish this research in the future.

I consent to be interviewed for this research on the above conditions.

Signed: research participant ---Date----------

Signed: researcher ---Date----------

Appendix 4

Interview guide

Biographical information:
Respondent's name…………………..pseudonym
Marital status……….   Ethnicity……….. Age band (60-64) (65-70)
Main earner/supplementary income….   How long been a RN?

Interview questions
What practice area do you work in?   Has this changed as you have become older?
What training have you done in the past few years?
Did you have a career break for children? Or the care of other family members?
Do you currently care for others- elderly parent, grandchildren, husband/partner with health problems?   What does this involve?

What has been your experience as an older person participating in the workforce? Any experience you would like to relate with regard to peers/colleagues or clients/patients?

What are the motivations that keep you in the nursing workforce?
 How do you manage your own health issues? Eg stress, recreation, other activities; existing medical and physical conditions? Does an ageing body pose any limitations on your work? What advice would you give to a nursing colleague considering retirement at 50 years of age?

Reminders to assist the interview
Prompts: a nod, smile, hmm, "oh really", "go on", "I see", "and then"
Repeat the `question. Repeat last few words spoken by the interviewee.
Remain silent….count to ten. "anything more you want to say about…?"
Probes: "What do you mean…", "Tell me more about?", "Why?", "Can you give me an example?", "How do you feel about…?".
Checks : "So, if I understand you correctly…", "So, what this means, then, is that..?", "You mean..?", "You are?".